ENGAGE PEO

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2026 Health and Welfare Benefit Summary Plan Description and Plan Document

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

This "summary plan description" or "SPD" is effective as of January 1, 2026, and describes the Engage PEO Health and Welfare Plan (the "Plan"). This document, together with the additional documents incorporated into it, constitutes both the written plan document required by ERISA § 402 and the Summary Plan Description required by ERISA § 102. The Plan is made up of the following component plans:

- Major Medical
- Dental
- Vision
- Life and Accidental Death & Dismemberment
- Short-term Disability
- Long-term disability
- Cancer and Specified Disease
- Critical Illness
- Accident
- Hospital Confinement
- Health Flexible Spending Accounts
- Dependent Care Flexible Spending Accounts[1]
- Pre-Tax Transit & Parking[2]
- Employee Assistance Program
- Pre-Paid Legal Benefits

Each of these component benefit programs are summarized in the following documents (referred to as "Component Benefit Program Documents"): a certificate of insurance (COI) or certificate of coverage (COC) issued by the insurance company; a component plan benefits booklet or component plan-specific SPD; or a governing document executed by your work-site employer as part of their co-employment arrangement with S2 HR Solutions Group 1, LLC or any subsidiary or affiliate of the S2 HR Solutions Group 1, LLC (unless the context requires otherwise, all such entities together hereinafter to be referred to as "Engage PEO"). A copy of each Component Benefit Program Document is available upon request. The Component Benefit Program Documents are incorporated into and made a part of this SPD.

It is possible that your work-site employer may have opted to offer a benefit that is not associated with this ERISA plan. In that event, please reach out to your work-site employer for any plan documents and notices, COBRA information or any other questions. For additional details, please see the addendum attached to the end of this document.

Component Benefit Program Documents are available to you separately. You should refer to your enrollment instructions to find out where you should go for a description of the benefits you are eligible to enroll in and for your costs for benefits under each of the component plans.

You are permitted to pay your share of the cost of medical, dental and vision premiums and contributions to the health flexible spending account and dependent care flexible spending account on a pre-tax basis if you meet the eligibility requirements for participation in the Engage PEO Flexible Benefits Plan and IRC Section 125. Please refer to the Engage PEO Flexible Benefits Plan for additional details.

Some of these component programs require you to make an annual election to enroll or make changes to your coverage. Refer to the Enrollment and Eligibility section of the applicable Component Benefit Program Document for more information.

Please note that this document contains several important sections including:

- Information about the Plan
- Eligibility and Enrollment
- COBRA and Initial Notice of COBRA Continuation Rights
- Health Insurance Marketplace
- Other Administrative Information
- ERISA Rights and Responsibilities

1 Not subject to ERISA. 2 Not subject to ERISA.

S2 HR Solutions Group 1, LLC ("Company") is the Plan Sponsor for the Plan. The Plan Administrator for the Plan is the Engage ERISA Benefits Committee. The Engage ERISA Benefits Committee has the right to amend or terminate, at any time and without notice, the Plan and any component plan that is part of this Plan. Receipt of the SPD, Enrollment Guide or any other Health and Insurance literature does not guarantee eligibility for benefit coverage. Eligibility is determined only by meeting the requirements in the applicable Component Benefit Program Document. The benefit descriptions in the Enrollment Guide are brief highlights of the benefits offered.

Unless otherwise noted, if there is a conflict between a specific provision under a Component Benefit Program Document or this Summary Plan Description/Plan Document, the Summary Plan Description/Plan Document controls. If the Summary Plan Description/Plan Document is silent, the terms of the applicable Component Benefit Program Document controls. However, with respect to fully insured benefits, the terms of the COI or COC control when describing specific benefits that are covered or insurance-related terms.

Please review each section of this document because they describe important information you need to know about the Plan. If you have any questions about the Plan, contact the Engage PEO's Benefits Department either in writing or by telephone:

Engage PEO Benefits Department
4211 W. Boy Scout Boulevard
Suite 500
Tampa, FL 33607
Phone: 1-888-780-8807
Or email us at benefits@engagepeo.com
You can visit our website at: www.engagepeo.com

INFORMATION ABOUT THE PLAN

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate for each of your group health and welfare benefits is the Summary Plan Description (SPD) and the Plan document required by ERISA.

Name of Plan:
The Engage PEO Health and Welfare Plan ("the Plan")

Plan Sponsor:
S2 HR Solutions Group 1, LLC

Employer Identification Number:
45-2568460

Plan Number:
501

Plan Year:
January 1st through December 31st

Type of Plan:
Health and Welfare Plan comprised of component group health and welfare plans which may include (but are not limited to) medical, dental and vision, life and accident death and dismemberment plans, and short-term and long-term disability plans.

Type of Administration:
The component plans may be either self-funded or fully insured. For the fully insured component plans, the insurance companies and the HMO, not the work-site employer or Engage PEO, are responsible for paying claims. Engage PEO and the work-site employer share responsibility with the insurance companies and the HMO for administering these benefits as described in this document.

Plan Administrator:
Engage ERISA Benefits Committee, Engage PEO
4211 W. Boy Scout Boulevard
Suite 500
Tampa, FL 33607
Telephone Number: 1-888-780-8807

Agent for Service of Legal Process:
Engage ERISA Benefits Committee, Engage PEO
4211 W. Boy Scout Boulevard
Suite 500
Tampa, FL 33607
Telephone Number: 1-888-780-8807

Source of Contributions:
Contributory and Non-contributory. Certain insurance premiums for employees and their eligible family members are paid out of general assets, the trust, and, in part, by the employee's payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request for each component benefit program as applicable.

Collective Bargaining Agreement
The Plan is not maintained pursuant to any collective bargaining agreements.

Plan Administration
This section contains additional information about the Plan, including information that the Engage ERISA Benefits Committee, as Plan Administrator, is required to provide to you under the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Engage ERISA Benefits Committee Role
The administration of the Plan is under the supervision of the Engage ERISA Benefits Committee as "Plan Administrator." The principal duty of the Plan Administrator is to see that the Plan is carried out in accordance with the terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures for determining eligibility for, and the amount of benefits, authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make factual determinations as to whether any individual is entitled to receive benefits under the Plan or to carry out the administrative duties related to the Plan.

WORK-SITE EMPLOYER ROLE
The work-site employer is responsible for notifying eligible employees and following the processes determined by the Plan for participation under the various components of the Plan and for determining eligibility of its worksite employees, as required by the Plan Administrator. The work-site employer will bear any incidental costs related to administering the Plan. Additionally, but importantly, the work-site employer will be responsible for reviewing and approving certain fees and commissions related to such Plan administration, including, specifically, any payable to Engage PEO.

INSURANCE CARRIER/THIRD PARTY ADMINISTRATOR ROLE
Some component benefits provided under the Plan are fully insured and provided under an insurance contact or a contract with an HMO.
Group insurance contracts with Aetna Inc., Kaiser Permanente, MetLife, and Unum may provide the following benefits (as determined and adopted by each work-site employer):

- Medical Insurance
- Dental Insurance
- Vision Insurance
- Life/Accidental Death and Dismemberment (AD&D) Insurance
- Short Term Disability Insurance
- Long Term Disability Insurance
- Cancer and Specified Disease Insurance
- Critical Illness Insurance
- Accident Insurance
- Hospital Confinement Insurance

The insurance companies have full discretionary authority for the benefits they provide and are responsible for determining eligibility and the amount, if any, of benefits payable under their respective component benefit plans and for prescribing the claims procedures and forms to be used by participants pursuant to their respective component benefit plans.

The component benefits provided under the Plan that are not insured and are administered by a third party administrator are:

- Health Flexible Spending Accounts
- Employee Assistance Program
- Pre-Paid Legal Benefits

For specific provisions, see the applicable Component Benefit Program Document. The insurance companies and third party administrators for each component benefit are listed in the Benefit Option Appendix.

ELIGIBILITY TO PARTICIPATE IN THE PLAN

FOR EMPLOYEE COVERAGE

Corporate employees of Engage PEO and employees who share a co-employment relationship through a participating work-site employer with Engage PEO (herein after referred to as "employees") in an eligible class for benefits under each component plan are eligible to participate in and receive benefits under such component plan.

To determine whether you or your eligible family members are eligible to participate in a component plan, please read the eligibility information contained in the applicable Component Benefit Program Document. Please note that some work-site employers may not elect to offer all component plan options under the Plan.

An eligible employee, who works more than an average of 30 hours per week and/or is deemed a full-time employee under for purposes of the federal tax rules that govern the employer mandate provisions of the Affordable Care Act, may commence participation in the Plan on the first day of the month following or concurrent with the completion of the waiting period (which may vary in accordance with your work-site employer or Engage PEO). In no case will this waiting period exceed the 1st of the month after 60 days of your date of hire or reclassification.

Rehired Employees

Rehired employees who previously participated in the Plan must satisfy the work-site employer's waiting period (or Engage PEO's waiting period if they are employees of Engage PEO) before commencing participation after their rehire. However, if a rehired employee returns to active service within thirty (30) days following the employee's termination of employment, the employee will be re-enrolled upon rehire in his or her previously selected Plan options without satisfying a new waiting period the first of the month after the rehire date.

Reclassification

This section applies if you are classified by Engage PEO or a participating work-site employer as an independent contractor or other non-employee or ineligible designation.

Such individuals are not eligible to participate in the Plan, regardless of whether or not such individual is determined by the Internal Revenue Service, the Department of Labor, or any other governmental agency, or by any court or other tribunal, to be a common law employee, until the time you are designated by the Plan Administrator as an eligible employee. Such designation shall only provide for eligibility prospectively from the time it is made.

FOR DEPENDENT COVERAGE

You may elect to cover your eligible dependents only if you also elect coverage for yourself. Your eligible dependents include:

- Your legal spouse (An individual who is lawfully married to an eligible employee and who is not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following is true: (1) the individual was married in a state, possession, or territory of the U.S. and the individual is recognized as lawfully married by that state, possession, or territory of the U.S.; or (2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the U.S. would recognize the individual as lawfully married.)
- Your dependent children
  - For medical, dental or vision coverage only: generally available until the end of the month or year in which your child reaches age 26 (however, some plan options have different rules; see the applicable Component Benefit Program Document)
  - All other benefit plans: available until the end of the year in which your child reaches age 25
- A child who for whom you are required to provide coverage under a Qualified Medical Child Support (see "Procedures for QMCSOs" below).

Specific details on the dependent limiting age can be found in each Component Benefit Program Document. Dependent children include biological children, legally adopted children, children placed with you for adoption, stepchildren, and foster children. Grandchildren who live in your household and qualify as your dependents under Internal Revenue Code ("Code") section 105(b) are also included.

- Your adult children who are physically or mentally disabled and dependent on you for support and are dependents under Code section 105(b).

You may also cover your domestic partner and children of your domestic partner if certain requirements are met (documentation required). Domestic partner coverage is subject to year-end imputed income.
Tax note: For domestic partner benefits, the IRS treats employment-based contributions (as applicable) as taxable. Contributions will be treated on an after-tax basis (even though contributions for married partners are not). It is important that you understand the tax and legal implications of covering your domestic partner and/or your partner's eligible children.
Therefore, you may want to consult your tax and legal advisors to determine the impact on you.
For documentation purposes, you must complete and send a Domestic Partner affidavit to the Plan Administrator in order for you to cover these dependents.

Additional Dependent Coverage Information

If you and your dependent are employees and are eligible to participate in certain plans (medical, dental and vision), you may not be covered both as an employee and a dependent.
You may be covered as the employee or as the "dependent" but not both.
You are not eligible for dependent coverage if you elect coverage for yourself.
In addition, if both you and your spouse work for Engage PEO or a participating work-site employer, only one of you may enroll your child(ren) as a dependent.

Other Important Dependent Eligibility Information

Adopted Children. A child will be considered "placed for adoption" when you legally become obligated to support that child, totally or partially, prior to that child's adoption.

ENROLLMENT PROCEDURES

You must enroll for benefits under the Plan within 30 days of the date you are first eligible for coverage. Your enrollment material will provide you with information about how to enroll and indicate your Open Enrollment period as well as your deadline to enroll.
If you do not enroll prior to your deadline, your next opportunity to enroll will be:

- at your next Annual Enrollment period or,
- if you qualify for a Special Enrollment event or,
- if you have a valid change in status situation.

Code section 125 requires employee benefit elections under a cafeteria plan to be made prior to the beginning of the plan year and such elections are treated as irrevocable during the plan year unless you have a special enrollment right or experience a qualified change in status event, as provided below. Additional information regarding mid-year election changes can be found in your Enrollment Guide and within the Component Benefit Program Document for the Engage PEO Flexible Benefits Plan.
You may also contact the Engage PEO Benefits Department at 1-888-780-8807 if you have any questions about these enrollment procedures.

CHANGE IN STATUS EVENTS
You may change certain elections mid-year if you experience a change in status event listed below. You must notify the work-site employer so communication can be made to the Company within 30 days in order to make a change in your election during the year. Where applicable, the changes you make to your coverage must be consistent with and "on account of and correspond with" the event. For example, if your child no longer is eligible for medical benefits, you may cancel medical coverage only for that child, not yourself or your spouse.

- **Legal marital status**: Any event that changes your legal marital status, including marriage, divorce, death of a spouse, legal separation, and annulment.
- **Change in domestic partnership status:** Commencement or dissolution of a domestic partnership.
- **Number of eligible dependents**: Any event that changes your number of eligible dependents, including birth, death, adoption, legal guardianship, and placement for adoption.
- **Employment status**: Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage.
- **Dependent Status**: Any event that causes your eligible dependents to become eligible or ineligible for coverage because of age, disability, or similar circumstances.
- **Residence**: A change in the place of residence for you or your eligible dependents if the change results in you or your eligible dependents living outside the network service area of your medical coverage.

Your coverage will be effective as of the date enrolled, except in the case of birth, adoption, or placement for adoption (in which case the change will be effective on the date of the event).

In addition, you may also change your election mid- year if you experience a change listed below. You must notify the Employer within 30 days in order to make a change in your election during the year.

- Special Enrollment Event: The events listed below as Special Enrollment events.
- Entitlement to Medicare or Medicaid: If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid.
- Judgment, Decree, or Order: If a judgment, decree, or order, such as a QMCSO, requires your dependent child to be covered under this Plan (or another plan).
- Significant Change in Coverage: If the cost of coverage is significantly increased or decreased, or if benefits are significantly improved or curtailed.

Your coverage will be effective as of the date enrolled, except for a judgment, decree, or order, in which case coverage is effective on the date the Plan processes the judgment, decree, or order.

SPECIAL ENROLLMENT EVENTS
If you decline enrollment for medical benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents in the medical benefits under this Plan mid-year if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your eligible dependents' other coverage). However, you must request enrollment within 30 days after your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll both yourself and any eligible dependents within 30 days after the marriage, birth, adoption, or placement for adoption.

You also may enroll in medical benefits mid-year if you or your eligible dependents no longer are eligible for Medicaid or a state Children's Health Insurance Program (CHIP) coverage, or if you or your eligible dependents become eligible for a state's premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days from the date of the Medicaid/CHIP event.

Assuming the applicable notification and election timeframes described above are met, your election change will be effective on the later of the date of the event or the date that you notify the Plan of the change (for example, loss of coverage, birth, marriage date), except, in cases where you are dropping a spouse or a domestic partner, a new spouse or domestic partner cannot be added until the beginning of the following month.

To request enrollment under these HIPAA special enrollment rules or to obtain more information, including possible extensions of time for enrollment in certain circumstances, contact Engage at 888-780-8807.

CLAIMS PROCEDURES

The claims procedures applicable to the medical, dental, vision, life & AD&D and disability component plans are described in the relevant Component Benefit Program Document.

NOTE: The component plans of the Plan described above are fully insured by the various insurance companies that provide each benefit. As such, the insurance companies retain full discretionary authority with respect to the interpretation and disposition of all claims paid on behalf of Plan participants. Each insurance company has established member service protocols and procedures. In addition, they alone are responsible for any and all applicable appeals processes that may be available. If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims' procedures, as required by ERISA.
The claims procedures for all other benefits covered under the Plan are described in the relevant Component Benefit Program Document.

Please refer below to the Exhaustion/Statute of Limitations and Failure to Follow Claims Procedures sections.

Exhaustion/Statute of Limitations
For all claims under the Plan, you must follow the claims procedures for the appropriate component plan before taking action in any other forum regarding the claim.

You must initiate any suit or legal action for benefits under the Plan no later than one (1) year following a final decision on the claim.
This one-year limitation period on suits shall apply in any forum where a suit is initiated.

Failure to follow Claims Procedures
In the case of the Plan's failure to follow the claims procedures, you shall be deemed to have exhausted the administrative remedies under the Plan and shall be entitled to pursue any available remedies under section 502(a) of ERISA.

NO RIGHT TO EMPLOYMENT
The Plan shall not be deemed to constitute a contract of employment between Engage PEO or a work-site employer and you. The Plan shall not be deemed to give you the right to be retained in the service of Engage PEO or a work-site employer or to interfere with the right of Engage PEO or a work-site employer to discharge you at any time.

TERMINATION OF PARTICIPATION

Employee Participation
Your participation in the Plan will terminate on the earliest date you:

- Terminate employment (including death);
- Experience a status change that results in the termination of your benefits;
- No longer meet the definition of an eligible employee; or
- Cease making the required contribution.

Your coverage also ends if the Plan terminates.

With respect to medical, dental and vision benefits, your coverage will terminate on the last day of the calendar month in which one of the above occurs.

Any other benefit provided under the Plan ceases on your last day worked.

Dependent Participation
Coverage for your dependent ends when your coverage ends or at other time period specified in the applicable Component Program Document the end of the calendar month in which your dependent no longer meets the Plan's definition of an eligible dependent.

Coordination of Benefits
The below provisions of this "Coordination of Benefits" section apply with respect to a benefit program that is self- funded and does not, in its governing documents (but excluding this Plan document) have a coordination of benefits section. If the benefit program does have such a section that section shall control. With respect to a fully insured benefit program, the contract or policy from the insurer shall control with respect to coordination of benefits matters.

This section applies when you also have group health coverage with another plan. Other plans with which the Plan will coordinate include:

- other employer group health plan coverage for you or your eligible dependents;
- group, blanket, or franchise insurance coverage;
- no-fault motor vehicle laws;

- hospital service prepayment plan on a group basis, medical service prepayment plan on a group basis, group practice, or other prepayment coverage on a group basis;
- coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans; and
- as permitted by law, any coverage, including Medicare, under any tax-supported or government program.

When you receive a covered service, your benefit payments may be coordinated with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments. In no case will you be entitled to benefits totaling more than 100% of the covered charges incurred or, where this plan pays primary, the covered charges otherwise payable under this Plan.

Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a coordination of benefits provision, then it is the primary plan.
2. If the person receiving benefits is the employee and is only covered as a dependent under the other plan, this Plan will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan that covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
   - The plan of the parent who has custody will be primary;
   - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third.
   - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

Effects of Coordination.

When this Plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this Plan during a claim determination period will not exceed the Plan's maximum available benefit for each covered service. Also, the amount this Plan will pay will not be more than the amount it would pay if it were primary. As each claim is submitted, we will determine our obligation to pay for covered services based upon all claims that have been submitted up to that point in time during the claim determination period.

Right to Receive and Release Necessary Information.
We may release or receive information that we need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give us any needed information for coordination purposes, in the time frame requested.

Our Right to Recover Overpayment.
If the Plan paid primary when it should have paid secondary, you agree to pay the Plan any amount by which it should have reduced its payment. Also, the Plan may recover any overpayment from the primary plan or the provider receiving payment and you agree to sign all documents necessary to help the Plan recover any overpayment.

Coordination with "Always Excess," "Always Secondary," or "Non-Complying" Plans.
We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Plan is primary, as described in this section, the Plan will pay benefits first.
2. If this Plan is secondary, as described in this section, the Plan will pay only the amount it would pay as the secondary insurer.
3. If we request information from a non-complying plan and do not receive it within 30 days, we will calculate the amount the Plan should pay on the assumption that the non-complying plan and this Plan provide identical benefits. When the information is received, we will make any necessary adjustments.

Subrogation and Reimbursement
The below provisions of this "Subrogation and Reimbursement" section apply with respect to a benefit program that is self-funded and does not, in its governing documents (but excluding this Plan document) have a subrogation and reimbursement section. If the benefit program does have such a section that section shall control. With respect to a fully insured benefit program, the contract or policy from the insurer shall control with respect to subrogation and reimbursement matters.

If an individual has a claim for benefits under this Plan or any benefit program, and that individual acquires any right or action against a third party for the person's injury, sickness or other illness which is so covered, then: (a) the Plan shall be entitled to reimbursement for such benefits from such third party up to 100% of the benefits paid by the Plan; and (b) the Plan is automatically subrogated to all such rights or claims of the covered person. The covered person shall cooperate fully with the Plan in the enforcement of the Plan's subrogation and reimbursement rights. In addition, the person shall permit suit to be brought in the person's name under the direction of and at the expense of the Company if the Company so chooses. The Plan shall not be liable for such a person's attorney's fees absent prior written approval from the Plan. The Plan Administrator may require the receipt of a signed and dated subrogation and reimbursement agreement from the person before advancing any monies.

The failure or refusal of a covered person to fully cooperate with the Plan in the enforcement of the Plan's subrogation and reimbursement rights shall result in a forfeiture of all benefits payable to that person, even if such benefits have already been paid, in which event the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

The Company, on behalf of this Plan, shall have a first priority right to recover from and a lien against any payment, whether designated as a payment for medical benefits or any other type of damages, from the proceeds of any recovery, including but not limited to any settlement, award or judgment which results from a claim or lawsuit by or on behalf of a covered person who received benefits under this Plan (even if such covered

person is not made whole). The plan is not required to contribute to any expenses or fees (including attorney's fees or costs) incurred in obtaining the funds. The plan's recovery will not be limited or reduced by doctrines (equitable or other) including but not limited to, the make-whole doctrine, contributory or comparative negligence, or the common fund doctrine. The plan's right to full recovery is not reduced if settlement funds or other payments to you are spent or no longer in an individual's possession or control. Notice of the Plan's claim shall be sufficient to establish this Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the covered person or payee if the covered person or payee fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to this Plan's subrogation and reimbursement rights.

In the event that the Plan obtains a recovery against a third party in excess of payments made to or on behalf of the covered person and reasonable out of pocket expenses of the recovery, then the Plan shall pay to the covered person that excess amount recovered by the Plan.

In the event of any direct conflict between this Section and the subrogation and reimbursement provisions in any benefit program, the subrogation and reimbursement provisions in the benefit program shall control. Otherwise, the provisions of this Section shall apply and may supplement those contained in any benefit program.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and the Initial Notice of COBRA Continuation Rights

COBRA
Federal law requires that most employers who sponsor group health plans (medical, dental, vision, and health care flexible spending account plans) offer employees and eligible dependents the opportunity to purchase a temporary extension of these plans at group rates in certain instances where coverage under the plan would end. Under COBRA, employees and beneficiaries have the right to choose continuation coverage under certain qualifying events.

Employees also have the right to choose continuation coverage under the Uniformed Service Employment and Reemployment Rights Act (USERRA) as amended, while on a military leave of absence. An election of COBRA will be deemed to be an election of USERRA coverage and both coverage(s) will run concurrently. The cost of USERRA coverage will be the same as the cost of COBRA coverage. Refer to the USERRA section below for more information.

When COBRA Coverage Ends
COBRA coverage will end if:

- The Company stops providing coverage for all employees;
- You or your eligible dependents do not pay your premiums on time;
- You or your eligible dependents become covered by another group health plan;
- You or your eligible dependents become covered by Medicare; or
- You or your eligible dependents extended COBRA coverage to 29 months due to disability, but are no longer considered disabled.

COBRA
Initial Notice of COBRA Continuation Coverage Rights

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.
When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, see below or contact the Plan Administrator.

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

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event. This is also known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The work-site employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

<u>You Must Give Notice of Qualifying Events</u>

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to:
Engage PEO Benefits at:
4211 W. Boy Scout Boulevard, Suite 500
Tampa, FL 33607
Phone: 1-888-780-8807
Benefits@engagepeo.com

For a qualifying event due to divorce or legal separation, a copy of the final divorce decree or court order regarding the legal separation may be requested as documentation. For a qualifying event due to losing eligibility for coverage as a dependent child, verification of the dependent child's limiting age may be requested.

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

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

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.
There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.
Notice must be given within 60 days of the date that the qualified beneficiary has been determined to be disabled by the Social Security Administration to:

Engage PEO COBRA Administration
ThrivePass
PO Box 220
Minneapolis, MN 55440
cobra@thrivepass.com
866-855-2844

A copy of the disability determination letter from the Social Security Administration may be requested as documentation of the qualifying event.

Second qualifying event extension of 18-month period of COBRA continuation coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
Notice must be given within 60 days of the date that of the second qualifying event to the Plan Administrator.

Special Rule for Health Care Flexible Spending Account
You, your spouse, and/or your dependent may only elect COBRA coverage if the maximum benefit available under the health care flexible spending account for the year as of the date of the qualifying event equals or exceeds the COBRA premium that applies for coverage for the remainder of the Plan Year. COBRA coverage for the health care flexible spending account ceases at the end of the plan year in which the qualifying event occurs.

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

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period*, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.
If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

*https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start.

If You Have Questions
Questions concerning your Plan, or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below.
For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.
For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Additional information regarding the Plan may be obtained from the COBRA plan administrator or group health plan administrator as indicated below or in the Benefit Option Appendix

COBRA Administrator
Engage PEO COBRA Administration
ThrivePass
PO Box 220
Minneapolis, MN 55440
cobra@thrivepass.com
866-855-2844

Plan Administrator
Engage PEO Benefits Department
4211 W. Boy Scout Boulevard
Suite 500 Tampa, FL 33607
Phone: 1-888-780-8807
Or email us at benefits@engagepeo.com
www.engagepeo.com

USERRA

If you take military leave under USERRA, whether for active duty or for training, you are entitled to continue medical coverage for up to 24 months as long as you give your employer advance notice (with certain exceptions) of the leave, and provided that your total leave, when added to any prior periods of military leave from your employer, does not exceed five years (with certain exceptions). If the entire length of the leave is 30 days or less, you will not be required to pay any more than your regular contribution (if applicable) for coverage. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the entire cost (including employer contributions).

If you take military leave and your coverage under the Plan is terminated, when you return to work, you will be treated as if you had been actively employed during your leave when determining whether any exclusion or waiting period applies to health plan coverages. However, USERRA permits a health plan to impose an exclusion or waiting period for an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage for the remainder of the COBRA coverage period.

These procedures are intended to comply with USERRA's final regulations. If there are any inconsistencies in USERRA's final regulations and these procedures, USERRA's final regulations will control.

HEALTH INSURANCE MARKETPLACE

NOTE: Your Health Insurance Exchange Notice (Notice of Coverage Options) is generally included in your New Hire packet and available by request to your work-site employer.

PART A: General Information
Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace").
To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 8.39% (for 2024; indexed annually) of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 8.39% (for 2024; indexed annually) of the employee's household income.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15. Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan. There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage. Marketplace-eligible individuals who live in states served by HealthCare.gov and either-submit a new application or update an existing application on HealthCare.gov between March 31, 2023, and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage. In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?
If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023, and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan. Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/gettingmedicaid-chip/ for more details.

How Can I Get More Information?
For more information about your coverage offered through your employment, please contact your work-site employer or Engage PEO, as applicable.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit www.healthcare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer
If you decide to complete an application for coverage in the Marketplace, you will be asked to provide certain information from your work-site employer.
Please contact your work-site employer directly to receive a copy of the Healthcare Insurance Marketplace Exchange Part B notice information.

1 An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the “minimum value standard,” the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

OTHER ADMINISTRATIVE INFORMATION

This document contains important information concerning the administration of the Plan. Although you will not need this information on a day-to-day basis, it is important for you to understand your rights, the procedures you need to follow should certain situations occur and where you can find out additional information. Please refer to applicable Component Benefit Program Document and this summary plan description (SPD) for additional details. If you have any questions regarding any of these notices, please contact the Engage PEO Benefits Department at 1-888-780-8807 or email us at benefits@engagepeo.com.

Women's Health and Cancer Rights Act of 1998
This law requires group health plans that provide coverage for mastectomies, also provide coverage for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema a. These services will be subject to the same deductible, co-insurance or co- pay, if any, and pre-certification requirements that apply to any other medical and surgical benefits covered by the medical plan.

Newborns' and Mothers' Health Protection Act of 1996
Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for mother or newborn child to less than 48 hours following a normal vaginal delivery; or 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay of not more than 48 hours (or 96 hours). The medical plan provides for this coverage.

Preventive Care Services
The Engage PEO medical plans are non-grandfathered and as such are subject to rules under the ACA for covering certain types of preventive care services without any cost- sharing requirements.

The Plan follows the USPSTF Grade A & B recommendations, CDC and HRSA guidelines for preventive care. A full list of the covered services is available at www.HealthCare.gov/center/regulations/prevention.html. Except as otherwise noted, the Plan is not required to cover preventive services until the first Plan year (which begins on January 1) beginning on or after the date that is one year after the new recommendation or guideline is issued. For example, if the US Preventive Services Tasks Force issues an "A" or "B" recommendation for a preventive service on February 15, 2023, the Plan is not required to cover it until January 1, 2025. For the most up-to-date list of preventive services that are covered by the Plan, contact your insurance carrier directly by calling the number on the back of your medical identification card.

Notice of Patient Protections
Some of the Plan's health plans allow the designation of a medical primary care provider (PCP). You have the right to designate any primary care provider (PCP) who participates in that plan's network and who is available to accept you or your family members.
For children, you may designate a pediatrician as the primary care provider (PCP). Until you make this designation, the plan may designate one for you. For information on how to select a primary care provider (PCP)

and for a list of the participating primary care providers, contact the carriers directly at the number on the back of your identification card or call the Engage PEO Benefits Department at 1-888-780-8807.
You do not need prior authorization from the Plan's health plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the carrier(s) directly at the number on the back of your medical ID card or the Engage PEO Benefits Department at 1-888-780-8807. Additionally, coverage for emergency services in a hospital must cover emergency services provided at hospitals that are out-of- network without any administrative requirements or limitations more stringent than those imposed on in-network hospital emergency services.
Participant copays or coinsurance amounts cannot be higher than that imposed on in-network emergency services. However, participants may be required to pay any excess amount that the out-of-network hospital charges over the amount the plan or insurer pays to its in-network hospitals. The plan may not require preauthorization if the plan provides benefits for emergency services. For more information on coverage for emergency services contact the carrier(s) directly at the number on the back of your medical ID card or call the Engage PEO Benefits Department at 1-888-780-8807.

Summary of Benefits and Coverage (SBC)
Availability of Summary Health Information - As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. A Summary of Benefits and Coverage is available for each medical benefit plan available to you. We encourage you to read and review this information. A paper copy of the SBC is available, free of charge, by either emailing the Engage PEO Benefits Department at benefits@engagepeo.com or by calling 1-888-780-8807 anytime between 8:30 a.m. and 5:00 p.m. Eastern Time (EST), Monday through Friday.

MISCELLANEOUS PROVISIONS

No Guarantee of Employment. Neither the Plan nor any provisions contained in the Plan nor the Component Benefit Program Documents shall be construed to be a contract between Engage PEO or a work-site employer and an employee, or to be a consideration for, or an inducement of, the employment of any employee by Engage PEO or a work-site employer. Nothing contained in the Plan shall grant any employee the right to be retained in the service of Engage PEO or a work-site employer or shall limit in any way the right of Engage PEO or a work-site employer to discharge or to terminate the service of any employee at any time, without regard to the effect such discharge or termination may have on any rights under the Plan.

Procedures for QMCSOs. The Group Health Benefit Programs (major medical, dental, vision, and health flexible spending account coverage) provide benefits in accordance with a QMCSO. If you are subject to a Medical Child Support Order, Engage PEO will notify you and each affected child (or the child's representative) about the procedures that determine the validity of that order and how it will be implemented. Federal law provides that a Medical Child Support Order must meet certain content requirements in order to be a QMCSO. After Engage PEO verifies that an order is a QMCSO, Engage PEO enrolls the child according to the terms of the order.

a) Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.
b) Where a National Medical Support Notice is received by the Plan the following apply:
   i. If the Plan Administrator receives a National Medical Support Notice on behalf of a Child of a team member who is a noncustodial parent of the Child, the Notice will be deemed to be a QMCSO if the Notice is appropriately completed and meets the requirements of paragraphs (b) and (c) above.
   ii. Where an appropriately completed Notice is issued in the case of a Child of a Participant who is a noncustodial parent of the Child, and the Notice is deemed under subparagraph (i) to be a QMCSO, the Plan Administrator will, within 40 business days after the date of the Notice:
      a. Notify the state agency issuing the Notice with respect to such Child whether coverage of the Child is available under the terms of the Plan and, if so, whether such Child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a state or political subdivision thereof substituted for the name of such Child pursuant to paragraph (b)(i)) to effectuate coverage; and
      b. Provide the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
   iii. No National Medical Support Notice may require the Plan to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before receipt of such Notice.
   iv. Where an eligible Employee is not enrolled under a Group Health Benefit Program but his or her Child is subject to a National Medical Support Notice that is a QMCSO, to the extent feasible (taking into account payroll withholding requirements) both the eligible Employee and the Child will automatically be enrolled under the Plan without regard to enrollment period restrictions.
c) If a Plan fiduciary acts in accordance with the fiduciary responsibility provisions of ERISA, in treating a Medical Child Support Order as being (or not being) a QMCSO, then the Plan's obligation to the Participant and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the fiduciary.
d) Any payment of Group Health Benefit Program benefits pursuant to a QMCSO in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian will be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. In the event such payment or reimbursement is made to a state official or agency whose name and address have been substituted for the address of an Alternate Recipient in a QMCSO, such payment will be treated as payment of benefits to the Alternate Recipient.
   i. An Alternate Recipient under a QMCSO will be considered a Plan Participant for purposes of the reporting and disclosure requirements and will be considered a beneficiary under the Plan for purposes of ERISA.

Information to Be Furnished

Participants must provide the Plan with any information and evidence as well as sign any documents, requested from time to time for Plan purposes.

Titles

Titles are provided herein for convenience only and are not to serve as a basis for interpretation or construction of this Plan.

Gender and Number

As used in this Plan, the masculine gender shall include the feminine and neuter genders. Whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

Assignment of Interests
Neither an employee nor a dependent may assign any benefits under the Plan. In no event shall benefits provided to a Participant be alienated and any attempted assignment will be void. Notwithstanding the foregoing, the Plan may choose to remit payments direct to health care providers with respect to covered services, if authorized by the Participant, but only as a convenience to Participants. Health care providers are not, and will not be construed as, either "participants" or "beneficiaries" under this Plan and have no right to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants under any circumstances. Nevertheless, the Plan will comply with a qualified medical child support order, as defined in Section 609(a) of ERISA.

Permanence of the Plan
The Plan shall continue in full force and effect unless terminated, modified, altered or amended by the Company, including any properly designated delegate, including the Engage Benefits Committee.

The Company is not and shall not be under any obligation or liability whatsoever to continue or maintain the Plan for any given length of time. The Company, through action of its board of directors or governing benefits committee, may in its sole and absolute discretion, discontinue or terminate the Plan at any time without any liability whatsoever for such discontinuance or termination.

Right to Amend
The Company reserves the right at any time and from time to time to modify, alter, or amend, in whole or in part, any or all of the provisions of the Plan. Any Plan modification, alteration or amendment shall be accomplished by a written instrument which is signed by an officer of the Company that is duly authorized by the Company's Board of Directors or the Engage ERISA Benefits Committee as a delegate thereof.

No modification, alteration or amendment shall have any retroactive effect so as to deprive any Participant of any benefit then payable. Notwithstanding the foregoing, any modification, alteration, or amendment of the Plan may be made retroactive to the extent necessary for the Plan to comply with any applicable law.

No agent or representative of the Company is authorized to change the form or content of this Plan in any manner or degree other than by an endorsement issued to form a part hereof and over the signature of an authorized officer of the Company.

Employee's Responsibility
Each employee shall be responsible for providing Engage PEO and/or the work-site employer with his current address. Any notices required or permitted to be given by Engage PEO, a work-site employer, or the Plan Administrator hereunder shall be deemed given if directed to such address and mailed by regular United States mail; however, nothing contained herein shall preclude the use of electronic delivery so long as in accordance with applicable laws and communications furnished via ERISA-qualifying electronic delivery shall be deemed delivered. If notice is required to be given to a dependent spouse of an employee, notice to such spouse shall be deemed notice to all other Qualified Beneficiaries residing with such spouse. Any notices required or permitted to be given by the employee hereunder shall be deemed given if directed to Plan Administrator or Engage PEO and mailed by regular United States mail. Neither the Plan Administrator, Engage PEO, nor a work-site employer shall have any obligation or duty to locate an employee. In the event an employee becomes entitled to a payment under the Plan and such payment cannot be made (a) because the current address referred to above is incorrect, (b) because such employee fails to respond to the notice sent to the current address referred to above, (c) because of conflicting claims to such payment, or (d) because of any other reason, the amount of such payment, if and when made, shall be that determined without interest thereon.

Indemnification
To the extent permitted by law, the work-site employer and employee shall indemnify and hold harmless the Plan Administrator, board of directors and any employee to whom any fiduciary responsibility with respect to the Plan is allocated or delegated from and against any and all liabilities, costs and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities and obligations under the Plan and under ERISA, other than such liabilities, costs and expenses as may result from the gross negligence or willful misconduct of any such person. The foregoing right of indemnification shall be in addition to any other right to which any such person may be entitled as a matter of law or otherwise. The work-site employer may obtain, pay for and keep current a policy or policies of insurance, insuring the Plan Administrator, the board of directors or any employee who has any fiduciary responsibility with respect to the Plan from and against any and all liabilities, costs and expenses incurred by any such person as a result of any act, or omission to act, in connection with the performance of his duties, responsibilities and obligations under the Plan.

Electronic Communications
Notwithstanding anything to the contrary contained in this Plan, any notice, form or other communication required hereunder or by the component plans shall be made in the manner prescribed by the Plan Administrator in accordance with applicable law, which may include, in appropriate circumstances, communication by e-mail, fax, and telephone or by other electronic means.

Governing Law
This Plan shall be construed and enforced according to the laws of the State of Florida, other than its laws respecting choice of law, to the extent not preempted by any federal law.

PRIVACY OF HEALTH INFORMATION

Definitions. Terms used in this section are as defined in the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R. Parts 160 and 164 ("HIPAA Privacy Regulations") or 45 C.F.R. Part 160 and Subparts A and C of Part 164 ("HIPAA Security Standards").

Disclosures to Plan Sponsor. The Plan may disclose protected health information to the Company, to enable the Company, as Plan Sponsor, to carry out plan administration functions, or as otherwise permitted by HIPAA Privacy Regulations.

Use of Protected Health Information. The Plan will not use or disclose protected health information that is genetic information for underwriting purposes.

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

a) the Plan Administrator;
b) members of the benefits, legal, finance, information system, audit, accounting, and human resources department of the Plan Sponsor to the extent they perform functions with respect to the Plan; and
c) such other individuals or classes of individuals identified by the Plan's privacy officer as necessary for the Plan's administration.

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

a) Not use or disclose protected health information other than as permitted or required by the Plan documents or as required by law;
b) Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
c) Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which Plan Sponsor becomes aware;
d) Make protected health information accessible to covered persons in accordance with the HIPAA Privacy Regulations;
e) Allow covered persons to amend or correct their protected health information in accordance with the HIPAA Privacy Regulations;
f) Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;
g) Make its internal practices, books and records available to the Secretary of Health and Human Services for determining compliance;
h) Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information, or if not feasible, restrict access and uses as required by the HIPAA Privacy Regulations;
i) Ensure that any agents, including a subcontractor; of the Plan Sponsor to whom it provides protected health information also agree to these same restrictions.
j) Ensure that adequate separation between the Plan Sponsor and Plan is established as required under the HIPAA Privacy Regulations; and
k) Restrict the use of protected health information by those individuals identified above for plan administration functions within the meaning of the HIPAA Privacy Regulations.

Permitted Disclosure to Plan Sponsor.
Notwithstanding the foregoing, the Plan may disclose to the Plan Sponsor the following types of information:

a) Summary health information may be disclosed to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.
b) Information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
c) Information provided pursuant to an authorization within the meaning of section 164.508 of the HIPAA Privacy Regulations.
d) De-identified information, as defined under the HIPAA Privacy Regulations.

Non-Compliance. In the event of noncompliance with the restrictions above by a designated employee or other individual receiving protected health information on behalf of the Plan Sponsor, the employee or other individual shall be subject to discipline in accordance with the Plan Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such person shall be filed with the Plan's privacy officer.

HIPAA Security Standards.

a) **Safeguards**. The Plan Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.

b) **Agents**. The Plan Sponsor will ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate safeguards to protect such information.
c) **Security Incidents**. The Plan Sponsor will report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.
d) **Adequate Separation**. The Plan Sponsor will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and Plan Sponsor, in support of the requirements of this section.

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

Medical Reimbursements, Stipends or Incentives
The Plan does not allow or support the use of medical compensation reimbursements, stipends or incentives that would encourage employees to waive out of the employer sponsored benefit plans. The use of these incentives can directly conflict with ACA, Federal Medicare and other regulations and will not be supported.

ERISA RIGHTS AND RESPONSIBILITIES

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

Receive Information about Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) that is filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), and an updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Receive a copy of the procedures used by the Plan for determining a qualified medical child support order (QMCSO).

Continue Group Health Plan Coverage
Continue health care coverage for yourself, your spouse, or your 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 up to $ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory; or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PARTICIPATING EMPLOYERS' APPENDIX

Effective 1/1/2026

Participating Affiliated Employers (companies under common ownership)
The following organizations and entities shall be Participating Employers under the Plan in relation to the benefits made available to their employees:

Participating Companies

The S2 HR Group, LLC DBA Engage PEO

S2 HR Solutions Group 1, LLC

Innovative Employer Solutions, Inc

CEOHR, Inc

Fusion Employer Services, LLC

Fusion Employer Services II, LLC

Fusion Employer Services III, LLC

Genesis HR Solutions, Inc.

United Benefits Consulting, LLC DBA Zamp HR

Human Resources Inc.

Cornerstone Employer Solutions, LLC DBA Synchrony HR

Axios, LLC

FullStack Inc

Aspen HR PEO, LLC

AspenHR, LLC

In the event of amendment of this Participating Employer Appendix, a new Participating Employer Appendix may be attached to the Summary Plan Description in the place hereof without further amendment to the Summary Plan Description

BENEFIT OPTION APPENDIX

Effective 1/1/2026

Benefit	Provider Name and Address	Policy Number	Funding
Medical	Aetna Inc. P. O. Box 1125 Blue Bell, PA 19422 1-800-323-9930	326465 326465 HNO 326465 TH 326465 BH	Fully-Insured
Medical	Kaiser Permanente Health Plans **Northern California** Kaiser Permanente Attn: California Claims Department P.O. Box 12923 Oakland, CA 94604-2923 Ph: 800-464-4000 Fax: 866-889-6021 **Southern California** Kaiser Permanente Attn: California Claims Department P.O. Box 7004 Downey, CA 90242-7004 800-464-4000 **Colorado** Claims Department Kaiser Foundation Health Plan of Colorado P.O. Box 373150 Denver, CO 80237 (303) 338-3600 **Georgia** Kaiser Permanente Claims Administration P.O. Box 190849 Atlanta, GA 31119-0849 (888) 865-5813 **Hawaii** Claims Department Kaiser Permanente P.O. Box 378021 Denver, CO 80237 1-877-875-3805	606686 234858 47083 10529 18043	Fully-Insured
Dental	Aetna Inc. P. O. Box 1125 Blue Bell, PA 19422 1-800-323-9930	326465	Fully-Insured
Dental	MetLife P.O. Box 14593 Lexington, KY 40512 1-800-275-4638	227795	Fully-Insured
Vision	Aetna Inc. P. O. Box 1125 Blue Bell, PA 19422 1-800-323-9930	326465	Fully-Insured

Vision	MetLife P.O. Box 14593 Lexington, KY 40512 1-800-275-4638	227795	Fully-Insured
Basic Life Insurance and Accidental Death & Dismemberment (AD&D), Voluntary Life Insurance and Accidental Death & Dismemberment (AD&D)	MetLife P.O. Box 14593 Lexington, KY 40512 1-800-275-4638	227795	Fully-Insured
Short-Term Disability	MetLife P.O. Box 14593 Lexington, KY 40512 1-800-275-4638	227795	Fully-Insured
Long-Term Disability	MetLife P.O. Box 14593 Lexington, KY 40512 1-800-275-4638	227795	Fully-Insured
Accident, Critical Illness, Hospital	MetLife P.O. Box 14593 Lexington, KY 40512 1-800-275-4638	227795	Fully-Insured
Healthcare Savings Account, Health Care Flexible Spending Account, Dependent Care Flexible Spending Account, Transit/Commuter Accounts	Inspira Financial (fka Payflex Systems USA) P.O. Box 8606 Omaha, NE 68154 (1-844-729-3539) (TTY: 711)	Engage	Self-Funded
Employee Assistance Program (EAP)	Health Advocate Solutions 3043 Walton Road Plymouth Meeting, PA 19462	Engage	Self-Funded
Pre-Paid Legal	Legal Shield 1-800-654-7757	Engage	Self-Funded

In the event of amendment of this Benefit Option Appendix, a new Benefit Option Appendix may be attached to the Summary Plan Description in the place hereof without further amendment to the Summary Plan Description
***Note**: From time to time, the Plan Sponsor may offer or make available to its eligible employees additional non-ERISA benefits, under a voluntary employee pay all safe harbor or otherwise.*
***Note**: Some work-site employers may not elect to offer all component plan options available in this Benefit Option Appendix*