ALLIED UNIVERSAL®

HEALTH AND WELFARE BENEFIT PLAN

AND

SUMMARY PLAN DESCRIPTION

Effective January 1, 2020

*** * * IMPORTANT * * ***

Please read this Summary Plan Description in its entirety.

This document, together with any booklets or other descriptive material you have received from your Participating Employer, describes benefits available under the Plan and summarizes situations in which those benefits may be reduced, delayed, forfeited, or denied, as well as your rights and responsibilities and the procedures and deadlines for filing a claim or appeal and taking legal action against the Plan and its fiduciaries.

If you cannot find answers to your questions in this booklet or any booklets or other descriptive material you have received or want more information about the Plan, please contact the Benefits Department at 1-888-670-7106 or benefits@aus.com or the Claims Administrator listed in this document.

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INTRODUCTION

Universal Services of America, LP ("Universal" or the "Company") sponsors the Allied Universal Health and Welfare Benefit Plan (the "Plan") for the benefit of all eligible employees of the Company and Participating Employers. (Participating Employers are listed in Appendix E.) **This document sets forth the terms of the Plan effective January 1, 2020**.

This document serves two important functions related to the Plan under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), a federal law applying to employee benefit plans:

First, ERISA requires that employers provide eligible employees with a description of the various benefit plans it maintains. Such information is to be included in a summary plan description ("SPD") for each plan. This document constitutes the SPD for the Plan.

Second, ERISA requires that employee benefit plans be maintained pursuant to a written plan document. This document constitutes the written plan document under ERISA.

You and your beneficiaries may examine the Plan, all amendments, and certain other documents and records pertaining to the Plan during regular business hours or by appointment at a mutually convenient time with your Plan Administrator. You may obtain copies of the Plan and of certain reports from the Plan Administrator (a reasonable charge may be imposed for those copies, as prescribed by federal regulation). Because benefits under the Plan will be of importance to you and your family, you should retain this document as part of your permanent records. A copy may be obtained through the Plan Administrator upon request.

Important Note: *Notwithstanding anything herein to the contrary, the Dependent Care Flexible Spending Account ("FSA") and the Health Savings Account are not subject to ERISA. This document does not give participants any rights thereunder.*

The Plan, any changes to it, or any payments to you under its terms, does not constitute a contract of employment with the Company or any Participating Employer (as detailed below) and does not give you the right to be retained in the employment of the Company or any Participating Employer. The Company reserves the right to change, amend or terminate the Plan at any time.

ELIGIBILITY AND PARTICIPATION

Eligible Employees.

Initial Eligibility and Waiting Periods.

Administrative Employees. In general, employees classified as "regular" and "full-time" on the Participating Employer's payroll records who work 30 hours or more per week are eligible the first of the month following a sixty (60) day waiting period beginning on your date of hire. The minimum hours requirement and/or the length of the waiting period may vary as required by state law and will be set forth in your enrollment materials. However, please note that your continued eligibility for benefits depends, in part, on your status as a "full-time employee" for purposes of the Patient Protection and Affordable Care Act of 2010 ("ACA"), as determined by the Company. See "Ineligible Employees" below.

Service Professionals. Generally, if you are expected to work at least 30 hours per week for your first sixty (60) days of employment with a Participating Employer, you will be eligible to receive benefits effective on the first of the month following a sixty (60) day waiting period beginning on your date of hire. The minimum hours requirement and/or the length of the waiting period may vary as required by state law and will be set forth in your enrollment materials. For example, if you are hired on May 11, 2020, your initial eligibility date would be August 1, 2020. However, please note that your continued eligibility for benefits depends, in part, on your status as a "full-time employee" for purposes of the ACA, as determined by the Company. See "Ineligible Employees" below.

Please note that eligibility requirements (i.e., number of hours worked and length of waiting period (not to exceed 90 days)) are subject to client contract and/or collective bargaining agreement and you may work at a location subject to an eligibility exception. Please call the Benefits Department at 1-888-670-7106 for more information on exceptions.

Certain Collectively Bargained Employees. Certain collectively bargained employees are offered medical coverage only under the applicable collective bargaining agreement(s). In such cases, the Participating Employer may offer those employees all other benefits available under the Plan (excluding medical). If you are included in this group, you will be notified by your Participating Employer and/or the Benefits Department prior to making any enrollment elections.

Boon Group Employees. Benefits offered to certain employees are administered by The Boon Administrative Services, Inc. ("Boon Group Employees"). Boon Group Employees consist of: (1) employees working 30 or more hours per week pursuant to a contract between the Participating Employer and the Federal government which are subject to the Service Contract Act ("SCA"); and (2) employees located at other governmental or quasi-governmental locations subject to state laws and/or local ordinances similar to the SCA. Welfare benefits for certain Boon Group Employees are

offered in addition to the fringe contributions paid by the Participating Employer as more fully described in the Boon Group booklet and/or summary of coverage and/or certificate of insurance ("The Boon Group Materials").

Benefits offered to Boon Group Employees are medical, dental, vision, short-term disability and life insurance as more fully described in The Boon Group Materials. Certain Boon Group Employees may have the option to waive medical coverage and direct their fringe contribution to their account in the Allied Universal 401(k) Plan. Certain other collectively bargained Boon Group Employees may receive an additional Company-sponsored life insurance Benefit at no cost. Please see The Boon Group Materials for more information on these options.

Please note that eligibility requirements may vary depending on the requirements of the state law or local ordinance. Further, eligibility requirements are also subject to the client contract and hours worked. A waiting period (not to exceed 90 days) may also apply. Please see The Boon Group Materials for more information on eligibility requirements, waiting periods and the applicable effective date of coverage for your location.

Additional locations may be included in the Boon Group Employees in the future and eligibility requirements may vary. **Please call the Benefits Department at 1-888-670-7106 for more information or for a current list of locations for Boon Group Employees**.

Grandfathered Employees. When a Participating Employer obtains a new client, there are times when the Participating Employer may hire existing specified employees at that location (in accordance with the Participating Employer's hiring practices). Such existing specified employees, who are retained by the Participating Employer, are eligible for health benefits on the first day of the month after their date of hire with a Participating Employer. Individuals who become employees through an acquisition, merger or other transaction, will be eligible to participate under the Plan as specified herein or in accordance with the terms of the pertinent business transaction documents, as applicable.

Leaves of Absence. If you are on a leave of absence on the date your coverage would otherwise become effective, your enrollment will be processed in accordance with the practices and procedures set forth in your Participating Employer's leave policies.

Recommencement of Participation for Rehires. Generally, if your employment terminates and you again become an eligible employee, the following rules will apply:

- If you become an eligible employee within thirty (30) days of your termination date, your benefits will be automatically reinstated back to the date of termination.

- If you become an eligible employee after thirty (30) days, but within thirteen (13) weeks of your termination date, your benefits will be reinstated on the first of the month following your return to employment, subject to your ability to make appropriate election changes upon reinstatement.

- If you become an eligible employee more than thirteen (13) weeks after your termination date, you will be treated as a new hire and you will not be eligible for benefits until the first of the month following a sixty (60) day waiting period beginning on your date of rehire.

- If you are rehired in the same Plan Year as you terminated, you will be reinstated into the benefits that covered you before your termination.

- If you are rehired and your benefit effective date is after the beginning of a new Plan Year, you will be entitled to re-elect your benefits options.

Failure to Pay for Your Benefits. If you fail to pay for some or all of your benefits, the Plan will notify you of the date on which you will lose coverage for all benefits under the Plan.

Transferring Employees. If you are transferred from one location to another location, the benefit offerings and costs may differ. Such changes will be effective as soon as practicable following your transfer. Please call the Benefits Department at 1-888-670-7106 for more information.

Promoted Employees. If you are promoted from a Service Professional position to an Administrative Employee position, you will continue in the benefits for which you are already enrolled, to the extent those benefits are available to you. Within thirty-one (31) days of the effective date of your promotion, you may enroll in any benefit(s) for which you are eligible but are not enrolled, including a Health Care or Dependent Care FSA. You may also increase the amount of your Supplemental Life Insurance. Your Basic Life/AD&D Coverage amount will automatically increase to one times your eligible earnings on the first of the month following the date of your promotion. Similarly, your eligibility for any other benefits will begin on the first of the month following the date of your promotion. Please note that such a promotion does not allow you to drop any coverage that you previously elected. If you would like more information, please contact the Benefits Department at 1-888-670-7106.

Ineligible Employees. The following individuals are ineligible to participate in the Plan: (1) part-time employees (as determined in accordance with your Participating Employer's personnel policies and practices); (2) temporary and/or seasonal employees (as determined in accordance with your Participating Employer's personnel policies and practices); (3) interns (as determined in accordance with your Participating Employer's personnel policies and practices); (4) those who perform services for a Participating Employer pursuant to an arrangement with a leasing organization, including but not limited to "leased employees" within the meaning of section 414(n) of the Code; (5)

independent contractors; and (6) those who are not on a Participating Employer's payroll, whether or not they are later determined to be an employee of a Participating Employer.

Employees who are otherwise ineligible for coverage but are determined to be "full-time employees" under the ACA (as determined by the Company or a Participating Employer) may nonetheless be eligible for medical coverage (as well as dental, vision and life insurance coverage) under the Plan. For example, the Plan generally provides benefits only to full-time employees and their dependents. However, if you are determined to be a "full-time employee" during a particular measurement period, then you will continue to be eligible for coverage throughout the subsequent stability period, even though your hours may have dropped below 30 per week during that stability period. The Participating Employer will establish appropriate initial and on-going measurement periods for purposes of determining which ineligible employees meet the definition of "full-time employee" under ACA. If the Participating Employer chooses to use a look-back measurement period, the look-back measurement period may vary in length by category of employee and may be changed prospectively from year-to-year at the Participating Employer's discretion and to the extent permitted by Treas. Reg. §54.4980H-3. If an employee meets the definition of "full-time employee" during the applicable measurement period, as determined by the Participating Employer, the employee will be offered coverage for the duration of the next stability period. The length of the stability period shall comply with Treas. Reg. §54.4980H-3. The rules governing determination of full-time status will be made in accordance with the Participating Employer's Affordable Care Act Measurement Guidelines.

Eligible Dependents.

You can elect to provide medical, dental, vision, voluntary life insurance, voluntary accident insurance, voluntary critical illness insurance and voluntary hospital insurance for your eligible dependents who meet the eligibility requirements set forth in Appendix A. In general, you may be required to pay the full premium amount for any dependent coverage that you elect. If you are an Administrative Employee, you can also establish one or more Flexible Spending Accounts ("FSAs") to pay eligible expenses for your eligible dependents who meet the applicable eligibility requirements. PLEASE SEE APPENDIX A FOR MORE DETAILED INFORMATION ON WHO MAY BE COVERED AS A DEPENDENT UNDER THIS PLAN. PLEASE NOTE THAT ELIGIBLE DEPENDENTS MAY VARY DEPENDING ON THE BENEFIT.

CESSATION OF PARTICIPATION

Coverage under the Plan will terminate automatically for medical, dental, vision and life insurance as of the last day of the month in which your employment terminates, or you and/or your dependent(s) lose eligibility. All other benefits offered under this Plan will terminate on the date you cease to be an eligible participant. In addition, coverage will terminate as of the first to occur of the following:

- the date all coverage or certain benefits are terminated for your particular employment classification, due to a modification of the Plan;

- with respect to a dependent, the last day of the month in which the dependent ceases to be an eligible dependent as defined by the particular benefit provider under the applicable contract;

- the last day of the last period for which any required contribution toward the cost of coverage was made;

- the first day of the stability period which follows an on-going measurement period during which you fail to meet the definition of "full-time employee" under the ACA (as determined by the Participating Employer) if you are otherwise ineligible but gained eligibility during an initial measurement period or preceding on-going measurement period; or

- the date the Plan terminates.

Your Participating Employer may continue coverage during certain periods of absence, such as a leave of absence under the Family and Medical Leave Act of 1993, in accordance with its written personnel policies and practices. Your Participating Employer may require contributions during periods of absence in accordance with its written personnel policies and practices.

PARTICIPATION AND COST OF THE PLAN

Participation. If you are an eligible employee, you may become a participant in each benefit as of the expiration of the applicable waiting period, subject to your making the appropriate election and paying any required contribution. If dependent coverage is available (and elected), such coverage will begin when your coverage begins.

Once you make an election to participate in the Plan, you may change that election only (1) if you have a change in status, as described below under COVERAGE OPTIONS AND ENROLLMENT, or (2) during an open enrollment period (the change in such case will commence with the first day of the next succeeding "Plan Year," January 1 through December 31 or "stability period," as applicable).

Failure to Make an Election. If you fail to make an election for benefits within the specified election period established by the Plan Administrator:

- upon your *initial* eligibility for coverage, you will be automatically enrolled in Basic Life Insurance and AD&D Insurance and will be deemed to have elected no other benefits unless you are a Boon Group Employee (as described above);

- upon any ***subsequent*** eligibility for coverage, unless the Enrollment Materials specify otherwise or such coverage is no longer available, you will be deemed to have elected the same coverage as in the preceding Plan Year or stability period, as applicable (except that *Administrative Employees* will be deemed to have elected no benefits for the Health Care FSA and Dependent Care FSA); however, the Company retains the right to require a re-enrollment. If a re-enrollment is required, you will be notified;

- upon ***both initial*** eligibility and any ***subsequent*** eligibility for coverage if you are a ***Boon Group Employee***, you will receive certain self-only coverage ***automatically*** (as described in the Boon Group booklet). However, an election must be made for dependents to receive coverage.

Therefore, it is extremely important that you enroll online (or, in the case of Boon Group Employees, return your enrollment materials) within the time period prescribed by the Company or a Participating Employer.

Cost of Plan. Your Participating Employer may share a portion of the cost of coverage under this Plan with eligible employees. The enrollment application for coverage will include a compensation reduction agreement, where applicable. Some contributions are made on a pre-tax basis and some contributions are made on an after-tax basis. Some benefits may be fully paid by your Participating Employer.

The level of any employee contributions is set by the Company and/or a Participating Employer(s). The Company and the Participating Employers reserve the right to change the level of employee contributions at any time. Contributions, both pre-tax and after-tax, are made by entering into a compensation reduction agreement with your Participating Employer. "Pre-tax" means that the cost of coverage will be deducted from the employee's pay before federal income taxes, social security taxes and in most cases state or local income taxes are withheld. This allows the employee to purchase coverage with more valuable pre-tax dollars. Therefore, the employee will be taxed on a slightly lower gross income and employment taxes will be lower. Note that certain exceptions apply. For example: (1) for New Jersey residents, all amounts deducted from pay will be subject to New Jersey state income taxation; (2) contributions to the Dependent Care FSA will be subject to Pennsylvania state income taxation; (3) contributions to the Health Savings Account (HSA) will be subject to California state income taxation and (4) amounts deducted from pay may be subject to local income taxation (such as in Philadelphia). Benefits purchased on a pre-tax basis include medical coverage, dental coverage, vision coverage, Health Savings Account (HSA) and, for Administrative Employees only, Dependent Care FSA and Health Care FSA coverage.

Contributions for a Domestic Partner, a Domestic Partner's Dependent Child(ren) or a Child(ren) for whom you are Legal Guardian

The amount of your contribution to provide health benefits for a domestic partner (as defined in Appendix A) and children of a domestic partner or a child for whom you are

legal guardian will be the same as for a spouse and/or his or her children. However, the value of health coverage will be taxable to you unless the person being covered is a "dependent" as defined in the Internal Revenue Code.

Unless your domestic partner and/or his or her child(ren) or a child(ren) for whom you are legal guardian meet certain requirements (see below), the payments for coverage under the Plan will be deducted from your salary on a pre-tax basis and then the total value of the coverage provided on behalf of your domestic partner and his or her children or a child for whom you are legal guardian under the Plan will be considered taxable income to you. You will not actually receive additional income in your paycheck, but your Participating Employer will withhold federal taxes and, where applicable, city and state taxes on this additional "imputed" amount and it will be reported on your Form W-2 for the year. The value of the coverage provided to your domestic partner and his or her children or a child for whom you are legal guardian will be based on the cost of the coverage under the Plan, as determined by the Company and/or a Participating Employer(s). Some employees may be able to avoid imputed income if they are able to complete and submit an Affidavit of Tax Dependency and/or an Affidavit of State Tax Treatment.

If Domestic Partner and His/Her Children or a Child for Whom You Are Legal Guardian Do Not Meet Requirements to Receive Medical, Dental and/or Vision Benefits on a Tax-Favored Basis		
Who is Covered	**Premium Paid by Employee (Pre-Tax Contribution)**	**Imputed Income**
Employee and partner	Employee contribution for Employee +Spouse/Partner coverage	Cost to the Plan of Employee Single coverage
Employee, partner and employee's dependent child(ren)	Employee contribution for Employee + Family coverage	Cost to the Plan of Employee Single coverage
Employee, partner and partner's dependent child(ren)	Employee contribution for Employee + Family coverage	Cost to the Plan of Employee + Child(ren) coverage
Employee, partner, employee's dependent child(ren) and partner's dependent child(ren)	Employee contribution for Employee + Family coverage	Cost to the Plan of Employee + Child(ren) coverage

If your domestic partner and/or his or her child(ren) or a child for whom you are legal guardian meet certain requirements, and you provide your Participating Employer with an "Affidavit of Tax Qualified Dependency" form demonstrating that those requirements have been satisfied, coverage for those individuals will be provided on a tax-favored basis. Your domestic partner and/or his or her child(ren) or a child for whom you are legal guardian meet these requirements if:

- The individual is a member of your household, has his or her principal place of residence in your home and the relationship is not in violation of local law;

- The individual is a citizen, national, or legal resident of the United States or a resident of Canada or Mexico. (This requirement does not apply to a child adopted by a US citizen or national if the child lives with you for the entire year.)

- You furnish over half of the individual's support for the year. In making this calculation, the amount you contribute towards such support must be compared with the amounts received for support by such individual from all other sources, including any amounts supplied by him or her and including earnings; and

- The individual cannot be claimed by another taxpayer as a dependent child for federal income tax purposes.

If your domestic partner and/or his or her child(ren) or a child for whom you are legal guardian meet these requirements, the cost of coverage under the Plan will be deducted from your pay on a pre-tax basis and no additional income will be imputed to you.

We suggest that you consult a tax advisor to determine whether you may claim your domestic partner and/or his or her children or a child for whom you are legal guardian as dependents for tax purposes, before you certify that they are dependents.

COVERAGE OPTIONS AND ENROLLMENT

During each annual open enrollment period, you will be given the opportunity to make your benefit choices for the upcoming Plan Year (January 1 through December 31). Except as provided in the following sentence, if you do not elect to change your selection from the previous year, the Company and your Participating Employer will assume that you want to continue under the same option, unless the Company determines that reenrollment will be required for a particular Plan Year. However, for Administrative Employees to contribute to a Dependent Care FSA or a Health Care FSA, they must make an election for each Plan Year. FSA elections will not carry over from year to year.

Each year during the annual open enrollment period, eligible employees will be able to elect from available benefit coverage options based on which benefits and coverage levels are right for them. Benefits may differ slightly depending on the coverage option offered to and elected by the employee. Further, certain union employees may be eligible to opt out of medical coverage under the applicable union fund and receive a monetary award in lieu of said coverage. Please call your district office for more information.

Eligible employees may elect to receive benefits as detailed in Appendix B.

CHANGE IN STATUS RULES

Generally, **you may not make changes to your coverage elections during the Plan Year, whether or not you make contributions for your coverage**. (This restriction is due primarily to requirements under federal law.) However, you may make a change to an election which is on account of and consistent with a "change in status." If you have a change in family or work status or under certain other circumstances, you may join, re-join, opt out, increase or decrease coverage (e.g., change from employee to family or vice versa) if you notify the Benefits Department within 31 days of the change. Your election change, however, must be consistent with your change in status. If your election change is consistent with the change in status and you notify the Benefits Department within 31 days of the change (within 45 days in the case of a change that would necessitate the addition of a dependent following the date of birth, adoption or placement for adoption), your election change will become effective on the first of the month following the date of notice (except for birth and adoption, in which case coverage will become effective as of the date of birth, adoption or placement for adoption). You may be required to provide the Plan Administrator with documentation supporting your change in status. Please note that Special Enrollment rights, as described in the Special Enrollment Rights section, may apply.

Note: *Any changes related to a spouse or child(ren) will apply equally to a domestic partner and his or her child(ren) (including providing the Benefits Department with documentation supporting your change in status – i.e., Affidavit of Domestic Partnership or Civil Union or Termination of Domestic Partnership).*

The following list describes circumstances that may permit you to make an election change:

Legal marital status. Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation, or annulment.

Number of dependents. Events that change your number of dependents (as defined for income tax purposes), including birth, adoption, placement for adoption, or death of a dependent.

Employment status. Generally, this includes events that change the employment status of you, your spouse, or your dependent, including a termination or commencement of employment, the reduction or increase in hours of employment (i.e. switching from full-time to part-time or part-time to full-time employment status, a strike or lockout), a commencement of or return from an unpaid leave of absence, or a change in worksite affecting coverage.

Reduction of Hours During Plan Year. You may make an election change by cancelling your coverage if you experience a reduction of hours below 30 hours per week during a Plan Year (which results in a change in your work status to part-time) and you

certify that you will obtain coverage on the Health Insurance Marketplace/Exchange within two months of the cancellation of your coverage under this Plan.

Dependent satisfies or ceases to satisfy the requirements for dependents. An event that causes your dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any similar circumstance.

Residence. A change in the place of residence of you, your spouse, or your dependent that would affect your coverage (e.g., moving into or out of an HMO service area).

Change in Coverage Under Another Employer's Plan. You may be able to make an election change that is on account of and corresponds with a change made under the plan of the spouse's, former spouse's, or dependent's employer under certain circumstances.

Significant Change in Cost or Coverage under the Plan. You may be able to make an election change that is on account of and corresponds with a significant change in the cost or coverage under the Plan, as determined by the Plan Administrator.

Judgment, Decree or Order. You may make an election change as may be required pursuant to a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) that required health coverage for your child.

Medicare Entitlement. You may make an election change that is on account of and corresponds with you, your spouse or child becoming entitled to (i.e., being enrolled in), or cessation of eligibility for, Medicare (Part A or Part B), Medicaid or Children's Health Insurance Program "CHIP" benefits.

Change in Dependent Care Provider. You may make an election change to the contribution to your Dependent Care FSA that is due to a change in the cost of dependent care (as long as your dependent care provider is not your relative) or a change in dependent care provider.

Health Insurance Marketplace Coverage. You may make an election change by cancelling your health coverage if you experience a special enrollment period allowing you to enroll under the Health Insurance Marketplace/Exchange and you obtain coverage on the Health Insurance Marketplace/Exchange immediately upon the cancellation of your coverage under this Plan.

Other Changes. You may make changes on account of such other events that the Plan Administrator determines would permit a change of election under applicable governmental regulations. Note: Inability to afford the cost of the coverage you elected is not a legally approved reason to change status/plans during the Plan Year.

You are permitted to change health insurance providers or HMOs during the Plan Year under only exceptional and extremely limited circumstances. Such a change may take place during the annual open enrollment period prior to each Plan Year if you have more than one benefit option to choose from. Please contact the Benefits Department for more information.

BENEFITS

This section briefly summarizes the health and welfare benefits available under the Plan and describes some important rules regarding your annual elections under the Plan. For a more complete description of the benefits available under each coverage option, please refer to your Enrollment Materials and the benefits microsite at www.allieduniversalbenefits.com (which houses the separate descriptive booklets from the Company, your Participating Employer, third-party administrators, insurance companies, and HMOs, as these documents may be updated from time to time). Complete descriptions of the health care and dependent care FSAs are provided below.

Please note that certain benefits are only available to "Administrative Employees" as defined above.

Decisions on Health Care. The Plan's health care benefits provide solely for the payment of certain health care expenses. All decisions regarding health care will be solely the responsibility of each covered individual in consultation with the personal health care provider selected by the individual. The Plan and any applicable insurance contracts contain rules for determining the percentage of allowable health care expenses that will be reimbursed and whether particular treatments or health care expenses are eligible for reimbursement. Any decision with respect to the level of health care reimbursement, or the coverage of a particular health care expense, may be disputed by the covered individual in accordance with the Plan's claims procedure. Each covered individual may use any source of care for health treatment and health coverage as selected by such individual, and the Plan, the Company and your Participating Employer will not have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a covered individual not to seek or obtain such care, other than liability under the Plan for the payment of benefits.

To the extent applicable, group health coverage under the Plan shall comply with the patient protections regarding choice of health care professionals and emergency care services under the Public Health Services Act 2719A.

Privacy of Health Information. The receipt, use and disclosure of protected health information by the medical, prescription drug, dental, vision and health care flexible spending account portions of the Plan is governed by regulations issued under the Health Insurance Portability and Accountability Act (commonly referred to as "HIPAA"). In accordance with these regulations, the Plan Administrator, certain employees of the plans and the plans' business associates may receive, use and disclose protected health information in order to carry out payment, treatment and health care operations under the

plans. These entities and individuals may use protected health information for such purposes without your consent or written authorization. In addition, your protected health information may be shared with the Plan Sponsor without your consent or written authorization for administrative purposes. In the normal course, if your protected health information is used or disclosed for any other purpose, your written authorization for such use or disclosure will be required. See the section of this booklet entitled **HIPAA PRIVACY** for information regarding the privacy of your protected health information.

Special Enrollment Rights. If you are declining enrollment in medical, prescription drug, dental and vision coverage for yourself and/or your spouse, domestic partner and/or dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and/or your spouse, domestic partner and/or dependents in health coverage under this Plan or change your medical coverage option in the following circumstances:

- if you and/or your spouse, domestic partner and dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage),
- if you or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- if you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

However, you must request enrollment (i) within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage) including the exhaustion of COBRA coverage, or (ii) within 60 days in the case of changes related to Medicaid or CHIP.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in health coverage under this Plan or change your medical coverage benefit. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption (and complete all required applications).

In general, coverage added under these rules will be effective on the first of the following month following receipt of notification except in the case of birth, adoption or placement for adoption. In such cases, the effective date of coverage will be the date of birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact the Benefits Department.

Medical Coverage

You have the option to elect medical coverage for you and your dependents which will become effective at the expiration of the applicable waiting period. This medical coverage may include a prescription drug benefit, as described in the booklets prepared by the third-party administrators, insurers or HMOs. To enroll in medical coverage, *you must make an online election prior to the deadline date provided to you* (or in the case of Boon Group Employees who would like to cover dependents or waive coverage, return your enrollment materials). **The medical benefit option for which you are eligible depends on your work location**.

You may review current medical options on the Allied Universal benefits microsite at www.allieduniversalbenefits.com. The options available to you will be shown on the on-line enrollment site (or in the case of Boon Group Employees, in your enrollment materials).

Depending on your location, you may have a choice of medical benefit options unless governed by a collective bargaining agreement. Each option has its advantages and disadvantages, and the Company and your Participating Employer hope you will consider each carefully before making your decision. You should make your decision based on individual and family health care needs. In determining coverage options for you and your family, you should consider whether or not you have dependents residing outside of an HMO's coverage area or any restrictions that an HMO may have with regard to coverage while traveling.

Your dependents (as detailed in Appendix A) are also eligible to participate in the option you select. See the section of this booklet entitled **COVERAGE OPTIONS AND ENROLLMENT** for rules governing your election (and your ability to change your election) and the manner in which contributions are made. Dependents may not be covered under a benefit option other than the one the employee chooses for him/herself.

Certain collective bargaining agreements may provide for a cash payment to certain union employees who waive medical coverage. Please see your Enrollment Materials or contact your district office to determine if you are eligible for a cash payment.

Paying for Coverage. You may be required to contribute toward the cost of medical coverage you select (minus any subsidies that may be available to you). Any contribution you are required to pay is made on a pre-tax basis and is determined by the Company and your Participating Employer each year.

Tobacco Usage Surcharge. A Tobacco Usage Surcharge of $50 a month will be automatically deducted from your pay if you are enrolled in a medical benefit under this Plan and you self-identify as someone who uses tobacco products. You will be asked to indicate your status as user of tobacco products during your initial enrollment period and during each annual enrollment period thereafter. If you are subject to the Tobacco Surcharge and complete the Quit for Life program (which is offered at no cost by the

Company), the surcharge will be eliminated. If you register for and complete the Quit for Life program within 6 months of your initial medical plan enrollment effective date or by June 30 following any subsequent annual open enrollment effective date, your surcharge will be removed and the surcharge amount paid by you will be refunded. If you complete the Quit for Life program later than the time period described above, your surcharge will stop but you will not be refunded any surcharge previously paid. Please see the Company's Tobacco Usage Surcharge Policy, for more information. Please note that falsely indicating non-tobacco usage could lead to loss of coverage, termination of employment and/or other consequences.

Medical Loss Ratio Rebates. With respect to any insurance company rebates received by the Plan Sponsor that are subject to the Medical Loss Ratio ("MLR") provisions of the ACA, the Plan Administrator will determine what portion (if any) of such rebate must be treated as "plan assets" under ERISA. If any portion of the rebate must be treated as plan assets, the Plan Administrator will determine in its sole discretion the manner in which such amounts will be used by the Plan or applied to the benefit of participants; which participants need not be the same participants who made contributions under the policy that issued the rebate. Any portion of the rebate that is not treated as plan assets will be allocated among one or more of the Participating Employers as the Plan Sponsor in its sole discretion determines appropriate.

Special Rules Related to Pregnancy and Childbirth. The Plan 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 normal delivery, or less than 96 hours following a Cesarean section, or require that a health care provider obtain authorization from the Plan or any insurance issuer (including an HMO) for prescribing a length of stay not in excess of the above periods. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with and obtaining the consent of the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Special Coverages Required by the Women's Health and Cancer Rights Act. The Women's Health and Cancer Rights Act of 1998 requires the Plan to cover the following medical services in connection with coverage for a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

These services will be provided in a manner determined in consultation with the attending physician and the patient. Coverage for these medical services is subject to applicable deductibles and coinsurance amounts as well as other applicable plan provisions.

Termination of Employment. If your employment with your Participating Employer terminates, you and your dependents will remain covered through the end of the month in which termination occurs. However, under federal law, you and your dependents may be entitled to continuation of health care coverage. You may also have rights under any insurance policy that provides your coverage. The section of this booklet entitled **CONTINUATION OF COVERAGE UNDER COBRA** describes certain circumstances under which health care coverage may be continued after the date coverage would otherwise end.

Dental Coverage

You have the option to elect dental coverage for you and your dependents which will become effective after the expiration of the applicable waiting period. The available dental benefits (as detailed in Appendix A) are described on the benefits microsite at www.allieduniversalbenefits.com and the booklets prepared by the insurer. To enroll in dental coverage, *you must make an on-line election (or, in the case of Boon Group Employees, who would like to cover dependents or waive coverage, return your enrollment materials) prior to the deadline date provided to you*. See the section of this booklet entitled **COVERAGE OPTIONS AND ENROLLMENT** for rules governing your election (and your ability to change your election) and the manner in which contributions are made. Please see the above-mentioned booklets for additional waiting periods that may apply to certain services under this benefit.

Paying for Coverage. You are required to contribute the full cost of the dental coverage you select (minus any subsidies that may be available to you). Any contribution you are required to pay is made on a before-tax basis and is determined by the Company and your Participating Employer each year.

Termination of Employment. If your employment with your Participating Employer terminates, you and your dependents will remain covered through the end of the month in which termination occurs. However, under federal law, you and your dependents may be entitled to continuation of dental coverage. The section of this booklet entitled **CONTINUATION OF COVERAGE UNDER COBRA** describes certain circumstances under which dental coverage may be continued after the date coverage would otherwise end.

Vision Coverage

You have the option to elect vision coverage for you and your dependents, which will become effective after the expiration of the applicable waiting period. The available vision benefits (as detailed in Appendix A) are described on the benefits microsite at www.allieduniversalbenefits.com and the booklets prepared by the insurer. To enroll in vision coverage, *you must make an on-line election (or, in the case of Boon Group Employees who would like to cover dependents or waive coverage, return your enrollment materials) prior to the deadline date provided to you*. See the section of this booklet entitled **COVERAGE OPTIONS AND ENROLLMENT** for rules governing your election

(and your ability to change your election) and the manner in which contributions are made. Please see the above-mentioned booklets for additional waiting periods that may apply to certain services under this benefit.

Paying for Coverage. You are required to contribute the full cost of the vision coverage you select (minus any subsidies that may be available to you). Any contribution you are required to pay is made on a before-tax basis and is determined by the Company and your Participating Employer each year.

Termination of Employment. If your employment with your Participating Employer terminates, you and your dependents will remain covered through the end of the month in which termination occurs. However, under federal law, you and your dependents may be entitled to continuation of vision coverage. The section of this booklet entitled CONTINUATION OF COVERAGE UNDER COBRA describes certain circumstances under which vision coverage may be continued after the date coverage would otherwise end.

Life and Accidental Death & Dismemberment ("AD&D") Insurance

For Administrative Employees only: At the expiration of the applicable waiting period, your Participating Employer will automatically provide you with a basic life and AD&D insurance benefit, as follows:

For hourly-paid employees, an amount equal to the employee's current hourly rate of pay times 2080, plus the amount of commissions paid over the 52-week period immediately prior the covered loss triggering payment by the carrier (or the period of employment, if less than 52 weeks).

For salaried employees, an amount equal to the employee's current, bi-weekly rate of pay times 26 (as reported by the Participating Employer as of the date the covered loss), plus commissions paid over the 52-week period immediately prior the covered loss (or the period of employment, if less than 52 weeks), but not including bonuses, overtime pay or other extra compensation.

A change in the rate of pay for insurance purposes is effective on the first of the month following such change.

The benefit will be rounded up to the nearest $1,000, from a minimum amount of $10,000 to a maximum of $500,000.

Once initially enrolled in life and AD&D insurance coverage, you will be asked to designate a beneficiary. Please refer to the information on the benefits website at www.allieduniversalbenefits.com (or in the case of Boon Group Employees, in your enrollment materials) for additional information. Note that once you attain age 70, the benefit reduces to 67% of the original amount.

Note: The first $50,000 of basic life and AD&D insurance coverage is tax-free. However, under current federal tax laws, employer provided life insurance coverage in excess of $50,000 results in taxable income to employees. Although this amount is not actually received by you in your paycheck, the value of life insurance coverage in excess of $50,000 is taxable to you as imputed income in each paycheck and is be reported as such on your Form W-2.

See the section of this booklet entitled **COVERAGE OPTIONS AND ENROLLMENT** for rules governing your election.

Paying for Coverage. Your Participating Employer provides this coverage at no cost to you.

Termination of Employment. If your employment with your Participating Employer terminates, your life insurance coverage will be terminated at the end of the month in which your employment terminates. You may be able to convert your coverage into an individual policy within sixty (60) days of termination of employment. The policy may also include a portability option. Contact the carrier for more information.

For Service Professionals only: After the expiration of the applicable waiting period, your Participating Employer will automatically provide you with a core life and AD&D insurance benefit equal to $10,000. Some locations may offer different amounts based on client contracts or collective bargaining agreements. Please see your online Benefit Election information (or in the case of Boon Group Employees, in your enrollment materials) for the amount of your benefit.

Once initially enrolled in life and AD&D insurance coverage, you will be asked to designate a beneficiary. Please refer to the information on the benefits website at www.allieduniversalbenefits.com for additional information. Note that once you attain age 70, the benefit reduces to 67% of the original amount.

See the section of this booklet entitled COVERAGE OPTIONS AND ENROLLMENT for rules governing your election.

Paying for Coverage. Your Participating Employer provides this coverage at no cost to you.

Termination of Employment. If your employment with your Participating Employer terminates, your life insurance coverage will be terminated at the end of the month in which your employment terminates. You may be able to convert your coverage into an individual policy within sixty (60) days of termination of employment. The policy may also include a portability option. Contact the carrier for more information.

Additional Life Insurance

Employee Supplemental Life Insurance. Employee supplemental life insurance coverage is available to you in increments (or tiers) of $10,000 not to exceed five times

your base salary, or $500,000, whichever is less, and becomes effective after the expiration of the applicable waiting period, provided you timely submitted any required Evidence of Insurability information. Evidence of Insurability may be required on amounts over $200,000. Coverage that you purchase is term life insurance. You may increase your coverage amount on account of certain changes in status or during annual enrollment, but proof of good health may be required. Further, if you do not enroll upon your initial eligibility, proof of good health may be required.

Once enrolled, you will be asked to complete certain required paperwork, including designating a beneficiary. Please refer to the benefits microsite at www.allieduniversalbenefits.com for additional information. Note that once you attain age 70, the benefit reduces to 67% of the original amount.

Spouse Life Insurance. You may also purchase term life insurance for your dependent spouse or a qualified domestic partner, provided your spouse or domestic partner is not covered as an employee of a Participating Employer or as a dependent under another employee's coverage. Additionally, you may not be covered both as an employee and as a dependent spouse. Coverage becomes effective after the expiration of the applicable waiting period, provided you timely submitted any required Evidence of Insurability information. You are the beneficiary of any coverage you have for your spouse or domestic partner.

The coverage amount that you may elect for your spouse or domestic partner is in $5,000 increments, up to $100,000. However, Spouse life insurance may not exceed 50% of the employee's supplemental life insurance, rounded down to the nearest increment or tier. Cost of Spouse life insurance is calculated using the spouse's age. At your initial eligibility, proof of good health will be required if electing amounts over $75,000. After initial enrollment (even if you do not enroll your spouse or domestic partner upon your initial eligibility), proof of good health is required for any amount.

Please refer to the benefits microsite at www.allieduniversalbenefits.com for additional information including, but not limited to, reduction of benefits due to age.

Child(ren) Life Insurance. You may also purchase life insurance for your dependent child(ren) from birth up to 26 years of age (coverage continues if the child is disabled) in the amount of either $5,000 or $10,000 per child. All children will be covered for one premium. All children will be covered for the same amount – you may not choose different amounts for each child. You are the beneficiary of any coverage you have for your child(ren). Note that if a child dies prior to reaching six months of age, the amount paid will be only $500, regardless of the amount elected.

Please refer to the benefits microsite at www.allieduniversalbenefits.com for more information.

Paying for Coverage. If you elect to purchase additional life insurance on yourself, your spouse or your child(ren), you will be responsible for paying for the

coverage you elect on an after-tax basis. *Please note that, rates for all additional life insurance coverage may increase each year in January*. Rates are age-based and will increase when you move to a new age band.

Termination of Employment. If your employment with your Participating Employer terminates, your life insurance coverage will be terminated at the end of the month in which your employment terminates. You may be able to convert your coverage into an individual policy within 60 days of termination of employment. If you die before 60 days, it will be assumed that you converted. The policy may also include a portability option. Contact the carrier for more information.

Short-Term Disability

If you are unable to work due to non-occupational illness or injury, your Participating Employer provides you the option of purchasing Short-Term Disability ("STD") coverage. Benefits commence after you have been absent from work for a period of 14 calendar days.

- If you work in a state other than California, Hawaii, New Jersey, New York or Rhode Island, the Plan pays 60% of your pre-disability weekly base salary up to a maximum benefit of $2,500 per week.

- If you work in California, Hawaii, New Jersey, New York or Rhode Island, the Plan pays 20% of your pre-disability weekly base salary up to a maximum benefit of $2,500 per week.

The benefit is paid for up to 180 days or the end of your disability, whichever comes first. Your STD benefits may be offset by other sources of income and disability earnings, including, but not limited to employer-provided disability benefits and/or disability retirement benefits. Benefits may also be reduced on account of any third-party recovery if benefits are paid due to an injury caused by a third party and you receive an award from that party. Please refer to the information on www.allieduniversalbenefits.com for more information.

Paying for Coverage. If you elect to purchase Short-Term Disability coverage on yourself, you will be responsible for paying for the full cost of coverage you elect on an after-tax basis.

Termination of Employment. If your employment with your Participating Employer terminates, your short-term disability coverage will be terminated on your termination date. STD benefits in pay status at termination of employment will not end due to termination unless otherwise stated in the descriptive booklet provided by your Participating Employer.

Long-Term Disability

You have the option to purchase Long-Term Disability ("LTD") coverage. You pay the full cost of this Plan. The plan pays 60% of your pre-disability base salary up to a maximum benefit of $14,000 per month if you are totally disabled (as defined by the insurance carrier) for more than 180 days. In general, the benefit will continue until age 65 so long as you remain totally disabled. However, special rules may apply in the case of a disability commencing after age 60. Please refer to the descriptive booklet provided by your Participating Employer for more information.

Your LTD benefits may be offset by other sources of income and disability earnings, including but not limited to, social security benefits, any payments under any state compulsory benefit law (such as a mandatory state disability plan), workers' compensation or other occupational disease law, employer-provided disability benefits or governmental disability retirement benefits received as a result of your employment. Please note that you are required to file for social security disability benefits. Please refer to the information on the www.allieduniversalbenefits.com for more information.

Paying for Coverage. If you elect to purchase Long-Term Disability coverage on yourself, you will be responsible for paying for the full cost of coverage you elect on an after-tax basis.

Termination of Employment. If your employment with your Participating Employer terminates, your long-term disability coverage will be terminated on your termination date. LTD benefits in pay status at termination of employment will not end due to termination unless otherwise stated in the descriptive booklet provided by your Participating Employer.

Employee Assistance Program ("EAP")

The EAP provides employees and their dependents with professional, confidential assistance with issues relating to work, family, grief counseling, substance abuse, stress, etc.

All benefits eligible employees are provided with EAP benefits. You are provided with unlimited telephonic access and up to three face-to-face visits with professionals for each issue. Please refer to the materials provided by your Participating Employer for more information.

Paying for Coverage. Although this EAP benefit is provided by your Participating Employer at no cost to you, you will be responsible for fees if you seek treatment beyond that provided by the program, However, your medical insurance may cover some or all the required fees if you seek further treatment.

Termination of Employment. If your employment with your Participating Employer terminates, your EAP benefit will be terminated at the end of the month following your termination date.

Voluntary Accident Insurance Benefit

You may elect a voluntary accident insurance benefit for yourself and your spouse ages 18 and older and your dependent children from age 18 to 26 (as described in Appendix A). This benefit covers your family for a wide variety of accidental injuries. It supplements your medical benefits by providing payment when a covered person has a medical service and/or treatment related to accidental injuries. For more information (including, but not limited to an actively at work requirement), please see the booklet from the provider.

Paying for Coverage. If you elect the accident insurance benefit, you will be responsible for paying for the full cost of coverage you elect on an after-tax basis.

Termination of Employment. If your employment with your Participating Employer terminates, your accident insurance benefit will be terminated at the end of the month in which your employment terminates.

Voluntary Hospital Coverage

If you are between the ages of 18 and 64 years old, you may elect voluntary hospital coverage for you and your dependents (as described in Appendix A). Once you are enrolled, coverage may continue beyond age 64. This benefit option pays additional benefits over and above any benefit paid by your medical benefit if you or a covered dependent is hospitalized. For more information, see the description of the benefit on the benefits microsite.

Paying for Coverage. If you elect the Voluntary Hospital Coverage benefit, you will be responsible for paying for the full cost of coverage you elect on an after-tax basis.

Termination of Employment. If your employment with your Participating Employer terminates, your Voluntary Hospital Coverage benefit will be terminated at the end of the month in which your employment terminates.

Voluntary Critical Illness Coverage

If you are between the ages of 18 and 64 years old, you may elect a voluntary critical illness coverage for you and your dependents (as described in Appendix A). Once you are enrolled, coverage may continue regardless of your age. This benefit option pays benefits over and above those paid by your medical benefit for expenses related to certain severe illnesses. For more information, see the description of the benefit on the benefits microsite.

Paying for Coverage. If you elect the Voluntary Critical Illness benefit, you will be responsible for paying for the full cost of coverage you elect on an after-tax basis.

Termination of Employment. If your employment with your Participating Employer terminates, your Voluntary Critical Illness benefit will be terminated at the end of the month in which your employment terminates.

Voluntary Legal Services

You may elect a voluntary legal service benefit for you [and your dependents (as described in Appendix A).] This benefit provides a wide variety of legal services. Please refer to the information on the www.allieduniversalbenefits.com for more information.

Paying for Coverage. If you elect the voluntary legal services benefit, you will be responsible for paying for the full cost of coverage you elect on an after-tax basis.

Termination of Employment. If your employment with your Participating Employer terminates, your voluntary legal services benefit will be terminated at the end of the month in which your employment terminates.

Wellness Programs

From time to time, the Plan may offer wellness programs designed to promote the health and wellbeing of all employees. These wellness programs may provide financial incentives to engage in activities that encourage healthy lifestyle changes, provide you with information about your current health condition by undergoing health screenings or answering questionnaires, give you the opportunity to receive health "coaching" and participate in disease management programs, provide on-line education tools, etc. These wellness programs are designed to help mitigate risks and allow you to be more involved in your healthcare, which may lead to a healthier employee population with lower healthcare costs, ultimately saving you and the Participating Employers money. Information collected as part of any wellness program will be analyzed and considered when developing future wellness programs and making future plan design changes affecting all participants. The terms of any wellness program will be communicated to you separately as part of open enrollment material or other communications. Any wellness program and related financial incentive offered under the Plan shall comply with the requirements and limitations of HIPAA, the ACA and related guidance.

Flexible Spending Accounts (FSAs) (For Administrative Employees Only)

Highlights. FSAs provide valuable benefits designed to give you an effective way to reimburse yourself on a tax-free basis for certain health care and dependent care expenses. The Health Care FSA is designed to help you pay certain health care expenses that you and your family may incur. For Administrative Employees other than Executives, the Dependent Care FSA is intended to qualify as a dependent care assistance benefit within the meaning of Section 129 of the Code and help you pay qualified dependent care expenses.

Before the Plan Year begins, or prior to the expiration of the applicable waiting period, you may elect to have a portion of your pay placed in either or both FSAs on a

pre-tax basis. You estimate the amounts that you will require in each account for the year and divide the result by the number of pay periods left in the year. This equal amount will be deducted from your gross pay each pay period ***before taxes***. You may contribute ***from $100 up to the applicable IRS maximum ($2,750 for 2020) to a Health Care FSA and from $100 up to $5,000 to a Dependent Care FSA***. (Please note that the amount that can be paid tax-free from a Dependent Care FSA may be less than $5,000, as described below). If you establish an FSA, you can use "untaxed" money to pay for services that you used to pay for with after-tax dollars. The ACA does not apply to the Health Care FSA because it is a "limited excepted benefit" under Federal tax law.

Remember, it is important that you be conservative when estimating your expenses for the next Plan Year. IRS regulations state that any money set aside in these accounts not used for expenses incurred during the same year must be ***forfeited***. ***THE DOLLARS CANNOT BE RETURNED TO YOU***. This is the "use it or lose it" rule required by the IRS. Please note that you will not be entitled to receive interest or any other earnings on contributions allocated to your FSA(s).

In summary:

- Dollars you place in your FSA are taken out of your pay before they are taxed;
- The money in your FSA can only be used to reimburse eligible expenses incurred in the same Plan Year;
- You will not be entitled to receive interest or any other earnings on contributions made to your FSA(s);
- Money in one FSA cannot be used to pay for items covered by the other FSA; nor can money in one FSA be transferred to the other FSA;
- Claims are paid on a daily basis or as soon as is practicable thereafter; and
- You have up to March 31 of the following Plan Year to submit claims to either FSA for expenses incurred during the preceding Plan Year. If you terminate your employment, you will also have up to March 31 of the following Plan Year to submit claims for expenses incurred during the preceding Plan Year but before your date of termination (unless you elect COBRA for your Health Care FSA).

Here are a few other key considerations to keep in mind when evaluating and planning participation in your FSA:

- Your eligible and ***predictable*** health care expenses;
- Your eligible child care expenses;

- Your gross income (including your spouse's income) and tax bracket; and

- Your ability to afford a reduction in your paycheck, since part of your salary is set aside for expenses.

Please note that you cannot be reimbursed for expenses incurred for an individual who does not meet the definition of a "Qualifying Child" or a "Qualifying Relative." See Appendix A for more information on eligible dependents.

More detailed information on the Health Care FSA and the Dependent Care FSA, including how to file for reimbursement, can be found in Appendix C.

Health Savings Account

If you enroll in a high deductible health plan ("HDHP"), you may establish a Health Savings Account ("HSA"). An HSA is a tax savings account that you can use to pay for eligible health care expenses for you and your eligible dependents now, as well as save to pay for future health care expenses.

The HSA provides a triple tax advantage: money goes in tax-free, grows tax-free and is tax-free when used to pay for eligible medical expenses. If you don't use all of the money in the HSA during the plan year, it rolls over to the next year. Once your balance reaches $1,000 you can invest your account in a selection of investment funds through the HSA administrator. You can also take the money in the HSA if you leave the Company/Participating Employer or retire. Once money is in the account, it's yours to keep or use toward eligible medical expenses.

Important HSA Rules:

- You are not allowed to be enrolled in any other health coverage plan, including Medicare, or union plans (i.e., no secondary coverage permitted under spouse's plan unless it is also an HDHP).

- You cannot participate in the Health Care Flexible Spending Account if you elect the HDHP with HSA. Also, you will not be permitted to make contributions to an HSA if your spouse has a health care pre-tax flexible spending account with his or her employer, other than a special "limited purpose" FSA that is designed to work with HSAs.

- For the 2020 calendar year, the maximum amount you can contribute to an HSA is $3,550 if you have single HDHP coverage and $7,100 if you have family HDHP coverage. Contribution limits are subject to change from year to year. You may make contributions to an HSA with any financial institution of your choosing.

- If you are age 55 or older, you can contribute an additional $1,000 per year.

- Any post-tax contributions must be counted towards the HSA limits.
- Money must be in an HSA account to receive reimbursement.
- After-tax contributions can be made by anyone to your HSA.
- You may change your HSA pre-tax contribution amounts anytime during the year.
- Please note: Expenses for domestic partners and/or children not claimed as dependents on your tax return are ineligible for reimbursement under the HSA.

IMPORTANT: This is only a brief description of the HDHP/HSA option. Please refer to the PayFlex website, www.payflex.com, for further information about this coverage.

CLAIMS PROCEDURE FOR BENEFITS UNDER THE PLAN

This section describes the Plan's procedures pursuant to which you can make a claim for benefits under the Plan and appeal a denied claim for benefits. Please note that these claims and appeals procedures generally only apply if the booklet or Contract that governs the particular benefit or issue in question does not, itself, contain claims and appeals procedures. For purposes of this section, the Plan Administrator (or any individual or entity to whom the Plan Administrator has delegated the authority to review and evaluate claims) shall be referred to as the "Claims Administrator" at the initial claim level and the "Appeals Administrator" at the appeal level.

Please note that this section does not apply to eligibility claims or inquiries. If you have a question or claim regarding your or your dependent's eligibility for benefits under the Plan, please contact the Plan Administrator.

Claims Procedure and Appeal of Benefit Denials. The process by which a Claim for Benefits shall be handled by the Plan Administrator or its designated agent and the process by which a Participant may appeal the denial of a Claim for Benefits shall comply with the requirements of ERISA Section 503 and ACA and related guidance. The ACA requires the Plan to comply with additional internal claim and appeal procedure standards and offer claimants a new external review option. An external appeal option is available for adverse benefit determinations that do not relate to failure to meet the eligibility requirements under the Plan. If a claim for benefits has been denied, the denial letter will contain information relative to external review, if applicable. Please contact the Plan Administrator for more information on external review.

What Constitutes a Claim for Benefits. A request for benefits is a "claim" subject to these procedures only if it is a communication by you or your authorized representative that is filed in accordance with the Plan's claim filing guidelines. In general, claims must

be filed in writing (except urgent care claims which may be made orally) with the applicable provider identified in Appendix D. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim) must be filed with the Plan Administrator at the address set forth in the ADDITIONAL INFORMATION section below. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a pre-service claim. If a claim is received, but there is not enough information to allow the Claims Administrator to process the claim, you will be given an opportunity to provide the missing information.

Designation of an Authorized Representative. If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the Claims Administrator and/or the Appeals Administrator identifying such authorized representative. In the case of a claim involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative.

Claims Involving Health Benefits

Types of Claims. There are several different types of claims that you may bring under the Plan. The Plan's procedures for evaluating claims (for example, the time limits for responding to claims and appeals) depend upon the particular type of claim. The types of claims that you generally may bring under the Plan are as follows:

- ***Pre-Service Claim*** – A "pre-service claim" is a claim for a particular benefit under the Plan that is conditioned upon you receiving prior approval in advance of receiving the benefit. A pre-service claim must contain, at a minimum, the name of the individual for whom benefits are being claimed, a specific medical condition or symptom, and a specific treatment, service or product for which approval is being requested.

- ***Post-Service Claim*** – A "post-service claim" is a claim for payment for a particular benefit or for a particular service after the benefit or service has been provided. A post-service claim must contain the information requested on a claim form provided by the applicable Claims Administrator.

- ***Urgent Care Claim*** – An "urgent care claim" is a claim for benefits or services involving a sudden and urgent need for such benefits or services. A claim will be considered to involve urgent care if the Claims Administrator or a physician with knowledge of your condition determines that the application of the claims review procedures for non-urgent claims (i) could seriously jeopardize your life or your health, or your ability to regain maximum function or (ii) in your physician's opinion, would subject you to

severe pain that cannot adequately be managed without the care or treatment that is the subject of the claim.

- ***Concurrent Care Review Claim*** – A "concurrent care review claim" is a claim relating to the continuation/reduction of an ongoing course of treatment.

Time Periods for Responding to Initial Health Claims. If you bring a claim for benefits under the Plan, the Claims Administrator will respond to your claim within the following time periods:

- ***Post-Service Claim*** – In the case of a post-service claim, the Claims Administrator shall respond to you within 30 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 30-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is necessary because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- ***Pre-Service Claim*** - In the case of a pre-service claim, the Claims Administrator shall respond to you within 15 days after receipt of the claim. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, the Claims Administrator will notify you within the initial 15-day period that the Claims Administrator needs up to an additional 15 days to review your claim. If such an extension is because you failed to provide the information necessary to evaluate your claim, the notice of extension will describe the information that you need to provide to the Claims Administrator. You will have no less than 45 days from the date you receive the notice to provide the requested information.

- ***Urgent Care Claim*** – In the case of an urgent care claim, the Claims Administrator shall respond to you within 72 hours after receipt of the claim. If the Claims Administrator determines that it needs additional information to review your claim, the Claims Administrator will notify you within 24 hours after receipt of the claim and provide you with a description of the additional information that it needs to evaluate your claim. You will have no less than 48 hours from the time you receive this notice to provide the requested information. Once you provide the requested information, the Claims Administrator will evaluate your claim within 48 hours after the earlier of the Claims Administrator's receipt of the requested information, or the end of the extension period given to you to provide the requested information. There is a special time period for responding to a request to extend an

ongoing course of treatment if the request is an urgent care claim. For these types of claims, the Claims Administrator must respond to you within 24 hours after receipt of the claim by the Plan (provided, that you make the claim at least 24 hours prior to the expiration of the ongoing course of treatment).

- ***Concurrent Care Review Claim – If the Plan has already approved an ongoing course of treatment*** for you and contemplates reducing or terminating the treatment, the Claims Administrator will notify you sufficiently in advance of the reduction or termination of treatment to allow you to appeal the Claims Administrator's decision and obtain a determination on review before the treatment is reduced or terminated.

Notice and Information Contained in Notice Denying Initial Health Claim. If the Claims Administrator denies your claim (in whole or in part), the Claims Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally). This notice will include the following:

- ***Reason for the Denial*** – the specific reason or reasons for the denial;

- ***Reference to Plan Provisions*** – reference to the specific Plan provisions on which the denial is based;

- ***Description of Additional Material*** – a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;

- ***Description of Any Internal Rules*** – a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request; and

- ***Description of Claims Appeals Procedures*** – a description of the Plan's appeals procedures and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims).

Appealing a Denied Claim for Health Benefits. If your initial claim for benefits is denied by the Claims Administrator, you may appeal the denial by filing a written request (or an oral request in the case of an urgent care claim) with the Appeals Administrator within 180 days after you receive the notice denying your initial claim for benefits. If you decide to appeal a denied claim for benefits, you will be able to submit written comments, documents, records, and other information relating to your claim for benefits (regardless of whether such information was considered in your initial claim for

benefits) to the Appeals Administrator for review and consideration. You will also be entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your appeal.

Time Periods for Responding to Appealed Health Claims. If you appeal a denied claim for benefits, the Appeals Administrator will respond to your claim within the following time periods:

- Post-Service Claim – In the case of an appeal of a denied post-service claim, the Appeals Administrator shall respond to you within 60 days after receipt of the appeal.

- Pre-Service Claim – In the case of an appeal of a denied pre-service claim, the Appeals Administrator shall respond to you within 30 days after receipt of the appeal.

- ***Urgent Care Claim*** – In the case of an appeal of a denied urgent care claim, the Appeals Administrator shall respond to you within 72 hours after receipt of the appeal.

- ***Concurrent Care Review Claim*** – In the case of an appeal of a denied concurrent care review claim, the Appeals Administrator shall respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

Notice and Information Contained in Notice Denying Appeal. If the Appeals Administrator denies your claim (in whole or in part), the Appeals Administrator will provide you with written notice of the denial (although initial notice of a denied urgent care claim may be provided to you orally or via facsimile or other similarly expeditious means of communication). This notice will include the following:

- ***Reason for the Denial*** – the specific reason or reasons for the denial;

- ***Reference to Plan Provisions*** – reference to the specific Plan provisions on which the denial is based;

- ***Statement of Entitlement to Documents*** – a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that is relevant to your claim and/or appeal for benefits;

- ***Description of Any Internal Rules*** – a description of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that a copy of such rule, guideline, protocol, or other criterion will be provided to you free of charge at your request; and

- ***Statement of Right to Bring Action*** – a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits.

Notwithstanding the foregoing, the Plan will comply with the applicable requirements of the ACA unless the Health Benefit is an Excepted Benefit to which the ACA does not apply, including but not limited to the following:

- ***Adverse Benefit Determination***. The definition of adverse benefit determination shall include rescissions of coverage, regardless of whether the rescission had an adverse effect on any particular benefit;

- ***Right to Review Claim File***. Claimants shall be given the right to review their claim file, including access to and copies of documents, records and other information relevant to their claim;

- ***Opportunity to Present Evidence and Testimony***. Claimants shall be given the opportunity to present evidence and testimony as part of the appeals process. The terms "evidence" and "testimony" shall be interpreted in accordance with Department of Labor guidance;

- ***Disclosure of New Rationale and Opportunity to Respond***. In the event the Plan (or the entity hearing an internal appeal of an adverse benefits determination on behalf of the Plan) considers, relies upon or generates new or additional evidence in connection with the claim, or is considering a new or additional rationale for the denial of the claim at the internal claims appeal stage, the Plan will advise the claimant in advance of the determination of the new evidence or rationale being considered, and shall allow the claimant no less than 45 days to respond to such new evidence or rationale, except with respect to appeals of urgent care claims, in which event the claimant will be provided no less than two (2) days to respond to the new evidence or rationale;

- ***No Conflict of Interest***. To the extent Plan personnel are involved in the claims process, the Plan will not consider in connection with any decision regarding the hiring, compensation, promotion, termination or other similar matters with respect to an individual involved, directly or indirectly, with the evaluation or determination of the claims or appeals of any claimant, whether or not such individual is likely to support the denial of benefits to a claimant; and

- ***External Review***. The external review is available for final adverse benefit determinations involving (1) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer, or (2) rescission of coverage (i.e., a retroactive termination of coverage, whether or not the rescission has any

effect on any particular benefit at the time). Claimants in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process. External review is not available for final adverse determinations that relate to a failure to meet the eligibility requirements under the Plan.

Claims Not Involving Health Benefits or Disability Benefits.

In the case of a claim not involving health or disability benefits, initial claims for benefits under a Plan shall be made by you in writing to the Claims Administrator.

The Claims Administrator shall act within 90 days after its receipt, and shall notify you in writing as to whether the claim has been denied in whole or in part. If special circumstances require an extension of time for processing the initial claim, a written notice of the extension and the reason therefore shall be furnished to you before the end of the initial 90-day period. In no event shall such extension exceed 90 days.

Any notice of denial of a claim in whole or in part shall set forth, in a manner calculated to be understood by you:

- the specific reason or reasons for the determination;
- reference to the specific Plan provisions on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;
- a description of the Plan's review procedure and the time limits applicable for such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.

Within 60 days of receipt of a notice denying a claim, you may appeal the denial by filing a written request with the Appeals Administrator in the manner described in the plan material - The 60-day period may be extended where the nature of the benefit involved or other attendant circumstances make such extension appropriate. In connection with such review, you may examine the Plan and obtain, upon request and without charge, copies of all information relevant to your appeal and may submit issues and comments in writing. The decision on review will be made promptly, and not later than 60 days after receipt of a request for review, unless special circumstances (such as the need to hold a hearing if one is deemed necessary) require an extension of time for processing, in which case a decision will be rendered as soon as possible, but not later than 120 days after receipt of a request for review.

The decision will be written in a manner calculated to be understood by you and will include:

- the specific reasons for the decision;
- reference to the specific Plan provisions on which the decision is based;

  an explanation of your right 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; and

- a statement of your right to bring a civil action under section 502(a) of ERISA.

If the time limitations set forth above have not been exceeded, no person may bring an action in a court of law unless the claims review procedure is exhausted and a final determination has been made. If you challenge the decision, a review by a court of law will be limited to the facts, evidence, and issues presented during the claims review procedure described above. Facts and evidence that become known to you, your dependent, your beneficiary, or another interested person after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the initial appeal will be deemed waived.

Claims Involving Disability Benefits

In the case of a claim involving benefits under a disability plan (long-term or short-term), initial claims for benefits shall be made by you in writing to the Claims Administrator.

The Claims Administrator shall act within 45 days after its receipt and shall notify you in writing as to whether the claim has been granted in whole or in part. If the Claims Administrator determines that an extension is necessary due to matters beyond the control of the Plan, a written notice of the extension stating the reason therefore and the date by which the Plan expects to render a decision shall be furnished to you before the end of the initial 45-day period. In no event shall such extension exceed 30 days. If, prior to the end of the first 30-day extension period, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within that extension period, the determination period may be extended for up to an additional 30 days, provided that the Claims Administrator notifies you, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan expects to render a decision. Any such notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you shall be afforded at least 45 days within which to provide the specified information.

- Any notice of denial of a claim in whole or in part shall set forth, in a culturally and linguistically appropriate manner:

- the specific reason or reasons for the determination;

- reference to the specific Plan provisions on which the denial is based;

- a description of any additional material or information necessary for you to perfect the claim and an explanation as to why such information is necessary;

- a description of the Plan's review procedure and the time limits applicable for such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal;

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, the Claims Administrator will state that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and either provide a copy of it with the denial or state that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you, if those views were presented by you to the Plan, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on your behalf by the Social Security Administration, if that determination was presented by you to the Plan; and

- a statement that the 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.

Note that an adverse benefit determination shall include rescissions of coverage, regardless of whether the rescission had an adverse effect on any particular benefit.

If you have been denied a claim in whole or in part, you shall be entitled to appeal the denial of your claim to the Appeals Administrator by filing a written request for a review within 180 days after the claim has been denied under the above Claims Procedure.

You shall be afforded the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.

The Appeals Administrator's review shall take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The Appeals Administrator shall act within 45 days after receipt of such request for review from you, unless special circumstances require an extension of time for processing. If the Appeals Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to you prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Appeals Administrator expects to render the determination on review.

- Any notice of denial of a claim on appeal in whole or in part shall set forth, in a culturally and linguistically appropriate manner:

- the specific reason or reasons for the determination;

- reference to the specific Plan provisions on which the denial is based;

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

- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the determination, the Appeals Administrator will state that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and either provide a copy of it with the denial or state that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;

- if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request;

- a discussion of the decision including an explanation of the basis for disagreeing with or not following (i) the views of health care professionals treating you and vocational professionals who evaluated you, if those views were presented by you to the Plan, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (iii) a disability determination made on your behalf by the Social Security Administration, if that determination was presented by you to the Plan; and

- a statement that you are entitled to bring a civil action in Federal court under Section 502 of ERISA to pursue the claim for benefits.

The decision of the Appeal Administrator shall be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the Appeals Administrator, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure set forth above. The appeal process described herein must be exhausted before you can pursue the claim in federal court. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Exhaustion and Statute of Limitations

You must use and exhaust this Plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the Plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

The Plan's decision will be final and conclusive on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the Plan's decision, a review by a court of law will be limited to the facts, evidence and issues presented during the claims procedure. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

Any claim or lawsuit related to benefits under the Plan must be brought in the correct court or forum no later than 24 months after the earliest of:

- the date your first benefit payment was made or due,

- the date your request for a Plan benefit was first denied or

- the earliest date you knew or should have known the material facts on which your lawsuit is based (the "24-month Claims Period").

However, if you start the claims and appeals procedure described in this document or individual benefit booklet by submitting your claim to the Claims Administrator within the 24-month Claims Period, the deadline for you to file your lawsuit will not expire until the later of the last day of the 24-month Claims Period and three months after the final notice of denial of your appealed claim is sent to you by the Claims Administrator. Any claim or action filed under the administrative claims and appeals procedures described in this document or individual benefit booklet or any lawsuit that is filed in a court or any other forum after the end of this 24-month period (or, if applicable, after the end of the three-month period following exhaustion the administrative claims and appeals procedures described in this document or individual benefit booklet) will be time-barred.

LOSS OF BENEFITS

Except for Short- or Long-Term Disability (and as may otherwise be described in this document), your coverage ends at the end of the month in which your employment with your Participating Employer terminates. This will occur upon your retirement, resignation, discharge, or death. Your Participating Employer will, however, discuss with you at your request what, if any, arrangements may be made to continue coverage beyond the date your employment ceases. The section entitled CONTINUATION OF COVERAGE UNDER COBRA also describes certain circumstances under which health care coverage may be continued after the date your employment ends, or, in the case of your dependents, after the date on which they become ineligible for health care coverage under the Plan.

CONTINUATION OF COVERAGE UNDER COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") is a federal law that has several provisions designed to protect you and your family against a sudden loss of health care coverage if you have a qualifying event (explained below) that would cause the loss of your health care coverage provided by the Company and your Participating Employer. The following information outlines the continuation of coverage available under COBRA.

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

Explanation of COBRA Continuation Coverage. COBRA requires most employers who sponsor group health care plans to provide a temporary extension of

health care coverage to employees and their dependents when, due to certain circumstances, coverage would otherwise terminate under the employer's plan. This temporary extension of benefits is commonly called continuation coverage.

Individuals who are eligible for COBRA coverage are called *qualified beneficiaries*. The events which entitle them to coverage are called qualifying events. In general, to be a qualified beneficiary for a specific type of health coverage (i.e., medical, dental, vision, EAP or health care flexible spending account), you must have had that particular coverage under the Plan on the day before a qualifying event occurs. However, a child born to, adopted by, or placed for adoption with the covered employee during the continuation coverage will be a qualified beneficiary for COBRA purposes.

Who Must Provide Notice When Coverage is Lost. When a qualifying event occurs, you and the Company/your Participating Employer have certain responsibilities.

If the qualifying event is divorce or a legal separation, loss of dependent status, or a second qualifying event, you or a covered family member must notify the Plan Administrator of the qualifying event.

The notice must be in writing and contain the following information:

- *Your name;*
- *Names of all qualified beneficiaries;*
- *Your address and addresses of each qualified beneficiary, if different from yours;*
- *Qualifying event;*
- *Date of qualifying event;*
- *Health benefits under which you and all qualified beneficiaries are currently covered; and*
- *Supporting documentation evidencing* the Qualifying Event, if applicable.

The notice must be sent to the Allied Universal Benefits Department, 1551 N. Tustin Ave., Suite 650, Santa Ana, CA 92705, by hand delivery or regular mail within 60 days after the later of:

- *The date on which the qualifying event occurs; or*
- *The date on which the qualified beneficiary loses (or would lose) coverage under the Plan as a result of the qualifying event.*

Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the qualifying event.

In order to extend continuation coverage from 18 months to 29 months on account of disability, as explained below, notice of the Social Security Administration disability determination must be sent to the Allied Universal Benefits Department, 1551 N. Tustin Ave., Suite 650, Santa Ana, CA 92705, by regular mail within 60 days of the disability determination and prior to the end of the initial 18-month continuation coverage period.

Your Participating Employer will notify the Plan Administrator if the event is death, termination of employment, reduction in hours, or entitlement to Medicare benefits.

When the Plan Administrator is notified of a qualifying event, the Plan Administrator or its third-party administrator will send you and/or your dependent(s) a written explanation of the right to elect continuation coverage. You then have 60 days from the later of the date of this explanation from the Plan Administrator or the date on which your existing coverage would end to notify the Plan Administrator of your election. *If you and/or a dependent do not respond in writing within the time limit, the right to elect to continue coverage under COBRA will be lost and cannot be reinstated*.

The chart below summarizes who is eligible for continuation coverage under COBRA, under what circumstances, and for how long. Coverage under Health Care FSA will not continue beyond the Plan Year in which the Qualifying Event occurs.

The chart below summarizes who is eligible for continuation coverage under COBRA, under what circumstances, and for how long. Coverage under Health Care FSA will not continue beyond the Plan Year in which the Qualifying Event occurs.

PERSON AFFECTED (Qualified Beneficiary)	REASON FOR LOSS OF COVERAGE (Qualifying Event)	PERIOD OF CONTINUATION COVERAGE
Employee	Reduction in hours of employment Termination of employment for reasons other than gross misconduct	18 months* 18 months*
Covered Spouse of an Employee	Death of employee Divorce or legal separation from employee Employee becomes entitled to Medicare benefits Reduction in employee's hours of employment Termination of employee's employment for reasons other than gross misconduct	36 months 36 months 36 months 18 months* 18 months*
Covered Child of an Employee	Death of employee Divorce or legal separation of employee and spouse Employee becomes entitled to Medicare benefits Failure of child to qualify as a dependent under the Plan Reduction in employee's hours of employment Termination of employee's employment for reasons other than gross misconduct	36 months 36 months 36 months 36 months 18 months* 18 months*

* The 18-month continuation coverage period will be extended to 29 months for all qualified beneficiaries if any qualified beneficiary is disabled under the Social Security laws at any time during the first 60 days of COBRA coverage. To qualify for this extension, the qualified beneficiary must notify the Plan Administrator within 60 days of the determination that s/he is disabled under the Social Security laws and before the expiration of the 18-month period. The Plan Administrator is permitted to charge a higher premium for continuation coverage during the 19th through 29th months. If the employee finds that s/he is no longer disabled, s/he must notify the Plan Administrator within 30 days of such a determination. Note: In the case of military leave of absence, continuation of coverage may be available for 24 months as described below.

The 18, 29, or 36 months of continuation coverage begin on the date that coverage would originally end.

If You Elect to Continue Coverage. Each member of a family who is eligible to elect continuation coverage may make a separate election to continue coverage, or one member of the family may make an election that covers some or all of the others.

If you elect to continue coverage, you must pay a total premium equal to the cost to the Plan of such coverage, plus a two percent (2%) monthly administration charge (or such higher charge as may be permitted by law). The total premium includes your Participating Employer's contribution and any contribution an active participant is required to make under the Plan.

The first payment must be made within 45 days following the date of your election and must cover the number of full months from the date coverage ended to the time of your payment. Premiums for each month after your election are due by the 1st day of the month and must be postmarked within the 30-day grace period. Payments not received by the end of the grace period will result in termination of coverage, which cannot be reinstated.

Premium rates will change periodically for all qualified beneficiaries if costs to the Company and/or your Participating Employer change, but no more often than once in a 12-month period.

Continuation coverage will be identical to the coverage provided similarly-situated employees and/or dependents. Your health care coverage will continue to be provided by the insurer, HMO, or other provider which is providing benefits to you on the date of the qualifying event. Should benefit levels increase or decrease, both active and COBRA participants will experience the same change.

Coverage You May Elect. You may elect to continue medical coverage only, dental coverage only, vision coverage only, health care FSA coverage only, EAP only or any combination of these coverages. For instance, you may elect to receive medical and dental, but not health FSA and vision, or you may elect medical and health FSA, but not dental, etc. You may elect to continue only those coverages that were in effect on the date of the qualifying event. Since life insurance, accidental death and dismemberment insurance, voluntary life insurance, disability insurance, and dependent care FSA are not health care benefits protected by COBRA, you may not elect continuation coverage of those benefits under the Plan. You may, however, have conversion rights under the applicable insurance policy.

Coverage for Eligible Dependents. If you elect continuation coverage that also covers your eligible dependents, these dependents may not make an independent selection of coverage until the next annual open enrollment period. At that time, they may change their coverage if they wish.

However, if you continue some, but not all, of the coverages to which you are entitled, or if you decide not to continue your coverage at all, each dependent may make an independent coverage selection.

Changes to Continuation Coverage. Qualified beneficiaries have the same opportunities to change coverage as active employees during each annual open enrollment period. During each annual open enrollment period, you may elect different coverage or add or delete dependents in the same manner as an active employee.

If You Have Region-Specific Coverage. If you are enrolled in a region-specific coverage option (such as an HMO) on the day before your qualifying event occurs, you may elect continuation coverage. However, you must remain in that coverage until the

next annual open enrollment period, at which time you may change coverage if you so wish.

If you move out of the service area during your period of continuation coverage, you may be able to elect alternate coverage. This will apply only to a benefit option that is not offered in your current location.

When COBRA Benefits End. Generally, continuation coverage runs for 18, 29 or 36 months, depending on the qualifying event, as described in the chart above. However, COBRA benefits will end immediately if:

- The person whose coverage is being continued fails to pay the premium on time;
- The person whose coverage is being continued becomes, after the date of the election of continuation coverage, covered under another employer's group health plan (other than an exclusion or limitation which does not apply to (or is satisfied by) the person under applicable provisions of federal law);
- The person whose coverage is being continued becomes, after the date of the election of continuation coverage, entitled to Medicare benefits;
- In the case of a person whose coverage is being continued under the special extended coverage period for disabled individuals, it is determined that the person is no longer disabled under the Social Security laws; or
- The Company no longer maintains and/or your Participating Employer no longer participates in a group health plan covering any employee.

Two Qualifying Events. An 18-month period of continuation coverage may be extended if another qualifying event occurs during that time. However, no one may extend coverage for more than 36 months from the occurrence of the first qualifying event. For example, if your employment ends and you get divorced during the initial 18-month continuation period, your dependents (but not you) may extend coverage for up to 36 months from the date your employment ended. If the covered employee becomes entitled to Medicare benefits and during the subsequent 18-month period loses coverage due to a termination of employment (for reasons other than gross misconduct) or a reduction in hours of employment, all qualified beneficiaries other than the employee will be entitled to a maximum of 36 months of coverage from the date of Medicare entitlement, subject to the rules regarding earlier termination of COBRA coverage. Medicare entitlement, however, will not be treated as a second qualifying event

Continuation Coverage During Military Service. Employees and dependents that lose health coverage due to the employee's military leave of absence under the Uniformed Services Employment and Reemployment Rights Act may elect to continue coverage for up to 24 months. Any individual who elects to continue such coverage will

be required to make the same premium payments as a COBRA participant except as required by law.

PLAN ADMINISTRATOR

Within the meaning of ERISA, the Plan Administrator is the Allied Universal Employee Benefits Committee.

In general, the Plan Administrator is the sole judge of the application and interpretation of the Plan, and has the discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. However, the Plan Administrator has the authority to delegate certain of its powers and duties to a third party. The Plan Administrator has delegated certain administrative functions under the Plan to various service providers. As the Plan Administrator's delegate, these service providers have the authority to make decisions under the Plan relating to benefit claims, including determinations as to the medical necessity of any service or supply.

The decisions of the Plan Administrator (or its delegate) in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties.

PLAN AMENDMENT OR TERMINATION

The Company reserves the right to amend or modify the Plan at any time and for any reason with respect to both current and former employees and their dependents. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease employee contributions, (3) increase or decrease deductibles and/or co-payments, (4) change the class(es) of employees and/or dependents covered by the Plan, and (5) change insurers, HMOs, or other providers. The Vice President, Benefits of the Company may also make certain administrative, technical and legal changes to the Plan and amendments to the benefits provided under the Plan. Further, the Plan's Privacy Officer may make any changes to the **HIPAA PRIVACY & PROTECTED HEALTH INFORMATION** section of the Plan as may be required to comply with HIPAA. The Company also reserves the right to terminate the Plan, or any portion of the Plan, at any time and for any reason. No amendment, termination or partial termination of the Plan will affect claims incurred for which items or services have been provided prior to the date of amendment, termination, or partial termination.

The Plan creates no vested rights of any kind. No Participant, nor any person claiming through him or her, shall have any right, title or interest in or through the Plan, or part thereof, except as otherwise expressly provided herein. Nothing in the Plan shall be construed as giving any person rights against the Plan, the Company, the Plan Administrator or any Participating Employer or any of their employees or agents, except as provided in the Plan.

ADDITIONAL INFORMATION

Plan Sponsor Information: The sponsor of the Plan is Universal Services of America, LP. The address and telephone number as well as the employer identification number assigned to the Company by the Internal Revenue Service are as follows:

Address:	1551 N. Tustin Avenue, Suite 650 Santa Ana, CA 92705
Telephone:	1-888-670-7106
Employer ID #:	61-1790568

Plan Information: The official Plan name, Plan identification number, and Plan Year (fiscal year used for plan records) for the Plan are as follows:

Plan Name:	Allied Universal Health and Welfare Benefit Plan
Plan ID #:	502
Plan Year:	Begins on January 1 and ends on December 31.

Type of Plan: The Plan is a welfare benefit plan providing the following types of benefits: (a) medical coverage, (b) vision coverage, (c) dental coverage, (d) life and accidental death and dismemberment insurance, (e) additional life insurance (employee supplemental life, spouse life and child(ren) life), (f) long-term disability insurance, (g) short-term disability insurance, (h) dependent care spending account, (i) health care spending account, (j) employee assistance program (k) health savings account, (l) voluntary accident insurance, (m) voluntary hospital coverage, (n) voluntary critical illness coverage, and (o) voluntary legal services. The benefits described in items (a), (b), (c), (i), (m) and (n) are provided under a "group health plan" within the meaning of ERISA. The benefits described in items (h) and (k) are not subject to ERISA.

Administration: Benefits under the Plan are administered by various providers in accordance with contracts the Company or a Participating Employer has entered into with various insurance companies, HMOs, and other providers or administrators of health and welfare benefits. A list of benefit providers and their roles under the Plan is included in Appendix D.

Agent for Legal Process: The agent for the service of legal process for the Plan is the VP/Deputy General Counsel at the address set forth above.

Funding Medium: The benefits under the Plan are funded through direct payments from the general funds and assets of the Plan Sponsor or one or more insurance contracts.

THIRD PARTY LIABILITY

General Principle

When you or your dependent receive benefits under the Plan which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, you or your dependent shall reimburse the Plan for the related benefits received out of any funds or monies you or your dependent recovers from any third party.

Specific Requirements and Plan Rights

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

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring you or your dependent to assert a claim to any of the benefits to which you or your dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that you or your dependent has received a third-party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to you or any of your dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of you or your dependents.

Participant Duties and Actions

By participating in the Plan you and your dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that

constructive trust, lien or equitable lien by agreement, you and your dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once you or your dependent has any reason to believe that you or they may be entitled to recovery from any third party, you or your dependent must notify the Plan. And, at that time, you and your dependent (and your or their attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your dependent to any payment, amount or recovery from a third party.

If you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement, the Plan may deny payment of any benefits to you and any of your dependents until the agreement is signed. Alternatively, if you or your dependent fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of you or your dependent, your or your dependent's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

You and your dependent consent and agree that you or they shall not assign your or their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Employer.

RECOUPMENT

The Plan has the right to recover any mistaken payment, any overpayment, any payment that is made to any individual who was not eligible for that payment or any payment that was required to have been made to the Plan under the "Third Party Liability" section above. The Plan, or its designee, may withhold or offset future benefits payments, sue to recover such amounts, or may use any other lawful remedy to recoup any such amounts.

NO ASSIGNMENT OF BENEFITS

You cannot assign, pledge, encumber or otherwise alienate any legal or beneficial interest in benefits under the Plan, and any attempt to do so will be void. The payment of benefits directly to a health care provider, if any, shall be done as a convenience to the covered person and shall not constitute an assignment of benefits under the Plan.

COORDINATION OF BENEFITS

The following coordination of benefits ("COB") applies *unless a different COB rule is contained in the booklets provided by the insurance carriers or third-party administrators*. The Plan coordinates the medical benefits available under the Plan with comparable benefits that a participant or his or her dependents may have under other insurance. In

no event will payment from the Plan, when combined with benefits available under other insurance, exceed one hundred percent (100%) of the amount payable under the Plan. If the Plan's benefit coverage is secondary and such coverage is self-insured, the general rule is that the Plan will in no event pay a benefit that would cause the maximum benefit paid under all plans to be more than the benefit that would have been paid by this Plan has this Plan been the primary. If the Plan's benefit coverage is secondary and such coverage is fully insured, the general rule is that the maximum benefit will be the maximum amount payable by the primary carrier or the participant's liability, whichever is less.

Other insurance includes the following types of insurance:

- Any group insurance coverage, including any plan covering individuals as employees of an employer or as members of any other group which provides medical, prescription drug or dental care benefits or services on an insured or a prepayment basis.

- Any group insurance or other prepayment group coverage.

- Any coverage under a jointly trusted plan or other welfare plan, employer organization plan, employee benefit organization plan or other arrangement for benefits for individuals of a group.

- Any coverage under any governmental program, including, but not limited to, worker's compensation, occupational disease or similar programs, or coverage afforded on account of a participant or dependent's service in any branch of the armed forces; provided, however, that such coverage shall not be deemed other insurance coverage for purposes of coordination of benefits if federal or state law mandate that the Plan provide primary coverage.

- Any other insurance, private or otherwise, carried by the participant or a dependent, including, but not limited to, motor vehicle coverage, including fault, no-fault, financial responsibility, catastrophe, liability, collision or other coverage.

The primary carrier, whether the Plan or other insurance, shall be the payer of all medical, dental and prescription drug benefits.

The other insurance shall be the primary carrier when it is the primary carrier under the terms of that Plan or does not include provisions for the coordination or nonduplication of benefits.

In determining whether such group insurance is the primary plan, the following rules and regulations shall apply:

- The insurance plan covering the patient other than as dependent, retiree, COBRA participant, etc., will be deemed the primary plan.

- Except for situations where the parents of a child are separated or divorced, if both the Plan and other insurance cover a dependent child, the primary carrier will be the plan of the parent whose birthday falls first during the calendar year. If the birthday of both parents occurs on the same day or if the other insurance does not follow the "first birthday" coordination rule, the plan which has covered the dependent child for the longer period of time will be the primary plan.

- The insurance plan covering the patient for the longest period of time will be deemed the primary plan.

If the parents are living separate and apart or are divorced, the determination about which plan is primary will be made as follows:

- A court decree may determine the primary plan. You should advise the Company and your Participating Employer of any court decree. (You should also refer to the summary of the Plan's rules regarding Qualified Medical Child Support Orders as described below.)

- If there is not a court decree which establishes financial responsibility for the health care expenses of the dependent child, the plan which covers the child as a dependent of the parent with the custody on the date the services were rendered will be deemed the primary plan.

- If the parent with custody of the child has remarried, the stepparent's plan will pay for covered services before the Plan of the parent without custody.

Under no circumstances will the Plan pay any benefits as primary plan when a participant or a dependent has elected to make the Plan the primary plan by paying a reduced premium to his motor vehicle insurance carrier. Where an injury is caused by an accident for which the individual is required by state law to carry automobile insurance, the coverage under this Plan is secondary and the automobile insurance is responsible for paying the charges for that injury first.

The participant's spouse is not required to purchase coverage through his or her employer if the spouse is required to pay the entire premium for the coverage. The Company may implement rules and regulations regarding the level of co-payment for employer-provided insurance required of a participant's spouse under this provision. Notwithstanding any other provision, if the participant and his spouse are employed by a Participating Employer, the spouse will not be treated as having waived employer-provided coverage if she/he is covered as a dependent under this Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

If a qualified medical child support order ("QMCSO") issued in a domestic relations proceeding (e.g., a divorce or legal separation proceeding) requires you as a parent to cover a child who is not in your custody, you may do so. To be qualified, a medical child support order must include:

- name and last known address of the parent who is covered under this Plan;
- name and last known address of each child to be covered under this Plan;
- type of coverage to be provided to each child; and
- period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator. Upon receipt, the Plan Administrator will review the order to determine if it is qualified and will notify you. If the order is qualified, you may cover your eligible child(ren) under the Plan. You must be covered under the Plan in order to cover your child(ren). If you are not enrolled in a medical benefit option at the time of the order, you will automatically be enrolled in the Boon MVP benefit option. You will receive a letter confirming you and your dependent(s) enrollment. You will have thirty (30) days from the effective date of your coverage to change your medical benefit from the Boon MVP to another medical benefit option. You will be required to make contributions to the cost of this coverage through payroll deductions. You will be required to maintain this coverage for as long as the QMCSO is in effect. In order to remove a child(ren) from the plan, you will be required to provide a court order rescinding the original QMCSO.

As a beneficiary covered under the Plan, your child will be entitled to information that the Plan provides to other beneficiaries under ERISA's reporting and disclosures rules. You may receive from the Plan Administrator, without charge, a copy of the Plan's QMCSO procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan, you are entitled to certain rights and protections under ERISA, which provides that all participants will be entitled to:

- Examine, without charge, at the Company or a Participating Employer's office, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefits Administration.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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 NW, 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.

HIPAA PRIVACY & PROTECTED HEALTH INFORMATION

The following provisions permit the Plan to disclose your protected health information ("PHI"), as defined in HIPAA, to the Plan Sponsor to the extent that such PHI is necessary for the Plan Sponsor to carry out its administrative functions related to the Plan.

Disclosure to the Plan Sponsor. The Plan (or health insurance issuer or HMO with the Plan's permission) may disclose your PHI to the Plan Sponsor that is necessary for the Plan Sponsor to carry out the following administrative functions related to the Plan.

The Plan Sponsor needs access to PHI to:

- Determine the amount of benefits, if any, you and/or your dependent are entitled to from the Plan;
- Determine or find facts that are relevant to any claim for benefits from the Plan;
- Determine whether a participant's benefits should be terminated or suspended;
- Perform duties relating to the establishment, maintenance and administration of the Plan;
- Communicate with participants regarding the status of their claims;
- Recover any overpayment or mistaken payments made to claimants; and
- Handle participant issues with regard to subrogation and third-party claims.

The Plan Sponsor may use and disclose your PHI provided to it from the Plan (or health insurance issuer or HMO) only for the administrative purposes described above.

Limitations and Requirements Related to the Use and Disclosure of PHI. The Plan Sponsor agrees to the following limitations and requirements related to its use and disclosure of your PHI received from the Plan:

(a) ***Use and Further Disclosure***. The Plan Sponsor will not use or further disclose your PHI other than as permitted or required by this document or as required by law.

(1) ***Minimum Necessary Standard***. When using or disclosing your PHI or when requesting your PHI from the Plan, the Plan Sponsor will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

(b) ***Agents and Subcontractors***. The Plan Sponsor will require any agents, including subcontractors, to whom it provides your PHI received from the Plan to agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information.

(c) ***Employment-Related Actions and Decisions***. Except as permitted by HIPAA and other applicable law, the Plan Sponsor will not use your PHI to take employment-related actions or make employment-related decisions about you, or in connection with any other employee benefit plan of the Plan Sponsor.

(d) ***Reporting of Improper Use or Disclosure***. The Plan Sponsor shall promptly report to the Plan any improper use or disclosure of your PHI of which it becomes aware.

(e) ***Adequate Protection***. The Plan Sponsor will provide adequate protection of your PHI and separation between the Plan and the Plan Sponsor by:

(1) ensuring that only the Vice President, Benefits; Director, Benefits; Manager, Benefits; Privacy Officer; Deputy Privacy Officer; Sr. Benefits Specialist, HIPAA; QMCSO; Benefits Specialist, HIPAA; VP/Deputy General Counsel; Security Officer; Benefits Administrator, Health & Welfare; and IT support personnel will have access to your PHI provided by the Plan;

(2) restricting access to and use of your PHI to only the employees identified above and only for the administrative functions performed by the Plan Sponsor on behalf of the Plan that are described above;

(3) requiring any agents of the Plan who receive your PHI to abide by the Plan's privacy rules; and

(4) using the following procedure to resolve issues of noncompliance by the employees identified above:

a. The Plan will be immediately notified, and the Plan and Plan Sponsor will work together to remedy the situation and mitigate any harmful effect resulting from the use or disclosure of PHI;

b. After an investigation into the alleged incident, those employees who are found to be in violation of these policies or the HIPAA Privacy Regulations will be sanctioned as is deemed appropriate; and

c. The Plan and Plan Sponsor will work together to create new safeguards and procedures so as to prevent a future incident of noncompliance.

(f) ***Return or Destruction of PHI***. If feasible, the Plan Sponsor will return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

(g) ***Participant Rights***. The Plan Sponsor will provide you with the following rights:

(1) the right to access to your PHI;

(2) the right to amend your PHI upon request (or the Plan Sponsor will explain to you in writing why the requested amendment was denied) and incorporate any such amendment into your PHI; and

(3) the right to an accounting of all disclosures of your PHI.

(h) ***Cooperation with HHS***. The Plan Sponsor will make its books, records, and internal practices relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for verification of the Plan's compliance with HIPAA.

(i) ***Protection of Electronic PHI***. The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits.

(j) ***Security Incidents***. The Plan Sponsor will report to the Plan any security incident of which it becomes aware.

Certification. The Plan will disclose PHI to the Plan Sponsor only upon receipt of a Certification by the Plan Sponsor that this Plan document has been amended in accordance with HIPAA, and that the Plan Sponsor will protect the PHI as described above.

[Signature Page Follows]

IN WITNESS WHEREOF, the undersigned officer of Universal Services of America, LP hereby executes this Allied Universal Health and Welfare Benefit Plan this ____ day of _____, 2021.

By:_____

APPENDIX A
DEPENDENT ELIGIBILITY REQUIREMENTS

This Appendix A sets forth the eligibility requirements for dependent coverage under the various components of the Plan.

Except as provided below, the following definitions apply for eligibility purposes:

Spouse – A spouse is the individual to whom you are legally married in accordance with the laws of any State or foreign jurisdiction. Please note that you may be required to provide proof of marriage. The Plan Administrator can provide you with additional information.

Note: Coverage of a same sex spouse may result in state tax consequences.

Domestic Partner – A domestic partner is an individual of the same or opposite sex with whom you have registered with any State or local governmental domestic partner registry. Alternatively, if there is no State or local government registry, you can demonstrate that a domestic partnership has been established if all of the following are met:

- You and your partner are both at least age 18.
- Neither you nor your partner is legally married to another person or in a civil union or domestic partnership with another person.
- You and your partner are not related by blood to a degree of closeness that would prohibit marriage in your state of residence.
- You and your partner are in a long-term committed relationship that is intended to be permanent.
- You and your partner are financially interdependent.
- You and your partner share a principal residence and intend to do so permanently.

Please note that you may be required to provide either: (1) documentation showing you are registered with a State or local governmental domestic partner registry or (2) if there is no State or local government registry, a completed "Affidavit of Domestic Partnership or Civil Union" (along with the required documentation specified on the Affidavit). As noted above, some benefits require a State or local governmental registration. If needed, the Affidavit can be obtained from the Plan Administrator.

The term Domestic Partner includes a Civil Union. If you are in a Civil Union, you may be required to provide your Civil Union Certification.

Note: Coverage of a domestic partner or civil union partner may result in federal or state tax consequences.

Dependent Child - A dependent child is:

- Your dependent child(ren) to age 26 (or older if required by state insurance law)

- Unmarried children of any age, who are permanently and totally disabled, who do not provide more than 50% of their own support and who live with you for more than half the year. You must provide proof of your child's disability to the claim administrator within 31 days of the disability or the date his or her coverage under the Plan would otherwise terminate. Your child must have been enrolled in the Allied Universal Health & Welfare Benefit Plan before the age of 26. Coverage for your child will continue until he or she recovers, you fail to provide proof when required or requested that the disability continues, you fail to submit the child to an exam requested to determine whether he or she remains disabled, or your participation in the plan as an employee ceases, whichever comes first.

The following children may qualify:

- a natural born child; a legally adopted child;

- a child placed with you and your spouse or your domestic partner for adoption;

- a stepchild;

- a child of a domestic partner (provided that you have completed and signed an Affidavit of Domestic partnership); or

- a child for whom you are the legal guardian including foster children.

You may be required to provide proper documentation to the Plan Administrator supporting your relationship to the child who you seek to cover.

***Note*: Coverage of a child of a domestic partner or civil union partner may result in federal or state tax consequences.**

Medical, Dental and Vision Coverage

The following individuals are eligible dependents for medical, dental and vision coverage:

- You.

- Your legal spouse or qualified domestic partner.

- Your and your spouse's natural children, step- children. Legally adopted children or children placed for adoption who are younger than age 26 or

- Any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You and your Spouse must furnish proof of this incapacity and dependency Insurance company within 31 days following the child's 26th birthday.

Special Continuation Rules for Certain Dependents (For Medical Coverage Only). In the case of fully insured arrangements in certain states, Dependents who no longer meet the applicable eligibility requirements due to age may nonetheless be eligible to continue coverage. This extended coverage may be in addition to any continuation coverage rights that may be available under the Plan's COBRA continuation coverage provisions. For more information about these special continuation rules, please refer to separate materials provided by the Plan Administrator. These special rules do not apply to any other benefits offered under the Plan, except medical coverage.

Health Care Flexible Spending Account (For Administrative Employees)

The Health Care Flexible Spending Account ("Health Care FSA") can be used to reimburse medical expenses incurred by the following individuals:

- you,

- your spouse,

- your child, stepchild, legally adopted child (or a child placed with you for adoption) or foster child who has not attained age 27 as of the close of the year,

- any other child who is a "qualifying child" (defined below) and

- a "qualifying relative" (defined below).

For this purpose, a "qualifying child" is a child who meets the following requirements:

- the child is your child, adopted child, stepchild, foster child, grandchild, brother, stepbrother, sister, stepsister, niece or nephew

- the child lives with you for more than one-half of the year;

- the child has not attained age 19 as of the close of the year (has not attained age 24 as of the close of the year in the case of a child who was a full-time student for at least five months of the year) (Note: These age

limits do not apply in the case of a child who is permanently and totally disabled), and

- the child does not provide over one-half of his or her own support for the year.

For this purpose, a "qualifying relative" is an individual who meets the following requirements:

- the individual is your child, adopted child, stepchild, foster child, grandchild, parent, grandparent, brother, stepbrother, sister, stepsister, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law (Note: this requirement is also met if the individual does not have one of these specified relationships to you, but the individual lives with you and the relationship between you and that individual is not in violation of local law);

- you provide over one-half of the individual's support for the year; and

- the individual is not a qualifying child (as defined above) of you or any other taxpayer for the year.

For purposes of any requirement above that a child live in your household, temporary absences due to special circumstances, including absences due to illness, education, business, vacation or military service are not treated as absences.

Special Rule for Children of Divorced or Separated Parents Applicable to Health Care FSA. For purposes of Health Care FSA coverage, in the case of a child who receives over one-half of his or her support during the calendar year from his or her parents (i) who are divorced or legally separated under a decree of divorce or separate maintenance, (ii) who are separated under a written separation agreement, (iii) who lived apart at all times during the last six months of the year, (iv) who have agreed that the custodial parent will not claim the child as an income tax exemption, and (v) where such child is in the custody of one or both parents for more than one-half of the year, such child will be considered the dependent of both parents, regardless of the child's place of residence or the amount of support provided by either parent. Contact your tax advisor or refer to IRS Publication 502 (Medical and Dental Expenses) for more information.

Dependent Care Flexible Spending Account (For Administrative Employees other than Executives)

The Dependent Care Flexible Spending Account can be used to reimburse day care expenses for any of the following individuals:

- your child, grandchild, brother or sister who is under age 13, who resides in your household for more than one-half of the year and who does not provide more than one-half of his or her own support for the year;

- a disabled spouse who resides in your household for more than one-half of the year; and

- a disabled relative or household member who is principally dependent on you for support and who resides in your household for more than one-half of the year.

Special Rule for Children of Divorced or Separated Parents Applicable to Dependent Care FSA

For purposes of Dependent Care FSA coverage, in the case of a child who receives over one-half of his or her support during the calendar year from his or her parents (i) who are divorced or legally separated under a decree of divorce or separate maintenance, (ii) who are separated under a written separation agreement, (iii) who lived apart at all times during the last six months of the year, and (iv) where such child is in the custody of one or both parents for more than one-half of the year, such child will be a qualifying dependent with respect to the custodial parent even if the non-custodial parent is entitled to claim the dependency exemption for the child on his or her federal tax return. The noncustodial parent cannot treat the child as a qualifying dependent even if that parent is entitled to claim the child as a dependent on his or her federal tax return. Contact your tax advisor or refer to IRS Publication 503 (Child and Dependent Care Expenses) for more information.

Employee Assistance Program ("EAP")

The following individuals are eligible for EAP benefits:

- All members of your household who are:
    - your immediate family, and
    - your Qualifying Child or Qualifying Relative (as defined above).

- Except that your dependent children are covered even if they do not reside with you.

- Dependents who are in military service are not covered.

Spouse Life Insurance

Spouse life insurance coverage can be purchased for your lawful spouse or qualified domestic partner.

Child(ren) Life Insurance

Child(ren) life insurance coverage can be purchased for your unmarried dependent child up to 26 years of age.

"Child" includes natural, step, child of a qualified domestic partner, legally adopted children (or those placed for adoption) and children for whom you are legal guardian.

Voluntary Accident Insurance

Voluntary Accident Insurance can be purchased for the following individuals:

- You.
- Your legal spouse or qualified domestic partner (age 18 and older).
- Your and your spouse's natural children, step- children. Legally adopted children or children placed for adoption who are younger than age 26 or
- Any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You and your Spouse must furnish proof of this incapacity and dependency to the Voluntary Accident Insurance company within 31 days following the child's 26th birthday.

Voluntary Hospital Coverage

Voluntary Hospital Coverage can be purchased for the following individuals:

- You.
- Your legal spouse or qualified domestic partner (ages 18 to 64 years old).
- Your and your spouse's natural children, step- children. Legally adopted children or children placed for adoption who are younger than age 26 or
- Any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You and your Spouse must furnish proof of this incapacity and dependency to the Voluntary Hospital Coverage Insurance company within 31 days following the child's 26th birthday.

Voluntary Critical Illness Coverage

Voluntary Critical Illness Coverage can be purchased for the following individuals:

- You.
- Your legal spouse or qualified domestic partner (ages 18 to 64 years old).
- Your and your spouse's natural children, step- children. Legally adopted children or children placed for adoption who are younger than age 26 or

- Any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You and your Spouse must furnish proof of this incapacity and dependency to the Voluntary Critical Illness Insurance company within 31 days following the child's 26th birthday.

Voluntary Legal Services

Voluntary Legal Services can be purchased for the following individuals:

- You.
- Your lawful spouse or qualified domestic partner.
- Your dependent child(ren) under age 26.

Dependent children are:

- Your and your spouse's natural children, step- children. Legally adopted children or children placed for adoption who are younger than age 26 or
- Any child who is incapable of self-sustaining employment due to mental or physical handicap and is dependent on a parent for support. You and your Spouse must furnish proof of this incapacity and dependency to the Voluntary Legal Services company within 31 days following the child's 26th birthday.

APPENDIX B
BENEFIT OPTIONS

Administrative Employees

Employer-provided Benefits. The following benefits are provided by your Participating Employer at no cost to employees:

Basic Life and AD&D Insurance
Employee Assistance Program

Optional Benefits. The following benefits may be elected by employees. Contributions are made on a before-tax or after-tax basis, as indicated:

Medical (with Prescription Drug) Insurance	Before-tax
Dental Insurance	Before-tax
Vision Insurance	Before-tax
Health Savings Account	Before-tax
Health Care Flexible Spending Account	Before-tax
Dependent Care Flexible Spending Account (other than Executives)	Before-tax
Short-Term Disability Insurance	After-tax
Long-Term Disability Insurance	After-tax
Employee Supplemental Life Insurance	After-tax
Spouse Life Insurance	After-tax
Child Life Insurance	After-tax
Voluntary Accident Insurance	After-tax
Voluntary Hospital Coverage	After-tax
Voluntary Critical Illness Coverage	After-tax
Voluntary Legal Services	After-tax

Service Professionals

Employer-provided Benefits. The following benefits are provided by your Participating Employer at no cost to employees:

Basic Life and AD&D Insurance
Employee Assistance Program

Optional Benefits. The following benefits may be elected by employees. Contributions are made on a before-tax or after-tax basis, as indicated:

Medical (with Prescription Drug) Insurance	Before-tax
Dental Insurance	Before-tax
Vision Insurance	Before-tax
Health Savings Account	Before-tax
Short-Term Disability Insurance	After tax

Long-Term Disability Insurance	After-tax
Employee Supplemental Life Insurance	After-tax
Spouse Life Insurance	After-tax
Child Life Insurance	After-tax
Voluntary Accident Insurance	After-tax
Voluntary Hospital Coverage	After-tax
Voluntary Critical Illness Coverage	After-tax
Voluntary Legal Services	After-tax

Boon Group Employees

Employer-provided Benefits. The following benefits are provided by your Participating Employer at no cost to employees:

Basic Life and AD&D Insurance
Medical (with Prescription Drug), Dental, Vision and Short-Term Disability (STD) Insurance for employee only

If you waive Medical, Dental, Vision and STD coverage under the Plan, your Employer will make a contribution to your 401(k) account. Please refer to the Welcome Letter provided in your Boon coverage enrollment materials for more information on the wavier process.

Optional Benefits. The following benefits may be elected by employees. Contributions are made on a before-tax or after-tax basis, as indicated:

Medical (with Prescription Drug), Dental and Vision Insurance for employee plus dependents	Before-tax

APPENDIX C
HEALTH CARE FLEXIBLE SPENDING ACCOUNT AND
DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

Health Care FSA (Administrative Employees only): The Health Care FSA may be used to pay any health care expense that would qualify for a medical deduction under IRS rules, with the exception of premiums paid for other health plan coverage (including Medicare or plans maintained by the employer of your spouse or dependent) and certain long-term care expenses. Generally, the expenses covered must be "medically necessary" or prescribed by a licensed physician to qualify. Health care expenses reimbursed through your Health Care FSA cannot be claimed as an additional deduction for income tax purposes. Expenses must be incurred on behalf of you, your spouse or any dependent with respect to whom you are entitled to claim a deduction on your federal income tax return.

Eligible Expenses. Sample health care expenses include, but are not limited to:

- Deductibles, coinsurance and co-payments;
- Medical, dental and vision expenses not covered by any insurance;
- Prescription drug expenses not covered by any insurance;
- Expenses for medicines or drugs, including over the counter medicines and drugs;
- Ambulance fees;
- Chiropractic services;
- Oral contraceptives;
- Contact lenses;
- Hearing aids;
- Orthodontia
- Infertility services;
- Wheelchairs;
- Smoking cessation programs;
- Prosthetics;
- Breast pumps and supplies that assist lactation;
- Menstrual care products;
- Personal protection equipment (such as masks, hand sanitizer and sanitizing wipes);
- Durable medical equipment; and
- Weight loss programs to the extent necessary for treatment of a disease or other medical condition.

Ineligible Expenses. In general, any expenses that cannot be claimed as medical expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to the following:

- Premiums for health insurance

- Certain long-term care expenses;
- Cosmetic surgery (except in limited circumstances);
- Electrolysis;
- Health club dues not related to a specific medical condition;
- Non-prescribed medicines and drugs;
- Weight loss programs (unless related to the treatment of a disease or other medical condition);
- Dental bonding and bleaching;
- Non-prescription items (such as vitamins) that are merely beneficial for your or your dependent's general health;
- Services for which any insurance reimburses you; and
- Services rendered before you become a participant in the Plan and after your participation has ended.

Refer to IRS Publication 502, "Medical and Dental Expenses," for more information regarding eligible and ineligible medical expenses.

Dependent Care FSA (Administrative Employees other than Executives): The Dependent Care FSA is designed to help you (1) pay for child care services for a child under age 13 or (2) pay for dependent care services for a disabled spouse or other "Qualifying Relative" (as defined above). This program does not provide health care benefits for dependents. To be eligible, the services must make it possible for you and your spouse to work or to attend school on a full-time basis; provided, however that care provided during certain "short" or "temporary" absences for illness or vacation may be eligible if you are required to pay for such care on a weekly or longer basis. Also, if you work part-time, you do not have to allocate expenses between time worked and time not worked if you are required to pay for care on a weekly or longer basis. Any type of dependent care that you could legally claim if you were filing for credit on your income taxes is eligible for funding under the Dependent Care FSA. Expenses must be incurred prior to the termination of the Plan Year.

Qualifications for Dependent Care FSA. You qualify to use this account if:

- You are a single parent;
- You have a working spouse;
- Your spouse is a full-time student for at least five (5) months during the year you are working; or
- Your spouse is disabled and unable to provide for his or her own care.

To be eligible to use this account, you must be actively working during the time your eligible dependent(s) is (are) receiving care.

Eligible Expenses. Expenses may be reimbursed for services provided:

- Inside or outside your home by anyone other than:

> Your spouse
> Someone who is your dependent for income tax purposes, or
> One of your children under the age of 19:

- In a dependent care center or a child care center (if the center cares for more than six (6) children, it must comply with all applicable state or local regulations); or
- By a housekeeper whose services include, in part, providing care for an eligible dependent.
- Day camp

To make sure your situation and the type of care being provided meets IRS requirements, refer to IRS Form 2441 and IRS Publication 503, "Child and Dependent Care Expenses." In addition, you should know that if you use a dependent care provider inside your home, you may be considered the employer of that individual and may be responsible for withholding and paying employment taxes. For more information, refer to IRS Publication 926, "Employment Taxes for Household Employees." These forms and publications should be available at your local post office or public library.

Ineligible Expenses. In general, any expenses that cannot be claimed as dependent care expenses for income tax purposes are not reimbursable. Ineligible expenses include, but are not limited to the following:

- Overnight camp;
- Activity fees;
- School transportation;
- Schooling in the first grade and beyond;
- Pre-first grade schooling that can be separated from the cost of care;
- Expenses incurred for an individual who does not meet the definition of "Qualifying Relative" above; and
- Any expenses that would also qualify as medical expenses under federal law.

Maximum Tax-Free Reimbursement. Generally, amounts reimbursed from your Dependent Care FSA are tax-free to you. However, federal law provides that the amount excluded from your gross income cannot exceed the lesser of:

- $5,000 ($2,500 if you are married and filing separate federal income tax returns);
- Your annual income; or
- Your spouse's annual income.

If your spouse is (1) a full-time student for at least five months during the year or (2) physically and/or mentally handicapped, there is a special rule to determine his or her annual income. To calculate the income, determine your spouse's actual taxable income

(if any) earned each month that he or she is a full-time student or disabled. Then, for each month, compare this amount to either $250 (if you claim expenses for one dependent) or $500 (if you claim expenses for two or more dependents). The amount you use to determine your spouse's annual income is the greater of the actual earned income or these assumed monthly income amounts of either $250 or $500. By making an election under the Plan to contribute to a Dependent Care FSA, you are representing to your Participating Employer that your contributions to the Account are not expected to exceed these limits.

If you are married and filing separate federal income tax returns, the $2,500 limit described above will not apply if you are (1) legally separated or (2) your spouse did not reside with you for the last six (6) months of the calendar year, you maintained a household that was your dependent's primary residence for more than six (6) months during the year and you paid more than half of the expenses of that household.

To qualify for tax-free treatment, you are required to list on your federal income tax return the names and taxpayer identification numbers of any person who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. The identification number of a care provider who is an individual and not a care center is that individual's social security number. Your care provider should be made aware of this reporting requirement.

Nondiscriminatory Benefits. Under federal tax law, benefits under the Dependent Care FSA cannot discriminate in favor of highly compensated employees. In order to meet this requirement, it may be necessary to limit pre-tax contributions made by highly compensated employees. You will be notified if your contributions will be affected in this manner.

Federal Dependent Care Tax Credit. Dependent care expenses for which you are reimbursed from your Dependent Care FSA will not qualify for the federal tax credit available with respect to dependent care expenses. Under the Internal Revenue Code, you are entitled to a dollar for dollar credit against your income tax liability in an amount equal to a specified percentage of your qualifying dependent care expenses. For purposes of the credit, there are limitations on the dollar amount of qualifying dependent care expenses that can be taken into account. These limitations are reduced dollar for dollar by dependent care expenses reimbursed under the FSA. In addition, these expenses cannot be taken into account to the extent they exceed the lesser of your or your spouse's earned income.

Therefore, you must determine whether it is more advantageous for you not to establish a Dependent FSA in order to avail yourself of the federal tax credit. In making this determination, it is important to consider that the amount of compensation you elect to reduce under the Plan is not only not subject to federal income tax, but also is not subject to Social Security withholding tax (FICA).

As a general rule, depending upon your particular situation, paying for qualifying dependent care expenses through compensation reduction under the Dependent Care FSA will produce greater tax savings the higher your income level. ***If you are not certain as to what extent, if any, it is to your advantage to participate in the Plan, you should consult your personal tax advisor.***

Federal Earned Income Credit. Another tax credit available under current tax law is the earned income credit. This credit also reduces dollar-for-dollar the federal tax you have to pay, but is calculated somewhat differently from the child care credit described above. The credit is available to individuals with a child who is under age 19 (under age 24 if a student) or who is totally and permanently disabled. An additional credit is available to individuals with a child who is under one year old. The credit does not depend on the amount you pay in child care expenses. The earned income credit has no effect on the amount you can contribute under the Dependent Care FSA for dependent care expenses, and the earned income credit cannot be claimed for any individual for whom you claim the child care credit described above. Moreover, the use of the Dependent Care FSA may result in a reduction in your taxable income thus qualifying you for the earned income credit where you would not otherwise have qualified.

How to File for Reimbursement from the FSAs. When you want to be reimbursed for expenses, you must submit the appropriate claim forms and supporting documentation to PayFlex for Health Care FSA and Dependent Care FSA. There is no minimum amount required for a release of a check for reimbursement. Direct deposit is available as well. These forms are available from PayFlex, the third party administrator, and must be accompanied by a copy of your bill, invoice or receipt – which includes: the name and tax ID number of the provider of service/product; the date service/product was provided; the type of service/product; your out-of-pocket expense for the service/product (amount not covered or reimbursed elsewhere); the name of employee or dependent for whom the service/product was provided – together with any additional documentation that the Company or your Participating Employer may request to support your claim. Claims are paid on a daily basis or reasonably soon thereafter. Remember, an incomplete claim form increases the amount of time required to send you your reimbursement check.

Expenses under the Health Care FSA will be reimbursed in full up to the amount of your yearly election, less any claim amounts previously reimbursed. Expenses under the Dependent Care FSA will be reimbursed only up to your current account balance.

For the Health Care FSA, expenses are treated as having been incurred when the participant is provided with the medical care that gives rise to the expenses and not when the participant is formally billed, charged or pays for the medical care. For the Dependent Care FSA, expenses are treated as being incurred when the dependent is provided with the services that give rise to the expenses and not when the participant is formally billed, charged or pays for the dependent care services.

Health Care FSA Debit Card - When you enroll in the Health Care FSA, you will receive a debit card that can be used to purchase services and products that are reimbursable

through your Health Care FSA. The debit card can be used to pay for office visit co-payments, deductibles, non-covered services, prescription drugs, etc. Just as when you file claims manually, the full amount of your annual Health Care FSA balance is available through the debit card. It is important that you keep all receipts from Health Care FSA debit card transactions as you may be asked to submit the receipts after the transaction in order to meet IRS claim filing guidelines. If you are unable to provide adequate or timely substantiation as requested by the Plan, you must repay the Plan for the unsubstantiated expense. In addition, your usage of the card may be terminated.

Note: Do not discard your Health Care FSA Debit Card if you use all of your Health Care FSA funding. The card will be updated with new elections in subsequent years up to the expiration date listed on the card. If your Health Care FSA Debit Card is ever lost or stolen, please contact PayFlex for a replacement card. A charge may be incurred for the replacement card. You may also request additional cards for your spouse and your dependents (18 years of age or older) by contacting PayFlex.

Termination of Employment. If your employment with your Participating Employer terminates, your (and your dependents') coverage under the Health Care and/or Dependent Care FSA terminates on your last day of employment. However, under federal law, you and your dependents may be entitled to continuation of *Health Care* FSA coverage *only*. The section of this booklet entitled **CONTINUATION OF COVERAGE UNDER COBRA** describes certain circumstances under which Health Care FSA coverage may be continued after the date coverage would otherwise end.

APPENDIX D
BENEFIT PROVIDERS

(As of January 1, 2020)

FOR EMPLOYEES OTHER THAN BOON GROUP EMPLOYEES

Self-Insured Medical and Prescription Coverage

Aetna
P.O. Box 14079
Lexington, KY 40512-4079
888-410-3681 (non-HSA), 877-869-4077 (HSA Compatible)
www.aetna.com

Express Scripts (Prescription Drug Coverage for self-insured Aetna medical plans)
P.O. Box 66583
Saint Louis, Mo 63166-6583
844-583-7037
www.express-scripts.com/allieduniversal

Lucent Health Solutions
P.O. Box 7020
Appleton, WI 54912-7020
877-236-0844
www.lucenthealth.com/cypress

The Boon Group, Inc. (Medical Claims)
P.O. Box 559017
Austin, TX 78755
866-292-3374
www.theboongroup.com/contactus

The Boon Group, Inc (Prescription Drug Coverage)
CVS/Caremark
P.O. Box 52137
Phoenix, AZ 85072-2136
www.theboongrooup.com/contactus

The Company or a Participating Employer has contracted with the above-mentioned companies to provide administrative and claim services under the Plan. Claims are funded by the Company or a Participating Employer.

Fully-Insured Medical Coverage

Aetna Life Insurance Company (for Fixed Indemnity Plans)
151 Farmington, Avenue
Hartford, CT 06156
888-772-9682
www.myaetnasupplemental.com

Aetna (for the Executive PPO)
P.O. Box 14079
Lexington, KY 40512-4079
888-410-3681
www.aetna.com

Blue Cross Blue Shield of Massachusetts
P.O. Box 986030
Boston, MA 022998
800-424-0794
www.bluecrossma.com

Cigna
900 Cottage Grove Road
Bloomfield, CT 06002
800-224-6224
www.cigna.com

Kaiser Permanente
S. CA: P.O. Box 7004
Downey, CA 90242-7004
N. CA: P.O. Box 12923
Oakland, CA 94604-2923
800-464-4000
www.kp.org

Kaiser Hawaii
711 Kapiolani Blvd.
Honolulu, HI 96813
800-966-5955
www.kp.org/hawaii

Kaiser Washington
601 Union Street, Suite 3100
Seattle, WA 981010-1374
888-901-4636
www.kp.org/wa

The Company or a Participating Employer has contracted with the above-mentioned companies to provide medical benefits under the Plan. Benefits are paid entirely by the insurers and are guaranteed under the agreements.

Fully Insured Dental Coverage (PPO and DHMO)

CIGNA
P.O. Box 188037
Chattanooga, TN 37422-8037
800-244-6224
www.mycigna.com

The Company or a Participating Employer has contracted with the above-mentioned company to provide dental benefits under the Plan. Benefits are paid entirely by the insurer and are guaranteed under the agreements.

Fully Insured Vision Coverage

EyeMed
4000 Luxottica Place
Mason, OH 45040
866-800-5457
www.eyemed.com

Vision Service Plan (VSP)
3333 Quality Drive
Rancho Cordova, CA 95670
800-852-7600
www.vsp.com

The Company or a Participating Employer has contracted with the above-mentioned companies to provide vision benefits under the Plan. Benefits are paid entirely by the insurers and are guaranteed under the agreements.

Life Insurance and/or Life and AD&D Coverages (Employer-Provided and Additional)

Cigna
1601 Chestnut Street
Two Liberty Place
Philadelphia, PA 19192
866-253-1054
www.cigna.com

The Company or a Participating Employer has contracted with the above-mentioned company to provide all life insurance and life insurance and AD&D benefits and claims services under the Plan. Benefits are paid entirely by the above-mentioned insurance company and guaranteed under the agreement.

Short Term Disability Coverage and Long-Term Disability Coverage

Cigna
1601 Chestnut Street
Two Liberty Place
Philadelphia, PA 19192
866-253-1054
www.cigna.com

The Company or a Participating Employer has contracted with the above-mentioned company to provide all disability benefits under the Plan. Benefits are paid entirely by the above-mentioned insurance company and guaranteed under the agreement.

Employee Assistance Program (EAP)

Cigna
1601 Chestnut Street,
Two Liberty Place
Philadelphia, PA 19192
800-538-3543
www.cigna.com

The Company or a Participating Employer has contracted with the above-mentioned company to provide all EAP services under the Plan. Benefits are paid entirely by the above-mentioned company and guaranteed under the agreement.

Third Party Administrator for Health Care FSA and Dependent Care FSA and Health Savings Account

PayFlex
P.O. Box 4000
Richmond, KY 40476-4000
888-678-8242
www.payflex.com

Voluntary Accident, Voluntary Hospital and Critical Illness Insurance Benefit

Aflac
Continental American Insurance Co.
P.O. Box 84075
Columbus, GA 31993

800-433-3036
www.aflacgroupinsurance.com

The Company or a Participating Employer has contracted with the above-mentioned company to make available voluntary accident, voluntary hospital and critical illness insurance and all related administrative and claims services under the Plan. Benefits are paid entirely by the above-mentioned company and guaranteed under the agreement.

Quit for Life Program

999 Third Avenue, Suite 2000
Seattle, WA 98104
866-784-8454
www.quitnow.net

The Company or a Participating Employer has contracted with the above-mentioned company to provide wellness services under the Plan. Benefits are paid by the Company or the Participating Employer from its general assets.

Voluntary Legal Services

MetLife Legal Plans
1111 Superior Ave, Suite 800
Cleveland, OH 44114
http://www.legalplans.com/

The Company or a Participating Employer has contracted with the above-mentioned company to make available voluntary legal services and all related administrative and claims services under the Plan. Benefits are paid entirely by the above-mentioned company and guaranteed under the agreement.

FOR BOON GROUP EMPLOYEES ONLY

Fully-Insured Medical/Prescription, Dental and Vision Coverage

SRC/Aetna Claims
P.O. Box 14079
Lexington, KY 40512-4079
1-866-337-8417

The Company or a Participating Employer has contracted with the above-mentioned company to provide medical benefits under the Plan. Benefits are paid entirely by the insurers and are guaranteed under the agreements.

Life Insurance and/or Life and AD&D Coverages (Employer-Provided)

Aetna

c/o The Boon Group (Life & AD&D Claims)
P.O. Box 9788
Austin, TX 78766

The Company or a Participating Employer has contracted with Aetna to provide all life insurance and AD&D benefits and claims services under the Plan. Benefits are paid entirely by Aetna and guaranteed under the agreement. Claims are filed with The Boon Group at the address above.

Short Term Disability Coverage
SRC/Aetna Claims
P.O. Box 14079
Lexington, KY 40512-4079
1-866-337-8417

The Company or a Participating Employer has contracted with the above-mentioned company to provide short-term disability benefits under the Plan. Benefits are paid entirely by the insurer and are guaranteed under the agreements.

Recordkeeper

The Boon Group, Inc.
6300 Bridgepoint Parkway
Building 3, Suite 500
Austin, TX 78730

The Company or a Participating Employer has contracted with the above-mentioned company to provide recordkeeping services.

APPENDIX E
PARTICIPATING EMPLOYERS
(As of January 1, 2020)

The Participating Employers in this Plan are:

- Universal Protection Service, LP DBA Allied Universal Security Services
- Universal Building Maintenance, LLC DBA Allied Universal Janitorial Services
- Universal Protection Service, LLC (formerly Security Forces, LLC) DBA Allied Universal Security Services
- Universal Protection Service of Seattle, LLC DBA Allied Universal Security Services
- Peoplemark, LLC;
- AlliedBarton Security Services (NC) LLC
- Securadyne Systems Intermediate, LLC DBA Allied Universal Technology Services
- Staff Pro, Inc. DBA Allied Universal Event Services