PLAN DOCUMENT AND

SUMMARY PLAN DESCRIPTION

Niagara Bottling, LLC
Employee Welfare Benefit Plan

Niagara Bottling, LLC
Flexible Benefits Plan

Restated Effective January 1, 2024

This document, together with the Component Program Documents referenced in the appendices, constitute the Plan Document and Summary Plan Description required by ERISA §402.

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Introduction

Overview

The Niagara Bottling, LLC Employee Welfare Benefit Plan and Niagara Bottling, LLC Flexible Benefits Plan (the "Plan") is an employer-sponsored health and welfare employee benefit plan. The purpose of the Plan is to provide Participants and Beneficiaries certain health and welfare benefits described herein. This Plan is intended to meet all applicable requirements of the Code and ERISA, as well as rulings and regulations issued or promulgated thereunder. Nothing in this Plan shall be construed as requiring compliance with Code or ERISA provisions to the extent not otherwise applicable.

A detailed list of benefit types provided under the Plan, along with contact information and more information about how to access Component Program Documents describing these benefits, can be found at Appendix A. Unless otherwise noted in Appendix A, the benefits under the Plan are governed under ERISA.

The terms and conditions of the Plan are set forth in this document ("Wrap Document") and the Component Program Documents related to the benefits under the Plan. Together, the Wrap Document and the Component Program Documents constitute the written instrument under which the Plan is established and maintained (i.e., Plan Document) for purposes of ERISA section 402(a) and the Summary Plan Description. An amendment to one of these documents constitutes an amendment to the Plan.

This Wrap Document should be read in connection with the applicable Component Program Documents provided by the Employer or the Insurers or Claims Administrators listed at Appendix A. Unless otherwise noted regarding insured benefits, if there is a conflict between a specific provision under this Wrap Document and a Component Program Document, this Wrap Document controls. If this Wrap Document is silent, then the applicable Component Program Document controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or Insurance Policy/Evidence of Coverage control when describing specific benefits that are covered or insurance-related terms. See Appendix A to determine whether a particular benefit is self-funded by the Employer or fully insured by the Insurer. Notwithstanding anything to the contrary, this Wrap Document shall control for purposes of determining which persons are eligible to participate in the Plan.

Neither this Wrap Document, nor any of the benefits described herein, is to be considered an employment contract or a limit on the Employer's right to terminate the employment of any Employee. Further, nothing contained herein shall operate or be construed to give any person any legal or equitable right against the Employer, except as expressly provided herein or as required by law. Niagara Bottling, LLC reserves the right to change, amend, suspend, or terminate any or all of the benefits under the Plan, in whole or in part, at any time for any reason at its sole discretion.

Niagara Bottling, LLC (referred to as the "Employer" in this document) offers you a variety of benefit options to protect your health, your way of life, and your family.

When selecting which benefits to offer, your Employer considers the following key objectives:

Providing a variety of benefits and choices for Niagara team members and their eligible family members;

Choosing programs that provide access to quality care; and

Offering plans that meet the needs of the majority of employees.

Employer maintains the **Niagara Bottling, LLC Employee Welfare Benefit Plan and Niagara Bottling, LLC Flexible Benefits Plan ("**the Plan") for the exclusive benefit of its Eligible Employees **and spouses or domestic partners and dependents of those Eligible Employees.** The Plan provides benefits through the following component benefit programs:

- **Medical**
- **Dental**
- **Vision**
- **Life & AD&D**
- **Short Term Disability Benefits**
- **Long Term Disability Benefits**
- **Section 125 Cafeteria Plan (premium conversion)**
- **Healthcare Flexible Spending Account**
- **Health Savings Account**
- **Voluntary Benefits** (Legal Shield, Identity Theft, Pet Discount Plans, Accident Plan, Critical Illness)
- **Employee Assistance Program**

Some of these component benefit programs require you to make an annual election to enroll for coverage. The details of such annual elections are described under the heading "Eligibility and Enrollment" beginning on page 14.

Each of these component benefit programs is described in a contract or certificate of coverage issued by an insurance company, or another governing document prepared by the Employer (referred to herein as the Component Program Documents). A copy of each contract, or other governing document is incorporated by reference into this document as listed in Appendix A at the end of this document.

Plan Contact Information

Questions about this Plan can be directed to the Plan Administrator listed in the Administrative Information section or the applicable Insurer or Claims Administrator listed at Appendix A.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, Federal law gives you more choices about your prescription drug coverage. Please see the notice regarding Medicare and prescription drug coverage in Article 11 for more details.

Administrative Information

Plan Name & Number	**Niagara Bottling, LLC Employee Welfare Benefit Plan** Plan Number 503
Plan Sponsor	Niagara Bottling, LLC 1440 Bridgegate Drive Diamond Bar, CA 91765 (909) 230-5000
Employer Identification Number	33-0843510
Plan Administrator & Agent for Service of Legal Process	Niagara Bottling, LLC 1440 Bridgegate Drive Diamond Bar, CA 91765
Plan Year	January 1 – December 31
Plan Type	Welfare benefit plan providing the following health and welfare benefits: medical, dental, vision, life and AD&D, short term disability, long term disability, healthcare flexible spending account, health savings account, and employee assistance program.
Administration & Funding	Administered according to the Component Program Documents. Self-funded benefits are administered by the third-party Claims Administrators listed at Appendix A, which may include insurance companies. In those cases where an insurance company has been hired to administer a self-insured plan, the insurance company does not insure or guarantee the benefits that it administers. Insured benefits are administered by the Insurers listed at Appendix A. Fully insured benefits will be paid out of the Insurance Polices listed at Appendix A. Contributions will be paid out of Niagara's general assets and through employee contributions, in the amounts determined by the Employer in its discretion. The Employer may maintain a stop-loss or reinsurance policy to protect the Employer against catastrophic loss under the comprehensive medical benefit program offered under this Plan. However, the stop-loss insurance merely reimburses the Employer for benefits it funds under the program, and it is not to be construed as "insuring" the comprehensive medical benefits under the program.
Source of Contributions	Employer and Employee Contributions

Glossary

ACA	The Patient Protection and Affordable Care Act.
Benefits Booklet or Benefits Summary	The benefits booklets or summaries of benefits provided by the Claims Administrators listed at Appendix A that describe the benefits that are self-funded by Niagara Bottling, LLC.
Claims Administrator	A third party that makes claims determinations with respect to self-funded benefits under the Plan pursuant to a contractual arrangement with the Employer. These third-party administrators do not insure any benefits under the Plan. Appendix A lists the Claims Administrators and which benefits are self-funded by the Employer.
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which provides continuation coverage for certain benefits when an Eligible Employee or Eligible Dependent has experienced a loss of coverage due to a qualifying event.
Code	The Internal Revenue Code of 1986, as amended.
Dependent Child	A dependent child of the Eligible Employee who is: a natural child; an adopted child or a child placed for adoption; a stepchild; a foster child; or a child for whom an Eligible Employee has legal custody or legal guardianship. In addition, a Dependent Child must be under the age of 26. Note: In New York, your Dependent Child may be eligible to purchase his or her own individual medical coverage under the group policy through age 29 by paying the full cost of coverage, if the Dependent Child: Is under the age of 30; Is not married; Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured; Lives, works, or resides in New York State; and Is not covered by Medicare. A Dependent Child also includes a child of any age, if the child is mentally or physically incapable of self-support, provided the child was designated as permanently disabled by the Social Security Administration prior to age 19.

Domestic Partner	A domestic partner within the meaning of the Insurance Policies/Evidence of Coverage. [Note: This will require that you attest to domestic partner status or demonstrate that you otherwise meet certain criteria intended to show financial interdependence sufficient to indicate partnership status. Please also note that even if your partner qualifies as a domestic partner under the relevant Insurance Policies/Evidence of Coverage, in certain instances the coverage for your domestic partner/domestic partner's children may result in additional tax liability to you by reason of federal law.]
Eligible Dependent	A person who is a Spouse, Domestic Partner, or a Dependent Child of an Eligible Employee or covered Domestic Partner
Eligible Employee	Any Employee on the Employer's W-2 payroll who meets the eligibility requirements described in the "Eligibility" Section of this document.
Employee	Any common-law employee of Employer, living within the United States or its territories.
Employer	Niagara Bottling, LLC
ERISA	The Employee Retirement Income Security Act of 1974, as amended from time to time.
FMLA	The Family and Medical Leave Act of 1993, as amended.
Full-Time Employee	An Employee who is not a Seasonal Employee, who works at least 30 hours per week and is either designated as a Full-Time Employee or is determined to be a Full-Time Employee under the look-back measurement method. An Employee will be designated as a Full-Time Employee if he/she is reasonably expected to work at least 30 hours per week at his/her start date.
HIPAA	The Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
Insurance Policy	The policies provided by the Insurers listed at Appendix A that describe the fully insured benefits under the Plan. The terms of the Insurance Policies are described in an Evidence of Coverage or Certificate.
Insurer	The insurance companies listed at Appendix A that the Employer has contracted with to provide insurance coverage. Insurers process your claims with respect to the Plan's fully insured benefits. These benefits are paid by the Insurer under the terms of the Insurance Policy.
Intern	A temporary employee who works for a predetermined, period of time, is designated as an Intern, and has not been determined to be a full-time, regular Employee under the look-back measurement method.
Internal Revenue Code or Code	The Internal Revenue Code, as amended from time to time.

NMHPA	The Newborns' and Mothers' Health Protection Act of 1996, as amended.
Open Enrollment	The annual enrollment opportunity designated by the Plan Administrator.
Part-Time Employee	An Employee who works fewer than 30 hours per week and is designated as a Part-Time Employee.
Participant	An individual who has satisfied the Plan's eligibility requirements and has elected to participate or has been automatically enrolled in a component benefit program under the Plan.
Plan	Niagara Bottling, LLC Employee Welfare Benefit Plan
Plan Administrator	The administrator of the Plan, within the meaning of Section 3(16)(A) of ERISA. The Plan Administrator shall be Niagara Bottling, LLC
Plan Document	This Wrap Document, and the Component Program Documents, together constitute the plan document for purposes of ERISA.
Plan Year	The twelve-month period beginning on January 1 and ending on December 31.
Qualified Medical Child Support Order (QMCSO)	A final court or administrative order requiring an Eligible Employee to provide health care coverage for a Dependent Child, usually following a divorce or child custody proceeding, as defined in section 609(a)(2)(A) of ERISA.
Seasonal Employee	An Employee who is hired into a position for which the customary annual employment is six months or less.
Spouse	An individual who is lawfully married to an Eligible Employee and who is not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following is true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.
Summary Plan Description (SPD)	This Wrap Document, and the Component Program Documents, together constitute the Summary Plan Description for purposes of ERISA.
Variable Hour Employee	An Employee whose hours are variable or uncertain so that the Employer cannot determine whether the Employee is reasonably expected to work on average at least 30 hours per week at the Employee's start date and the Employee has not been determined to be a Full-Time Employee under the look-back measurement method.
Component Program Documents	Any and all Insurance Policies and certificates of insurance or other documents that set forth the terms and conditions of an insured benefit under this Plan, and any and all Benefits Booklets or Benefits Summaries for self-insured benefits. The list of current Component Program Documents is included in Appendix C.
WHCRA	The Women's Health and Cancer Rights Act of 1998, as amended.

Article 1
Eligibility and Enrollment

Your Eligibility – Core Benefits Plan

If you are an Eligible Employee, you may elect to participate in one or more of the component benefit programs that are part of the Plan, in accordance with the terms of the applicable component benefit program(s).

To be an Eligible Employee, you must be regularly scheduled to work at least 30 hours per week.

Your Eligibility – Limited Benefits Plan

Part Time, Seasonal Employees, and Interns are eligible for a limited benefits package that includes Cigna HSA, Delta Low, VSP Low, HSA, and non-ERISA voluntary benefits such as Legal Shield and Pet Assure.

You are not an Eligible Employee if:

- **You are classified and treated by an Employer as an independent contractor; if someone so classified and treated is subsequently determined by the Employer or any governmental agency or court not to be an independent contractor, such person will not be considered an Employee until the day after the final determination that such person is not an independent contractor; or**

- **You are a nonresident alien who receives no United States source income from an Employer; or**

- **You are an individual included in a unit covered by a collective bargaining agreement, unless the Employer and the collective bargaining unit have agreed upon coverage under a Component Program Document; or**

- **You are an individual characterized as a leased Employee (as defined by Code Section 414(n)) or an individual who would be a leased Employee but for the fact that you are a common law Employee of an Employer; or**

- **You are an employee of Wtrshd Capital; or**

- **You reside outside of the United States and its territories.**

In the event a person listed in one or more subsections above is specifically included as an "Employee" under a Component Program Document, the person will be considered an Employee under this Plan only with respect to the benefit described within such Component Program Document, and not necessarily with respect to any other benefits hereunder, described in other Component Program Documents.

Please contact your local human resources representative or third-party administrator for an explanation of how your employment status affects benefits eligibility.

Your Family Members' Eligibility

If you are an Eligible Employee, you may enroll your eligible dependents in certain component benefit programs under the Plan. You must enroll your Eligible Dependents within the same timeframes for electing coverage as a new hire, during Open Enrollment, or during certain Qualifying Life Events. Your eligible dependents include:

- Your legal spouse
- Your domestic partner*
- Children of the employee, spouse, or domestic partner, including biological children, stepchildren, adopted children, children placed for adoption, and children the Employee is legally obligated to support. The limiting age for children is 26.
- Dependent children who are mentally or physically disabled, if they were disabled prior to age 19
- Children for whom you are required to provide health coverage pursuant to a Qualified Medical Child Support Order (QMCSO)

*For purposes of the Plan, to qualify as a domestic partner means an individual who is engaged in a committed relationship of mutual caring and support and are jointly responsible for common welfare and living expenses. Interdependence must be demonstrated by at least three factors listed in *Niagara's Declaration of Domestic Partnership*. See Appendix D for more information.

Eligible dependents may be covered under the following component benefit plans:

- **Medical**
- **Dental**
- **Vision**
- **Life Insurance**
- **Critical Illness**
- **Accident Plan**
- **Legal Shield & Identity Theft**
- **EAP**

If you are married to another Niagara Bottling employee, you may enroll as an employee or as a dependent, but you cannot be covered as both. Dependent children may be insured under one employee's coverage only. You may be required to provide proof of your dependents' eligibility. **False or misrepresented eligibility information will cause both your coverage and your dependents' coverage to be irrevocably and immediately terminated and you will be responsible for the repayment of any benefits paid under false pretenses.**

In general, when the terms of this document conflict with a Component Program Document, the Component Program Document will control. However, with respect to eligibility (including eligibility of employees and dependents as described above), this document will control. Thus, to determine whether you or your dependents are eligible to participate in the Plan, you should refer to the paragraphs above. The eligibility provisions of the component benefit programs are not applicable to the extent they conflict with this document.

Automatic Enrollment

Once you are eligible, Employer automatically enrolls you in those plans for which you are eligible at no cost to you:

Individual Contributors & Supervisors: *Life and AD&D Insurance* provides you with $25,000 of basic life and accidental death and dismemberment (AD&D) Insurance coverage at no cost to you.

Managers, Directors, Vice Presidents, Executive Vice Presidents, CEO: *Life and AD&D Insurance* provides you with basic life and accidental death and dismemberment (AD&D) Insurance coverage of 1x your annual base wages and target bonus (as of January 1st of each year) at no cost to you.

Because enrollment is automatic, you do not need to take any action to enroll in these plans.

Non-Automatic Enrollment

If you are requesting coverage for medical, dental, vision**,** or any voluntary benefits, you must enroll for these benefits through Workday, accessible via personal computer, work or shared workstation computers, or the Workday mobile application. To access Workday on a computer, you are required to be on a Niagara network or through a VPN (virtual private network) accessed by entering your Niagara username and password. Mobile data rates shall apply when accessing Workday's mobile app.

Alternatively, you may request enrollment changes by phone by contacting Niagara's Benefit Service Center at 1-844-462-2236.

When To Enroll

If you are a new Eligible Employee, unless there are special circumstances as determined by Employer, you must enroll within **30 days** following the date you first become eligible. In general, enrollment for subsequent plan years is made during the Plan's open enrollment period that is held during the preceding fall**.** You will be notified in a separate communication of the date of your enrollment and the enrollment deadline.

When Coverage Begins

Your coverage generally begins on the first day of the month following 30 days of employment. That is, if someone is hired on March 21st, the individual becomes eligible for coverage on April 22nd and coverage becomes effective May 1st.

If you are not determined to be an Eligible Employee at the time you are hired, your coverage will start when you become eligible as determined under the attached Policy for Determining Eligibility Status. Please contact **your Human Resources partner** for further information. If you enroll family members in your insurance, generally their coverage begins when yours does**.**

Open Enrollment

You may enroll or change elections during the Plan's annual Open Enrollment period, in accordance with

procedures established by the Employer in its sole discretion. Your elections will remain in effect for the remainder of the Plan Year, unless you experience an event allowing a mid-year change, as described below.

Mid-Year Changes: Qualified Medical Child Support Orders

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, or "QMCSO" (defined in ERISA § 609(a)), and will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA § 609(c). 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.

Mid-Year Changes: HIPAA Special Enrollment Events

If you decline enrollment for medical, dental, or vision component benefit programs for yourself or your Eligible Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Eligible Dependents in the medical, dental, and vision component benefit programs under this Plan mid-year if you or your Eligible Dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your Eligible Dependents' other coverage). However, you must request enrollment within 30 days after your Eligible Dependents' other coverage ends (or after the other employer stops contributing toward the other coverage). Your election change will be effective as soon as practicable after the date the Plan receives your request for special enrollment.

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 both yourself and any Eligible Dependents within 30 days after the marriage, birth, adoption, or placement for adoption. For a new spouse or dependent acquired by marriage, your election change will be effective first of the month following the event date. When a new dependent is acquired through birth, adoption, or placement for adoption, your election change will be effective retroactively as of the date of the birth, adoption, or placement for adoption.

You also may enroll in the medical component benefit program mid-year if you or your Eligible Dependents no longer are eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, or if you or your Eligible Dependents become eligible for a state's premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event. Your election change will be effective as soon as practicable after the date the Plan receives your request for special enrollment.
To request enrollment under these HIPAA special enrollment rules or to obtain more information, contact the Plan Administrator.

Mid-Year Changes: Change in Status Events

This section applies only to changes to elections with respect to the medical, dental, and vision component benefit programs.
You also may change certain elections mid-year if you experience a change in status event listed below. You must report the Qualifying Event in Workday or by contacting Niagara's Benefit Service Center at 1-844-462-2236

within 30 days in order to make a change in your election during the year. In addition, you will be asked to provide supporting documentation for the event. **Where applicable, the changes you make to your coverage must be consistent with and "on account of and correspond with" the event.** For example, if your child no longer is eligible for medical benefits, you may cancel medical coverage only for that child, not yourself or your Spouse.

Legal marital status: Any event that changes your legal marital status, including marriage, divorce, death of a Spouse, legal separation, and annulment.

Number of Eligible Dependents: Any event that changes your number of Eligible Dependents including birth, death, adoption, legal guardianship, and placement for adoption.

Employment status: Any event that changes your or your Eligible Dependents' employment status that results in gaining or losing eligibility for coverage.

Dependent Status: Any event that causes your Eligible Dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.

Residence: A change in the place of residence for you or your Eligible Dependents if the change results in you or your Eligible Dependents living outside the network service area of your medical, dental, or vision coverage.

HIPAA Special Enrollment Event: The events listed above as HIPAA Special Enrollment events.

Entitlement to Medicare or Medicaid: If you or your Eligible Dependents become entitled to or lose entitlement to Medicare or Medicaid.

Judgment, Decree, or Order: If a judgment, decree or order, such as a QMCSO, requires your Dependent Child to be covered under this Plan (or another plan).

For HIPAA Special Enrollment events, your election change will be effective on the dates set forth earlier in the section "Mid-Year Changes: HIPAA Special Enrollment Events." For all other events, your election change will be effective as soon as practicable after the date the Plan receives your election change request (including any required supporting documentation).

Federal law does <u>not</u> provide a special enrollment right where a new dependent is a registered domestic partner or their dependents. **However, Niagara will offer special enrollment to new registered domestic partners and their dependents, under the same terms and conditions as marital unions covered under federal guidelines.** Please contact **the Niagara Benefits Department** for additional information.

Please see chart at end of this document which indicates life events and what may occur.

Article 2
Employee Contributions

You, the Employer, and any Participating Employers share the cost of your benefits.
Information describing your share of the cost for each option will be available at enrollment and each open enrollment.

The Plan provides you and your eligible dependents with the opportunity to elect **medical, dental, vision, EAP, and life and disability benefit coverage for employees.** A description of each benefit provided under the Plan is set forth in the incorporated Component Program Documents.

Pre-Tax Payroll Deductions: Medical

The cost of the benefits provided through the component benefit programs will be funded in part by Employer contributions and in **part** by employee contributions. In most cases, employee contributions will be made on a **pre-tax** basis. Your Employer will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time. Employer will make its contributions in an amount that (in your Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. Your Employer will pay [its contribution and] your contributions to an insurer. Your 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. With respect to component benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, HIPAA, NMHPA and WHCRA.

Important Domestic Partner Tax Considerations

Contributions toward your Domestic Partner's medical coverage will be withheld on a post-tax basis rather than a pre-tax basis. In addition, the Employer-paid portion of that coverage is taxable to you and treated as imputed income. These amounts will be reflected on your paychecks throughout the year and will be reported on your W-2 Form at the end of each calendar year.

We advise you to consult with your tax advisor to determine if your Domestic Partner and his or her dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage.

Article 3
When Your Coverage Ends

Unless otherwise provided in the applicable Component Program Document, your coverage under the Plan will end on the earlier of:

For medical, dental, and vision, the end of the month that your employment terminates, or you are no longer an Eligible Employee. For other plan coverage, it ends on the last day of employment.

Upon your death, coverage will terminate unless you have coverage for Eligible Dependents. If you have coverage for Eligible Dependents, then coverage will terminate as of the last day of the month for which the premium has been paid.

For Spouses in cases of divorce, the end of the month following the legal date of the divorce.

For Dependent Children, until the end of the month in which the Dependent Child turns 26 years of age. (Note that in New York, this is 29 years of age if your Dependent Child purchases his or her own individual medical coverage under the group policy.)

For all other Eligible Dependents, the end of the month in which the Eligible Employee ceases to be eligible.

The end of the month during which you or the Employer provides written notice to the Insurer requesting termination of coverage, or on such later date requested for such termination by the notice.

The date that the applicable Insurance Policy or the Plan is terminated.

Under some circumstances, you or your Eligible Dependents may continue coverage through COBRA continuation coverage. See the COBRA section.

Rescission in Event of Fraud

Any act, practice, or omission by a Plan Participant that constitutes fraud or an intentional misrepresentation of material fact is prohibited by the Plan, and the Plan may rescind coverage retroactively as a result. Any such fraudulent statements, including on Plan enrollment forms and in electronic submissions, may invalidate any payment or claims for services and may be grounds for rescinding coverage.

Coverage During Leave of Absence

Unless otherwise provided in the applicable Component Program Document:

If you are on an approved leave of absence and are receiving pay directly from the Employer, your elections and premium deductions will continue in accordance with the elections you made.

If you are on an approved leave where you are not receiving pay directly from the Employer, the Employer will continue your coverage for the duration of time required under the Family and Medical Leave Act (FMLA) or other applicable law.
You are responsible for any premium deductions missed during an approved leave. In the event of missed premium deduction(s), you will be contacted to make direct payments to the Employer's direct billing administrator in the month following the missed deduction. A reasonable amount of time will be provided to submit missing premium amounts. If payment in full is not received within the agreed-upon repayment period, the Employer may terminate coverage for non-payment, retroactive to the last day of fully paid premium.
If coverage is terminated due to non-payment and the Employee returns to work from FMLA leave, all coverage

will be reinstated to previous plan elections and family coverage tiers in effect on the last day worked, and reinstated effective the first day the Employee returns to work; however, where permitted by applicable law, unpaid premiums for coverage provided during FMLA leave will be collected through a third party direct billing service (One Source Virtual, Niagara's benefit administrator, or any provider selected by Niagara Bottling, LLC).

Military Leave

If you are absent from employment for more than 30 days by reason of service in the Uniformed Services, you may elect to continue Plan coverage for you and your Eligible Dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, Army National Guard, and Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, you may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, if possible, and providing payment of any required contribution for the health coverage. This may include the amount the Plan Administrator normally pays on your behalf. If your Military Service is for a period of time less than 31 days, you may not be required to pay more than the regular contribution amount, if any, for continuation of health coverage.

- You may continue Plan coverage under USERRA for up to the lesser of:
- the 24-month period beginning on the date of your absence from work; or
- the day after the date on which you fail to apply for, or return to, an employed position

Regardless of whether you continue health coverage, if you return to a position of employment within 5 years, your health coverage and that of your Eligible Dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on you or your Eligible Dependents in connection with this reinstatement, unless a sickness or injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue health coverage under USERRA.

Article 4
COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act (COBRA) provides for continuation of medical, dental, and vision coverage for "qualified beneficiaries" who lose their coverage due to a "qualifying event." You (or your Eligible Dependent) must be offered the same medical, dental, and vision coverage that you had the day before the qualifying event that caused you to lose coverage.

You are required to pay up to 102 percent of the applicable premium for COBRA coverage. When you enroll, you will receive a separate notice that gives more information on your COBRA rights. You also will receive an election notice if you experience a qualifying event. For more information, please contact the Plan's COBRA administrator.

You may also be entitled to certain additional rights with respect to medical, dental and vision coverage continuation under state law for the state in which you are employed. You will be provided with additional information on state mini-COBRA requirements if such requirements apply to you.

When You May Elect COBRA Coverage

You may continue coverage for yourself and your covered Eligible Dependents for up to 18 months (or longer if required by state law), if your medical, dental, or vision coverage ends for one of the following reasons:

You separate from employment with the Employer or a Participating Employer (for reasons other than gross misconduct on your part); or

Your hours are reduced so that you are no longer eligible for the Plan.

If you—or any of your Eligible Dependents—are determined to be disabled (for Social Security benefit purposes) when your coverage ends, or within the first 60 days of COBRA coverage, coverage for your entire family may continue for a total of 29 months.

Your covered Eligible Dependents may elect to continue coverage for up to 36 months if coverage ends for one of the following reasons:

- Your death;
- Your divorce or legal separation /Dissolution of Domestic Partnership*;
- Your eligibility for Medicare during a COBRA continuation period; or
- If your covered Dependent Child no longer meets the eligibility requirements under the Plan.

*Please note that Domestic Partners may be eligible to continue coverage in the same way and to the same extent as a Spouse; however, whether this is the case will depend on the underlying insurance contract to the extent the coverage is insured through a third party. If you or your Domestic Partner have questions about whether continuation coverage is available, please contact the Plan's COBRA administrator.

Applying for COBRA Coverage

When your coverage ends, you or your Eligible Dependents have 60 days to elect continued coverage. The 60 days is counted from the day your active benefits end or the date your COBRA notice is mailed, whichever is later.

If you lose coverage due to separation from employment or a reduction in work hours, you will automatically receive a notice of your COBRA rights.

In the case of a divorce, legal separation, dissolution of a domestic partnership, or when a child no longer qualifies for dependent coverage, you or your Eligible Dependent must notify the COBRA administrator within 60 days. Your dependents will not be eligible for COBRA coverage unless you notify the COBRA administrator that they have lost eligibility for coverage.

Early Termination of COBRA Coverage

COBRA coverage will end prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- the Employer stops providing coverage for all employees;
- You or your Eligible Dependents do not pay your premiums on time;
- You or your Eligible Dependents become covered by another group health plan or the Health Insurance Marketplace;
- You or your Eligible Dependents become covered by Medicare; or
- You or your Eligible Dependents extended COBRA coverage to 29 months due to disability, but are no longer considered disabled.

Article 5
Filing Claims and Appeals

Claims for Benefits: Deadline To File Claims

Unless otherwise provided in the applicable Component Program Document, you must file a claim for benefits within one (1) year following the date the service was rendered. You should file your claim for benefits with the applicable Insurer or Claims Administrator listed at Appendix A. The claim shall be in writing or electronic, in the form required by the Insurer or Claims Administrator. The claim shall identify a specific benefit that the Claimant seeks and shall include such evidence as the Insurer or Claims Administrator shall require.

Claims for Benefits: Initial Claims

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

If an applicable Component Program Document includes claims procedures, those claims procedures shall apply to any claim for benefits that are covered by such document. The claims procedures set forth in this Article 5 shall apply only to the extent that a claim for benefits is not subject to a compliant claims procedure set forth in such Component Program Document or the claims procedure set forth in the applicable Component Program Document does not comply with the requirements of 29 C.F.R. § 2560.503-1, PPACA (for group health benefits only), or other Department of Labor or other agency guidance. The provisions of this Article 5 shall be administered and interpreted in a manner consistent with the intent to comply with the requirements of 29 C.F.R. § 2560.503-1, PPACA (for group health benefits only), and other Department of Labor or other agency guidance. Insured benefits will be determined in the sole discretion of the Insurer listed at Appendix A. Self-funded benefits will be decided by the Claims Administrator listed at Appendix A.

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

Medical, Dental, and Vision ***Urgent Claims*** Any claim for medical care or treatment where making a determination under the normal timeframes could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject	Notice of the Plan's determination will be sent as soon as possible taking into account the medical exigencies, and in no case later than 72 hours after receipt of the claim. You may receive notice orally, in which case a written notice will be provided within 3 days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information. Within 48 hours after the earlier of (1) the Plan's receiving the required information or (2) the expiration of the period afforded to the Claimant to provide the information, the Plan Administrator or its delegate must notify the Claimant of the Plan's benefit determination. The Claimant may agree to extend these

you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim. Whether a claim involves "urgent care" (as defined in federal regulations) will be determined by the Claimant's attending physician, and the Plan will defer to the judgment of the Claimant's physician.	deadlines. An appeal of an adverse determination regarding an urgent care claim (where the claim is still an urgent care claim) must be decided as soon as possible, but no later than 72 hours after the Plan receives the request for review or appeal. Other requirements apply to the processing of appeals by non-grandfathered healthcare coverage subject to the Patient Protection and Affordable Care Act of 2010. See below. If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.
Medical, Dental, and Vision ***Pre-Service Claims*** A claim for services that have not yet been rendered and for which the Plan requires prior authorization.	If your pre-service claim is improperly filed, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the Plan must notify you within five (5) days; the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 15 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Medical, Dental, and Vision ***Post-Service Claims*** A claim for services that already have been rendered, or where the Plan does not require prior authorization.	Notice of the Plan's determination will be sent within a reasonable time period but no later than 30 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within

	30 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Medical, Dental, and Vision ***Concurrent Care Claims*** A concurrent health claim may be either an urgent care claim or a pre-service claim. Generally, it is a claim for an ongoing course of health care treatment to be provided over a period of time or number of treatments.	An adverse determination involving concurrent care must be made sufficiently in advance of any reduction or termination in treatment to allow the Covered Person to appeal the adverse determination. If a course of treatment involves urgent care, a request by the Claimant to extend the course of treatment must be decided as soon as possible, but not later than 24 hours after receipt of the request by the Plan, provided that the request is made at least 24 hours prior to the expiration of treatment. Expiration of an approved course of treatment is not an adverse determination under these rules. However, any reduction or termination by the Plan of the course of treatment (other than by Plan amendment or termination) before the end of the period of time or number of treatments originally prescribed is an adverse determination and may be appealed. Notice must be provided a reasonable time before the treatments will stop; however, the Plan is not required to allow the Claimant the 180 days to appeal the Plan's decision, before the Plan may terminate the treatment. Coverage must continue during the pendency of an appeal of an adverse determination involving a concurrent care claim to the extent required by, and in accordance with, applicable federal law.
Long-Term Disability Claims	Notice of the Plan's determination will be sent within a reasonable time period, but no later than 45 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to matters beyond control of the Plan, this time may be extended for two additional 30-day periods. You will receive notice prior to each extension that indicates the circumstances requiring the extension, the date by which the Insurer or Claims Administrator expects to render a determination, the standards on which entitlement to a benefit is based, and the unresolved issues that prevent a decision on the claim. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 30 days from the date the Plan receives your information, or, if earlier, the deadline to submit your information.
Life and AD&D	Notice of the Plan's determination will be sent within a reasonable time period, but no later than 90 days from receipt of the claim. If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an

	additional 90 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination.
Special Rule for Retroactive Health Care Coverage Rescissions	Where health care coverage subject to the Patient Protection and Affordable Care Act of 2010 is rescinded retroactively (for reasons other than failure to pay premiums or due to routine administrative delays in processing coverage additions and deletions), in addition to any other notice that may be required by these provisions the Plan will supply written notice of the rescission to each affected participant not fewer than 30 days prior to the effective date of the rescission.

Claims for Benefits: Appeals

Unless otherwise provided in the applicable Component Program Document, your appeal will be processed under the procedures described below.

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

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. The review will take into account all comments, documents, records, and other information submitted by the Claimant, regardless of whether such information was submitted or considered in the adverse benefit determination. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the Insurer or Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Insurer or Claims Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

In the case of an urgent care claim, you may request an expedited appeal of an adverse benefit determination either orally or in writing, and all necessary information, including the Plan's benefit determination on appeal, will be transmitted by telephone, fax, or other available expeditious method.

A final decision on appeal, made in the sole discretion of the Insurer or Claims Administrator, will be made within the time periods specified below.

Medical, Dental, and Vision ***Urgent Claims***	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination as soon as possible, taking into

	account the medical exigencies, but no later than 72 hours after receipt of the claim.
Medical, Dental, and Vision ***Pre-Service Claims***	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 30 days from the date your request is received.
Medical, Dental, and Vision ***Post-Service Claims***	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination within a reasonable period of time, but no later than 60 days from the date your request is received.

Medical, Dental, and Vision ***Concurrent Care Claim***	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination before treatment ends or is reduced, where the determination is a decision to reduce or terminate concurrent care early.
Long-Term Disability Claims	You must submit your appeal within 180 days of the date of your initial denial notice. You will be notified of the determination within a reasonable period of time, but no later than 45 days from receipt of the request for review. If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 45 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Insurer or Claims Administrator then will make its determination within 45 days from the date it receives your information, or, if earlier, the deadline to submit your information.
Life and AD&D	You must submit your appeal within 60 days of the date of your initial denial notice. You will be notified of the determination within a reasonable time, but no later than 60 days from receipt of the request for review. If the Insurer or Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Insurer or Claims Administrator expects to render a determination.

Claims for Benefits: Notice of Adverse Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will, where applicable:

state specific reason(s) for the adverse determination;

reference specific Plan provision(s) on which the benefit determination is based;

describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only);

describe the Plan's claims review procedures and the time limits applicable to such procedures (initial claim only);

include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal (for appeals of claims for disability benefits, this statement will also describe any applicable contractual limitations period that applies to the claimant's right to bring such an action and the calendar date on which the contractual limitations period expires for the claim);

state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;

describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only);

disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request);

if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request);

in the case of an adverse determination involving urgent care, include a description of the expedited review process available to such claims;

include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount (for medical claims);

include the denial code and corresponding meaning (for medical claims);

include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning (for medical claims);

describe the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for medical claims);

describe the external review process, if applicable (for medical claims);

include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for medical claims);

include a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration (for disability claims and appeals for disability claims); and

include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist (for disability claims and appeals for disability claims).

In the case of a group health plan subject to the PPACA, the notice will also include the following:

Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meanings);

The reason or reasons for the adverse benefit determination must include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim;

A description of available appeals and external review processes, including information regarding how to initiate an appeal; and

The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHSA section 2793 to assist individuals with the internal claims and appeals and external review processes.

In the case of an Adverse Benefit Determination by a Group Health Plan subject to the PPACA or with respect to a Disability Claim, the Notice shall be provided in a culturally and linguistically appropriate manner, as described under applicable Department of Labor Regulations.

No Conflicts of Interest

The Plan will adjudicate claims in a manner ensuring the independence and impartiality of those involved in decision-making. For example, the Plan may not hire, promote, provide incentives to or terminate the employment of individuals based on their support of a denial of benefits or on the number of claims denied.

Claims for Benefits: External Review

The procedures for any external review required by PPACA for group health claims shall be as set forth in the applicable Component Program Documents.

Claims Involving Eligibility, Enrollment and Election Changes

To the extent a claim involving eligibility, enrollment or election changes does not involve an adverse benefit determination, then it will not be subject to the ERISA claims and appeals procedures set forth above, but instead will be reviewed by the Plan Administrator (Niagara Bottling, LLC) in accordance with the following procedures:

(a) All such claims must be submitted in writing to the Plan Administrator at benefits@niagarawater.com. If your claim is approved, you will be notified in writing. Additionally, you will be responsible for any missed premium in full within 1-2 payroll periods of the approval.

(b) Your claim will be reviewed by a Benefits Analyst on behalf of the Plan Administrator. The Benefits Analyst, on behalf of the Plan Administrator, will respond to your claim within 90 days after receipt of your claim, unless special circumstances require an extension of time for processing the claim. In no event may the extension exceed 90 days from the end of the initial period. If such extension is necessary, you will be given a written notice

to this effect prior to the expiration of the initial 90-day period. If the claim is denied (in whole or in part), you will be provided written notice describing the reason for the denial and information regarding your right to appeal the denial.

(c) You or your authorized representative may file a written appeal of the denial with the Plan Administrator within 90 days after you are advised of the claim denial.

(d) Claim Appeals will be reviewed by a Manager or Director of Benefits & Wellness for final decision. The reviewer, on behalf of the Plan Administrator, will respond to you within 60 days after receipt of an appeal of a denial for this type of claim. If the Plan Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Plan Administrator will notify you within the initial 60-day period that the Plan Administrator needs up to an additional 60 days to review the claim. If the appeal is denied in whole or in part, you will be provided with written notice describing the reason for the denial of the appeal.

(e) You are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim for benefits. Please send your signed and written appeal to 1440 Bridgegate Drive, Diamond Bar, CA 91765 or email to benefits@niagarawater.com.

Deadline to Bring Legal Action

You may not bring a lawsuit to recover benefits under this Plan until you have exhausted the administrative process described in this section or as listed in the applicable Component Program Document. No action may be brought at all unless brought no later than three years following a final decision on your claim for benefits, unless a shorter period is provided in the applicable Component Program Document (in which case that time period controls). This statute of limitations on suits for all benefits shall apply in any forum where you may initiate such suit.

Article 6
Coordination of Benefits

If there is a conflict between the coordination of benefits provision in an Insurance Policy/Evidence of Coverage and the rules set forth below, the coordination of benefits provision in the Insurance Policy/Evidence of Coverage will govern.

In General

The Plan has the right to coordinate its payment of Plan benefits with "other plans" under which a Participant or Eligible Dependent are covered so that the total medical or dental benefits paid by the Plan together with other plans does not exceed the level of benefits that would otherwise be paid by the Plan. When a Participant or Eligible Dependent is covered by more than one plan, under this coordination of benefits rule, one plan is designated the primary plan. The primary plan will pay benefits first and will not take into account benefits payable under other plans when determining the benefits it pays. Any other plan that pays benefits after the primary plan is designated the secondary plan. A secondary plan reduces its benefits by those benefits payable under other plans and may limit the benefits it pays. These rules apply whether or not a claim is made under the other plan. If a claim is not made, benefits under the Plan will be pended or denied until documentation is received showing a claim made with the primary plan.

For purposes of this coordination of benefits rule, "other plans" is defined to include the following types of medical and health care benefits:

Coverage under a governmental program provided or required by statute, including no- fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation;

Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution;

Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans;

Any coverage under governmental plans, such as Medicare, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance, nongovernmental program;

- Any private or association policy or plan of medical expense reimbursement which is group or individual rated;
- Any excess insurance policy; and
- Any retiree medical plan.

Determining When the Plan Is Primary and When It Is Secondary

A plan without a coordination of benefits provision is always primary. The Plan has a coordination of benefits provision. If all plans have a coordination of benefits provision the following will apply:

With respect to no-fault coverage, personal injury protection, and medical payment coverage, the Plan is always secondary. This provision shall permit the Plan to pay first and then seek reimbursement in the case of no-fault

coverage.

The plan covering the participant for whom the claim is made, other than as a dependent, pays first and the other plan pays second.

For dependent children's claims, the plan of the parent whose birthday occurs earlier in the calendar year is primary.

When the birthdays of both parents are on the same day, the plan that has covered the dependent for the longer period of time is primary.

When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary.

When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan pays second, and the plan of the parent without custody pays last.

When there is a court decree that establishes financial responsibility for the health care expenses of the child, the plan that covers the parent with financial responsibility is primary.

When a person is covered under a right of continuation coverage pursuant to federal or state law (such as the Consolidated Omnibus Budget and Reconciliation Act) and also is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary.

When none of the above establishes an order of benefit determination, the plan that has covered the participant for whom the claim is made for the longest period of time will be primary.

Medicare

In general, the Social Security Act requires that the Plan be the primary payer if a Participant or Eligible Dependent is eligible or enrolled in Medicare and meets certain requirements. To the extent permitted by law, in certain limited circumstances the Plan will pay benefits secondary to Medicare.

Article 7
Right to Reduction, Reimbursement, and Subrogation

If there is a conflict between the reduction, reimbursement, and subrogation provision in a Component Program Document and the rules set forth below, the reduction, reimbursement, and subrogation provision in the Component Program Document will govern.

In General

The Plan has the right to reduce or deny benefits otherwise paid by the Plan, and recover or subrogate 100% of the medical or dental benefits paid by the Plan for a Participant or Eligible Dependent, to the extent of any and all of the following: (i) any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance, (ii) any automobile or recreational vehicle insurance coverage or benefits, including but not limited to uninsured or underinsured motorist coverage, (iii) any business medical and/or liability insurance coverage or payments, and (iv) any attorney's fees. The Plan's right to reimbursement applies when the Plan pays benefits, and a judgment, payment, or settlement is made on behalf of the Participant or Eligible Dependent for whom the benefits were paid. Reimbursement to the Plan of 100% of

these charges shall be made at the time any such payment is received by a Participant, Eligible Dependent or their representative or any other entity. The Plan's right to reduction, reimbursement and subrogation is based on the terms of the Plan in effect at the time of judgment, payment or settlement.

First Priority Right

The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation. The Plan has the right to recover interest on the amount paid by the Plan. The Plan has the right to 100% reimbursement in a lump sum. The Plan is not subject to any state laws or equitable doctrines, including, but not limited to, the common fund doctrine, which could otherwise require the Plan to reduce its recovery by any portion of a Participant or Eligible Dependent's attorney's fees or costs. The Plan is not responsible for the Participant or Eligible Dependent's attorney's fees, expenses, or costs. The Plan's right applies regardless of whether any payments to a Participant or Eligible Dependent are designated as payment for, but not limited to, (i) pain and suffering, or (ii) medical benefits. This applies regardless of whether a Participant or Eligible Dependent has been fully compensated for injuries. The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any Participant or Eligible Dependent. The Plan's first priority right shall not be reduced due to the negligence of the Participant or Eligible Dependent.

Cooperation

The Plan requires a Participant or Eligible Dependent, and their representatives, to cooperate in efforts to obtain reimbursement to the Plan from third parties. To aid the Plan in its enforcement of its right of reduction, recovery, reimbursement, and subrogation, Participants, Eligible Dependents and their representatives must, at the Plan's request and at its discretion (i) take any action, (ii) give information, and (iii) sign documents as required by the Plan. Failure to aid the Plan and to comply with such requests may result in the Plan's withholding or recovering benefits, services, payments, or credits due or paid under the Plan to a Participant or Eligible Dependent under the Plan. A Participant or Eligible Dependent and/or their representatives may not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by a Participant, Eligible Dependent or their representatives.

Right to File an Action

The Plan has the right to file suit on behalf of a Participant or Eligible Dependent for the claim related to the Plan expenses in order to recover benefits paid or to be paid by the Plan.

Article 8
Plan Administration

Plan Administrator

For purposes of ERISA, and unless otherwise delegated by the Plan Administrator, the Plan Administrator shall be the "administrator" with respect to the general administration of the Plan.

Discretion To Interpret Plan

The Plan Administrator, and Insurer if so delegated, shall have absolute discretion to construe and interpret any

and all provisions of the Plan and the Component Program Documents, including, but not limited to, the discretion to resolve ambiguities, inconsistencies, or omissions conclusively; provided, however, that all such discretionary interpretations and decisions shall be applied in a uniform and nondiscriminatory manner to all Participants and Eligible Dependents similarly situated. The decisions of the Plan Administrator, and Insurer to the extent delegated final decision-making authority, upon all matters within the scope of its authority shall be binding and conclusive upon all persons.

Powers and Duties

In addition to the powers described in this Article and all other powers specifically granted under the Plan, the Plan Administrator, and Insurer if so delegated, shall have all powers necessary or proper to administer the Plan and to discharge its duties under the Plan, including, but not limited to, the following powers:

To make and enforce such rules, regulations, and procedures as it may deem necessary or proper for the orderly and efficient administration of the Plan;

To enter into an administrative services agreement or insurance policy with an individual or entity to perform services with respect to one or more benefits under the Plan;

In its discretion, to interpret and decide all matters of fact in granting or denying benefits under the Plan, its interpretation and decision thereof to be final and conclusive on all persons claiming benefits under the Plan;

In its discretion, to determine eligibility under the terms of the Plan, its decision thereof to be final and conclusive on all persons;

In its discretion, to authorize the payment of benefits under the Plan, its decision thereof to be final and conclusive on all persons;

To prepare and distribute information explaining the Plan;

To obtain from the Employer, Eligible Employees, and Eligible Dependents such information as is necessary for the proper administration of the Plan;

To appoint an Insurer to review, determine, and authorize payment of requests for distribution under the Plan, to direct and supervise the payment of benefits, to review appeals of the denial of requests for distribution under the Plan, and to perform any other actions or duties the Plan Administrator may delegate to it;

To sue or cause suit to be brought in the name of the Plan and to compromise and settle claims brought against, by, or on behalf of the Plan;

To administer or pay benefits, or provide or receive any communications under the Plan, in electronic form, in accordance with applicable law; and

To take any other action necessary or advisable to carry out its duties with respect to the Plan.

Right To Delegate

The Plan Administrator may from time to time allocate to one or more of the Employer's officers, employees, or agents, and may delegate to any other person or organization, any of its powers, duties, and responsibilities with respect to the operation and administration of the Plan, including, without limitation, the administration of claims, the authority to authorize payment of benefits, the review of denied or modified claims, and the discretion to decide matters of fact and interpret Plan provisions, and may employ and authorize any person to whom any of

its fiduciary responsibilities have been delegated to employ persons to render advice with regard to any fiduciary responsibility held hereunder. Upon such designation and acceptance, the Plan Administrator shall have no liability for the acts or omissions of any such designee. All allocations and delegations of fiduciary responsibility shall be terminable upon such notice as the Plan Administrator in its discretion deems reasonable and prudent, under the circumstances.

Reliance on Reports, Certificates, and Participant Information

The Plan Administrator shall be entitled to rely conclusively upon all tables, valuations, certificates, opinions, and reports which will be furnished by an actuary, accountant, controller, counsel, insurer, or other person who is employed or engaged for such purposes. Moreover, the Plan Administrator and Employer shall be entitled to rely upon information furnished to the Plan Administrator or Employer by a Participant or Eligible Dependent, including such person's current mailing address.

Named Fiduciary

For purposes of ERISA, the Plan Administrator (Niagara Bottling, LLC) shall be the Plan's "named fiduciary" and may designate other named fiduciaries.

The Named Fiduciary has the authority to control and manage Plan operation and administration. The Claims Administrators have generally been designated to act on behalf of the Named Fiduciary for purposes of claims administration, except in the case of insured benefits.

The principal duty of the Named Fiduciary is 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 Named Fiduciary include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Named Fiduciary 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 Named Fiduciary has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Named Fiduciary also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

Indemnification

To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the officers and employees of the Plan Sponsor who provide services to the Plan shall be indemnified by the Plan Sponsor against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or

willful misconduct.

To the fullest extent authorized by law, and to the extent not first covered by insurance or the Plan Sponsor's indemnity set forth above in (1), the officers and employees of the Plan Sponsor who provide services to the Plan shall be fully indemnified by the Plan against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted a breach of fiduciary duty, gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted a breach of fiduciary duty, gross negligence or willful misconduct.

Plan Expenses

All fees and expenses incurred in connection with the operation and administration of the Plan, including, but not limited to, legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of Plan assets to the extent that it is legally permissible for these fees and expenses to be so paid. The Plan Sponsor may, but is not required, to pay such fees and expenses directly. The Plan Sponsor may also advance amounts properly payable by the Plan and then obtain reimbursement from the Plan for these advances. If the Plan Sponsor elects to pay any expense that may otherwise be paid from the Plan, such payment shall be deemed to be an unsecured, interest-free advance to the Plan that will be reimbursed by the Plan unless the Plan Sponsor fails to request reimbursement within 60 days after the end of the Plan Year in which the Plan Sponsor made such advance. The Plan Administrator shall review and approve any request for reimbursement by the Plan Sponsor made under this section.

Article 9
HIPAA Compliance

Disclosures to Plan Sponsor

The Plan may disclose participant information to the Plan Sponsor, as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to the Plan Sponsor as necessary to allow the Plan Sponsor to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

Use of PHI

The Plan will not use or disclose protected health information ("PHI") that is genetic information for underwriting purposes.

Access to Medical Information

The following employees or individuals under the control of the Plan Sponsor shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

Benefits personnel at the Plan's claims processing locations;

Members of the Legal, Finance, Information Technology, Audit, Accounting, and Human Resources Departments to the extent they perform functions with respect to the Plan; and

Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

Plan Sponsor Agreement to Restrictions

The Plan will not disclose protected health information to the Plan Sponsor until the Plan Sponsor has certified to the Plan that it agrees to:

Not use or disclose protected health information other than as permitted or required by law or as specified above;

Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which the Plan Sponsor becomes aware;

Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;

Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;

Make its internal practices, books and records relating to the use and disclosure of protected health information

received from the Plan available to the Secretary of Health and Human Services for determining compliance;

Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or, if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

Ensure that any agents, including a subcontractor, of the Plan Sponsor to whom the Plan Sponsor provides protected health information shall also agree to these same restrictions;

Ensure that adequate separation between the Plan Sponsor and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of employees or individuals identified above under "Access to Medical Information"; and

Restrict the use of protected health information by those employees or individuals identified above under "Access to Medical Information" for plan administration functions within the meaning of the HIPAA Privacy Regulations.

Permitted Disclosure to Plan Sponsor

Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Plan Sponsor the following types of information:

Summary health information may be disclosed to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.

Information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

De-identified information, as defined under the HIPAA Privacy Regulations.

Noncompliance

In the event of noncompliance with the restrictions herein by a designated Business Associate or other entity or person receiving protected health information on behalf of the Plan Sponsor, the employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

HIPAA Security Standards

Safeguards. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

Agents. The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

Security Incidents. The Plan Sponsor shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

Adequate Separation. The Plan Sponsor shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Plan Sponsor, in support of the requirements described herein.

Application

The provisions of this Article shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

Article 10
Other Legal Information

Applicable Law

The Plan and all rights hereunder are governed by and construed, administered, and regulated in accordance with the provisions of ERISA, HIPAA, and the Code to the extent applicable, and to the extent not preempted by ERISA. The Plan may not be interpreted to require any person to take any action, or fail to take any action, if to do so would violate any applicable law.

Plan Amendment & Termination

The Employer has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents.

Nothing in this document or other communication from the Employer or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by the Employer to provide or fund benefits to current employees or their dependents, or retired or terminated employees or their dependents or survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by Niagara Bottling, LLC.

Merger or Consolidation

In the event of any dissolution, merger, consolidation, or reorganization of the Employer in which the Employer is not the survivor, the Plan shall terminate with respect to the Employer and its Eligible Employees unless the Plan is continued by the successor to the Employer and such successor agrees to be bound by the terms and conditions of the Plan.

Assignment of Benefits

You may not transfer or assign any benefit or right under the Plan. Any such assignment shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by the Participant, but only as a convenience to Participants. Health care providers are not, and shall not be construed as, either “participants” or “beneficiaries” under this Plan and have no rights to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants under any circumstances.

Right To Recover Overpayment

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan has the right to recover the overpayment. The Plan will attempt to collect the overpayment from the party to whom the payment was made.

However, the Plan reserves the right to seek overpayment from any Participant. Failure to comply with this request will entitle the Plan to withhold benefits due a Participant. In addition, the Plan has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan's collection effort is not successful.

Missing Persons

If the Plan Administrator, Insurer, or Claims Administrator cannot locate an individual covered under the Plan, after making a reasonably diligent effort, including by giving written notice addressed to the individual's last known address as shown by the records of the Plan, the amount payable to the individual is forfeited.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and Employer to the effect that you will be employed for any specific period of time.

No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state and local income tax purposes, and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

Article 11
Legal Notices
Newborns' & Mothers' Health Protection Act

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

* * *

Statement of ERISA Rights

If you are a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be entitled to:

Receive Information About the Plan

Examine, without charge, at the Plan Administrator's office and at other specified locations all documents governing the Plan, including, if applicable, insurance contracts, collective bargaining agreements, and a copy of the latest annual report filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including, if applicable, insurance contracts and copies of the latest annual report (Form 5500 Series) and an updated SPD. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each participant with a copy of a summary annual report, if any.

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 the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights; and

Reduction or elimination of Exclusionary Periods of coverage for preexisting conditions under your group health plan (if any), if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health 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 up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and Beneficiaries. No one,

including your employer 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 the Plan or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have appealed all adverse determinations, 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. Any such suit must be brought no later than 180 days following a final decision on the claim for benefits. If it should happen that the 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.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

* * *

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

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

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

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

* * *

Women's Health and Cancer Rights Act

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 lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan.

* * *

Uniformed Services Employment and Reemployment Rights Act of 1994

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), also referred to as a "military leave," you are entitled to continue coverage for up to 24 months as long as you give Employer advance notice (with certain exceptions) of the leave. If the entire length of the leave is 31 days or less, you will not be required to pay any more than the portion of the premium you paid before the leave. If your leave continues beyond 31 days, you are required to pay your portion of the premium, **Employer's portion of the premium** and a 2% administrative fee in order to retain coverage. If you take a military leave, but your coverage under the Plan is terminated — for instance, because you do not elect the extended coverage — you will be treated as if you had not taken a military leave upon reemployment when determining whether an exclusion or waiting period applies upon your reinstatement into the Plan.

Under circumstances in which COBRA continuation coverage rights also apply (see the section entitled "Consolidated Omnibus Budget Reconciliation Act of 1985" below), an election to continue coverage during a military leave will be an election to take COBRA, and the two will run concurrently.

* * *

Important Notice from Niagara Bottling About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Niagara Bottling and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
2. **Niagara Bottling has determined that the prescription drug coverage offered by the plans below is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage.**

   - **Cigna HSA**
   - **Cigna PPO**
   - **Cigna PPO High**

   Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Niagara Bottling coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Niagara Bottling coverage, be aware that you and your dependents may be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Niagara Bottling and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Niagara

Bottling changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

Visit www.medicare.gov

Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help

Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Name of Entity/Sender:	Niagara Bottling, LLC.
Contact--Position/Office:	Niagara Bottling, LLC. Benefits Department
Address:	1440 Bridgegate Drive, Diamond Bar, CA 91765
Phone Number:	909-230-5000

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

* * *

Consolidated Omnibus Budget Reconciliation Act of 1985

The Consolidated Omnibus Budget Reconciliation Act ("COBRA") requires most employers that sponsor group health plans to offer employees and their covered family members the opportunity to temporarily extend health coverage at group rates under certain circumstances when coverage under the plans would normally end. This coverage is called COBRA continuation coverage. Qualified beneficiaries are eligible for COBRA continuation coverage if coverage would be lost due to certain qualifying events.

Qualified beneficiaries include you and your eligible dependents who were covered under the Plan at the time of an initial qualifying event (see below) that would otherwise lead to termination of coverage.

Qualified beneficiaries also include a child born to or placed for adoption with the covered employee while enrolled under COBRA continuation coverage, who the employee enrolls under COBRA continuation coverage within the Plan's special enrollment period for newborns and adopted children. Qualifying events are described in the following paragraphs.

18-Month Qualifying Event

If your employment ends for any reason except gross misconduct, or if your hours are reduced below the minimum required to be eligible for health care coverage, you and your dependents who are qualified beneficiaries may continue health care coverage for up to 18 months from the date you and your dependents would otherwise lose coverage.

Coverage for your dependents who are qualified beneficiaries can be extended for up to 36 months from the original event date if you become divorced, legally separated, entitled to Medicare, or die within the 18- month period. COBRA coverage for your dependent children who are qualified beneficiaries can also be extended for up to 36 months if during the original 18-month period your dependent child no longer meets the definition of dependent under the Plan.

29-Month Qualifying Event (Due to Disability)

COBRA provides for an additional 11 months of health coverage. If you or another qualified beneficiary becomes disabled (as determined by the Social Security Administration) anytime within the first 60 days of COBRA continuation coverage. This additional 11-month extension is available for all qualified beneficiaries in the family, not just the disabled individual.

This 29-month period of coverage (the basic 18 months plus an additional 11 months) begins when you or your dependent(s) would otherwise lose coverage because of your termination of employment or reduction of hours.

36-Month Qualifying Events

Your enrolled spouse and children who are qualified beneficiaries can continue coverage for up to 36 months from the date they would otherwise lose coverage due to one of the following qualifying events:

- Your death;
- Your divorce or legal separation from your spouse;
- Your child's loss of status as a dependent child under the terms of the Plan; or
- Your entitlement to Medicare.

Notification of Eligibility for COBRA

If your employment terminates or your hours are reduced, you will be sent an enrollment form for, and cost information on, continuing your benefits. The Covered Employee or Dependent, or their representative, must provide a completed enrollment form to the Claims Administrator. The Claims Administrator may require that additional information be provided, when necessary, to validate the Qualifying Event, before deeming the notice to be properly submitted. If the requested information is not provided within a reasonable period of time after the request, the Claims Administrator reserves the right to reject the deficient notice, which means that the individual has forfeited their rights to COBRA Continuation Coverage.

If you or your dependents want the additional 11-month extension due to disability, you must notify the Claims Administrator within 60 days after the date the disabled qualified beneficiary receives his or her Social Security disability determination and before the end of the initial 18-month COBRA continuation coverage period. You also must notify the Claims Administrator within 30 days if Social Security determines you or your dependent is no longer disabled.

If you become divorced or legally separated, or your child no longer meets the eligibility requirements, you, your spouse, or your child is responsible for notifying the Niagara Benefits team, within 60 days by reporting the change in Legal Marital Status through Workday and submitting the executed Divorce

Decree to niagarabenefits@onesourcevirtual.com and/or benefits@niagarawater.com. COBRA rights will be forfeited if the Claims Administrator is not notified within 60 days of the qualifying event. The Claims Administrator will in turn notify you or your dependents of your COBRA continuation rights within 14 days of receiving your notice. You must elect COBRA coverage within 60 days of receiving the notice, or, if later, within 60 days of the event causing the loss of coverage. COBRA rights will be forfeited if you or your dependent(s) do not elect COBRA coverage within this 60-day period.

Cost of COBRA Continuation Coverage

If you elect COBRA coverage, you pay the full cost of coverage for you and your dependents plus a 2% administration fee — in other words, 102% of the cost. The cost of COBRA continuation coverage for the additional 11 months due to disability (from the 19th to the 29th month) will may be up to 150% of the full cost of coverage.

The premium payments for the "initial premium months" must be paid for you (the employee) and for any spouse or dependent child by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made. Once a qualified beneficiary elects continuation coverage, the qualified beneficiary has the right to continue coverage subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until that month's premium is paid within the 45- day period after the election of continuation coverage is made.

All other premiums are due on the first of the month for which the premium is paid, subject to a 30-day grace period. A premium payment is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be cancelled retroactively to the first of the month.

COBRA Period

The COBRA "clock" starts when your regular coverage would otherwise end. COBRA coverage will end before the end of the 18-, 29-, or 36-month period for any of the following reasons:

- You or your dependents become covered under another group health plan that does not contain any exclusions or limitations for pre-existing conditions that apply to you or your dependents.
- You or your dependents become entitled to Medicare (COBRA coverage ends only for the person who is entitled to Medicare).
- You do not pay your premiums in a timely manner.
- Employer terminates all of its health plans.
- You or your dependents are on an 11-month disability extension and Social Security determines that you or your dependent is no longer disabled. In this instance, you are responsible for notifying the Claims Administrator within 30 days after the date Social Security determines you or your dependent is no longer disabled.

Additionally, if you lose group health coverage due to termination of employment or reduction of hours within 18 months of becoming entitled to Medicare, your dependent's COBRA continuation coverage will not end before 36 months from the date of your Medicare entitlement. Your initial COBRA continuation coverage generally must be identical to the coverage you had immediately before the qualifying event. However, qualified beneficiaries have the same enrollment and election change rights as active employees. For additional information on COBRA continuation coverage, rights, and obligations please contact your local human resources representative.

California Extension of Maximum Coverage Period for Medical Coverage

If you are a California employee and you and your covered dependents are covered under the insured medical benefit and become entitled to COBRA coverage with a maximum coverage period that is less than 36 months, you may be eligible for an extension of your coverage (medical only) up to a total of 36 months. You will be required to make a separate election for the California COBRA extension and will be notified of your right to this extension before the end of your 18- or 29-month coverage period.

COBRA and the Family and Medical Leave Act (FMLA)

An FMLA leave does not make you eligible for COBRA coverage. However, whether or not you lose coverage because of nonpayment of premium during an FMLA leave, you may be eligible for COBRA on the last day of the FMLA leave, which is the earliest to occur of:

- When you inform the company that you are not returning at the end of the leave;
- The end of the leave, assuming you do not return; and
- When the FMLA entitlement period ends.

For purposes of an FMLA leave, you will be eligible for COBRA, as described above, only if:

- You or your dependent is covered by the Plan on the day before the leave commences (or becomes covered during the FMLA leave); and
- You do not return to employment at the end of the FMLA leave; and
- You or your dependent loses coverage under the Plan before the end of what would be the maximum COBRA continuation period.

Medicare Entitlement & COBRA:

Medicare entitlement is not a Qualifying Event for any individual who is covered under the Plan by virtue of current employment status and, in accordance with IRS Revenue Ruling 2004-22, it is not the Plan's intent to recognize a terminated Employee's Medicare entitlement as a second Qualifying Event for a spouse or child who is covered under the Plan as a COBRA Qualified Beneficiary. For these purposes, a "terminated Employee" is an Employee who lost Plan coverage due to termination of employment or reduction of hours.

COBRA Coverage for Domestic Partners and Their Dependents

Federal law does not provide for an independent right to COBRA continuation coverage for Domestic Partners, however, the covered Employee may elect family coverage, including the Domestic Partner, if the Employee had family coverage including the Domestic Partner the day before the qualifying event. Dependents of Domestic Partners have an independent right to COBRA coverage as dependent children of the Employee. In addition, where allowed by benefits providers, the Employer will offer COBRA coverage to Domestic Partners in the event of a qualifying event, under the same terms and conditions as marital unions covered under federal guidelines. Please contact your local human resources representative for additional information.

Plan Changes

During the time you or your dependents have COBRA coverage, there may be changes to the Plan, such as new deductibles, covered expenses, or changes to your premium. All changes to the Plan will also apply to your COBRA coverage.

Other Coverage Options

Instead of enrolling in COBRA 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 www.healthcare.gov.

* * *

Notice of HIPAA Privacy Practices

Notice of Health Information Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can obtain access to this information. Please review it carefully.

This notice is required by law under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). One of its primary purposes is to make certain that information about your health is handled with special respect for your privacy. HIPAA includes numerous provisions designed to maintain the privacy and confidentiality of your protected health information (PHI). PHI is health information that contains identifiers, such as your name, address, social security number, or other information that identifies you.

Our Pledge Regarding Health Information

- We understand that health information about you and your health is personal.
- We are committed to protecting health information about you.
- This notice will tell you the ways in which we may use and disclose health information about you.
- We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are Required by Law To

- Make sure that health information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to health information about you;
- Follow the terms of the notice that are currently in effect.

The Plan Will Use Your Health Information for

Treatment: The plan may use your health information to assist your health care providers (doctors, pharmacies, hospitals, and others) to assist in your treatment. For example, the plan may provide a treating physician with the name of another treating provider to obtain records or information needed for your treatment.

Regular Operations: We may use information in health records to review our claims experience and to make determinations with respect to the benefit options that we offer to employees.

Business Associates: There are some services provided in our organization through contracts with business associates. Business associate agreements are maintained with insurance carriers and other third-parties who provide serves to the plan. Business associates with access to your information must adhere to a contract requiring compliance with HIPAA privacy and security rules.

As Required by Law: We will disclose health information about you when required to do so by federal, state or local law.

Law Enforcement: We may disclose your health information for law enforcement purposes, or in response to a valid subpoena or other judicial or administrative request.

Public Health: We may also use and disclose your health information to assist with public health activities (for example, reporting to a federal agency) or health oversight activities (for example, in a government investigation).

Your Rights Regarding Your Health Information

Although your health record is the physical property of the entity that compiled it, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information, where concerning a service already paid for;
- Obtain a paper copy of the Notice of Health Information Privacy Practices by requesting it from the plan privacy officer;
- Inspect and obtain a copy of your health information;
- Request an amendment to your health information;
- Obtain an accounting of disclosures of your health information;
- Request communications of your health information be sent in a different way or to a different place than usual (for example, you could request that the envelope be marked "Confidential" or that we send it to your work address rather than your home address);
- Revoke in writing your authorization to use or disclose health information except to the extent that action has already been taken, in reliance on that authorization;
- Authorize someone to exercise your rights and make choices about your health information (e.g., a medical power of attorney).

The Plan's Responsibilities

The plan is required to:

- Maintain the privacy of your PHI;
- Provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you;
- Abide by the terms of this notice;

- Notify you if we are unable to agree to a requested restriction, amendment or other request;
- Notify you of any breaches of your personal PHI within 60 days.
- Accommodate any reasonable request you may have to communicate PHI by alternative means or at alternative locations.

The plan will not use or disclose your PHI without your consent or authorization, except as provided by law or described in this notice.

The plan reserves the right to change our health privacy practices. Should we change our privacy practices in a material way, we will make a new version of our notice available to you.

For More Information or To Report a Problem

- If you have questions or would like additional information, or if you would like to make a request to inspect, copy, or amend health information, or for an accounting of disclosures, contact the plan privacy officer. All requests must be submitted in writing.
- If you believe your privacy rights have been violated, you can file a formal complaint with the plan privacy officer; or with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. You will not be penalized or retaliated against for filing a complaint.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you authorize us to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the payment activities that we provided to you.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Niagara Bottling, LLC Employee Welfare Benefit Plan, Niagara Bottling, LLC has caused this Plan to be executed in its name and on its behalf, on this 12th day of January, 2024.

Niagara Bottling, LLC

By: Kristi Morrissey

Title: Director, Benefits & Wellness

Appendix A
Plan Component Benefit Programs & Contact Information

This Wrap Document should be read in connection with the applicable Component Program Documents provided by the Insurers or Claims Administrators listed below.

If you have general questions regarding the Plan, please contact the Niagara Benefits Service Center at 1-844-462-2236. However, if you have questions concerning claims and appeals or the amount of Plan benefits payable under the Plan, please refer to the applicable Insurer or Claims Administrator listed below.

MEDICAL BENEFITS	
Eff 1.1.23 **Cigna HSA** **Cigna PPO** **Cigna PPO High**	• Self-Insured • Covered by ERISA • Group Number: 3345026 • For details, see Benefits Booklet • Claims Administrator: **Cigna** 800-244-6224 www.mycigna.com
VIRTUAL CARE BENEFITS	
Eff 1.1.24 **Teladoc**	• Covered by ERISA • For details, see Benefits Booklet • Claims Administrator: **Cigna** 800-244-6224 www.mycigna.com
PHARMACY BENEFITS	
Eff 1.1.20 **Magellan Rx**	• Self-Insured • Covered by ERISA • Group Number: MRX0306 • For details, see Benefits Booklet • Claims Administrator: **Magellan Rx** 855-371-9782 https://magellanrx.com/member/login/
DENTAL BENEFITS	
Eff 1.1.19 **Delta PPO Low** **Delta PPO High**	• Self-Insured • Covered by ERISA • Group Number: 16940 • For details, see Certificate • Claims Administrator: **Delta Dental** 800-422-4234 https://www.deltadentalins.com/

VISION BENEFITS	
Eff 1.1.19 **VSP Low** **VSP High**	• Fully Insured • Covered by ERISA • Group Number: 30044960 • For details, see Certificate • Claims Administrator: **VSP** 800-877-7195 www.vsp.com
DISABILITY BENEFITS	
Eff 1.1.20 **Unum Long-Term Disability** **Unum Short-Term Disability**	• Fully Insured • Covered by ERISA • Group Number: 912739 • For details, see Certificate • Claims Administrator: **Unum** 800-445-0402 www.unum.com
LIFE AND AD&D BENEFITS	
Eff 1.1.23 **Unum Basic Life and AD&D** **Unum Employee Supplemental Life** **Unum Dependent Spouse Life** **Unum Dependent Child Life**	• Fully Insured • Covered by ERISA • Group Number: 0917118 • For details, see Certificate • Claims Administrator: **Unum** 800-445-0402 www.unum.com
FERTILITY BENEFITS	
Eff 1.1.19 **Progyny**	• Covered by ERISA • Group Number: C00420 • Program Administrator: **Progyny** 888-597-5065 https://member.progyny.com/
WELLNESS	
Eff 1.1.23 **Hydrate Your Health 2.0 Wellness Program**	• Covered by ERISA • Program Administrator: **Sharecare** 855-201-7533 https://niagara.sharecare.com/
EAP	
Eff 1.1.23 **Lyra Mental Well-being**	• Covered by ERISA • Program Administrator: **Lyra Health** 877-782-4724 https://niagara.lyrahealth.com/

SPENDING ACCOUNTS	
Eff 1.1.23 **Medical FSA** **Limited Purpose FSA** **Dependent Care FSA**	• Covered by ERISA • Group Number: 51887 • For details, see FSA provisions in this document • Claims Administrator: **Fidelity** 866-402-7610 www.fidelity.com
SAVING ACCOUNTS	
Eff 1.1.23 **Fidelity HSA**	• Not covered by ERISA • Group Number: 51887 • For details, see HSA provisions in this document • Claims Administrator: **Fidelity** 866-402-7610 www.fidelity.com
VOLUNTARY BENEFITS	
Eff 1.1.19 **Critical Illness**	• Fully Insured • Not covered by ERISA • For details, see Certificate • Claims Administrator: **Chubb** 833-542-2013 www.chubb.com
Eff 1.1.23 **Unum Accident**	• Fully Insured • Not covered by ERISA • For details, see Certificate • Claims Administrator: **Unum** 800-445-0402 www.unum.com
Eff 1.1.19 **Legal Services & Identity Theft**	• Not covered by ERISA • Group Number: 47247 • For details, see vendor website • Plan Administrator: **LegalShield** 800-654-7757 www.legalshield.com
Eff 1.1.19 **Pet Discount Plans**	• Not covered by ERISA • Group Number: 644 • For details, see vendor website • Plan Administrator: Pet Benefit Solutions 888-789-7387 www.petassure.com

Appendix B
Determination of Full-Time Status and Coverage Period for Variable Hour, Part-Time, Seasonal, and Interns

All workers defined as Part-time, Seasonal, or Interns are eligible for a limited benefits package including comprehensive Medical, Dental, Vision, Health Savings Accounts and non-ERISA voluntary benefits on the first day of the month following 30 days of service, or first of month following rehire. Should a Part-Time, Seasonal, or Intern worker transfer to a Full-Time Employee position (working 30 or more hours per week), the full-time benefit package will be offered on the first day of the month following the transfer.

If your employment terminates and you are rehired after you have not performed an hour of service for at least 13 consecutive weeks, you will be treated as a new employee. If your employer chooses to apply the “rule of parity,” a shorter break in service (equal to your period of service prior to the break, and no less than 4 weeks) will result in being treated as a new employee for these purposes.

This process is intended to comply with the requirements of the Affordable Care Act (ACA). For more information on how your benefits plan complies with ACA requirements, , please contact benefits@niagarawater.com.

Appendix C
Sample Declaration of Domestic Partnership

Declaration of Domestic Partnership

Team Member Information	Please print:
Team Member Name	
Team Member ID #	
Domestic Partner Name	
Domestic Partner Dependent Children's Names (if covered)	
Start Date of Domestic Partnership	

I. DECLARATION

We, _____ (employee-print name) and _____ (domestic partner-print name), each certify and declare that we are domestic partners in accordance with the following criteria:

II. STATUS

1. We affirm that this domestic partnership began on or about _____/_____/_____.
2. We are each other's sole domestic partner, and we intend to remain so indefinitely.
3. Neither of us is married to or legally separated from anyone else nor had another domestic partner within the prior six months.
4. We are both at least eighteen (18) years of age and mentally competent to consent to contract.
5. We are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which we legally reside.
6. We cohabitate and reside together in the same residence and intend to do so indefinitely. We have resided in the same household for at least six months.
7. We are not in this relationship solely for the purpose of obtaining benefits coverage.
8. We are engaged in a committed relationship of mutual caring and support and are jointly responsible for our common welfare and living expenses. Our interdependence is demonstrated by **at least three** of the following (please check appropriate items):
   - ☐ Common ownership of real property (joint deed or mortgage agreement) or a common leasehold interest in property
   - ☐ Common ownership of a motor vehicle
   - ☐ Driver's license listing a common address for both parties
   - ☐ Proof of joint bank accounts or credit accounts
   - ☐ Proof of designation as the primary beneficiary for life insurance or retirement benefits, or primary beneficiary designation under a partner's will
   - ☐ Assignment of a durable property power of attorney or health care power of attorney

III. DEPENDENT CHILDREN OF DOMESTIC PARTNER

We understand that dependent children of the employees' domestic partner are eligible for coverage when they are:

- unmarried,
- primarily dependent on the employee for support, and
- meet the age/school and all eligibility requirements of the plan of benefits.

Submit completed Domestic Partner Affidavits to niagarabenefits@onesourcevirtual.com

IV. CHANGE IN DOMESTIC PARTNERSHIP:

1. We have an obligation to notify Niagara Bottling LLC by filing a *Declaration of Termination of Domestic Partnership* if there is any change in our Domestic Partnership status as attested to in this Declaration that would terminate this Declaration (e.g., due to death of a partner, a change in residence of one partner, termination of the relationship, etc.). We will notify Niagara Bottling LLC within thirty-one (31) days of such change.

2. We understand that termination of this coverage (obtained as a result of completion of this Declaration) will be effective on the date the relationship ends as indicated on the Declaration of Termination of Domestic Partnership, providing coverage has not otherwise terminated due to standard policy provisions.

IV. ACKNOWLEDGMENTS

1. We understand that a civil action may be brought against one or both of us for any losses (as well as attorneys' fees and costs) due to any false statement contained in this Declaration or for failure to notify Niagara Bottling LLC of changed circumstances as required in Section IV above. I, the undersigned employee, further understand that falsification of information in this Declaration, or failure to notify Niagara Bottling LLC of changed circumstances pursuant to Section IV above, may lead to disciplinary action against me, including discharge from employment.

2. We have provided the information in this Declaration for use by Niagara Bottling LLC for the sole purpose of determining our eligibility for certain domestic partner benefits. We understand and agree that Niagara Bottling LLC is not legally required to extend any such benefits. We understand that this information provided in this Declaration will be treated as confidential by Niagara Bottling LLC but will be subject to disclosure; a) upon the express written authorization of the undersigned employee, b) upon request of the insurer or plan administrator, or c) if otherwise required by law.

3. We understand that this Declaration may have legal implications relating, for example, to our ownership of property or to taxability of benefits provided, and that before signing this Declaration we should seek competent legal advice concerning such matters. We affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

Employee Signature	Date of Birth	Date
Domestic Partner Signature	Date of Birth	Date
Employee and Domestic Partner Address	City	State
Notary Public Signature	Date	Commission Expires

Submit completed Domestic Partner Affidavits to niagarabenefits@onesourcevirtual.com

Appendix D
Special Enrollment or Change of Coverage Situations

As a Participant, it is your responsibility to notify the Plan of any qualifying life events or other changes that could affect your health coverage, such as those described in this section. In general, you have 30 days to notify Niagara of these qualifying life events (see below for more information on events allowing more than 30 days); otherwise you may miss certain opportunities available to you, such as enrolling a new Dependent outside the Open Enrollment Period or preserving your former Dependent's rights under COBRA.

Enrollment of an individual who does not meet the Plan's eligibility requirements will be treated as an intentional misrepresentation of a material fact or fraud. You and any individual who obtains benefits from the Plan through misrepresentation or fraud will be held jointly and severally liable for such overpayment, and coverage may be rescinded retroactively to the date the individual was not eligible for coverage.

For the latest version of the *Midyear Enrollment Changes SOP* for instructions on how to enroll or make changes during a special enrollment opportunity, visit www.niagarabenefits.com, choose your region, and select Midyear Changes from the top navigation area. Alternatively, changes may be reported by phone to the OSV Benefits Service Center at 844-462-2236.

Disenrolling Dependents

If you are disenrolling a Dependent due to divorce or death, you must submit a copy of the final judgment of divorce or recorded death certificate. In the event of divorce, you must notify the Plan in writing within 60 days of the date of your divorce for your ex-spouse or former stepchildren to receive the right to COBRA Continuation Coverage. Medical expenses incurred by your ex-spouse or former stepchildren on or after the date of divorce are not covered by the Plan. You may be billed for any expenses paid by the Plan following the date of divorce if your ex-spouse or former stepchildren do not elect COBRA Continuation Coverage.

In general, eligible participants may make the following midyear changes during a special enrollment or qualifying life event:

HIPAA Special Enrollment Rights					
Event (Change Reason)	**Benefit Effective/ Cancellation Dates**	**Medical, Dental, Vision**	**FSA**	**Group Life, AD&D, and Disability Coverage**	**Voluntary Benefits**
Legal Marital Status Change: Marriage or formation of Domestic Partnership	**Coverage Start Date:** New Coverage is effective on the event date. *(new 1/1/24)* **Coverage End Date:** Cancellation of coverage is effective on the last day of the month following the event date. **Notification Requirement:** Must be reported within **30** days of event date	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for self and/or child(ren) consistent with change of status.	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage** **Enroll**: Team Member may increase or waive Long-term Disability insurance for self. Increases in coverage may require proof of good health.	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for self and/or child(ren) consistent with change of status.

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Legal Marital Status Change OR Legal Domestic Partner Change: Divorce or Legal Separation, or Dissolution of Domestic Partnership	**Coverage Start Date:** New Coverage is effective on the event date. *(new 1/1/24)* **Coverage End Date:** Cancellation of coverage is effective on the last day of the month following the effective date. **Notification Requirement:** Must be reported within **60** days of event date	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for spouse/DP and/or child(ren) consistent with change of status.	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self or child(ren) consistent with change of status. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll**: Team Member may increase or waive Long-term Disability insurance for self. Increases in coverage may require proof of good health.	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for spouse and/or child(ren) consistent with change of status.

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Birth/Adoption of Child	**Coverage Start Date:** Coverage is effective on event date. **Notification Requirement:** Must be reported within **30** days of event date	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage if new coverage is gained under Spouse	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage:** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll**: Team Member may increase or waive Long-term Disability insurance for self. Increases in coverage may require proof of good health.	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for spouse and/or child(ren) consistent with change of status.

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Change in Home Address Impacting Enrollment	**Coverage Start Date:** Coverage is effective on event date. **Notification Requirement:** Must be reported within **30** days of event date *Note: Team Members are responsible for maintaining their personal contact information in Workday. Your home address is important for benefit eligibility, W-2 mailing, etc.*	**Enroll:** Changes to dependent coverage not allowed **Changes**: Changes of Plans allowed **Cancellation**: If you move to a region where your current medical or dental plan is not offered, you will be required to make an active election. Team Member may lose coverage if they do not make an active election within 30 days of a home address change.	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage:** **Enroll:** Changes not allowed **Long-term Disability Coverage**: **Enroll**: Changes not allowed	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for spouse and/or child(ren) consistent with change of status.

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Dependent or Spouse Gains/Loses Other Coverage (ex: related to job changes)	**Coverage Begin Date:** Coverage begins on the first day following lost coverage **Coverage End Date:** Coverage ends on the day prior to new coverage beginning **Notification Requirement:** Must be reported within **30** days of event date	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for self, spouse, and/or child(ren), consistent with change of status.	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage:** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll**: Team Member may increase or waive Long-term Disability insurance for self. Increases in coverage may require proof of good health.	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for spouse and/or child(ren) consistent with change of status. +

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Change due to Spouse's Open Enrollment *Please use Spouse Gains/Loses Other Coverage to report change*	**Coverage Begin Date:** Coverage begins on the first day following lost coverage **Coverage End Date:** Coverage ends on the day prior to new coverage beginning **Notification Requirement:** Must be reported within **30** days of event date	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans not allowed **Cancellation**: Team Member may drop coverage for self, spouse, and/or child(ren), consistent with change of status.	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage:** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll**: Team Member may increase or waive Long-term Disability insurance for self. Increases in coverage may require proof of good health.	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may drop coverage for spouse and/or child(ren) consistent with change of status.

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Dependent Ceases to Satisfy Dependent Eligibility Requirements (ex: child turns age 26)	**Coverage End Date:** Coverage ends on the last day of the month, following the 26th birthday **Notification Requirement:** None. This is an automated transaction processed on your behalf.	**Enroll:** Only the aged dependent's enrollment will be changed to waive **Changes:** Changes of Plans not allowed	**Changes:** Changes not allowed	**Supplemental Life Coverage:** **Changes:** Changes not allowed **Long-term Disability Coverage:** **Changes:** Changes not allowed	**Changes:** Changes not allowed

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Medicare/ Medicaid Change	**Coverage End Date:** Coverage ends on the last day of the month prior to Medicare eligibility. **Notification Requirement:** Must be reported within **30** days of event date	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may waive coverage for self, spouse, and/or child(ren).	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage:** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll**: Team Member may increase or waive Long-term Disability insurance for self. Increases in coverage may require proof of good health.	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Team Member may waive coverage for self, spouse, and/or child(ren).

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Order That Requires Coverage for the Child (QMCSO, etc.)	**Coverage Begin Date:** Coverage begins on event date **Coverage End Date:** Coverage ends on the last day of the month following the dissolution of the court order **Notification Requirement:** Court orders are forwarded by the courts and processed once qualified	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: Changes of Plans allowed **Cancellation**: Not allowed until ordered by the Courts	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may change from full medical reimbursement FSA to limited purpose FSA and vice versa, consistent with any changes in medical plan election. **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change.	**Supplemental Life Coverage:** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll:** No changes allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation**: Not allowed

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Significant Change in Dependent Care Expenses *(childcare or eldercare)*	**Coverage Begin Date:** Coverage begins on event date **Coverage End Date:** Coverage ends on the last day of the month following the event. **Notification Requirement:** Must be reported within **30** days of event date	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation**: Not allowed	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** Team Member may increase or decrease annual election **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year, consistent with status change. Qualified expenses must be submitted by last day of month following event date.	**Supplemental Life Coverage:** **Enroll:** No changes allowed **Long-term Disability Coverage**: **Enroll:** No changes allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation**: Not allowed

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Health Savings Account Change	**Coverage Begin Date:** Coverage begins on event date **Coverage End Date:** Coverage ends on event date May request a change anytime!	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed	**Enroll:** Team Member may enroll in the HSA if enrolled in the Aetna PPO with HSA **Changes:** Team Member may increase or decrease annual election anytime **Cancellation**: Team Member may decrease or waive for the remainder of the Plan year	**Supplemental Life Coverage:** **Enroll:** No changes allowed **Long-term Disability Coverage**: **Enroll:** No changes allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation**: Not allowed
Voluntary Benefit Change (Critical Illness, Accident Plan, Pet Plans, Legal Plans)	**Coverage Begin Date:** Coverage begins on event date **Coverage End Date:** Coverage ends on event date May request a change anytime!	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed	**Supplemental Life Coverage:** **Enroll:** No changes allowed **Long-term Disability Coverage**: **Enroll:** No changes allowed	**Enroll:** May newly enroll in any plans **Changes**: May change coverage levels **Cancellation**: May terminate coverage

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Reduction in Hours, less than 30/week	**Coverage Begin Date:** N/A **Coverage End Date:** Based on ACA Measurement Period. Coverage will end on the last day of the plan year after the average weekly hours for the 12 month measurement period falls below 30 hours.	**Changes:** No Changes allowed at the time of hours reduction. Eligibility will remain the same until the end of the ACA Measurement period. **Cancellation**: Coverage ends on last day of the Plan Year (end of ACA Stability period) **A limited benefits package will be offered.**	**Changes:** No Changes allowed at the time of hours reduction. Eligibility will remain the same until the end of the ACA Measurement period. **Cancellation**: Coverage ends on last day of the Plan Year (end of ACA Stability period)	**Supplemental Life Coverage:** **Enroll:** No changes allowed **Cancellation**: Coverage ends on last day of the Plan Year (end of ACA Stability period) **Long-term Disability Coverage**: **Enroll:** No changes allowed **Cancellation**: Coverage ends on last day of the Plan Year (end of ACA Stability period)	**Changes:** No Changes allowed at the time of hours reduction. You will remain eligible at the next Open Enrollment.
Termination of Employment	**Coverage End Date:** Coverage ends on last day of the month following termination of employment from Niagara	**Cancellation**: Coverage ends on last day of the month following termination	**Cancellation**: Coverage ends on last day of the month following termination	**Cancellation**: Coverage ends on termination date	**Cancellation**: Coverage ends on last day of the month following termination

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Approved Leave of Absence – Non Military Leave	**Coverage Begin Date:** N/A – no change **Coverage End Date:** Coverage ends on event date	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** Not Allowed
Failure to Pay Premiums (during an Approved Leave of Absence)	**Coverage End Date:** Coverage ends on last day of the month paid in full 30 day grace period offered	**Cancellation**: Coverage ends on last day of the month paid in full	**Cancellation**: Coverage ends on last day of the month paid in full	**Cancellation**: Coverage ends on last day of the month paid in full	**Cancellation**: Coverage ends on last day of the month paid in full
Approved Leave of Absence – Paid USERRA Military Leave	**Coverage Begin Date:** N/A – no change **Coverage End Date:** N/A	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** N/A	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** N/A	**Supplemental Life Coverage: Enroll:** No changes allowed **Long-term Disability Coverage: Enroll:** No changes allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** N/A
Approved Leave of Absence – Unpaid Military Leave	**Coverage Begin Date:** N/A – no change **Coverage End Date:** Coverage ends on event date	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** On last day of month following event date	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** On last day of month following event date	**Supplemental Life Coverage: Enroll:** No changes allowed **Long-term Disability Coverage: Enroll:** No changes allowed	**Enroll:** Not allowed **Changes**: Not allowed **Cancellation:** On last day of month following event date

Event (Change Reason)	Benefit Effective/ Cancellation Dates	Medical, Dental, Vision	FSA	Group Life, AD&D, and Disability Coverage	Voluntary Benefits
Return from Leave of Absence – Military Leave or Others with Lost Coverage	**Coverage Begin Date:** Coverage begins on event date **Coverage End Date:** N/A **Notification Requirement:** None	**Enroll:** Team Member may elect coverage for self, spouse, and/or child(ren). **Changes**: N/A **Cancellation**: N/A	**Enroll:** Team Member may elect a Flexible Spending Account. **Changes:** N/A **Cancellation**: N/A	**Supplemental Life Coverage:** **Enroll:** Team Member may increase/decrease or newly elect supplemental life insurance and AD&D coverage for self, spouse, or child(ren) consistent with change of status. Insurance carrier guarantee issue rules shall apply to newly attained dependents. Increases in coverage may require proof of good health. **Long-term Disability Coverage**: **Enroll:** Team Member may elect or waive Long-Term Disability insurance for self. New elections may require proof of good health.	**Enroll:** Team Member may elect coverage for self and/or child(ren). **Changes**: N/A **Cancellation**: N/A

Appendix E
Wellness Plan

Effective 1.1.2023

As a covered member of Niagara's Medical Plan, you are eligible for the Hydrate Your Health 2.0 Wellness Program. The Hydrate Your Health 2.0 Wellness Program is designed to help you maintain a high level of wellbeing through physical wellbeing (including illness prevention and management), mental wellbeing, financial wellbeing, and community wellbeing, now through the Sharecare Platform.

Wellness Rewards
The program's goal is to reward activities, such as completing wellness exams at your in-network physician's office, completing preventive lab tests, and various other activities to support your total wellbeing. Information about the specific required activities and rewards for each plan year is provided at Open Enrollment. Covered Team Members and their covered partners who complete the specified reward activities have the opportunity to earn the rewards offered during the plan year.
The Hydrate Your Health 2.0 Wellness program will focus on four pillars good health: physical, community, mental, and financial wellbeing. The program is designed to meet you where you are on your personal journey to good health and total wellbeing.

Wellness Surcharges
The program also includes a potential Wellness Surcharge for those Team Members who are enrolled in medical coverage as of January 1 but do not complete the Nicotine Attestation Form by February 15 each year, or who self-attest to Nicotine Use. Any applicable wellness surcharges for each plan year, as well as the requirements for avoiding a surcharge, will be described in materials provided at Open Enrollment.

Biometric Screenings
If participation in biometric screenings is required as part of the wellness program, this information will be provided at Open Enrollment.

Alternative Standard

- Rewards for participating in a wellness program are available to all eligible Team Members/spouses. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by a different means. Contact the Benefits Department. We will work with you (and, if you wish, with your doctor) to develop another way to qualify for the reward.

NIAGARA BOTTLING, LLC
FLEXIBLE BENEFITS PLAN

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ARTICLE XII

HEALTH SAVINGS ACCOUNT

NIAGARA BOTTLING, LLC FLEXIBLE BENEFITS PLAN

INTRODUCTION

The Employer hereby restates the Niagara Bottling, LLC Flexible Benefits Plan (the "Plan"), effective upon adoption, to allow Employees to choose between cash compensation and certain different types of benefits based on their own particular goals, desires and needs.

The intention of the Employer is that the Plan qualify as a "cafeteria plan" within the meaning of Code Section 125 such that Employees' salary reduction elections under the Plan are excludable from the Employees' income under Code Section 125(a) and other applicable sections of the Code. The Plan provisions shall apply uniformly to all Eligible Employees. The Dependent Care Flexible Spending Account is intended to qualify as a dependent care assistance program within the meaning of Code Section 129, and the Health Flexible Spending Account Plan is intended to qualify as a self-insured medical reimbursement plan under Code Section 105.

The Health Flexible Spending Account Plan is an "employee welfare benefit plan" within the meaning of ERISA Section 3(1). Certain requirements of ERISA, including the fiduciary responsibility provisions, apply to the Health Flexible Spending Account Plan and Limited Purpose Health Flexible Spending Account Plan. The Premium Payment Plan, the Dependent Care Flexible Spending Account Plan, and the Health Savings Account portions of the Plan are not subject to the requirements of ERISA, and the Plan shall not be interpreted as applying the requirements of ERISA to such portions of the Plan.

ARTICLE I

DEFINITIONS

1.1 **"Administrator"** means the Employer unless another person or entity has been designated by the Employer pursuant to Section 9.1 to administer the Plan on behalf of the Employer. If the Employer is the Administrator, the Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator. Upon the resignation or removal of any individual performing the duties of the Administrator, the Employer may designate a successor.

1.2 **"Affiliated Employer"** means the Employer and any affiliated employer under Code Section 414(b), (c), (m), or (o) listed at Appendix A.

1.3 **"Benefit"** or **"Benefit Options"** means any of the optional benefit choices available to a Participant as outlined in Section 4.1.

1.4 **"Code"** means the Internal Revenue Code of 1986, as amended from time to time.

1.5 **"Compensation"** means the amounts received by the Participant from an Affiliated Employer during a Plan Year.

1.6 **"Dependent"** means any individual who qualifies as a dependent under Code Section 105(b). Any child of a Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA Section 609 shall be considered a Dependent under this Plan. Solely with respect to Benefits described in Section 4.1(3)(i), a Dependent includes a Domestic Partner's child, to the extent he/she is eligible for such Benefits.

1.7 **"Domestic Partner"** means an individual who qualifies as a domestic partner who is eligible for a Benefit described in Section 4.1(3)(i).

1.8 **"Effective Date"** means the date of adoption.

1.9 **"Election Form"** means an agreement between the Participant and the Employer under which the Participant agrees to reduce his Compensation and to have such amounts be applied as Salary Redirections. The Election Form shall apply only to Compensation that has not been actually or constructively received by the Participant as of the date of the agreement (after taking this Plan and Code Section 125 into account) and does not become subsequently available to the Participant.

1.10 **"Election Period"** means the period immediately preceding the beginning of each Plan Year established by the Administrator, such period to be applied on a uniform and nondiscriminatory basis for all Employees and Participants. An Employee's initial Election Period shall be determined pursuant to Section 5.1.

1.11 **"Eligible Employee"** means any Employee who has satisfied the provisions of Section 2.1.

An individual shall not be an "Eligible Employee" if such individual is (1) a member of any collective bargaining unit, unless collective bargaining resulted in eligibility for union members and the collective bargaining agreement adopts the Plan for the benefit of its union members; (2) not a citizen of the United States, resides and is employed outside the United States, and the individual's compensation from an Affiliated Employer does not constitute income from sources within the United States; (3) a leased employee, as defined in Code Section 414(n); (4) considered by an Affiliated Employer to be rendering services as an independent contractor, even if the individual is later determined to be an employee; (5) performs services for an Affiliated Employer pursuant to a written agreement that does not provide for participation in the Plan; or (6) performs services for an Affiliated pursuant to an agreement between the Affiliated Employer and another person or entity, such as an employment agency or employee leasing organization.

1.12 **"Employee"** means any person who is a common law employee of an Affiliated Employer and meets the following requirements:

(a) For the Benefits described in Section 4.1(1), 4.1(2), 4.1(3)(ii), and 4.1(3)(iii), at the date of hire, the individual must be reasonably expected to work 35 or more hours per week.

(b) For the Benefit described in Section 4.1(4), at the date of hire, the individual must be reasonably expected to work at least 30 hours per week at date of hire.

(c) For the Benefit described in Section 4.1(3)(i), the individual must either (1) be reasonably expected to work at least 30 hours per week at date of hire; or (2) if not reasonably expected to work at least 30 hours per week at date of hire, must work an average of at least 30 hours per week during a measurement period established by the Employer, as described in the plan document and summary plan description for the Niagara Bottling, LLC Employee Welfare Benefit Plan.

1.13 **"Employer"** means Niagara Bottling, LLC.

1.14 **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended from time to time.

1.15 **"Participant"** means any Eligible Employee who elects to become a Participant pursuant to Section 2.3 and has not for any reason become ineligible to participate further in the Plan.

1.16 **"Plan"** means the Niagara Bottling, LLC Flexible Benefits Plan.

1.17 **"Plan Year"** means the 12-month period beginning January 1 and ending December 31. The Plan Year shall be the coverage period for the Benefits provided for under this Plan. In the event a Participant commences participation during a Plan Year, then the initial coverage period shall be that portion of the Plan Year commencing on the date that such Participant begins participating in the Plan and ending on the last day of such Plan Year.

1.18 **"Premium Payment Plan"** means the arrangement contained in Section 4.1(3), which provides for the payment of Premiums.

1.19 **"Premiums"** mean the Participant's cost for the Benefits described in Section 4.1(3).

1.20 **"Salary Redirection"** means the elections for Benefits made by the Participant pursuant to Section 3.1.

1.21 **"Spouse"** means an individual who is lawfully married to an Eligible Employee and who is not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following is true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.

ARTICLE II

PARTICIPATION

2.1 ELIGIBILITY

An Employee shall be an Eligible Employee on the first of the month following date of hire.

Notwithstanding the foregoing, with respect to the Benefits described in Section 4.1(3)(i), an Employee described in Section 1.12(b)(2) is an Eligible Employee on the date provided in the plan document and summary plan description for the Niagara Bottling, LLC Employee Welfare Benefit Plan.

2.2 ELECTION TO PARTICIPATE

An Eligible Employee shall, during the applicable Election Period, complete an election to participate in a manner set forth by the Administrator. The election shall be irrevocable until the end of the applicable Plan Year unless the Participant is entitled to change his Benefit elections pursuant to Section 5.4 hereof.

An Eligible Employee shall also be required to complete an Election Form during the Election Period for the Plan Year during which he wishes to participate in this Plan. Any such Election Form shall be effective for the first pay period beginning on or after the Employee's effective date of participation pursuant to Section 2.3.

2.3 EFFECTIVE DATE OF PARTICIPATION

With respect to Benefits described in Section 4.1(3), participation in this Plan shall be effective as of the date the Eligible Employee's comprehensive major medical coverage under the Niagara Bottling, LLC Employee Welfare Benefit Plan is effective. The remainder of the Benefits shall become effective as of the same date but without regard for actual enrollment in such major medical coverage.

2.4 TERMINATION OF PARTICIPATION

A Participant shall no longer participate in the Plan with respect to a Benefit when he loses eligibility for that Benefit. A Participant shall no longer participate in this Plan upon the occurrence of any of the following events:

(a) **Termination of employment.** The last day of the month following the Participant's termination of employment, subject to the provisions of Section 2.6;

(b) **Death.** The last day of the month following the Participant's death, subject to the provisions of Section 2.76; or

(c) **Termination of the Plan.** The termination of this Plan, subject to the provisions of Article X.

2.5 TERMINATION OF EMPLOYMENT

If a Participant's employment with the Employer is terminated for any reason other than death, his participation in the Benefits Options provided under Section 4.1 shall be governed in accordance with the following:

(a) **Premium Payment Plan.** With regard to the Premium Payment Plan, the Participant's participation in the Plan shall cease on the last day of the month following the Participant's termination of employment, subject to the Participant's right to continue coverage under the terms of any Benefit for which Premiums have already been paid.

(b) **Dependent Care Flexible Spending Account Plan.** With regard to the Dependent Care Flexible Spending Account Plan, the Participant's participation in the Plan shall cease on the date of the termination of employment, and no further Salary Redirection contributions shall be made. However, such Participant may submit claims for Dependent Care Expense reimbursements for claims incurred through their FSA coverage end date (typically last day of the month following coverage or employment termination) and submitted for reimbursement by 12/31 of the Plan Year. Maximum benefit is based on the account balance of the Participant's Dependent Care Flexible Spending Account as of the date of termination.

(c) **Health Flexible Spending Account Plan and Limited Purpose Health Flexible Spending Account Plan**. With regard to the Health Flexible Spending Account Plan, the Participant's participation in the Plan shall cease on the last day of the month of the month in which employment terminates. No further Salary Redirection contributions shall be made after this date, except as provided in Section 2.6(c)(i) below.

(i) **COBRA Applicability.** A Participant whose participation in the Health Flexible Spending Account Plan ceases due to termination of employment may be entitled to continue participation in the Health Flexible Spending Account Plan pursuant to Code Section 4980B and Section 11.14 of the Plan.

2.6 DEATH

If a Participant dies, his participation in the Plan shall cease on the date of the Participant's death. However, such Participant's Spouse or Dependents may submit claims for expenses for benefits incurred, before the Participant's death, under the Dependent Care Flexible Spending Account Plan or Health Flexible Spending Account Plan by March 31 of the following year. In no event may reimbursements be paid to someone who is not a Spouse or Dependent. If the Plan is subject to the provisions of Code Section 4980B, then those provisions and related regulations shall apply for purposes of the Health Flexible Spending Account Plan.

ARTICLE III

CONTRIBUTIONS TO THE PLAN

3.1 SALARY REDIRECTION

Benefits under the Plan shall be financed by Salary Redirections sufficient to support Benefits that a Participant has elected hereunder and to pay the Participant's Premiums. The salary administration program of the Employer shall be revised to allow each Participant to agree to reduce his pay during a Plan Year by an amount determined necessary to purchase the elected Benefit Options. The amount of such Salary Redirection shall be specified in the Election Form and shall be applicable for a Plan Year. Notwithstanding the above, for new Participants, the Election Form shall only be applicable from the first day of the pay period following the date the Employee begins participating in the Plan up to and including the last day of the Plan Year.

Any Salary Redirection shall be determined prior to the beginning of a Plan Year (subject to initial elections pursuant to Section 5.1) and prior to the end of the Election Period and shall be irrevocable for such Plan Year. However, a Participant may revoke a Benefit election or an Election Form after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year, if both the revocation and the new election are on account of and

consistent with a change in status and such other permitted events as determined under Article V of the Plan and consistent with the rules and regulations of the Internal Revenue Service and the Department of the Treasury. Solely with respect to the Health Savings Account, a Participant may change his Election Form on a prospective basis at any time during the Plan Year. Salary Redirection amounts shall be contributed on a pro rata basis for each pay period during the Plan Year except that the Employer and Administrator may permit Salary Redirections on a non-pro rata basis for the Health Flexible Spending Account Plan. All individual Election Forms are deemed to be part of this Plan and incorporated by reference hereunder.

ARTICLE IV

BENEFITS

4.1 BENEFIT OPTIONS

Each Eligible Employee may elect any one or more of the following Benefits:

(1) Health Flexible Spending Account Plan

(2) Dependent Care Flexible Spending Account Plan

(3) Premium Payment Plan

(i) Health Insurance Benefit
(ii) Dental Insurance Benefit
(iii) Vision Insurance Benefit

(4) Health Savings Account

4.2 HEALTH FLEXIBLE SPENDING ACCOUNT PLAN

Each Eligible Employee may elect to participate in the Health Flexible Spending Account Plan, in which case Article VI shall apply.

4.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN

Each Eligible Employee may elect to participate in the Dependent Care Flexible Spending Account Plan, in which case Article VII shall apply.

4.4 HEALTH INSURANCE, DENTAL INSURANCE, AND VISION INSURANCE BENEFIT

Each Eligible Employee may elect to be covered under the Employer's health, dental, or vision plan for the Participant, his or her Spouse, his or her Domestic Partner, and his or her

Dependents.

4.5 HEALTH SAVINGS ACCOUNT BENEFIT

Each Participant may elect to make Salary Redirections to a health savings account ("HSA"), which is an individual trust or custodial account described in Article XIII.

4.6 NONDISCRIMINATION REQUIREMENTS

(a) **Intent to be nondiscriminatory.** It is the intent of this Plan to provide benefits to a classification of employees which the Secretary of the Treasury finds not to be discriminatory in favor of the group in whose favor discrimination may not occur under Code Sections 105(h), 125, and 129.

(b) **Adjustment to avoid test failure.** If the Administrator deems it necessary to avoid discrimination or possible taxation to a group of employees in whose favor discrimination may not occur in violation of Code Section 105(h), 125, or 129, it may, but shall not be required to, reject any election or reduce contributions or non-taxable Benefits in order to assure compliance with this Section. Any act taken by the Administrator under this Section shall be carried out in a uniform and nondiscriminatory manner. Contributions which are not utilized to provide Benefits to any Participant by virtue of any administrative act under this paragraph shall be forfeited and deposited into the benefit plan surplus.

ARTICLE V

PARTICIPANT ELECTIONS

5.1 INITIAL ELECTIONS

An Employee who meets the eligibility requirements of Section 2.1 on the first day of, or during, a Plan Year may elect to participate in this Plan for all or the remainder of such Plan Year, provided he elects to do so on or before his effective date of participation pursuant to Section 2.3.

5.2 SUBSEQUENT ANNUAL ELECTIONS

During the Election Period prior to each subsequent Plan Year, each Eligible Employee shall be given the opportunity to elect, through the Election Form, which Benefit Options he wishes to select. Any such election shall be effective for any Benefits for the Plan Year that follows the end of the Election Period. With regard to subsequent annual elections, the following options shall apply:

(a) A Participant or Eligible Employee who failed to initially elect to participate may elect different or new Benefits under the Plan during the Election Period;

(b) A Participant may terminate his participation in the Plan by notifying the Administrator in writing during the Election Period that he does not want to participate in the Plan for the next Plan Year, or by not electing any Benefit Options;

(c) An Employee who elects not to participate for the Plan Year following the Election Period will have to wait until the next Election Period before again electing to participate in the Plan, except as provided for in Section 5.4.

5.3 FAILURE TO ELECT

Any Participant failing to complete an Election Form pursuant to Section 5.2 by the end of the applicable Election Period shall be deemed to have elected not to participate in the Plan for the upcoming Plan Year. No further Salary Redirections shall therefore be authorized for such subsequent Plan Year.

5.4 CHANGE IN ELECTIONS

(a) **Change in status defined.** Any Participant may change a Benefit election after the Plan Year (to which such election relates) has commenced and make new elections with respect to the remainder of such Plan Year if, under the facts and circumstances, the change is necessitated by and is consistent with a change in status which is acceptable under rules and regulations adopted by the Internal Revenue Service and/or the Department of the Treasury, the provisions of which are incorporated by reference. Notwithstanding anything herein to the contrary, if the rules and regulations conflict with this Section 5.4, then such rules and regulations shall control.

In general, a change in election is not consistent if the change in status is the Participant's divorce, annulment or legal separation from a Spouse, termination of a domestic partnership with a Domestic Partner, the death of a Spouse or Dependent, or a Dependent ceasing to satisfy the eligibility requirements for coverage, and the Participant's election under the Plan is to cancel coverage under a Benefit Option for any individual other than the one involved in such event.

Regardless of the consistency requirement, if the Eligible Employee, the Eligible Employee's Spouse, or the Eligible Employee's Dependent becomes eligible for continuation coverage under Code Section 4980B or any similar state law, then the Eligible Employee may elect to increase payments under this Plan in order to pay for the continuation coverage. However, for COBRA eligibility due to divorce, annulment or legal separation, this only applies to after-tax contributions.

Any new election shall be effective at such time as the Administrator shall prescribe, but not earlier than the first pay period beginning after the election form is completed and returned to the Administrator. For the purposes of this subsection, a change in status shall only include the following events or other events permitted by the Internal Revenue Service and Treasury regulations or other guidance:

(1) Legal Marital or Domestic Partnership Status: Events that change a Participant's legal marital or domestic partnership status, including marriage, divorce, death of a Spouse or Domestic Partner, legal separation or annulment, and the termination of a domestic partnership with a Domestic Partner;

(2) Number of Dependents: Events that change a Participant's number of Dependents, including birth, adoption, placement for adoption, legal guardianship, or death of a Dependent;

(3) Employment Status: Any of the following events that change the employment status of the Participant, Spouse, or Dependent: termination or commencement of employment, a strike or lockout, commencement or return from an unpaid leave of absence, or a change in worksite. In addition, if the eligibility conditions of this Plan or other employee benefit plan of the Employer of the Participant, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection;

(4) Dependent satisfies or ceases to satisfy the eligibility requirements: An event that causes the Participant's Dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status, or any similar circumstance; and

(5) Residency: A change in the place of residence of the Participant, Spouse or Dependent, that would lead to a change in status (such as a loss of HMO coverage).

For the Dependent Care Flexible Spending Account, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a change in status.

(b) **Special enrollment rights.** Notwithstanding subsection (a), the Participant may change an election for group health plan coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP); provided that

such Participant meets the thirty (30) or sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Participants). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

(c) **Qualified Medical Support Order.** Notwithstanding subsection (a), in the event of a judgment, decree, or order (including approval of a property settlement) ("order") resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order defined in ERISA Section 609) which requires accident or health coverage for a Participant's child (including a foster child who is a Dependent of the Participant):

(1) The Plan may change an election to provide coverage for the child if the order requires coverage under the Participant's plan; or

(2) The Participant shall be permitted to change an election to cancel coverage for the child if the order requires the former Spouse to provide coverage for such child under that individual's plan and such coverage is actually provided.

(d) **Medicare or Medicaid.** Notwithstanding subsection (a), a Participant may change an election to cancel accident or health coverage for the Participant or the Participant's Spouse or Dependent if the Participant or the Participant's Spouse or Dependent is enrolled in the accident or health coverage of the Employer and becomes entitled to coverage (i.e., enrolled) under Part A or Part B of the Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). If the Participant or the Participant's Spouse or Dependent who has been entitled to Medicaid or Medicare coverage loses eligibility, that individual may prospectively elect coverage under the Plan.

(e) **Cost increase or decrease.** If the cost of a Benefit increases or decreases during the Plan Year, then the Plan shall automatically increase or decrease, as the case may be, the Salary Redirections of all affected Participants for such Benefit. Alternatively, if the cost of a benefit package option increases significantly, the Administrator shall permit the affected Participants to either make corresponding changes in their elections or revoke their elections and, in lieu thereof, receive on a prospective basis coverage under another benefit package option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.

(f) **Loss of coverage.** If the coverage under a Benefit is significantly curtailed or ceases during a Plan Year, affected Participants may revoke their elections of such Benefit and, in lieu thereof, elect to receive on a prospective basis coverage under

another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.

(g) **Change in dependent care provider.** A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care provider. The availability of dependent care services from a new childcare provider is similar to a new benefit package option becoming available. A cost change is allowable in the Dependent Care Flexible Spending Account Plan only if the cost change is imposed by a dependent care provider who is not related to the Participant, as defined in Code Sections 152(a)(1) through (8).

(h) **Health FSA cannot change due to insurance change.** A Participant shall not be permitted to change an election for the Health Flexible Spending Account Plan as a result of a cost or coverage change under any health insurance benefits.

(i) **Changes due to reduction in hours or enrollment in an Exchange Plan.** A Participant may prospectively revoke his election for coverage under a Benefit described in 4.1(3)(i) that provides minimum essential coverage (as defined in Code Section 5000A(f)(1)) provided the following conditions are met:

Conditions for revocation due to reduction in hours of service:

(1) The Participant has been reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change, even if that reduction does not result in the Participant ceasing to be eligible under the group health plan; and

(2) The revocation of coverage under the group health plan corresponds to the intended enrollment of the Participant, and any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

The Administrator may rely on the reasonable representation of the Participant who is reasonably expected to have an average of less than 30 hours of service per week for future periods that the Participant and related individuals have enrolled or intend to enroll in another plan that provides minimum essential coverage for new coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

ARTICLE VI

HEALTH FLEXIBLE SPENDING ACCOUNT PLAN

6.1 ESTABLISHMENT OF PLAN

This Health Flexible Spending Account Plan is intended to qualify as a medical reimbursement plan under Code Section 105 and shall be interpreted in a manner consistent with such Code Section and the Treasury regulations thereunder. Participants who elect to participate in this Health Flexible Spending Account Plan may submit claims for the reimbursement of Medical Expenses. All amounts reimbursed shall be periodically paid from amounts allocated to the Participant's Health Flexible Spending Account. Periodic payments reimbursing Participants from his Health Flexible Spending Account shall in no event occur less frequently than monthly. An Eligible Employee may not elect to participate in the Health Flexible Spending Account Plan for a Plan Year if he elects to make contributions to a Health Savings Account for that Plan Year.

6.2 DEFINITIONS

For the purposes of this Article and the Plan, the terms below have the following meaning:

(a) **"Health Flexible Spending Account"** means the account established for Participants pursuant to this Health Care Flexible Spending Account Plan to which part of their Salary Redirections may be allocated and from which all allowable Medical Expenses incurred by a Participant, his or her Spouse and his or her Dependents may be reimbursed.

(b) **"Medical Expenses"** means any expense for medical care within the meaning of the term "medical care" as defined in Code Sections 213(d) and 106(f) and the rulings and Treasury regulations thereunder, and not otherwise used by the Participant as a deduction in determining his tax liability under the Code. "Medical Expenses" can be incurred by the Participant, his or her Spouse, and his or her Dependents. "Incurred" means, with regard to Medical Expenses, when the Participant is provided with the medical care that gives rise to the Medical Expense and not when the Participant is formally billed or charged for, or pays for, the medical care.

A Participant may not be reimbursed for the cost of other health coverage, such as premiums paid under plans maintained by the employer of the Participant's Spouse or individual policies maintained by the Participant or his Spouse or Dependent.

A Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c).

(c) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Health Flexible Spending Account Plan.

6.3 FORFEITURES

The amount in the Participant's Health Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 6 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason, subject to Section 8.2.

6.4 LIMITATION ON ALLOCATIONS

Notwithstanding any provision contained in this Health Flexible Spending Account Plan to the contrary, the minimum amount of salary reductions that may be allocated to the Health Flexible Spending Account Plan by a Participant in or on account of any Plan Year is $130, and the maximum amount is $2,750, as adjusted for increases in the cost of living in accordance with Code Section 125(i)(2) and adopted by the Administrator. For any short Plan Year, the limit shall be an amount equal to the limit for the calendar year in which the Plan Year begins multiplied by the ratio obtained by dividing the number of full months in the short Plan Year by twelve (12).

6.5 COORDINATION WITH CAFETERIA PLAN

Matters concerning contributions, elections, and the like shall be governed by the general provisions of the Plan.

6.6 HEALTH FLEXIBLE SPENDING ACCOUNT PLAN CLAIMS

(a) **Expenses must be incurred during Plan Year.** All Medical Expenses incurred by a Participant, his or her Spouse, and his or her Dependents during the Plan Year shall be reimbursed during the Plan Year, through the time period specified in subsection (d). Medical Expenses are treated as having been incurred when the Participant is provided with the medical care that gives rise to the medical expenses, not when the Participant is formally billed or charged for, or pays for, the medical care.

(b) **Reimbursements.** The Administrator shall direct the reimbursement to each eligible Participant for all allowable Medical Expenses, up to a maximum of the amount of Salary Redirections designated by the Participant for the Health Flexible Spending Account for the Plan Year (minus any prior reimbursements during the Plan Year). Reimbursements shall be made available to the Participant throughout the year without regard to the level of Salary Redirections which have been allocated to the Participant's account at any given point in time. Furthermore, a Participant shall be

entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan covering the Participant and/or his Spouse or Dependents.

(c) **Payments.** Reimbursement payments under this Plan shall be made directly to the Participant. However, in the Administrator's discretion, payments may be made directly to the service provider. The application for payment or reimbursement shall be made to the Administrator on an acceptable form within a reasonable time of incurring the debt or paying for the service. The application shall include a written statement from an independent third party stating that the Medical Expense has been incurred and the amount of such expense. Furthermore, the Participant shall provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health plan coverage.

(d) **Claims for reimbursement.** Claims for the reimbursement of Medical Expenses incurred in any Plan Year shall be paid as soon after a claim has been filed as is administratively practicable; provided however, that if a Participant fails to submit a claim by March 31 after the end of the Plan Year, those Medical Expense claims shall not be considered for reimbursement by the Administrator. If a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be incurred on or before the coverage end date and submitted by 12/31 of the Plan Year.

6.7 DEBIT AND CREDIT CARDS

Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of Medical Expenses, subject to the following terms:

(a) **Card only for medical expenses.** Each Participant issued a card shall certify that the Health Flexible Spending Account portion of such card shall only be used for Medical Expenses. The Participant shall also certify that any Medical Expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's effective date of participation and reissued for each Plan Year the Participant remains a Participant in the Health Flexible Spending Account Plan. Such card shall be automatically cancelled upon the Participant's termination of participation in the Health Flexible Spending Account Plan.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year (minus any claims paid for the Plan Year). The maximum dollar amount of coverage available shall be the maximum amount for the Plan Year as set forth in Section **Error! Reference source not found.**.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for Medical Expense purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;

(2) Purchase of drugs prescribed by a health care provider, including, if permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;

(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as a Medical Expense or the Participant does not submit any required substantiation, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;

(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;

(3) Claims substitution or offset of future claims until the amount is repaid; and

(4) If subsections (1) through (3) fail to recover the amount, consistent with the Employer's business practices, the Employer may treat the amount as any other business indebtedness.

ARTICLE VII

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN

7.1 ESTABLISHMENT OF ACCOUNT

This Dependent Care Flexible Spending Account Plan is intended to qualify as a program under Code Section 129 and shall be interpreted in a manner consistent with such Code Section. Participants who elect to participate in the Dependent Care Flexible Spending Account Plan may submit claims for the reimbursement of Employment-Related Dependent Care Expenses. All amounts reimbursed shall be paid from amounts allocated to the Participant's Dependent Care Flexible Spending Account.

7.2 DEFINITIONS

For the purposes of this Article and the Plan the terms below shall have the following meaning:

(a) **"Dependent Care Flexible Spending Account"** means the notional account established for a Participant pursuant to this Article to which part of his Salary Redirections may be allocated and from which Employment-Related Dependent Care Expenses of the Participant may be reimbursed for the care of the Qualifying Dependents.

(b) **"Earned Income"** means earned income as defined under Code Section 32(c)(2), but excluding such amounts paid or incurred by the Employer for dependent care assistance to the Participant.

(c) **"Employment-Related Dependent Care Expenses"** means the amounts paid for expenses of a Participant for those services which if paid by the Participant would be considered employment-related expenses under Code Section 21(b)(2). Generally, they shall include expenses for household services and for the care of a Qualifying Dependent, to the extent that such expenses are incurred to enable the Participant and his/her Spouse to be gainfully employed or his/her Spouse to be a full-time student for any period for which there are one or more Qualifying Dependents with respect to such Participant. Employment-Related Dependent Care Expenses are treated as having been incurred when the Participant's Qualifying Dependents are provided with the dependent care that gives rise to the Employment-Related

Dependent Care Expenses, not when the Participant is formally billed or charged for, or pays for, the dependent care. The determination of whether an amount qualifies as an Employment-Related Dependent Care Expense shall be made subject to the following rules:

(1) If such amounts are paid for expenses incurred outside the Participant's household, they shall constitute Employment-Related Dependent Care Expenses only if (a) incurred for a Qualifying Dependent as defined in Section 7.2(d)(1) (or deemed to be, as described in Section 7.2(d)(1) pursuant to Section 7.2(d)(3)), or (b) incurred for a Qualifying Dependent as defined in Section 7.2(d)(2) (or deemed to be, as described in Section 7.2(d)(2) pursuant to Section 7.2(d)(3)) who regularly spends at least 8 hours per day in the Participant's household;

(2) If the expense is incurred outside the Participant's home at a facility that provides care for a fee, payment, or grant for more than 6 individuals who do not regularly reside at the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

(3) Employment-Related Dependent Care Expenses of a Participant shall not include amounts paid or incurred to a child of such Participant who is under the age of 19 or to an individual who is a Dependent of such Participant or such Participant's Spouse.

(d) **"Qualifying Dependent"** means, for Dependent Care Flexible Spending Account Plan purposes,

(1) a Participant's dependent child (as defined in Code Section 152(a)(1)) who has not attained age 13;

(2) a dependent (as defined in Code Section 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B)) or Spouse of a Participant who is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the Participant for more than one-half of such taxable year; or

(3) a child that is deemed to be a Qualifying Dependent described in paragraph (1) or (2) above, whichever is appropriate, pursuant to Code Section 21(e)(5).

(e) The definitions of Article I are hereby incorporated by reference to the extent necessary to interpret and apply the provisions of this Dependent Care Flexible Spending Account Plan.

7.3 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

The Administrator shall establish a Dependent Care Flexible Spending Account for each Participant who elects to apply Salary Redirections to Dependent Care Flexible Spending Account benefits.

7.4 INCREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be increased each pay period by the portion of Salary Redirections that he has elected to apply toward his Dependent Care Flexible Spending Account pursuant to elections made under Article V hereof.

7.5 DECREASES IN DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

A Participant's Dependent Care Flexible Spending Account shall be reduced by the amount of any Employment-Related Dependent Care Expense reimbursements paid or incurred on behalf of a Participant pursuant to Section 7.12 hereof.

7.6 ALLOWABLE DEPENDENT CARE REIMBURSEMENT

Subject to limitations contained in Section 7.9, and to the extent of the amount contained in the Participant's Dependent Care Flexible Spending Account, a Participant who incurs Employment-Related Dependent Care Expenses shall be entitled to receive from the Employer full reimbursement for the entire amount of such expenses incurred during the Plan Year or portion thereof during which he is a Participant.

7.7 W-2 REPORTING OF BENEFITS

On or before January 31st of each calendar year, the Employer shall furnish to each Employee who was a Participant and received benefits under Section 7.6 during the prior calendar year, a statement of all such benefits paid to or on behalf of such Participant during the prior calendar year. This statement is set forth on the Participant's Form W-2.

7.8 FORFEITURES

The amount in a Participant's Dependent Care Flexible Spending Account as of the end of any Plan Year (and after the processing of all claims for such Plan Year pursuant to Section 7.12 hereof) shall be forfeited and credited to the benefit plan surplus. In such event, the Participant shall have no further claim to such amount for any reason.

7.9 LIMITATION ON PAYMENTS

Code limits. Notwithstanding any provision contained in this Article to the contrary,

amounts paid from a Participant's Dependent Care Flexible Spending Account in or on account of any taxable year of the Participant shall not exceed the lesser of the Earned Income limitation described in Code Section 129(b) or $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)). The annual Dependent Care Flexible Spending account minimum contribution is $100.00.

7.10 COORDINATION WITH CAFETERIA PLAN

Matters concerning contributions, elections, and the like shall be governed by the general provisions of the Plan.

7.11 DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN CLAIMS

The Administrator shall direct the payment of all such Dependent Care Flexible Spending Account Plan claims to the Participant upon the presentation to the Administrator of documentation of such expenses in a form satisfactory to the Administrator. However, in the Administrator's discretion, payments may be made directly to the service provider. In its discretion in administering the Dependent Care Flexible Spending Account Plan, the Administrator may utilize forms and require documentation of costs as may be necessary to verify the claims submitted. At a minimum, the form shall include a statement from an independent third party as proof that the expense has been incurred during the Plan Year and the amount of such expense. In addition, the Administrator may require that each Participant who desires to receive reimbursement for Employment-Related Dependent Care Expenses submit a statement which may contain some or all of the following information:

(a) The Qualifying Dependent(s) for whom the services were performed;

(b) The nature of the services performed for the Participant, the cost of which he wishes reimbursement;

(c) The relationship, if any, of the person performing the services to the Participant;

(d) If the services are being performed by a child of the Participant, the age of the child;

(e) A statement as to where the services were performed;

(f) If any of the services were performed outside the home, a statement as to whether the Qualifying Dependent for whom such services were performed spends at least 8 hours a day in the Participant's household (for Qualifying Dependents described in Section 7.2(d)(2));

(g) If the services were being performed in a day care center, a statement:

(1) that the day care center complies with all applicable laws and regulations of the state of residence,

(2) that the day care center provides care for more than 6 individuals (other than individuals residing at the center), and

(3) of the amount of fee paid to the provider.

(h) If the Participant is married, a statement containing the following:

(1) the Spouse's salary or wages if he or she is employed, or

(2) if the Participant's Spouse is not employed, that

(i) he or she is incapacitated, or

(ii) he or she is a full-time student attending an educational institution and the months during the year which he or she attended such institution.

(i) **Claims for reimbursement.** If a Participant fails to submit a claim by March 31 after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for the reimbursement of Medical Expenses must be incurred on or before the coverage end date and submitted by 12/31 of the Plan Year.

ARTICLE VIII

BENEFITS AND RIGHTS

8.1 CLAIM FOR BENEFITS

(a) **Insurance claims.** Any claim for Benefits described in Section 4.1(3) shall be made under the terms of the Domino's Pizza Life and Medical Plan.

(b) **Dependent Care Flexible Spending Account and Health FSA claims.** If a Participant fails to submit a claim under the Dependent Care Flexible Spending Account Plan or Health Flexible Spending Account Plan by March 31 after the end of the Plan Year, those claims shall not be considered for reimbursement by the Administrator. However, if a Participant terminates employment during the Plan Year, claims for

reimbursement, for claims incurred prior to employment termination, must be submitted by the end of the plan year in which employment terminates. Once a claim is submitted, the following timetable for claims and rules below apply:

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

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

(1) the specific reason or reasons for the denial;

(2) reference to the specific Plan provisions on which the denial was based;

(3) 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;

(4) a description of the Plan's review procedures and the time limits applicable to such procedures. For the Health Flexible Spending Account Plan, this will include a statement of the right to bring a civil action under ERISA Section 502 following a denial on review;

(5) 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

(6) 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 the Participant receives a denial, the Participant shall have 180 days following receipt of the notification in which to appeal the decision. The Participant may submit written comments, documents, records, and other information relating to the claim. If the Participant requests, the Participant shall 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:

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

(2) 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;

(3) 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

(4) 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.

(d) **Forfeitures.** Any balance remaining in the Participant's Health Flexible Spending Account Plan or Dependent Care Flexible Spending Account Plan as of the end of the time for claims reimbursement for each Plan Year shall be forfeited and deposited in the benefit plan surplus of the Employer pursuant to Section **Error! Reference source not found.**, Section 7.8, or Section 12.3, whichever is applicable, unless the Participant had made a claim for such Plan Year, in writing, which has been denied or is pending; in which event the amount of the claim shall be held in his account until the claim appeal

procedures set forth above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Plan Year shall be forfeited and credited to the benefit plan surplus. If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited and returned to the Employer following a reasonable time after the date any such payment first became due.

8.2 APPLICATION OF BENEFIT PLAN SURPLUS

Any forfeited amounts credited to the benefit plan surplus by virtue of the failure of a Participant to incur a qualified expense or seek reimbursement in a timely manner may, but need not be, separately accounted for after the close of the Plan Year (or after such further time specified herein for the filing of claims) in which such forfeitures arose. In no event shall such amounts be carried over to reimburse a Participant for expenses incurred during a subsequent Plan Year for the same or any other Benefit available under the Plan; nor shall amounts forfeited by a particular Participant be made available to such Participant in any other form or manner, except as permitted by Treasury regulations. Amounts in the benefit plan surplus shall be used to defray any administrative costs and experience losses or used to provide additional benefits under the Plan.

8.3 NAMED FIDUCIARY

The Administrator shall be the named fiduciary pursuant to ERISA Section 402 and shall be responsible for the management and control of the operation and administration of the portions of the Plan subject to ERISA.

8.4 GENERAL FIDUCIARY RESPONSIBILITIES

The Administrator and any other fiduciary under ERISA shall discharge their duties with respect to the benefits under the Plan subject to ERISA solely in the interest of the Participants and their beneficiaries and

(a) for the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

(b) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

(c) in accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

8.5 NONASSIGNABILITY OF RIGHTS

The right of any Participant to receive any reimbursement under the Plan shall not be alienable by the Participant by assignment or any other method, and shall not be subject to the rights of creditors, and any attempt to cause such right to be so subjected shall not be recognized, except to such extent as may be required by law.

ARTICLE IX

ADMINISTRATION

9.1 PLAN ADMINISTRATION

The Employer shall be the Administrator, unless the Employer elects otherwise. The Employer may appoint any person, including, but not limited to, the Employees of the Employer, to perform the duties of the Administrator.

An Administrator may resign by delivering a resignation in writing (or such other form as acceptable to both parties) to the Employer or be removed by the Employer by delivery of notice of removal (in writing or such other form as acceptable to both parties), to take effect at a date specified therein, or upon delivery to the Administrator if no date is specified. The Employer shall be empowered to appoint and remove the Administrator from time to time as it deems necessary for the proper administration of the Plan to ensure that the Plan is being operated for the exclusive benefit of the Employees entitled to participate in the Plan in accordance with the terms of ERISA (to the extent applicable), the Plan and the Code.

The operation of the Plan shall be under the supervision of the Administrator. It shall be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Eligible Employees. The Administrator shall have full power and discretion to administer the Plan in all of its details and determine all questions arising in connection with the administration, interpretation, and application of the Plan. The Administrator may establish procedures, correct any defect, supply any information, or reconcile any inconsistency in such manner and to such extent as shall be deemed necessary or advisable to carry out the purpose of the Plan. The Administrator shall have all powers necessary or appropriate to accomplish the Administrator's duties under the Plan. The Administrator shall be charged with the duties of the general administration of the Plan as set forth under the Plan, including, but not limited to, in addition to all other powers provided by this Plan:

(a) To make and enforce such procedures, rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

(b) To interpret the provisions of the Plan, the Administrator's

interpretations thereof in good faith to be final and conclusive on all persons claiming benefits by operation of the Plan;

(c) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided by operation of the Plan;

(d) To reject elections or to limit contributions or Benefits for certain highly compensated participants if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

(e) To provide Employees with a reasonable notification of their benefits available by operation of the Plan and to assist any Participant regarding the Participant's rights, benefits or elections under the Plan;

(f) To keep and maintain the Plan documents and all other records pertaining to and necessary for the administration of the Plan;

(g) To review and settle all claims against the Plan, to approve reimbursement requests, and to authorize the payment of benefits if the Administrator determines such shall be paid if the Administrator decides in its discretion that the applicant is entitled to them. This authority specifically permits the Administrator to settle disputed claims for benefits and any other disputed claims made against the Plan;

(h) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Section 609; and

(i) To appoint such agents, counsel, accountants, consultants, and other persons or entities as may be required to assist in administering the Plan.

Any procedure, discretionary act, interpretation or construction taken by the Administrator shall be done in a nondiscriminatory manner based upon uniform principles consistently applied and shall be consistent with the intent that the Plan shall continue to comply with the terms of Code Section 125 and the Treasury regulations thereunder.

9.2 EXAMINATION OF RECORDS

The Administrator shall make available to each Participant, Eligible Employee and any other Employee of the Employer such records as pertain to their interest under the Plan for examination at reasonable times during normal business hours.

9.3 PAYMENT OF EXPENSES

Any reasonable administrative expenses shall be paid by the Employer unless the

Employer determines that administrative costs shall be borne by the Participants under the Plan or by any trust fund which may be established hereunder. The Administrator may impose reasonable conditions for payments, provided that such conditions shall not discriminate in favor of highly compensated employees.

9.4 INDEMNIFICATION OF ADMINISTRATOR

(1) To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the officers and employees of an Affiliated Employer who provide services to the Plan shall be indemnified by the Employer against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

(2) To the fullest extent authorized by law, and to the extent not first covered by insurance or the Employer's indemnity set forth above in (1), the officers and employees of an Affiliated Employer who provide services to the Plan shall be fully indemnified by the Plan against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan or the funds of the Plan, including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan or funds of the Plan, and amounts paid in compromise or settlement relating to the Plan or the funds of the Plan, unless (1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted a breach of fiduciary duty, gross negligence or willful misconduct, or (2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted a breach of fiduciary duty, gross negligence or willful misconduct.

ARTICLE X

AMENDMENT AND TERMINATION OF PLAN

10.1 AMENDMENT AND TERMINATION

The Employer has the right to amend or terminate the Plan at any time. This reservation of the right to amend or terminate benefits applies to benefits for current employees and their dependents and also to retired or terminated employees and their survivors or dependents. Nothing in this document or other communication from the Employer

or its delegee with respect to the Plan shall be deemed to create or imply a continuing obligation by the Employer to provide or fund benefits to current employees or their dependents, or retired or terminated employees or their dependents or survivors.

All amendments to the Plan shall be in writing, and any oral statements or representations made by any individual or entity that purport to alter, modify, amend, or are inconsistent with the written terms of the Plan shall be invalid and unenforceable and may not be relied upon by any individual or entity.

No further additions shall be made to the Health Flexible Spending Account or Dependent Care Flexible Spending Account upon termination of the Plan, but all payments from such fund shall continue to be made according to the elections in effect until 12/31 of the Plan Year. Any amounts remaining in any such fund or account as of the end of such period shall be forfeited and /deposited in the benefit plan surplus after the expiration of the filing period.

ARTICLE XI

MISCELLANEOUS

11.1 PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform, nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Section 11.12.

11.2 GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neuter gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

11.3 WRITTEN DOCUMENT

This Plan, in conjunction with any separate written document which may be required by law, is intended to satisfy the written Plan requirement of Code Section 125 and any Treasury regulations thereunder relating to cafeteria plans.

11.4 EXCLUSIVE BENEFIT

This Plan shall be maintained for the exclusive benefit of the Employees who participate in the Plan.

11.5 PARTICIPANT'S RIGHTS

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge shall have upon him as a Participant of this Plan.

11.6 ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

11.7 NO GUARANTEE OF TAX CONSEQUENCES

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable. Notwithstanding the foregoing, the rights of Participants under this Plan shall be legally enforceable.

11.8 FUNDING

Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

11.9 GOVERNING LAW

This Plan is governed by the Code and the Treasury regulations issued thereunder (as they might be amended from time to time). In no event shall the Employer guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan shall be construed, enforced, and administered according to the laws of the State of Michigan.

11.10 SEVERABILITY

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

11.11 CAPTIONS

The captions contained herein are inserted only as a matter of convenience and for reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof.

11.12 CONTINUATION OF COVERAGE (COBRA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan subject to the continuation coverage requirement of Code Section 4980B becomes unavailable, each Participant, Spouse, and Dependent will be entitled to continuation coverage as prescribed in Code Section 4980B and related regulations.

In general, the continuation coverage rules for the Health Flexible Spending Account Plan are as follows:

(a) **Account Balance**. A Participant, Spouse, or Dependent shall only be entitled to elect continuation coverage if the maximum benefit available under the Health Flexible Spending Account or the Limited Purpose Health Flexible Spending Account, whichever is applicable, for the year as of the date of the Qualifying Event equals or exceeds the continuation coverage premium that applies for coverage for the remainder of the Plan Year.

(b) **"Qualifying Event"** means any of the following events that would otherwise result in a Participant's or his/her Spouse or Dependent's loss of coverage under the Health Flexible Spending Account Plan in the absence of continuation coverage:

(1) A Participant's termination of employment, for any reason other than gross misconduct;

(2) A Participant's reduction in work hours resulting in a change of status such that the Participant is no longer eligible to be a Participant;

(3) A Participant's divorce or legal separation (Spouse only);

(4) A Dependent ceasing to qualify as a Dependent under the

provisions of the Health Flexible Spending Account; or

(5) The death of a Participant (Spouse or Dependent only).

(c) **Period of Continuation Coverage for Qualified Beneficiaries**. A qualified beneficiary who qualifies for continuation coverage may remain covered until the end of the Plan Year in which the Qualifying Event occurs. Continuation coverage may not continue beyond: (1) the date on which the Employer ceases to maintain any group health plan; or (2) the last day of the month for which premium payments have been made, if the individual fails to make Continuation Coverage Contributions on time.

(d) **Contribution Requirements for Continuation Coverage**. Qualified beneficiaries who elect continuation coverage will be required to pay "Continuation Coverage Contributions." Qualified beneficiaries must make the Continuation Coverage Contributions monthly prior to the first day of the month in which the coverage will take effect. However, a qualified beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month's payment and the cost for the period between the date medical coverage would otherwise have terminated due to the Qualifying Event and the date the qualified beneficiary actually elects continuation coverage. The qualified beneficiary shall have a thirty (30) day grace period to make the Continuation Coverage Contributions due thereafter. Continuation Coverage Contributions must be postmarked on or before the completion of the thirty (30) day grace period. If Continuation Coverage Contributions are not made on a timely basis, continuation coverage will terminate as of the last day of the month for which such premiums were made. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of Continuation Coverage Contributions as set out in this Section 11.14(d).

(e) **Limitation on Qualified Beneficiary's Rights to Continuation Coverage**. If a Spouse or Dependent loses, or will lose, coverage under the Health Flexible Spending Account Plan as a result of divorce, legal separation, annulment, or ceasing to be a covered Dependent, such Spouse or Dependent must notify the Administrator within sixty (60) days of the divorce, legal separation, or loss of Dependent status in order to elect continuation coverage. Failure to make timely notification will terminate the Spouse or Dependent's rights to continuation coverage. For all other Qualifying Events, no notification by the Participant, Spouse, or Dependent is required.

A qualified beneficiary (or a third party on behalf of the qualified beneficiary) must complete and return the required enrollment materials within sixty (60) days from the later of (i) loss of coverage, or (ii) the date the Administrator sends notice of eligibility for continuation coverage. Failure to enroll for continuation coverage during this sixty (60) day period will terminate all rights to continuation coverage. Elections for continuation

coverage may be made by the qualified beneficiary or on his/her behalf by a third party (including a third party that is not a qualified beneficiary).

(f) **Deficient Continuation Coverage Contribution Amount**. If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not less than $50 or 10% of the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the qualified beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made.

11.15 FAMILY AND MEDICAL LEAVE ACT (FMLA)

Notwithstanding anything in the Plan to the contrary, in the event any benefit under this Plan becomes subject to the requirements of the Family and Medical Leave Act and regulations thereunder, this Plan shall be operated in accordance with Treasury regulation 1.125-3.

11.16 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and regulations thereunder.

11.17 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Notwithstanding any provision of this Plan to the contrary, contributions, benefits and service credit with respect to qualified military service shall be provided in accordance with the Uniform Services Employment And Reemployment Rights Act (USERRA) and the regulations thereunder.

11.18 COMPLIANCE WITH HIPAA PRIVACY STANDARDS

(a) **Disclosures to Employer.** The Plan may disclose participant information to the Employer, as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to the Employer as necessary to allow the Employer to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

(b) **Use of PHI.** The Plan will not use or disclose protected health information ("PHI") that is genetic information for underwriting purposes.

(c) **Access to Medical Information.** The following employees or individuals under the control of the Employer shall have access to the Plan's protected health information

to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

(1) Benefits personnel at the Plan's claims processing locations;

(2) Members of the Legal, Finance, Information Technology, Audit, Accounting, and Human Resources Departments to the extent they perform functions with respect to the Plan; and

(3) Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(d) **Employer Agreement to Restrictions.** The Plan will not disclose protected health information to the Employer until the Employer has certified to the Plan that it agrees to:

(1) Not use or disclose protected health information other than as permitted or required by law or as specified above;

(2) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Employer;

(3) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which the Employer becomes aware;

(4) Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;

(5) Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;

(6) Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;

(7) Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for determining compliance;

(8) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or, if not feasible, restrict access and uses to those

that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;

(9) Ensure that any agents, including a subcontractor, of the Employer to whom the Employer provides protected health information shall also agree to these same restrictions;

(10) Ensure that adequate separation between the Employer and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of employees or individuals identified above under "Access to Medical Information"; and

(11) Restrict the use of protected health information by those employees or individuals identified above under "Access to Medical Information" for plan administration functions within the meaning of the HIPAA Privacy Regulations.

(e) **Permitted Disclosure to Employer.** Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the Employer the following types of information:

(1) Summary health information may be disclosed to the Employer if the Employer requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.

(2) Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(3) Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

(4) De-identified information, as defined under the HIPAA Privacy Regulations.

(f) **Noncompliance.** In the event of noncompliance with the restrictions herein by a designated Business Associate or other entity or person receiving protected health information on behalf of the Employer, the employee or other individual shall be subject to discipline in accordance with the Employer's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

(g) **HIPAA Security Standards**

(1) Safeguards. The Employer shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

(2) Agents. The Employer shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

(3) Security Incidents. The Employer shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

(4) Adequate Separation. The Employer shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Employer, in support of the requirements described herein.

(h) **Application.** The provisions of this Section shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

ARTICLE XII
HEALTH SAVINGS ACCOUNT

13.1 HSA BENEFITS

An Eligible Employee can elect to participate in the HSA by electing to salary reduce on a pre-tax basis to the Employee's HSA established and maintained outside the Plan by a trustee/custodian with which the Employer has entered into an agreement to forward contributions to be deposited (this funding feature constitutes the HSA benefits offered under this Plan). Such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

13.2 CONTRIBUTIONS FOR COST OF COVERAGE FOR HSA; MAXIMUM LIMITS

The annual contribution for a Participant's HSA benefits is equal to the annual benefit amount elected by the Participant, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's high-deductible health plan coverage option (i.e., single or family) for the calendar year in which the

contribution is made ($3,600 for single and $7,200 for family are the statutory maximum amounts for 2021). An additional catch-up contribution of $1,000 may be made for Participants who are age 55 or older.

In addition, the maximum annual contribution shall be:

(a) reduced by any matching (or other) Employer contribution made on the Participant's behalf; and

(b) prorated for the number of months in which the Participant is an HSA-eligible individual.

13.3 RECORDING CONTRIBUTIONS FOR HSA

The HSA is not an employer-sponsored employee benefit plan subject to ERISA—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The Employer will identify an HSA provider or providers to whom it will forward contributions that the Participant makes via Salary Redirection, but such choice is not an endorsement of any particular HSA provider. The Administrator will maintain records to track HSA contributions by a Participant, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

13.4 TAX TREATMENT OF HSA CONTRIBUTIONS AND DISTRIBUTIONS

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

13.5 TRUST/CUSTODIAL AGREEMENT; HSA NOT INTENDED TO BE AN ERISA PLAN

HSA benefits under this Plan consist solely of the ability to make contributions to the HSA. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Plan or subject to ERISA.

IN WITNESS WHEREOF, this Plan document is hereby executed this 25th day of March, 2024.

Niagara Bottling, LLC

By

_____

Title

Director, Benefits & Wellness