PARSONS CORPORATION

FLEXIBLE BENEFITS PLAN

AND

SUMMARY PLAN DESCRIPTION

Restated Effective January 1, 2023

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INTRODUCTION

The purpose of the Plan is to allow you to choose among different types of Benefits, and pay your share of the cost of those Benefits on a tax-favored basis. You may choose Benefits based on your own particular goals, desires, and needs. These plans are commonly called "cafeteria plans" because they offer a "menu" of benefit choices. This Plan, as reflected on the following pages, is restated effective January 1, 2023.

In reading this Plan document, there are capitalized terms that have special meaning as set forth in Article VIII, Definitions.

Important Note: Once you are eligible to participate and join the Plan, you cannot change your elections for the remainder of the Coverage Period, unless you meet certain requirements described in Article III.

ARTICLE I

BENEFITS AVAILABLE TO YOU

Plan Credits and Benefit Options. When your Employer reduces your Compensation to pay for coverage offered through the Plan, the Employer takes each dollar it withholds from your Compensation and converts it to an equivalent Plan Credit. For example, if you enroll in the Plan and reduce your Compensation by $500, your Plan Credits would be equal to the exact same amount. Your Plan Credits are then used to provide the Benefits in which you have enrolled.

> ***Example:*** Here's an example that shows how you enroll under the Plan, and explains why participating in this Plan is a good idea. Assume you and your family are covered under your Employer's health care plan, and that you pay $200 per month for this coverage. Also assume that your monthly pay is $2,000, and that 25% goes to pay state and federal income taxes and Social Security taxes.
>
> Without the Plan, your premium payments are taken into account when calculating your taxes. In other words, without the Plan, you would pay $500 in taxes (25% x $2,000) and have $1,300 in take home pay ($2,000 gross pay - $500 taxes - $200 premiums). With the Plan, your taxes are calculated after deducting your premium payments from your income. With the Plan, you would only pay $450 in taxes ([$2,000 gross pay - $200 premiums] x 25%) and have $1,350 in take home pay ($2,000 gross pay - $450 taxes - $200 premiums). **By paying your health care premiums with pre-tax dollars, you would save $50.00 in taxes in this example.**

You may choose to receive any or all of the following Benefits:

Payment of Premiums with Pre-Tax Dollars. You may choose to have Plan Credits used to pay Premiums for coverage (on behalf of yourself, your Spouse and/or other Dependents, depending on whether they're eligible for the coverage) under the Employer's health and welfare benefit plan(s) listed below:

- **Medical Plan**.
- **Dental Plan**.
- **Vision Plan**.

The rules concerning eligibility under, and the benefits available from, the plans listed above, are contained in the documents and contracts that comprise those plans.

***Medical FSA*.** You may elect coverage under the Medical FSA option. See the Medical FSA Appendix for rules that apply to this program.

Dependent Care FSA. You may elect coverage under the Dependent Care FSA option. See the Dependent Care FSA Appendix for rules that apply to this program.

Health Savings Account. If you are an eligible individual and enrolled in a high deductible health plan option offered by your Employer, then you may also choose to have Plan Credits used to

make contributions to your health savings account ("HSA"). Your Employer may limit the amount and timing of your contributions to your HSA made through this Plan.

ARTICLE II

PARTICIPATION

Becoming Eligible to Participate, and Beginning Your Participation. You must be an Eligible Employee and enroll for coverage under one or more of the Benefits offered through this Plan to actually *begin* your participation in this Plan.

Terminating Your Participation. Your participation in the Plan will end upon the occurrence of one or more of the following events:

1. Termination of your employment.

2. The date you cease to be an Eligible Employee.

3. Your death.

4. The termination of this Plan itself.

5. The date you validly revoke your coverage under the Benefits.

COBRA Coverage. If you or one of your covered Dependents lose coverage under your Employer's medical, dental and vision plans, then you may be eligible to continue that coverage for a limited time pursuant to COBRA. COBRA generally applies when your coverage ends due to termination of your employment (for reasons other than gross misconduct) or reduction in work hours, or your death. Your covered family members generally have the right to continue coverage when their coverage ends due to termination of your employment (for reasons other than gross misconduct) or your reduction in work hours; your death; divorce or legal separation; your entitlement to Medicare; or a covered child's ceasing to meet the definition of an eligible child under the medical, dental or vision plan. These events are known as "qualifying events" because they "qualify" you or the family member for COBRA coverage. Some family members, such as domestic partners and their children, may not be eligible for COBRA coverage in some circumstances.

USERRA Coverage. If you lose coverage under one or more of your Employer's medical, dental or vision plans because you commence a period of uniformed service to which the Uniformed Services Employment and Reemployment Rights Act applies, you may continue your coverage and, notwithstanding any other provision in this Plan to the contrary, your participation in this Plan (to the extent you have wages from the Employer) for the duration of your period of uniformed service or 24 months, whichever period is shorter.

Special Rules Concerning Reemployments. If you participate in the Plan during a Coverage Period, then terminate employment but are rehired during that same Coverage Period, you may be able to re-enroll for coverage for the remaining portion of the Coverage Period. You may do so if the termination of employment and the reemployment are *bona fide*. The termination and reemployment are deemed to be *bona fide* if there is at least a 30-day break in employment between the date of your termination and the date of your reemployment. If the break is for fewer than 30 days, then you may be automatically re-enrolled in the elections you had in effect at the time of

your termination. See also the special rules described in Article III, in the section titled, *Mid-Year Changes to Elections*.

Special Rules Concerning Death. If you die your participation in the Plan will cease. However, your beneficiary or representative of your estate may submit claims for expenses that you Incurred through the termination date of your coverage. You may designate a specific beneficiary for this purpose. If no beneficiary is specified, the Administrator or its designee may designate your Spouse, one of your other Dependents, or a representative of your estate. Claims Incurred by your Spouse or by other covered Dependents prior to termination of coverage may also be submitted for reimbursement.

ARTICLE III

BENEFIT ELECTIONS

Initial Benefit Elections. Once you meet the eligibility requirements described in Article II you can choose to participate in this Plan for the remainder of the Coverage Period. To do so, you must enroll for coverage within the initial enrollment period prescribed by your Employer after you first become eligible. In no event will your initial enrollment period be longer than 30 days.

Your enrollment serves two purposes: (1) you elect the Benefits you wish to receive and (2) you authorize the Employer to reduce your Compensation in order to provide for contributions to participate in the Benefits you elect.

For example, assume that you first become eligible to participate in this Plan on March 1 of a given Coverage Period and are given 30 days to enroll. Your initial Election Period will run from that March 1 to March 30. Your initial enrollment for coverage must be made within this Election Period, in order for you to receive any Benefits under this Plan for the remainder of that Coverage Period. If you fail to timely enroll for coverage, you must wait until the annual Election Period to enroll for coverage. However, you might be eligible for mid-year enrollment before the next annual Election Period if you meet the requirements for changing benefit elections described below, in the section titled, "*Mid-Year Changes to Elections.*"

Subsequent Annual Elections. During each annual Election Period, you may choose which Benefits you wish to purchase for the next Coverage Period. Any election you make must be filed before the end of the annual Election Period and will apply for the following Coverage Period.

Choosing to Participate After Initially Declining to Participate. In addition, if you fail to enroll for coverage when you are first eligible, you can choose during an ensuing annual Election Period to participate in the Plan effective for the ensuing Coverage Period. Of course, in order to be able to do this you must still be eligible to participate in the Plan.

Terminating Participation in the Plan. If you want to *terminate* your participation in the Plan, you can do that by notifying the Administrator or its designee in the manner acceptable to the Administrator during the annual Election Period that you do not want to participate in the Plan for the next Coverage Period. However, see the rules below titled, "Failure to Make a New Election."

If during the annual Election Period you choose not to participate for the next Coverage Period you will have to wait until the *next* annual Election Period before you will again have an opportunity to participate in the Plan. However, you might be eligible for mid-year enrollment before the next annual Election Period if you meet the requirements for changing benefit elections described below, in the section titled, "*Mid-Year Changes to Elections.*"

Failure to Make a New Election. With regard to coverage for which you must pay Premiums (such as coverage under a medical, dental or vision plan or disability insurance policy), you will be *deemed* to have made, for the Coverage Period, the *same* benefit elections that are then in effect for the current Coverage Period unless your Employer requires affirmative elections to be made

every year. You will also be deemed to have elected to have your Compensation reduced for the next Coverage Period in an amount necessary to purchase those Benefits.

With regard to Benefits for which you pay no Premiums, you will be deemed to have elected *not* to receive any of those Benefits for the upcoming Coverage Period. These benefits include the following, as applicable:

- Medical FSA
- Dependent Care FSA
- Health Savings Account

No further reductions from your Compensation will be made for the next Coverage Period in order to provide such Benefits to you.

General Rule for Mid-Year Changes to Elections. As a general rule, IRS rules do not allow you to change a benefit election after the start of a Coverage Period and make a new benefit election for the remainder of the Coverage Period. However, there are exceptions to this rule. The exceptions are described in the paragraphs below, and the exception that applies to you depends on the Benefits that will be affected by your change. ***If an exception applies to you, your new elections must be made (received by the Administrator) within 30 days after the date of the event that gives rise to your right to make the change.*** However, in some cases as described below, you may have up to 60 days to make your change.

These rules are complex; if you have questions, please contact your human resources or employee benefits representative. In addition, please note that even if you are able to change elections under this Plan, the terms of the benefit plan or program under which you are purchasing coverage under this Plan may prohibit a mid-year change—in that case, the terms of the benefit plan or program control over the terms of this Plan.

Events Entitling You to Change Elections Concerning Payment of Health Insurance Premiums. For purposes of this section, the term "health insurance" includes medical, dental, vision and any other group health plan, whether insured or self insured by the Employer.

1. **HIPAA Special Enrollment**. You may cancel your coverage (and make a new election for the remainder of the Coverage Period) with respect to coverage under a group health care plan where the cancellation of the old coverage and election of the new coverage corresponds with a "special enrollment" right under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

   Under the HIPAA special enrollment requirements, a group health plan must permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or his dependent, if the dependent is eligible, but not enrolled, for coverage) to enroll for coverage under the terms of the plan, if each of the following conditions is met:

   - the employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the employee or individual;

- the employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor (or the health insurance issuer offering health insurance coverage in connection with the plan) required such a statement at the time and provided the employee with notice of the requirement (and the consequences of the requirement) at the time;

- the coverage of the employee or dependent who had lost the coverage: (a) was under a COBRA continuation provision and the COBRA coverage was exhausted or (b) was not under a COBRA continuation provision and either: (i) the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or (ii) employer contributions towards the coverage were terminated; and

- the employee requests enrollment not later than 30 days after the HIPAA special enrollment event.

A special enrollment event also occurs upon the birth, adoption or placement for adoption of an eligible child. In this case, the group health plan must allow you to enroll the child retroactively (to the date of birth, adoption or placement for adoption), your election change may also be given retroactive effect.

Please note that notwithstanding the general rule that you must request the enrollment change within 30 days after the event giving rise to the special enrollment right, if you or your dependent (within the meaning of HIPAA) become eligible for a state granted premium subsidy for the Employer's health coverage, you may request enrollment under the Employer's health coverage within 60 days after the date Medicaid or the Children's Health Insurance Program (CHIP) determine that you or the dependent qualify for the subsidy. Similarly, if you or your dependent lose coverage under Medicaid or CHIP, you may request enrollment under the Employer's health coverage, again within 60 days of the date you or the dependent lose such coverage

2. **Court Decree**. You may cancel your coverage (and make a new election for the remainder of the Coverage Period) where a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in legal custody requires either you or your Spouse, former Spouse or other individual to provide health insurance coverage for your Dependent child. You may add coverage for the child if the court order requires you or the Employer's health care plan(s) to provide coverage for the child. You may drop coverage for the child if the court order requires your Spouse, former Spouse or other individual (or their employer's health care plan(s)) to provide coverage for the child, ***and*** your Spouse, former Spouse or other individual actually acquires coverage for the child. The Plan may make a *unilateral* change in your enrollment under these circumstances, to provide for coverage of your Dependent child under the Employer's health care plan(s), where the order is a qualified medical child support order and the order requires the plan(s) to provide coverage.

3. **Entitlement to Medicare or Medicaid**. You may cancel your coverage (and make a new election for the remainder of the Coverage Period) where you, your Spouse, or other Dependent becomes entitled to, or ceases to be entitled to, benefits under either Medicare or Medicaid. Where the individual becomes entitled to Medicare or Medicaid benefits you may modify your enrollment to drop coverage of the individual under your Employer's health care plan(s). Similarly, where the individual ceases to be entitled to Medicare or Medicaid benefits you may modify your election to add coverage of the individual under your Employer's health care plan(s).

4. **Changes in Status**. You may cancel your enrollment (and make a new election for the remainder of the Coverage Period) where you experience a "change in status" and the change to your enrollment is "consistent with" that change in status. A "change in status" is:

- A change in your legal marital status, including your marriage, the death of your Spouse, the annulment of your marriage, or your divorce or legal separation;
- A change in the number of your Dependents, including the birth, adoption, placement for adoption, or death of a Dependent;
- A change in the employment status of you, your Spouse or other Dependent; a "change in employment status" includes:
    - Termination or commencement of employment (if commencement of employment follows a termination of employment with the same employer, no new election is permitted unless the commencement follows at least 30 days after the termination);
    - Strike or lockout;
    - Commencement of, or the return from, an unpaid leave of absence;
    - Change in work site;
    - Satisfying, or ceasing to satisfy, eligibility conditions due to a change in employment status (a switch between part-time and full-time employment, salaried and hourly positions, etc.);
- An event that causes your Dependent to satisfy or cease to satisfy the eligibility requirements for coverage whether due to the attainment of a specified age, student status, or any similar circumstance described in such plan(s); or
- A change in the place of residence or employment of you, your Spouse, or your other Dependent.

Your change in your enrollment is "consistent with" a change in status if and only if the change in status affects eligibility for coverage under an employer's plan, and the election change is on account of and corresponds with the change in status.

A change in status that affects eligibility for coverage includes a change in status that causes an increase or decrease in the number of your family members who may benefit from coverage under the plan. For example, let's say you wish to change your election to drop coverage under this Plan for you or your Spouse because, due to a marital status change or a change in your Spouse's employment status, you or your Spouse now qualify for coverage under a plan provided by your Spouse's employer. You can make the election change so long as the person you wish to disenroll under this Plan acquires the newly available coverage under your Spouse's plan. We will allow the election change upon your certification that coverage has been or will be obtained under the other plan.

Notwithstanding this consistency rule, if you, your Spouse or other Dependent become eligible (under a health care plan maintained by the Employer) for COBRA, Public Health Service Act, or other applicable continuation coverage under any similar state health coverage continuation law, you may modify your enrollment in order to pay for that continuation coverage.

5. **Family and Medical Leave**. You may cancel your enrollment (and make a new election for the remainder of the Coverage Period) if you take a leave of absence pursuant to the Family and Medical Leave Act ("FMLA"). In addition,

- If you continue your participation during the period of FMLA leave, you will be entitled to change your election, in accordance with the rules described above, to the same extent as any other Participant who is not on FMLA leave;

- If you continue your participation during the period of FMLA leave the Employer may permit you, under procedures applied in a nondiscriminatory manner, to pay your share of the cost of coverage under one or more of the following methods (note, however, that where the period of FMLA leave is substituted paid leave, your method of paying your required contributions must be the same method normally used by Participants during paid leave):

    - ***Pre-pay option.*** You may, prior to beginning your FMLA leave, pre-pay on a pre-tax basis (from taxable Compensation payable to you, including the cashing out of unused sick days or vacation days) the contributions required on your behalf for the period of FMLA leave. But if the period of FMLA leave begins in one Coverage Period and ends in another Coverage Period, you may not pre-pay, on a pre-tax basis, for coverage during the period of FMLA leave that extends into the next Coverage Period. The cost of coverage for periods of FMLA leave in the next Coverage Period must be paid under the method described below.

    - ***Pay-as-you-go option.*** You may pay (on a pre-tax basis, from taxable Compensation otherwise payable to you, or on an after-tax basis) the contributions required on your behalf for the period of FMLA leave on the same schedule under which payments would be made if you were *not* on FMLA leave. For example, if while not on FMLA leave your contributions to the Plan were made bi-weekly, you may make your contributions

bi-weekly while on FMLA leave. Alternatively, you may pay the required contributions on the same payment schedule that applies to payment for COBRA or PHSA continuation coverage under the Employer's group health care plan or dental plan (i.e., typically monthly, with a 30-day grace period for each monthly payment).

- ***Catch-up option.*** To the extent you and the Employer agree in advance, the Employer may continue your coverage(s) during a period of unpaid FMLA leave, and that you will not pay your share of the premiums until you return from leave. You and the Employer must agree in advance of the period of continued coverage that: (i) you elect to continue your coverage while on unpaid leave; (ii) the Employer assumes responsibility for advancing premium payments on your behalf during the FMLA leave; and (iii) these advance amounts are repaid by you after your return from FMLA leave. However, the Employer has the option of using this "catch up" feature unilaterally, where you intend but fail to make premium payments while on leave (that is, you utilize the pay-as-you-go option but fail to make premium payments). In that case, the Employer may unilaterally pay your share of the premium while you're on FMLA leave, and then recoup its advance from you after your return. No advance agreement is required in this latter case.

Upon your return from FMLA leave, your "catch-up" contributions may be made on a pre-tax basis from any taxable compensation to which you're entitled (including unused sick leave and vacation days). Premiums may also be paid from Compensation reductions on a pre-tax basis if the premiums were not paid under any other method while you were on leave. You may also make "catch-up" contributions on an after-tax basis.

If your coverage under the Plan terminated while you were on FMLA leave (either because you cancelled your coverage, or because you failed to pay the required Premiums or other contributions), you may recommence participation after you return from FMLA leave by enrolling for coverage with the Administrator or its designee within 30 days of your return.

6. **Significant Changes in the Cost of Coverage**. If the cost of a benefit requiring contributions from you increases or decreases during the year, your enrollment will change automatically to keep pace with the change in required contributions. See the discussion about this automatic change, in Section IV.

You may cancel your enrollment where during a Coverage Period there is a significant increase *or* significant decrease in the cost of a benefit package option under the Employer's plan(s). (A "benefit package option" is a qualified benefit under Section 125(f) of the Code or an option for coverage under an underlying health care plan, such as an indemnity, HMO or PPO option.) In that case you may then make a new election to either (i) receive coverage under the option with the decrease in cost, (ii) revoke coverage under the option with an increase in cost and elect similar coverage under another benefit package option providing similar coverage or, if there is no other option with similar coverage

available, drop coverage entirely. No automatic adjustment in your election, as described in Article IV, will be made under these circumstances.

For purposes of this rule, a "cost increase" or "cost decrease" refers to an increase or decrease in the amount of contributions you make under this Plan, whether due to actions taken by you (switching between part-time and full-time employment, etc.) or from an action by your Employer (such as decreasing the cost of coverage for a classification of employees of which you're a member).

7. **Significant Changes in Coverage**. You may cancel your elections where during a Coverage Period your, your Spouse's or other Dependent's coverage under a plan of the Employer is significantly curtailed or ceases. Coverage is considered significantly "curtailed" if, among other things, there is a significant increase in the deductible, the copay, or out-of-pocket maximum amount under a health plan. In that event, you must then make a new election on a prospective basis for such person under another benefit package option providing similar coverage. Coverage under a plan is significantly curtailed only if there is an overall reduction in coverage provided to participants under the plan so as to constitute reduced coverage to participants generally.

   If there is a "loss" of coverage, you may elect coverage on a prospective basis for such person under another benefit package option providing similar coverage, or drop coverage if there is no other option providing similar coverage. A "loss" of coverage includes a complete loss of coverage (including the elimination of a benefit package option, an HMO ceasing to be available in the area where the person resides, the individual's attainment of an overall annual or lifetime benefit maximum under a plan, a substantial decrease in the number of medical providers available under the option (such as a major hospital ceasing to be a member of a managed care network, or a substantial decrease in the number of physicians participating in the network), a reduction in the benefits for a specific type of medical condition or treatment (where you, your Spouse or other Dependent is currently in a course of such treatment), or any other similar fundamental loss of coverage.

8. **Addition (or Improvement) of Benefit Package Option**. You may cancel your election where during a Coverage Period a plan of the Employer adds a new benefit package option or other coverage option (or significantly improves an existing benefit package option or other coverage option). In that case you may then make a new election to elect the newly-added or improved option prospectively.

9. **Loss of Coverage Under Certain Governmental or Educational Institution Plans**. You may cancel your election where during a Coverage Period you, your Spouse or other Dependent lose coverage under any group health plan sponsored by a governmental or educational institution, including a State children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Service or a tribal organization; a State health benefits pool; or a foreign government group health plan. You may then make a new election to provide coverage for such person on a prospective basis under a plan of the Employer.

10. **Change in Coverage under another Plan**. You may cancel your election, and file a new election for the remainder of the Coverage Period, where the change is on account of and corresponds with a change made under another plan maintained by your Employer or another employer if:

- That other plan permits participants to make an election change that would be permitted under the rules of this Article (disregarding this section concerning changes in coverage under another plan); or

- This Plan permits you to make an election for a period of coverage that is different from the period of coverage under the other plan.

Mid-Year Changes for the Medical FSA. The events and requirements under which you may make a mid-year change to your enrollment elections with respect to contributions to the Medical FSA include the following from the list of events under *Mid-Year Changes for Insurance Coverage* above:

1. ***Court Decree.***

2. Change in Status.

3. Family and Medical Leave.

Note also that if you change your benefit elections as to the Medical FSA, you may not reduce the amount you elect to contribute to the Program for the Coverage Period below a certain amount. That amount is equal to the amount of Benefits paid to you by the Program during the Coverage Period and prior to the event justifying your change in Benefit Election.

In addition, and notwithstanding any other provision in this Plan to the contrary (except the provisions concerning contributions and coverage during a period of FMLA leave), if after making a benefit election concerning the Medical FSA your Compensation is reduced (for example, due to an unpaid leave of absence) such that there is insufficient Compensation for the Employer to make Compensation reductions in the amount elected, the Employer may treat you as ineligible to continue your participation in the Program due to nonpayment of premiums, and may permit you to cancel your election and make a new election for no coverage under the Medical FSA. Alternatively, the Employer may unilaterally cancel your participation in the Program due to nonpayment of premium. However, otherwise covered claims incurred prior to the termination of your participation, and timely submitted for reimbursement, will still be considered for payment notwithstanding the subsequent termination of coverage.

Mid-Year Changes for the Dependent Care FSA. The events and requirements under which you may make a mid-year change to your benefit elections with respect to contributions to the Dependent Care FSA include the following from the list of events under *Mid-Year Changes for Insurance Coverage* above:

1. ***Change in Status***. An election change meets the consistency requirement if the election change is on account of and corresponds with a change in status that affects Employment-Related Dependent Care Expenses described in the Dependent Care

FSA Appendix. For purposes of the "change in status", the term "Dependent" means your Qualifying Dependent as described in the Dependent Care FSA Appendix. For example, a "change in status" occurs when your Dependent child attains age 13 and is no longer a "Dependent" for purposes of the Dependent Care FSA.

2. ***Significant Changes in the Cost of Coverage***. This rule only applies if the cost change is imposed by a dependent care provider who is not your relative. A "relative" means a child (including a stepchild) or grandchild, a brother or sister (or stepbrother or stepsister), parent (including a stepparent), grandparent or great-grandparent, a niece or nephew, uncle or aunt, or mother- or father-in-law, brother- or sister-in-law, or son- or daughter-in-law. A child includes a foster child and a child adopted by or placed for adoption with you. A sister or brother includes a sister or brother by half-blood.

3. ***Significant Changes in Coverage.***

4. ***Addition (or Improvement) of Benefit Package Option.***

5. ***Change in Coverage under another Plan.***

Mid-Year Changes for Health Savings Accounts. You may change your election concerning the amount of your pre-tax contributions to your health savings account at least monthly, but the change may be effective prospective only. Your new election will take effect as soon as the Employer's payroll department is able to effectuate the change. Please note that if the Employer has pre-funded your HSA account with all or a portion of the amount you elected to contribute for the year, and is entitled to be reimbursed the "advance" from deductions from your pay, you may not modify your HSA contribution election so that the total amount you elect to contribute for the year is less than the amount of the Employer's advance. The intent of this rule is to ensure that the Employer is allowed to recoup the amount of its advance, as long as you are still entitled to pay from the Employer.

The Employer may limit the amount and timing of your pre-tax contributions to your HSA, and such restrictions may affect your ability to change your election.

In addition to the rules described above, you may make changes to your Benefit elections (and make a new enrollment election for the remainder of the Coverage Period) to the extent consistent with the requirements of the Uniformed Services Employment and Reemployment Rights Act, when you commence or return from a period of uniformed service under circumstances protected by the provisions of that law.

ARTICLE IV

YOUR CONTRIBUTIONS TO THE PLAN

Compensation Reductions – General Rules. Recall that, in order to participate in the Plan, you must both choose the Benefits you want to receive and agree to reduce your Compensation to pay for the Benefits you choose. You agree to reduce your Compensation by making your enrollment elections discussed in Article III.

> ***NOTE***: If you elect to enroll in any coverage requiring the payment of employee Premiums, then you will be *deemed* to have elected to pay for your share of those Premiums on a pre-tax basis through this Plan. You may not pay for your share of any Premiums on an after-tax basis, except in the case of dependent coverage which cannot be paid for with pre-tax dollars under federal tax laws, or as otherwise permitted by your Employer in a nondiscriminatory manner.

Your Employer will administer its payroll program to allow you to agree to reduce your Compensation during a Coverage Period by the amount necessary to enroll for the Benefits you choose. Your enrollment elections will apply for the entire Coverage Period and cannot be changed except as provided under the special rules in Article III concerning *Mid-Year Changes to Elections*.

As a general rule, the amounts you agree to contribute to the Plan will be contributed on a *pro rata* basis for each pay period during the Coverage Period. Therefore, the same amount will be subtracted from your Compensation each pay period. Your Employer may also allow you to make your contributions to the Plan in advance (for example, in a single sum at the beginning of the Coverage Period).

Automatic Increases or Decreases to Your Contribution. Your Compensation reductions will *automatically* change to the extent necessary to conform to any increase or decrease in the cost of coverage of any of the Employer's health and welfare plans under which you are enrolled.

For example, assume that you choose coverage under the Employer's medical plan, and choose to have your cost of coverage paid under this Plan. Assume your monthly cost of coverage under the medical plan, at the beginning of the year, is $100.

If your cost of coverage increases or decreases during the course of the year, then as a general rule your elections will *automatically* change to correspond to the adjusted Premium amount. The rules in Article III concerning mid-year changes to benefit elections describe situations where, due to a change in the cost of some coverages, you might be entitled to cancel your benefit elections and make a new election.

What Your Employer Does with the Reductions From Your Compensation. As soon as practicable after each pay period your Employer will take the amount by which you agreed to have your Compensation reduced and convert those dollars into Plan Credits. It will then apply those Plan Credits to provide the Benefits in which you have enrolled.

Employer Discretionary Contributions on Your Behalf. Your Employer may choose to make its own contributions of Plan Credits to the Plan on your behalf, which you may then use to purchase one or more of the various Benefits offered under the Plan. Whether the Employer makes such contributions, and the amounts and timing of any such contributions, will be determined by the Employer in its discretion, subject only to applicable nondiscrimination requirements.

ARTICLE V

CLAIMS AND APPEALS

Any claim for Benefits (including eligibility for participation) under a medical, dental, vision or other benefit program must be made to the third party administrator or insurance carrier for the benefit program. If the third party administrator or insurance carrier denies any claim, the Participant or beneficiary must follow the claim review procedures set forth under such benefit program.

Any claim for reimbursement which arises under the Dependent Care FSA or the Medical FSA must be made in accordance with the claims procedures described in the applicable Appendix.

Any claim relating to a Participant's right to make pre-tax contributions under this Plan, or to modify a prior election due to a mid-year change in status event or otherwise, must be made to the Administrator in writing setting forth the reasons for the claim. The Administrator will review and respond to the claim within 60 days of receiving the claim. If the claim is denied, the Administrator will explain the basis for its decision in writing to the claimant. The Administrator's decision will be conclusive and final for all purposes.

ARTICLE VI

ADMINISTRATION

Plan Administration. The operation of the Plan will be conducted by the Administrator or a Claims Administrator designated by the Administrator designee. It will be a principal duty of the Administrator to see that the Plan is carried out in accordance with its terms, and for the exclusive benefit of Employees entitled to participate in the Plan. The Administrator will have full power to administer the Plan in all of its details, subject, however, to the pertinent provisions of the Code.

The Administrator has the greatest permissible discretion to construe the terms of the Plan and to determine all questions concerning eligibility, participation and benefits. Any such decision made by the Administrator will be binding on all Employees, Participants, and beneficiaries, and is intended to be subject to the most deferential standard of judicial review. Such standard of review is not to be affected by any real or alleged conflict of interest on the part of the Administrator. The Administrator's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

1. To make and enforce such rules and regulations as the Administrator deems necessary or proper for the efficient administration of the Plan;

2. To interpret the Plan, the Administrator's interpretations thereof to be final and conclusive on all persons claiming benefits under the Plan;

3. To decide all questions (including questions of fact) concerning or related to the Plan and the eligibility of any person to participate in the Plan and to receive benefits provided under the Plan;

4. To reject enrollment elections or to limit contributions or Benefits for certain Highly Compensated Employees, Individuals or Participants, or Key Employees, if it deems such to be desirable in order to avoid discrimination under the Plan in violation of applicable provisions of the Code;

5. To provide Employees with a reasonable notification of their Benefits available under the Plan;

6. To approve reimbursement requests, if any, and to authorize the payment of Benefits; and

7. To appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

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

Named Fiduciary. The Administrator will be the named fiduciary pursuant to ERISA Section 402 and will be responsible for the management and control of the operation and administration of the Plan.

General Fiduciary Responsibilities. The Administrator and any other fiduciaries under ERISA will discharge their duties with respect to this Plan solely in the interest of you and your beneficiaries and:

1. For the exclusive purpose of providing Benefits to Participants and their beneficiaries and defraying reasonable expenses of administering the Plan;

2. With the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

3. In accordance with the documents and instruments governing the Plan insofar as such documents and instruments are consistent with ERISA.

Nonassignability of Rights. Your right to receive any reimbursement under the Plan cannot be assigned by you, and will not be made subject to the rights of your creditors. Any attempt to cause such right to be subjected to your creditors will not be recognized, except to such extent required by law.

Examination of Records. The Administrator will make available to each Participant, Eligible Employee and any other Employee of the Employer, for examination at reasonable times during normal business hours, any records that pertain to his or her interest under the Plan.

Payment of Expenses. The Employer will pay any reasonable administrative expenses, unless the Employer decides that administrative costs will be paid by Participants under the Plan or by any Trust Fund that may be established in connection with the Plan. The Administrator and/or its designee may impose reasonable conditions for payments, but such conditions will not discriminate in favor of Highly Compensated Employees.

Insurance Contracts May Control Over Terms of this Plan. If there is a conflict between the terms of this Plan and the terms of an Insurance Contract of a particular Insurer whose product is being used in conjunction with this Plan, the terms of the Insurance Contract will control with respect to those Participants receiving coverage under such Insurance Contract. For this purpose, the Insurance Contract will control in defining the persons eligible for insurance, the dates of their eligibility, the conditions which must be satisfied to become insured, if any, the benefits Participants are entitled to and the circumstances under which insurance terminates.

Indemnification of Administrator. The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as the Administrator or as a member of a committee designated as Administrator (including any Employee or former Employee who previously served as Administrator or as a member of such committee) against the following: all liabilities, damages, costs and expenses (including reasonable attorneys' fees and amounts paid in settlement of any claims approved by the Employer) caused by or resulting from any act of, or omission to act by, any such Employee in connection with the Plan, if such act or omission is in good faith.

ARTICLE VII

AMENDMENT OR TERMINATION OF PLAN

Amendment. The Employer may at any time amend any provisions of the Plan without the consent of any other Affiliated Employer, Participating Employer, Employee, or Participant. No amendment will have the effect of modifying any enrollment election of any Participant in effect at the time of the amendment, unless the amendment is made to comply with Federal, state or local laws, statutes or regulations.

Termination. The Employer has established this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Employer reserves the right to terminate the Plan, in whole or in part, at any time. In the event the Plan is terminated, no further contributions will be made. Benefits under any Insurance Contract will be paid in accordance with the terms of the Insurance Contract.

Upon termination, no further additions will be made to your Reimbursement Accounts described in the Appendices. However, all payments from your Reimbursement Accounts will continue to be made, according to the benefit elections Forms in effect, until the earlier of two dates. The two dates are: (1) the end of the Coverage Period in which the Plan termination occurs (and for a reasonable period of time thereafter, if required for the filing of claims), and (2) the date on which the balances of all Reimbursement Accounts have been reduced to zero. Any amounts remaining in any such Reimbursement Accounts as of the end of the Coverage Period in which Plan termination occurs will be forfeited and deposited in the Benefit Plan Surplus after the expiration of the claim filing period.

ARTICLE VIII

DEFINITIONS

As used throughout this document and unless otherwise defined elsewhere, the following terms have the meaning set forth below.

"Administrator" the individual(s) or corporation responsible for carrying out or overseeing the administration of the Plan. The Employer will be deemed to be the Administrator unless it formally designates an employee or committee to serve in that capacity.

"Affiliated Employer" means with respect to the Plan Sponsor, any corporation that is a member of a controlled group of corporations (as defined in Code Section 414(b)) or any organization (whether or not incorporated) that is a member of an affiliated service group (as defined in Code Section 414(m)) that includes, and any trade or business (whether or not incorporated) that is under common control (as defined in Code Section 414(c)), or any other entity required by Code Section 414(o) to be aggregated, with, the Plan Sponsor.

"Benefit" means any of the benefits available under the Plan. These benefits are described in Article I.

"Benefit Plan Surplus" means amounts you forfeit and that are credited to such surplus as described in Appendices A and B, as applicable.

"Claims Administrator" means the person or entity designated by the Employer to administer claims.

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

"Compensation" means the total cash compensation you receive from the Employer during a Coverage Period, prior to any reductions under your benefit elections authorized under this Plan. "Compensation" includes overtime, commissions and bonuses.

"Coverage Period" means the period for which certain Benefits are provided to you under the Plan. The Coverage Period will be no less than 12 months, except that the Plan's first Coverage Period may, if it is commensurate with the Plan's fiscal year, be a short Coverage Period, and except where the Plan changes its fiscal year. In the event your participation begins during a Coverage Period, your initial Coverage Period is the portion of the Coverage Period remaining, beginning on the date your participation begins, and ending on the last day of that Coverage Period. The Plan may have different Coverage Periods for different Benefits, and a Coverage Period may be different than the Plan's fiscal year.

The Coverage Period is as follows:

Premium Conversion: January 1 to December 31

Medical FSA: January 1 to December 31

Dependent Care FSA: January 1 to December 31

"Dependent" means any individual who, with respect to you, is a "qualifying child" or "qualifying relative" for the taxable year under Section 152 of the Code as determined without regard to subsections 152(b)(1), (b)(2) or (d)(1)(B). Generally, this requires the individual to (i) be your child, parent, or other relative described in that Section, and (ii) rely upon you for over half of his or her support during the taxable year (special support rules apply in the case of a child of divorced or legally separated parents). In the case of a non-spouse Dependent who is not a child or relative described in Section 152, generally the individual must rely upon you for over half of his or her support, have the same principal place of abode as you, and reside with you as a member of your household in a manner that is not in violation of local law.

Notwithstanding anything in the preceding paragraph to the contrary, however, for purposes of your ability to (1) make pre-tax payment of Premiums under this Plan for health care coverage on behalf of a child and (2) obtain, under the Medical FSA, reimbursement of Medical Expenses on behalf of a child, "Dependent" shall also include any child of yours defined in Code Section 152(f)(1) (generally, your natural, step, foster and adopted child, or child placed with you for adoption) through the end of the calendar year in which the child attains age 26. This rule does not mean that a child described in Code Section 152(f)(1) is necessarily *eligible* for health care coverage to the end of such calendar year under a health care plan or program (other than the Medical FSA) funded through this Plan; the eligibility of a child for a benefit shall be determined by the specific terms of the health care plans or programs funded through this Plan.

"Dependent Care FSA" means the program, under this Flexible Benefits Plan, under which Plan Credits, contributed to your Dependent Care FSA Account pursuant to your benefit election, are used to pay eligible dependent care expenses Incurred by you.

"Dependent Care FSA Account" means your account under the Dependent Care FSA, to which Plan Credits may be credited on your behalf, in accordance with your benefit election, and from which this Plan will pay eligible dependent care expenses Incurred by you.

"Effective Date" means the date set forth in the "Introduction" section of this Plan.

"Election Period" means the annual period that precedes the beginning of a Coverage Period, and during which you may elect the Benefits you want to receive under this Plan during that Coverage Period. The annual Election Period under this Plan will be separately communicated to you prior to each Coverage Period.

"Eligible Employee" means any Employee who has satisfied the eligibility requirements to participate in the medical, dental, vision or other benefits plans identified in Article I. See the Appendices to the Plan for additional eligibility rules for the Medical FSA, Dependent Care FSA and HSA program.

"Employee" means any person who is employed by an Employer in the United States, but excluding the following persons (if any):

1. Any individual who at any time during the Employer's taxable year is a ***more than 2% shareholder*** in the Employer, if the Employer is a subchapter S corporation; and any individual who is the spouse, child, parent or grandparent of the more than 2% shareholder

2. ***independent contractors***, and any other person paid through accounts payable rather than payroll, even if such person is later determined to have been a common law employee

3. ***leased employees*** within the meaning of Section 414(n) of the Code

"Employer" means **Parsons Corporation** (also referred to as the "Plan Sponsor"), any Affiliated Employer that adopts this Plan, any other Participating Employer that adopts this Plan, any successor that maintains this Plan, and any predecessor that has maintained this Plan, with respect to their Eligible Employees.

Notwithstanding the foregoing, for purposes of the authority to amend or terminate the Plan, and for performing other settlor-type functions, the term "Employer" is limited to the Plan Sponsor.

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

"Highly Compensated Employee" means an Employee described in Code Section 414(q) and the Treasury regulations issued under that Section.

"Highly Compensated Individual" means a person described in Code Section 125(e)(2) and the Treasury regulations issued under that Section.

"Highly Compensated Participant" means a person described in Code Section 125(e)(1) and the Treasury regulations issued under that Section.

"Insurance Contract" means any contract issued by an Insurer.

"Insurer" means any insurance company that underwrites a Benefit.

"Key Employee" means an Employee described in Code Section 416(i)(1) and the Treasury regulations issued under that Section.

"Medical FSA" means the program, under this Flexible Benefits Plan, under which Plan Credits are contributed to your Medical FSA Account pursuant to your benefit elections, and used to pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents.

"Medical FSA Account" means your account under the Medical FSA of this Plan, to which Plan Credits may be allocated on your behalf, pursuant to your benefit elections, and from which this Plan will pay eligible Medical Expenses Incurred by you, your Spouse or other Dependents.

"Participant" means any Eligible Employee who chooses to become a Participant under Article II and has not, for any reason, become ineligible to participate further in the Plan.

"Participating Employer" means an Employer that is not an Affiliated Employer and participates in this Plan for the benefit of its Eligible Employees, pursuant to the approval of such participation by the Plan Sponsor. Participating Employers must execute a written Participation Agreement provided by the Plan Sponsor, in order to become a Participating Employer.

"Plan" means this document, including all amendments to this document.

"Plan Credits" means the amount available to you, pursuant to your benefit election described in Article IV, to purchase Benefits. Each dollar contributed to this Plan equals one Plan Credit.

"Premiums" mean the cost of your (and, where applicable, your Dependents') coverage under any or all of the health and welfare plans described in Article I under which you chose to be covered.

"Pre-Tax Health and Welfare Premium Account" means your account under this Plan to which Plan Credits may be credited on your behalf, under your benefit election, and from which this Plan will pay Premiums for your (and, where applicable, your Spouse's and/or your other Dependents') coverage under one or more of the health and welfare benefit plans described in Article II. If you elect coverage under more than one benefit plan, a sub-account will be established for each such plan.

"Qualifying High Deductible Health Plan" means a high deductible health plan described in and meeting the requirements of Code Section 223 and regulations issued under that Section.

"Spouse" means your legal spouse (regardless of gender). Your spouse will cease to be considered your Spouse" under this Plan upon the entry of a decree of divorce.

"You" means an Employee.

ARTICLE IX

MISCELLANEOUS

Nondiscrimination Requirements. The Plan is designed to provide Benefits that do not discriminate in favor of Highly Compensated Individuals with respect to eligibility to participate, or Highly Compensated Participants, with respect to contributions and benefits. In addition, it is the intent of this Plan not to provide "qualified benefits" (as defined under Code Section 125(e)) to Key Employees in amounts that exceed 25% of the aggregate of such Benefits provided for all Eligible Employees under the Plan.

If the Administrator or its designee deems it necessary to avoid discrimination or possible taxation to Key Employees or Highly Compensated Individuals or Highly Compensated Participants, it may, but is not required to, reject any election or reduce contributions or nontaxable Benefits in order to assure that the rules in these paragraphs are not violated. Any act taken by the Administrator or its designee under these paragraphs will be carried out in a uniform and nondiscriminatory manner.

If the Administrator or its designee decides to reject any election or reduce contributions or nontaxable Benefits, it will be done in the following manner: the nontaxable Benefits of the affected Participant (either a Highly Compensated Individual or Participant, or a Key Employee, whichever is applicable) who has elected the *highest amount* of nontaxable Benefits for the Coverage Period will have his or her nontaxable Benefits reduced until: (i) the discrimination tests set forth in these paragraphs are satisfied, or (ii) the amount of his or her nontaxable Benefits equals the nontaxable Benefits of the affected Participant who has elected the *second highest* amount of nontaxable Benefits.

This process will continue until the nondiscrimination tests described in these paragraphs are satisfied. With respect to any affected Participant who has had Benefits reduced pursuant to these paragraphs, the reduction will first be made proportionately among noninsured Benefits, and once all noninsured Benefits are expended, proportionately among insured Benefits.

Plan Interpretation. All provisions of this Plan will be interpreted and applied in a uniform, nondiscriminatory manner by the Administrator, as described in Article VI. This Plan will be read in its entirety and not severed, except as described below, in the section titled, *Severability*.

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

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

Exclusive Benefit. This Plan will be maintained for the exclusive benefit of the Employees who participate in the Plan.

Participants' Rights. This Plan is not an employment contract between the Employer and any Participant or Employee, nor is it consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan will be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him as a Participant of this Plan.

Action by the Employer. Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act, it will be done and performed by a person duly authorized by the Employer.

Employer's Protective Clauses. Upon the failure of either you or the Employer to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect or otherwise), your Benefits will be limited to the amounts described in the following sentence. The amounts described in this sentence are: (1) the insurance premium, if any, that remained unpaid for the period in question; and (2) the actual insurance proceeds, if any, received by the Employer or you as a result of your claim.

The Employer's liability to you will only extend—and be limited to—any payment actually received by the Employer from the Insurer. If the full insurance Benefit is not received by the Employer within a reasonable time after submission of a claim, the Employer will have no legal obligation whatsoever (except to execute any document called for by a settlement reached by you). You will be free to settle, compromise or refuse to pursue the claim as you, in your sole discretion, will see fit.

The Employer will not be responsible for the validity of any Insurance Contract issued under this Plan or with respect to which you purchase coverage under this Plan. Similarly, the Employer will not be responsible for the Insurer's failure to make payments called for under any Insurance Contract, or for the action of any person that might delay or render null and void or unenforceable, in whole or in part, an Insurance Contract. With regard to this paragraph, the following will apply:

1. Once insurance is applied for or obtained, the Employer will not be liable for any loss that might result from the failure to pay Premiums, where the Employer does not receive Premium notices.

2. Where the Employer receives Premium notices, its liability for the payment of such Premiums will be limited to the amount of such Premiums and will not include liability for any other loss that may result from failure to pay such Premiums.

3. The Employer will not be liable for the payment of any insurance Premium—or any loss that may result from the failure to pay an insurance Premium—if the Benefits available under this Plan are insufficient to provide for the amount of such Premium cost at the time it is due. In these circumstances you will be responsible for and see to the payment of such Premiums. The Employer will attempt to notify you if available Benefits under this Plan are insufficient to provide for payment of an insurance Premium but will not be liable for any failure to make such notification.

No Guarantee of Tax Consequences. The Administrator and the Employer make no guarantee that any amounts paid to you or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes. In addition, the Administrator and the Employer make no guarantee that any other federal or state tax treatment will apply to or be available to you. It will be your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes, and to notify the Employer if you have reason to believe that any such payment is not so excludable.

Indemnification of Employer by Participants. If you receive one or more payments or reimbursements under the Plan that are not for a permitted Benefit, or if the Employer incurs any liability on account of your having made excess contributions to a health savings account, you will indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement will not exceed the amount of additional federal and state income tax (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by you.

Funding. The Plan is funded through Compensation reductions made by Participants. Unless otherwise required by law, contributions to the Plan need not be placed in trust or dedicated to a specific Benefit, but will instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing in this Plan will be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for your benefit, and neither you nor any other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer from which any payment under the Plan may be made.

Other Salary-Related Plans. It is intended that any other employee benefit plans that are maintained or sponsored by the Employer will not be affected by this Plan. Any contributions or benefits under the other plans with respect to you will be based on your total compensation from the Employer, *including* any amounts by which your Compensation may be reduced under Article IV. However, this rule will not apply to the extent not permitted by law or not otherwise provided for in such other plans.

Governing Law. The Code and the Treasury regulations issued under the Code (as they might be amended from time to time) govern this Plan. The Employer does not guarantee the favorable tax treatment sought by this Plan. To the extent not preempted by Federal law, the provisions of this Plan will be construed, enforced and administered according to the laws of the State of **Virginia**.

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

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

Continuation of Coverage. In the event any Benefit under this Plan is subject to the continuation coverage requirement of Code Section 4980B or 42 U.S.C. § 300bb-1 (Public Health Service Act) and becomes unavailable, each Participant will be entitled to continuation coverage but only to the extent required in Code Section 4980B or 42 U.S.C. § 300bb-1, and regulations issued under the appropriate Section. In the event any Benefit under this Plan is subject to the continuation coverage requirement of the Uniformed Services Employment and Reemployment Rights Act and becomes unavailable on account of a Participant's uniformed service to which such Act applies, such Participant will be entitled to continuation coverage but only to the extent required in that Act and regulations issued under that Act.

Not in Place of Workers' Compensation. This Plan is not in place of and does not affect any requirement for coverage by Workers' Compensation insurance.

Plan Records and Plan Numbers. Plan records are maintained on the basis of the Plan's fiscal year. The Medical FSA is a component of the Parsons Corporation Health and Welfare Benefit Plan (ERISA plan #502).

Plan's Fiscal Year. The Plan's fiscal year is: January 1 to December 31.

Plan Sponsor Information. The Plan Sponsor's address is: **5875 Trinity Parkway, Suite 230, Centreville, CA 20120**. The Plan Sponsor's Tax Identification Number is: **95-3232481**.

Administrator's Address and Telephone Number. The Administrator's address and telephone number are: **5875 Trinity Parkway, Suite 230, Centreville, CA 20120; 833.867.8001.**

Other Participating Employers and Affiliates. None.

Agent for Service of Process. Service for the Plan may be made upon the Employer.

HEALTH SAVINGS ACCOUNT

APPENDIX

The Plan is also designed to allow HSA Eligible Employees (defined below) to elect to make pre-tax contributions to their health savings accounts ("HSA") established and maintained with an outside custodian or trustee. If you choose to make HSA contributions through the Plan, the Employer will forward your contributions to be deposited in your HSA. The Employer may select a single trustee/custodian to receive such contributions or allow HSA Eligible Employees to direct contributions to a trustee/custodian of their choosing.

HSA Eligible Employees. An Employee is eligible to make HSA contributions for a given month on a pre-tax basis through this Plan, if he is considered an "eligible individual" under Code Section 223 with respect to that month. Generally, this requires the Employee to be enrolled as of the first day of that month in the Employer's qualifying high deductible health plan ("HDHP") (as defined under Code Section 223) and not enrolled as of the first day of that month in other health coverage that is not a qualifying HDHP, unless such other coverage is permitted insurance as defined in Section 223 of the Code. Permitted insurance includes insurance for a specified disease or illness, and insurance paying a fixed amount per day (or other period) of hospitalization), or coverage for accidents, disabilities, dental care, vision care, preventive care, long-term care.

Section 223 of the Code, however, includes special "deeming" rules that may apply to allow an Employee to be considered an "eligible individual" with respect to months with respect to which the Employee was not enrolled in qualifying coverage as of the first day of the month. The Employer is permitted to rely upon the Employee's representation regarding the absence of such disqualifying coverage, unless the Employee is enrolled in such disqualifying coverage sponsored by the Employer.

Changes to Elections Concerning Health Savings Account Contributions. You may change your election concerning the amount of your pre-tax contributions to your HSA at least monthly, but the change may be effective prospective only, and will take effect as soon as the Employer's payroll department is able to implement your new election. However, if the Employer has pre-funded your HSA account with all or a portion of the amount you elected to contribute for the year, and is entitled to be reimbursed the "advance" from deductions from your pay, you may not modify your HSA contribution election so that the total amount you elect to contribute for the year is less than the amount of the Employer's advance. The intent of this rule is to ensure that the Employer is allowed to recoup the amount of its advance, as long as you are still entitled to pay from the Employer.

The Employer may limit the amount and timing of your pre-tax contributions to your HSA, and those restrictions may affect your ability to change your election.

Limit on Health Savings Account Contributions. The Employer has no authority or control over the funds deposited in your HSA and your HSA is not considered part of the Plan. However, the Employer may limit your pre-tax contributions made through this Plan to your HSA to your theoretical maximum HSA contribution after taking into account factors such as the number of months during

the Coverage Period during which you were an HSA Eligible Employee (or, pursuant to Section 223 of the Code, *deemed* to be an Eligible Employee) with respect to pre-tax HSA contributions, your age (for purposes of HSA "catch-up contributions"), the amount of Employer contributions made to your HSA, and other factors prescribed by law or within the Employer's discretion. The Employer may also confine your ability to make pre-tax HSA contributions through this Plan to months with respect to which you are an HSA Eligible Employee (or, pursuant to Section 223 of the Code, *deemed* to be an HSA Eligible Employee) with respect to HSA contributions, and may limit your pre-tax contribution in such a month to your "monthly limit" for such month, as that term is defined in Code Section 223 or regulations issued thereunder.

In addition to your own pre-tax contributions, the Employer may choose to make contributions through this Plan directly to the HSAs of Eligible Employees. The amount and timing of, and eligibility for, these contributions will be determined by the Employer in its sole discretion. For example, the Employer may determine to make HSA contributions to the HSA of just those Employees who complete a health risk assessment, or to make HSA contributions to the HSAs of just those Eligible Employees who are enrolled in the Employer's qualifying high deductible health plan, or to make "matching" HSA contributions to the HSAs of Eligible Employees who make their own contributions to their respective HSAs.

The Employer will communicate to Employees the terms and conditions, if any, under which such contributions may be made, and such communications will be considered part of this Plan. However, such contributions, if made, will be made in compliance with Internal Revenue Service requirements, and any such requirements are hereby incorporated into this Plan by reference.

Trust/Custodial Agreement; HSA Not Intended to be an ERISA Plan. HSA Benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax Compensation reduction basis. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims and appeals procedures, use of debit and credit cards, and investments) will be provided by and are set forth in the trust/custodial agreement, not this Plan.

The HSA is not an Employer-sponsored employee benefits plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Section 223(d)(2) of the Code. Even though this Plan may allow pre-tax Compensation reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

Neither the Administrator nor Employer guarantee the non-taxability of your or the Employer's (on your behalf) contributions to a health savings account, as the taxability of such contributions may turn, in some cases, on issues outside the Employer's knowledge or control or both.

Where the Employer allows you to make pre-tax contributions to an HSA, the Employer's obligation with respect to such contributions is limited to determining whether you are enrolled under the Employer's qualified HDHP, the deductible under such plan, the then extant statutory monthly and annual limit for HSA contributions, your age (for purposes of calculating the potential HSA "catch up" contribution, if any, under Code Section 223), the amount of any Employer contributions made to your HSA for the Coverage Period, and whether you are enrolled under any other health care program of the Employer that disqualifies you from making HSA contributions.

Submitting Claims for Benefits under your HSA. Any claim for benefits under your HSA must be submitted to your HSA custodian or trustee.

MEDICAL FSA

APPENDIX

This Appendix sets forth the terms of the Medical FSA. The Medical FSA is intended to qualify as a medical reimbursement plan under Code Section 105. It will be interpreted in a manner consistent with that Code Section and the Treasury regulations issued under that Section. If you choose to participate in the Medical FSA you may submit claims for the reimbursement of "Medical Expenses" (as defined below). All amounts reimbursed under this Medical FSA will be paid from amounts credited to your Medical FSA Account in accordance with your benefit elections. Except as otherwise provided in this Appendix, for a Medical Expense to be reimbursed from the benefit you elected for a Coverage Period, the Medical Expense must be Incurred within the Coverage Period.

Eligible Employees. For purposes of the Medical FSA, an Employee will become an "Eligible Employee" on the date he or she becomes eligible to participate in major medical plan coverage through the Employer**.**

Definitions. For purposes of the Medical FSA, the terms set forth below have the following meaning:

> ***"Medical Expenses"*** means expenses for medical care that meet the following requirements. First, the expense must fall within the meaning of the term "medical care" or "medical expense" as defined in Code Section 213 (and the rulings and Treasury regulations issued under that Section). Second, you may not deduct the expense from your gross income for purposes of determining your income tax. Medical Expenses do not include a medicine or drug unless such medicine or drug is a prescribed drug (but note the prescribed medicine or drug may be an over-the-counter medicine or drug if obtained with a valid prescription) or is insulin. ***This Program will not reimburse you for the cost of other health coverage, such as premiums paid under plans maintained by your Spouse's or other Dependent's employer or individual policies maintained by you or your Spouse or other Dependent.***
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> *Notwithstanding the foregoing,* reimbursable medicines and drugs for purposes of the Medical FSA shall include non-prescribed (i.e., over-the-counter) medicines and drugs, and menstrual care products, to the extent permitted by the Internal Revenue Code and applicable IRS guidance.
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> ***"Incur" or "Incurred"*** with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Special rules may apply with respect to a course of treatment such as orthodontic care, where payment is required in advance.

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Medical FSA.

Limited Coverage for Health Savings Account Participants. If you have enrolled in the Employer's Qualifying High Deductible Health Plan, such that you are eligible to make

contributions to a health savings account ("HSA"), your participation in the Medical FSA creates some issues for you. Coverage under the Medical FSA, which provides reimbursement for "medical care" as defined in the Tax Code, generally disqualifies you from eligibility to make HSA contributions (and disqualifies the Employer from making any discretionary HSA contributions on your behalf). Similarly, because as a general rule your Spouse is also covered under the Medical FSA if you are enrolled, that coverage would also disqualify your Spouse from making HSA contributions to his or her own HSA.

As a result, if you are enrolled in the Employer's Qualifying High Deductible Health Plan you are not able to participate in the Medical FSA.

Forfeitures. The amount in your Medical FSA Account as of the end of any Coverage Period (and after the processing of all claims for that Coverage Period pursuant to rules described below) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further individual claim to such amount for any reason. Forfeited amounts may include amounts credited to your Account and with respect to which checks were issued by the Medical FSA administrator but which remain uncashed after a reasonable period of time, as determined by the Employer or administrator in its sole discretion.

You may carry over unused amounts of up to $500, as indexed for inflation pursuant to IRS Notice 2020-33, remaining in your Medical FSA Account at the end of a Coverage Period to the immediately following Coverage Period. The amounts carried over may be used during the following Coverage Period to pay for qualifying Medical Expenses incurred by your or your Dependents in such Coverage Period. Amounts carried over do not affect the maximum amount of Flexible Benefit Plan Dollars, if any, your Employer will credit to your Medical FSA Account for the Coverage Period to which they are carried over. Amounts in excess of $500, indexed for inflation, may not be carried over and will be forfeited. The Plan will treat claims as being paid first from carryover amounts and then from the current year amounts.

For purposes of the above, the amount remaining unused as of the end of the Coverage Period is the amount unused after Medical Expenses have been reimbursed at the end of the Plan's run-out period for the Coverage Period (i.e., the period immediately following the end of the Coverage Period during which a Participant may submit a claim for reimbursement of expenses).

If you are enrolled in your Employer's Qualifying High Deductible Health Plan, then any unused amounts in your Medical FSA Account that are carried over to the next Coverage Period will be converted to a limited purpose Medical FSA. This restriction is in place to allow you to make HSA contributions.

As required by the IRS, any grace period following the close of the Coverage Period shall not be available concurrently with this carryover provision.

Limitation on Allocations. The maximum and minimum amount of Medical Expenses that may be reimbursed under this Plan during any Coverage Period will be determined by the Administrator in its discretion and will be communicated to you prior to be beginning of the Coverage Period. The maximum Compensation reduction election you may make cannot exceed $2,500, as indexed for inflation pursuant to Code Section 125(i)(2). Further, in no event will maximum amount of

reimbursable Medical Expenses for any Coverage Period exceed two times your reduction election for the Coverage Period (or, if greater, $500 plus the amount of your reduction election). This $2,500 limit (as adjusted for inflation) shall be applied by treating all Medical FSAs maintained within a controlled group of corporations, trades or businesses (as defined in Code Sections 414(b), (c) and (m)) as a single Program.

Medical FSA Claims. Medical Expenses that you, your Spouse or other Dependents Incur may be reimbursed even though the submission of the claim occurs after your participation under the Plan ends. However, the Medical Expenses must have been Incurred while you were a Participant, and the claims must be filed with the Claims Administrator within the time described in below.

Generally, the claim will include a written statement (*e.g.*, a receipt) from an independent third party (such as the health care provider that provided the service) stating that the Medical Expense has been Incurred and the amount of such expense. Furthermore, you must provide a written statement that the Medical Expense has not been reimbursed or is not reimbursable under any other health care plan coverage and, if reimbursed from the Medical FSA Account, such amount will not be claimed as a tax deduction. *However, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Medical FSA Claims Administrator*. The Claims Administrator will retain a file of all such claim forms.

The Claims Administrator will direct the reimbursement to you of all allowable Medical Expenses, up to a maximum equal to the amount of Plan Credits you chose—in your benefit elections—to have the Employer contribute to your Medical FSA Account for the Coverage Period. ***Reimbursements will be made available to you throughout the Coverage Period without regard to the amount of Plan Credits that have been credited to your Account at any given point in time***.

> ***Example:*** Assume you choose in your benefit elections to contribute $1,200 to the Medical FSA for the Coverage Period, in increments of $100 per month. The Coverage Period is the calendar year. During January, the Employer reduces your Compensation by $100, converts those dollars into Plan Credits and credits them to your Medical FSA Account. In that same month, you Incur an expense of $500 that is reimbursable under the Program. The claim is properly payable, even though at the time the claim is submitted you have only 100 Plan Credits credited to your Account.

In addition, you will be entitled to reimbursements only for amounts in excess of any payments or other reimbursements under any health care plan that may be sponsored by the Employer, any governmental agency or any other plan covering you and/or you Spouse or other Dependents.

Claim Filing Deadline. A claim for the reimbursement of Medical Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if you fail to submit a properly executed claim before the end of the claim filing deadline, the claim will not be accepted. The claim filing deadline is: **90 days** after the close of the Coverage Period.

A claim will be deemed submitted when the Claims Administrator receives the completed claim form. However, if a claim form is filed by U.S. Postal Service, it will be deemed to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with Article V.

Notwithstanding the foregoing, see the discussion below about electronic claim submissions where a debit or credit card is provided for your use by the Medical FSA Claims Administrator.

Claim Payments Are Made to You. Except where this Program provides for your use of a debit or credit card to obtain services and supplies that would otherwise have been reimbursable under the Program had you paid cash for them, reimbursements under this Program will be made directly to you. In the event a payment from this Plan is made by check and such check is not negotiated by the payee within a reasonable time, the Plan Administrator may direct that such payment be forfeited, escheated to the State, or otherwise dealt with in such manner as the Employer may decide.

Review of Medical FSA Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement under the Medical FSA within 30 days after receipt of the claim. The Claims Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Plan. The Claims Administrator will notify the claimant within the initial 30-day timeframe of the reason for the extension and the date by which the Plan expects to render its decision.

If the Plan cannot render a decision within 30 days because the claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the notice of extension will describe the specific information needed to complete the claim. The claimant will have at least 45 days from receipt of the notice to provide the required information. The Plan will then have 15 days from the date of receiving the claimant's information to render its decision. The claimant may agree to extend these deadlines.

Form and Content of Notice of Adverse Determination on Medical FSA Claims. If a claim is denied in whole or in part, notice of such adverse determination will be provided to the claimant. Notice will be written or electronic. The notice will include the following:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific Plan provisions on which the determination is based;

3. If applicable, a description of any additional information needed for the claimant to perfect the claim and an explanation of why such information is needed;

4. A description of the Plan's review procedures, including the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request;

6. If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request; and

7. In the case of an adverse determination involving urgent care, a description of the expedited review process available to such claims.

Right to Appeal Decision on Medical FSA Claims. Any claimant who has had a claim for benefits denied in whole or in part by the Claims Administrator, or is otherwise adversely affected by action of the Claims Administrator, has the right to request review by the Administrator. Such request must be in writing, and must be made within 180 days after the claimant is advised of the Claim Administrator's action. If written request for review is not made within such 180-day period, the claimant will forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all pertinent documents and submit issues and comments in writing. The Administrator or its designee may prescribe a reasonable procedure under which a claimant may designate an authorized representative.

Action on Appeal of Medical FSA Claim. The Administrator or its designee will then review the claim. The person or entity that reviews the claim will be a fiduciary under the Plan, and will not be the same person, or a person subordinate to the person, who initially decided the claim. If the adverse benefit determination was based on medical judgment, the person handling the appeal will consult with a health care professional with an appropriate level of training and expertise in the field of medicine involved, and such professional will not be the same professional who was consulted with respect to the initial action on the claim.

The person or entity deciding the appeal may hold a hearing if it deems it necessary and shall issue a written or electronically disseminated decision reaffirming, modifying or setting aside the initial decision on the claim. The decision on appeal will be made within 60 days; the time period begins to run on the date the appeal is received by the Plan or its designee. The claimant may agree to further extend these deadlines.

A copy of the decision will be furnished to the claimant. The decision shall set forth:

1. The specific reason or reasons for the adverse determination;

2. Reference to the specific plan provisions on which the determination is based;

3. A statement that the claimant is entitled to receive without charge reasonable access to any document: (1) relied on in making the determination; (2) submitted, considered or generated in the course of making the benefit determination; (3) that demonstrates compliance with the administrative processes and safeguards required in making the determination; or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;

4. A statement of any voluntary appeals procedures and the claimant's right to receive information about the procedures as well as the claimant's right to bring a civil action under Section 502(a) of ERISA;

5. A copy of any internal rule, guideline, protocol or other similar criteria relied on in making the adverse determination or a statement that it will be provided without charge upon request; and

6. If the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical circumstances, or a statement that this will be provided without charge upon request.

The decision will be final and binding upon the claimant and all other persons involved.

Conformity with Patient Protection and Affordable Care Act of 2010. To the extent the Medical FSA is or becomes subject to the Patient Protection and Affordable Care Act of 2010, as amended (and regulations thereunder), the claims and appeals rules applicable to that Program shall be construed and applied in a manner consistent with applicable requirements of such Act and regulations.

The Status of Your Plan Accounts Pending Appeal. Any balance remaining in a Reimbursement Account described in one or more Appendices (as applicable) at of the end of a Coverage Period will be forfeited and credited to the Employer's Benefit Plan Surplus as described in the appropriate Appendices, as applicable. However, if you had made a claim for such Coverage Period, in writing, which was denied or is pending, the amount of the claim will be held in your Account until the claim appeal procedures described above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Coverage Period will be forfeited and credited to the Benefit Plan Surplus.

Debit or Credit Card Usage for Obtaining Covered Services and Supplies. The Employer may contract with the Claims Administrator to allow you to use a debit or credit card to access your Medical FSA Account. This allows you, where you obtain a service or supply from a provider that is willing to accept such debit or credit card transactions, to avoid having to pay cash for the service or supply, and then seek reimbursement from the Claims Administrator. However, your use of a debit or credit card is subject to specific and mandatory requirements imposed by the Claims Administrator, including (among other things), "after-the-fact" documentation or substantiation of the expense in some cases. If you fail to provide adequate after-the-fact documentation or substantiation of an expense paid via a debit card, you agree that the Employer may deduct the amount of the expenses paid via the debit card from your wages, or set-off the amount you owe the Employer or the Program against future covered claims for Medical Expenses Incurred during the same Coverage Period

COBRA Continuation Coverage. If you and/or your Spouse and/or other Dependent loses coverage under the Medical FSA due to a "qualifying event," you and/or your Spouse and/or Dependent, as the case may be, might be entitled to continue coverage for a period of time after the qualifying event, in accordance with the COBRA provisions of Article II and this Appendix.

"Qualifying events" include:

1. Termination of your employment for any reason (including death), except for gross misconduct;

2. Your termination of eligibility due to reduced work hours;

3. Your eligibility for Medicare;

4. Your divorce or legal separation; and

5. A Dependent child's ceasing to satisfy the definition of "Dependent."

Under the law, you or the affected Spouse or Dependent has the responsibility to inform the Administrator of a qualifying event that is a divorce, legal separation, or a child losing Dependent status under this Plan within 60 days of the date of the later of the event or the date on which coverage would end under the Plan because of the event. The notice must be sent, ***in writing***, to the person indicated below, and the notice must describe the qualifying event and the date it occurred:

Benefits Department
5875 Trinity Parkway
Centreville, VA 20120

When the Administrator is notified that one of these events has happened, the Administrator will in turn notify the person entitled to COBRA coverage ("qualified beneficiary") of his or her COBRA rights. Under the law, qualified beneficiaries have at least 60 days from the date coverage would be lost because of one of the events described above to inform the administrator that they want continuation coverage.

Special COBRA rights might apply if you lose coverage as a result of termination or reduction of hours and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 1974. You may be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which you begin receiving a trade readjustment allowance (or would be eligible to begin receiving the allowance but for the requirement to exhaust unemployment benefits) or begin receiving alternative trade adjustment assistance, but only if the election is made within the six months immediately after your group health plan coverage ended.

The duration for which a qualified beneficiary may purchase COBRA coverage depends on a number of factors. If (1) you are eligible for major medical coverage through your employer, and (2) the maximum amount of Benefits available to you under the Medical FSA does not exceed two times your Compensation reduction contribution for the year or, if greater, your Compensation reduction contribution plus $500, your COBRA coverage rights are limited. COBRA coverage is not available beyond the end of the Coverage Period in which the qualifying event occurred; in addition, if at the time of the qualifying event the amount available for reimbursement for the remainder of the Coverage Period is *less* than the amount of contributions the COBRA qualified beneficiary would be required to pay for the remainder of that Coverage Period, then the qualified beneficiary is not eligible for COBRA coverage under the Medical FSA. These rules are described in additional detail in Article II.

However, if (1) you are *not* eligible for major medical coverage through your Employer, or (2) the maximum amount of Benefits available to you under the Medical FSA exceeds two times your Compensation reduction contribution for the year or, if greater, your Compensation reduction

contribution plus $500, COBRA coverage can continue for 18 months (for qualifying events that are a termination of employment (for reasons other than death) or reduction in work hours) or 36 months (for other qualifying events). If a qualified beneficiary is disabled (within the meaning of the Social Security Act) at the time of a qualifying event that is a termination of employment (for reasons other than death) or reduction in hours, or is so disabled during the first 60 days of COBRA coverage following such a qualifying event, COBRA coverage for that beneficiary—and any other qualified beneficiary affected by the same qualifying event—can continue for up to 29 months. Where there are multiple qualifying events the 18- or 29-month limit may be extended to 36 months.

You must pay for the COBRA coverage you elect, typically on an after-tax basis, in monthly amounts. For the remainder of the Coverage Period in which the qualifying event occurs the monthly amount is equal to the monthly amount you chose (in your benefit elections) to pay during the Coverage Period, plus two percent. If COBRA coverage can be continued into a subsequent Coverage Period the monthly amount is equal to the $1/12^{th}$ of the total Benefits you elected to have available under the Program for that Coverage Period, plus two percent. Where a disabled qualified beneficiary continues COBRA coverage for the additional 11-month period described above, the surcharge per month is fifty percent rather than two percent during the 11-month extension.

A qualified beneficiary's continuation coverage may be cut short for any of the following three reasons:

1. The Employer no longer provides group health coverage to any of its employees;

2. The premium for continuation coverage is not paid on time; or

3. The beneficiary becomes covered, after the date of the election of COBRA coverage, under Medicare or under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition he or she may have.

Payments are due monthly. There is a grace period of at least 30 days for payment of the regularly scheduled premium.

For additional questions about continuation coverage, please contact the Administrator.

***Continuation of Coverage under USERRA*.** When an Eligible Employee participating in the Medical FSA commences a period of uniformed service to which the Uniformed Services Employment and Re-employment Rights Act applies, he or she may continue coverage under the Program, on a self-pay basis, for up to 24 months or, if shorter, the duration of the period of uniformed service. The Employer may prescribe reasonable procedures under which the Eligible Employee must elect and pay for this continued coverage, if the Eligible Employee chooses to continue the coverage.

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

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

1. Obtain, upon written request to the Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Program 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.

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 Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, 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 benefit under the Program is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the 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 Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Nondiscrimination under Code Section 105(h). The Administrator may designate portions of the Medical FSA as separate plans for purposes of satisfying nondiscrimination testing under Section 105(h) of the Internal Revenue Code. In addition, where this Plan is included as a component program in a comprehensive health and welfare benefit plan that includes other health care benefits subject to Section 105(h), the Medical FSA may be designated as a separate testing plan, that is, it may be tested separately from other component health care programs included in such plan. Where the Administrator makes such a separate testing plan designation it shall disclose the separate testing plans to the Participants, to the extent required by applicable law or regulations.

Notwithstanding any other language in this Plan to the contrary, each Participating Employer's participation in the Medical FSA shall, to the extent the Participating Employer's participation, be considered a separate welfare benefit plan. No contributions made by any Participating Employer or an Eligible Employee of such Participating Employer shall be used to pay Medical FSA claims incurred by an Eligible Employee of any other Participating Employer.

Health Insurance Portability and Accountability Act (HIPAA). HIPAA imposes upon the Plan and certain other entities certain responsibilities to ensure that Protected Health Information ("PHI") pertaining to covered persons remains confidential, subject to limited exceptions in which PHI may be disclosed. PHI also includes electronic or "ePHI". "Protected Health Information" means health information (including oral information) that:

1. is created or received by health care providers, health plans, or health care clearinghouses;

2. relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual; and

3. identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

Electronic Protected Health Information or "ePHI" is PHI that is transmitted by or maintained in electronic media, as defined in 45 C.F.R. § 160.103.

Disclosures of PHI to the Employer. Provided that the Plan (or the Employer on behalf of the Plan) provides to covered person a HIPAA Privacy Notice that, among other things, states the Plan may disclose PHI to the Employer, the Plan may disclose PHI (relating to a covered person) to the Employer, as further described below, without the consent or authorization of the covered person. In no event may the Plan disclose PHI to the Employer, without the consent or authorization of the

covered person or his authorized representative, for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

The Plan may disclose PHI to the Employer, without the consent or authorization of the covered person, subject to the Employer's obligations described below (in the section titled, *Employer Obligations with Respect to PHI Obtained from the Plan*) for Plan administrative functions such as quality assurance, claims processing, auditing, and monitoring. However, only the minimum amount of PHI necessary to accomplish a particular Plan administration function may be disclosed to the person(s) performing such functions.

In addition to disclosing PHI to the Employer to allow the Employer to perform Plan administrative functions, the Plan may disclose certain limited summary health information to the Employer, without the consent or authorization of the covered person, for purposes such as obtaining premium bids for health insurance or reinsurance, or for modifying, amending or terminating the Plan. "Summary health information" is health information that summarizes claims history, expenses, or types of claims by individuals, but from which has been removed at least 18 specific identifiers, including names, dates (except year), telephone numbers, Social Security numbers, medical record numbers, and other identifiers. In addition, the Plan may disclose enrollment and disenrollment information to the Employer without the consent or authorization of the covered person.

Employer Obligations with respect to PHI obtained from the Plan. As a condition of receiving PHI from the Plan for Plan administrative functions the Employer specifically agrees to:

1. not use or further disclose the PHI other than as permitted by this Plan or as required by law, or as permitted by the covered person to whom the PHI relates;

2. ensure that any agents or subcontractors to whom it shares or provides the PHI received from the Plan agree to these same restrictions and conditions;

3. not use the PHI for employment-related actions or in connection with any of its other benefit plans without the consent or authorization from the covered person to whom the PHI relates;

4. report to the Plan any improper uses or disclosures of the PHI;

5. provide covered persons access to PHI that relates to them, allow them to request amendments to the PHI, and upon request provide covered persons an accounting of all disclosures of their PHI by the Employer (except for those disclosures with respect to which no accounting is required);

6. make available to appropriate federal authorities the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan; and

7. return or destroy (to the extent feasible) all copies of the PHI received from the Plan once the Employer's need for which the PHI was requested no longer exists or, if this is not feasible, limit further uses and disclosures of the PHI.

Use and Disclosure of PHI by the Employer; Dispute Resolution. When the Employer obtains PHI from the Plan for Plan administrative functions, the PHI will be provided to the human resources or employee benefits department of the Employer, and may also be provided to the Employer's payroll department (for purposes of processing payroll deductions for payment of premium) and chief financial officer and his designees. The persons in these departments, except as otherwise provided in a specific authorization granted by the covered person or his authorized representative to the Employer, will have access to and may use the PHI solely to perform Plan administrative functions that the Employer performs for or with respect to the Plan.

The Employer may use PHI that it receives from the Plan to carry out Plan administrative functions and may use summary health information for the purposes described in section above titled, *Disclosures of PHI by the Plan to the Employer*. The Employer may also disclose PHI relating to a covered person, without the consent or authorization of the covered person, as required or as otherwise permitted by law. For example, the law allows PHI to be disclosed, without the consent or authorization of the covered person, to law enforcement, public health, and judicial agencies in certain circumstances. PHI pertaining to a minor covered person may, to the extent permitted by local law, be disclosed to the covered person's parent or guardian without the consent or authorization of the minor. There are other situations in which PHI may be disclosed without the covered person's consent. For more information please review the Plan's Privacy Notice or see the Plan's Privacy Official.

In the event a covered person or any other person believes that the Employer or any of its agents have misused PHI disclosed to it or to them by the Plan, such persons may notify the Employer's Privacy Official (contact the human resources or employee benefits department for more information regarding how to contact the Privacy Official), or may file a complaint as described in the Plan's Privacy Notice, a copy of which you should have already received (an additional copy is available from the human resources or employee benefits department). If the complaint is filed with the Privacy Official the Privacy Official will investigate the complaint and the events and circumstances related to it, as provided in the Employer's Privacy Policy and Procedure.

Employer Obligations with respect to ePHI obtained from the Plan. In addition to the rules discussed above with respect to all PHI, as a condition of receiving ePHI from the Plan for Plan administrative functions the Employer specifically agrees to:

1. implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;
2. Ensure that the adequate separation, between the ePHI and persons who have no legitimate need to access such ePHI, as required by 45 C.F.R. § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures;
3. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any security incident of which it becomes aware.

DEPENDENT CARE FSA

APPENDIX

This Appendix sets forth the terms of the Dependent Care FSA. The Dependent Care FSA is intended to qualify as a program under Code Section 129. It will be interpreted in a manner consistent with that Code Section and the Treasury regulations issued under that Section. If you choose to participate in this Program you may submit claims for the reimbursement of Employment-Related Dependent Care Expenses (defined below). All amounts reimbursed under this Dependent Care FSA will be paid from amounts credited to your Account under this Program. **See the section at the end of this Appendix for information about whether the Dependent Care FSA is more beneficial to you than the tax credit for dependent care expenses available to you under the Code.** Except as otherwise provided in this Appendix, for an Employment-Related Dependent Care Expense to be reimbursed from the benefit you elected for a Coverage Period, the Employment-Related Dependent Care Expense must be Incurred within the Coverage Period.

Eligible Employees. For purposes of the Dependent Care FSA, an Employee will become an "Eligible Employee" on the date he or she becomes eligible to participate in major medical plan coverage through the Employer.

Definitions. For purposes of the Dependent Care FSA, the terms set forth below have the following meaning:

> ***"Earned Income"*** means earned income as defined under Code Section 32(c)(2) (generally wages and salaries, plus net earnings from self-employment) but excluding amounts paid or Incurred by the Employer for dependent care assistance to you or on your behalf.
>
> ***"Employment-Related Dependent Care Expenses"*** means expenses Incurred by you for those services that, if paid by you, would be considered employment-related expenses under Code Section 21(b)(2). Generally, they include expenses for household services or for the care of a Qualifying Dependent, to the extent that such expenses are Incurred to enable you to be gainfully employed for any period for which you have at least one Qualifying Dependent. Whether an amount qualifies as an Employment-Related Dependent Care Expense will be decided under the following rules:
>
> - If the amounts are paid for expenses Incurred outside your household, they will constitute Employment-Related Dependent Care Expenses only if Incurred for a Qualifying Dependent as defined below (if the Qualifying Dependent is not a Dependent child under the age of 13, the Qualifying Dependent must also regularly spend at least 8 hours each day in your household);
>
> - If the expense is Incurred outside your home at a facility that provides care for a fee, payment, or grant for more than six individuals who do not regularly reside at

the facility, the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any; and

- Your Employment-Related Dependent Care Expenses will not include amounts paid or Incurred for service performed by a person who is your child (as defined in Code Section 151(c)(3)) and who is under the age of 19, or to an individual who is claimed as a Dependent by your or your Spouse (that is, an individual with respect to whom a personal exemption is claimed on your or your Spouse's federal income tax return).

- Expenses for "household services" means expenses paid for the performance in your home of ordinary and usual services necessary to the maintenance of your household. The expenses must also be attributable to the care of a Qualifying Dependent.

"Incur" or "Incurred" with respect to an expense means the following: An expense is Incurred at the time the service giving rise to the expense is furnished, and not when the individual is formally billed for, is charged for, or pays for the service. Thus, with respect to Employment-Related Dependent Care Expenses, for example, services rendered for the month of June are not fully Incurred until June 30th and cannot be reimbursed in full until then.

"Qualifying Dependent" means, for purposes of this Dependent Care FSA:

- Your Dependent (as defined in Section 152(a)(1) of the Code (*e.g.*, a "qualifying child") who is under the age of 13;

- Your Spouse or other Dependent who is physically or mentally incapable of caring for himself or herself, and who has the same principal place of abode as you, for over half the taxable year, and whose relationship with you is not in violation of local law at any time during the year; or

- Any other Dependent who is deemed to be a Qualifying Dependent described in one of the preceding two paragraphs, whichever is appropriate, pursuant to Code Section 21(e)(5) (dealing with special rules for establishing dependency in the case of divorced parents).

The definitions of Article VIII are incorporated into this Appendix to the extent necessary to interpret and apply the provisions of this Dependent Care FSA.

Your Account Under this Program. The Claims Administrator will establish an Account under this Program for you when you choose to apply Plan Credits to Dependent Care FSA Benefits.

Increases and Decreases in Dependent Care FSA Accounts. Your account under this Program will be *increased* each pay period by the portion of Plan Credits that you chose to apply toward your account under this Program pursuant to your benefit elections.

Your account under this Program will be *reduced* by the amount of any Employment-Related Dependent Care Expense reimbursements paid or Incurred on your behalf, as described below in the section titled, *Dependent Care FSA Claims.*

Allowable Dependent Care FSA. Subject to (1) limitations reflected below, in the section titled, *Limitations on Payments*, and (2) the extent of the amount credited to your account under this Program, if you Incur Employment-Related Dependent Care Expenses you will be entitled to receive from the Program full reimbursement for the entire amount of such expenses Incurred during the Coverage Period (or portion of the Coverage Period) during which you are a Participant.

Annual Statement of Benefits. If you participate in this Program during a Coverage Period, then on or before January 31 of the ensuing Coverage Period the Employer will furnish to you a statement of all Benefits paid to you or on your behalf under this Program during the preceding Coverage Period.

Forfeitures. The amount credited to your account under this Program as of the end of any Coverage Period (and after the processing of all claims for such Coverage Period pursuant to the section below titled, *Coordination with Flexible Benefits Plan*) will be forfeited and credited to the Benefit Plan Surplus. In that case, you will have no further claim to such amount for any reason. Forfeited amounts may include amounts credited to your Account and with respect to which checks were issued by the Dependent Care FSA administrator but which remain uncashed after a reasonable period of time, as determined by the Employer or administrator in its sole discretion.

Limitation on Payments. Amounts paid from your account under this Program, in or on account of any single taxable year, will not exceed: (i) the Earned Income limitation described in Code Section 129(b), or (ii) $5,000 ($2,500 if a separate tax return is filed by a Participant who is married as determined under the rules of paragraphs (3) and (4) of Code Section 21(e)), whichever is *less*.

Dependent Care FSA Claims. You are required to file a claim with the Claims Administrator in order to receive Benefits from this Program. The claim must be in a form satisfactory to the Claims Administrator, and must include a statement from an independent third party (for example, the caregiver) as proof that the expense has been Incurred, and the amount of such expense. In addition, the Claims Administrator may require that the claim include a statement containing the following information:

1. The name and age of each Dependent for whom the services were performed.

2. The nature and dates of the services that were performed.

3. Your acknowledgment that you will include on your federal income tax return the name, address, and (except in the case of a tax-exempt provider) the taxpayer identification number of the provider (or will exercise due diligence in attempting to obtain such information).

4. The relationship, if any, of the person performing the services for you.

5. If another of your Dependents performed the services, the age of the other Dependent.

6. Where the services were performed.

7. If any of the services were performed outside your home, whether the Dependent for whom such services were performed regularly spends at least 8 hours each day in your household.

8. If the services were performed in a day care center that provides care for more than six individuals (other than individuals residing at the center) and receives a fee, payment, or grant for providing any of such care:

    - Whether the day care center complies with all applicable state and local laws and regulations of the state of residence, and

    - The amount of the fee, payment, or grant paid to the provider.

9. If you are married:

    - Whether you and your Spouse plan to file a joint return or separate returns of federal income taxes; and

    - The amount, if any, of nontaxable dependent care assistance benefits received from any other employer by you or your Spouse for the Coverage Period.

Claim Payments Are Made to You. The Claims Administrator will pay Benefits under this Program directly to you or, in the Claims Administrator's discretion, directly to the service provider. In the event a payment from this Plan is made by check and such check is not negotiated by the payee within a reasonable time, the Plan Administrator may direct that such payment be forfeited, escheated to the State, or otherwise dealt with in such manner as the Employer may decide.

A claim for the reimbursement of Employment-Related Dependent Care Expenses Incurred in any Coverage Period will be decided within a reasonable time after it is received. However, if a Participant fails to submit a properly executed claim form within the claim filing deadline, the Claims Administrator will not consider the claim. The claim filing deadline is: **90 days** after the close of the Coverage Period.

The Claims Administrator will deem a claim to have been submitted when the Claims Administrator receives the claim form. However, if a claim form is filed by U.S. Postal Service, the Claims Administrator will deem it to have been submitted on the date of the United States postmark stamped on the envelope in which the claim form is mailed. Claims will be decided in accordance with the rules in Article V.

Review of Dependent Care FSA Claims. The Claims Administrator will review and decide a claim (appropriately filed with it) for reimbursement under the Dependent Care FSA within 90 days after it is timely filed. If the Claims Administrator denies a claim, the Claims Administrator will provide notice to you or your beneficiary, in writing, within 90 days after the claim is filed, unless special circumstances require an extension of time for processing the claim. No extension will be for more than 90 days after the end of the initial 90-day period.

If an extension of time for processing is required, written notice of the extension will be furnished to you or your beneficiary before the end of the initial 90-day period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which a final decision will be rendered. You will be informed in writing of the time limits set forth in this paragraph. If the Claims Administrator does not notify you of the denial of the claim within the period specified above, then the claim will be deemed denied.

Form and Content of Notice of Adverse Determination on Dependent Care FSA Claims. If a claim appropriately filed with the Claim Administrator is wholly or partially denied, you or your beneficiary will be furnished a written notice setting forth in a manner calculated to be understood:

1. The specific reason or reasons for the denial;

2. Specific references to the pertinent Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for you or your beneficiary to perfect the claim and an explanation as to why such information is necessary; and

4. An explanation of the Plan's claim procedure, including the steps to be taken if you or your beneficiary wishes to appeal the claim, the period within which the appeal must be filed, and the period within which it will be decided.

Right to Appeal Decision on Dependent Care FSA Claim. Within 60 days after receipt of the above material, you or your beneficiary will have a reasonable opportunity to appeal the claim denial to the Administrator for a full and fair review. You or your beneficiary or your (or the beneficiary's) duly authorized representative may:

1. Request a review upon written notice to the Administrator;

2. Review pertinent documents; and

3. Submit issues and comments in writing.

Action on Appeal of Dependent Care FSA Claim. A decision on the review by the Administrator will be made not later than 60 days after receipt of a request for review, unless special circumstances require an extension of time for processing (such as the need to hold a hearing). In that case a decision will be rendered as soon as possible, but not later than 120 days after receipt. If such an extension of time for deciding the appeal is required, written notice of the extension will be furnished to you or your beneficiary prior to the commencement of the extension. The decision of the Administrator will be written and will include specific reasons for the decision, written in a manner calculated to be understood by you or your beneficiary, with specific references to the pertinent Plan provisions on which the decision is based.

The Status of Your Plan Accounts Pending Appeal. Any balance remaining in a Reimbursement Account described in one or more Appendices (as applicable) at of the end of a Coverage Period will be forfeited and credited to the Employer's Benefit Plan Surplus as described in the appropriate Appendices, as applicable. However, if you had made a claim for such Coverage

Period, in writing, which was denied or is pending, the amount of the claim will be held in your Account until the claim appeal procedures described above have been satisfied or the claim is paid. If any such claim is denied on appeal, the amount held beyond the end of the Coverage Period will be forfeited and credited to the Benefit Plan Surplus.

Nondiscrimination Requirements. It is the intent of this Dependent Care FSA that:

1. Contributions or Benefits not discriminate in favor of Highly Compensated Employees or their Dependents, as prohibited by Code Section 129(d), and

2. Not more than 25 percent of the amounts paid by the Employer for dependent care assistance during the Coverage Period be provided for the class of individuals who are shareholders or owners (or their Spouses or Dependents), each of whom (on any day of the Coverage Period) owns more than 5 percent of the stock or the capital or profits interest in the Employer.

If the Claims Administrator deems it necessary to avoid discrimination or possible taxation to Highly Compensated Employees (as defined under Article VIII) or to principal shareholders or owners as described above, it may reject any benefit elections or reduce contributions or nontaxable benefits in order to assure compliance with these rules. Any act taken by the Claims Administrator under these rules will be carried out in a uniform and nondiscriminatory manner. If the Claims Administrator decides to reject any benefit election or reduce contributions or Benefits, it will be done in the following manner. First, the Benefits designated for the account under this Program of the Highly Compensated Employee that elected to contribute the highest amount to such account for the Coverage Period will be reduced until the nondiscrimination tests set forth in these rules are satisfied, or until the amount designated for the account equals the amount designated for the account of the Highly Compensated Employee who has elected the second highest contribution to an account under this Program for the Coverage Period. This process will continue until the nondiscrimination tests described above are satisfied.

Coordination with Flexible Benefits Plan. All Participants under the Flexible Benefits Plan are eligible to receive Benefits under this Dependent Care FSA. The enrollment and termination of participation under the Flexible Benefits Plan will constitute enrollment and termination of participation under this Dependent Care FSA. In addition, other matters concerning contributions, benefit elections, and the like will be governed by the general provisions of the Flexible Benefits Plan.

What You Should Know — Comparison of the Dependent Care FSA and the Dependent Care Tax Credit. Many people find it necessary to pay for the care of their children or other dependents so that they can work outside of the home. If that is your situation, you may be eligible for certain tax benefits provided in the Code. This subsection describes two of those benefits, so that you can judge which would be best suited to your own circumstances.

The Code helps you to pay for dependent care expenses in two different ways. First, it may be possible to exclude from your taxable income a portion of the dependent care expenses you Incur. Second, you may receive a credit against your taxes equal to a portion of such expenses. Although the exclusion and credit are calculated in entirely different ways, they are both subject to essentially

the same eligibility requirements. Moreover, the dependent care expenses to which each applies are limited to the earned income of you or your Spouse, *whichever is smaller*. These requirements and limitations are described in earlier sections of this Appendix. The remainder of this discussion will assume that you are eligible for at least a certain level of both such benefits.

Dependent Care Exclusion. You will note that the dependent care exclusion is described in earlier sections of this Appendix. The exclusion works like this. You elect to have the Employer withhold a portion of your Compensation each month and contribute that amount to your account under this Plan's Dependent Care FSA. Those amounts, up to the maximum set forth in this Appendix, may be used to pay for the expenses of dependent care, and are then excluded from the amount of compensation reported on your Form W-2. In other words, this would not be a deduction (which you would have to itemize on your income tax return), but would simply never be considered a part of your income.

The actual benefit of such a dependent care exclusion would depend on your income tax bracket. For example, if you were in a 15% tax bracket, the monetary benefit of $5,000 dependent care exclusion would be 15% of that amount, or *$750*. If you were in a 28% bracket would receive a $1,400 benefit from the full $5,000 exclusion.

Dependent Care Credit. The dependent care credit is entirely different from the exclusion described above. A credit is applied directly against the amount of taxes you would otherwise pay at the end of the year. To calculate the estimated credit, you must know your tax bracket, your adjusted gross income, how much you spend on daycare & how many qualified dependents you have.

For additional assistance in deciding whether to elect to participate in the Plan's Dependent Care Assistance Benefit, to claim the Dependent Care Credit, or both, please consult your tax advisor.

SAMPLE

GENERAL NOTICE
OF COBRA CONTINUATION COVERAGE RIGHTS

[Date]

[Recipient's Name and Address]

Re: CONTINUATION COVERAGE RIGHTS UNDER COBRA

You are receiving this Notice of COBRA Health Care Coverage Continuation Rights because you have recently become covered under a group health plan ("the Plan"). The Plan (or Plans) under which you have gained coverage are listed at the end of this Form.

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. 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 and/or to other members of your family who are covered under the Plan when you and/or they would otherwise lose the group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. ***This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it***. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or contact the Plan Administrator. In some cases the Plan Document also serves as the Summary Plan Description.

COBRA Continuation Coverage and "Qualifying Events"

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and certain children of employees may be qualified beneficiaries. Certain newborns, newly-adopted children and alternate recipients under qualified medical child support orders may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage generally must pay for this 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 enrolled in any part of Medicare (it is extremely rare for coverage of an employee's dependents to be terminated on account of the employee's Medicare enrollment); or
- You become divorced or legally separated from your spouse. Note that if your spouse cancels your coverage in anticipation of a divorce or legal separation and a divorce or legal separation later occurs, then the divorce or legal separation will be considered a qualifying event even though you actually lost coverage earlier. ***If you notify the Plan Administrator within 60 days after the divorce or legal separation and can establish that the employee canceled the coverage earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation (but not for the period between the date your coverage ended, and the date of divorce or legal separation).*** But you <u>*must*</u> provide timely notice of the divorce or legal separation to the Plan Administrator or you will not be able to obtain COBRA coverage after the divorce or legal separation. See the rules in the box below, under the heading entitled, *"Notice Requirements,"* regarding the obligation to provide notice, and the procedures for doing so.

Your ***covered 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 enrolled in any part of Medicare;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as an eligible child.

Notice Requirements

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been ***timely notified*** that a qualifying event has occurred. When the qualifying event is:

- the end of employment or reduction of hours of employment,
- death of the employee, or
- enrollment of the employee in any part of Medicare,

The employer (if the employer is not the Plan Administrator) must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

IMPORTANT:

For the other qualifying events (divorce or legal separation of the employee and spouse or a child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator in writing within 60 days after the qualifying event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, any spouse or child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

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

Parsons HR Central
100 Walnut Street, Pasadena, CA 91124
HRCentral.Parsons@parsons.com
833-867-8001(phone)
626-604-1026 (fax)

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

- the ***name of the plan or plans*** under which you lost or are losing coverage,
- the ***name and address of the employee*** covered under the plan,
- the ***name(s) and address(es) of the qualified beneficiary(ies)***, and
- the ***qualifying event*** and the ***date*** it happened.

If the qualifying event is a ***divorce or legal separation***, your notice must include ***a copy of the divorce decree or the legal separation agreement***.

There are other notice requirements in other contexts. See, for example, the discussion below under the heading entitled, *"Duration of COBRA Coverage."* That explanation describes other situations where notice from you or the qualified beneficiary is required in order to gain the right to COBRA coverage.

Once the Plan Administrator receives *timely notice* that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost ***If you or your spouse or covered children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.***

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in any part of Medicare, your divorce or legal separation, or your child losing eligibility as an eligible child, COBRA continuation coverage lasts for up to ***36 months***.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to ***18 months***.

There are *three ways* in which the period of COBRA continuation coverage can be extended…

1. Disability extension of 18-month period of continuation coverage.

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled as of the date of the qualifying event or at any time during the first 60 days of COBRA continuation coverage ***and you notify the Plan Administrator in writing and in a timely fashion***, you and your entire family can receive up to ***an additional 11 months*** of COBRA continuation coverage, for a total maximum of ***29 months***.

You must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. The Plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* In addition, your notice must include:

- the name of the disabled qualified beneficiary,
- the date that the qualified beneficiary became disabled, and
- the date that the Social Security Administration made its determination.

Your notice must also include a copy of the Social Security Administration's determination. ***If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required period, then there will be no disability extension of COBRA continuation coverage.***

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

If your family experiences ***another qualifying event*** while receiving COBRA continuation coverage, the spouse and your children in your family can get additional months of COBRA continuation coverage, up to a maximum of ***36 months (including the initial period of COBRA coverage)***.

This extension is available to ***the spouse*** and ***your children*** if, while they and the covered former employee are purchasing COBRA coverage, the former employee:

- dies,
- enrolls in any part of Medicare, or
- gets divorced or legally separated.

The extension is also available to your ***child*** when that child stops being eligible under the Plan as an eligible child.

In all of these cases, you must make sure that the Plan Administrator is notified in writing of the second qualifying event within 60 days of the second qualifying event. The Plan requires you to follow the procedures specified in the box above, under the heading entitled *"Notice Procedures."* Your notice must also ***name the second qualifying event*** and ***the date it happened***. If the second qualifying event is a divorce or legal separation, your notice must include ***a copy of the divorce decree or legal separation agreement***.

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator within the required 60-day period, then there will be no extension of COBRA continuation coverage due to the second qualifying event.

3. Medicare Extension for Spouse and Your Children.

If a qualifying event that is a termination of employment or reduction of hours occurs within 18 months after the covered employee becomes entitled to any part of Medicare, then the maximum coverage period for the spouse and your children is 36 months from the date the employee became entitled to Medicare (but the covered employee's maximum coverage period will be 18 months).

Shorter Maximum Coverage Period for Health Flexible Spending Accounts

The maximum COBRA coverage period for a health flexible spending arrangement (health "FSA") maintained by the employer ends on the last day of the cafeteria or flexible benefits plan "plan year" in which the qualifying event occurred. In addition, if at the time of the qualifying event the employee

has withdrawn (during the plan year) more from the FSA than the employee has had credited to the FSA, no COBRA right is available at all.

Other Rules and Requirements

Same Rights as Active Employees to Add New Dependents. A qualified beneficiary generally has the same rights as similarly situated active employees to add or drop dependents, make enrollment changes during open enrollment, etc. Contact the Plan Administrator for more information. See also the paragraph below titled, "Children Born or Placed for Adoption with the Covered Employee During COBRA Period," for information about how certain children acquired by a covered employee purchasing COBRA coverage may actually be treated as qualified beneficiaries themselves. ***Be sure to promptly notify the Plan Administrator if you need to make a change to your COBRA coverage. The Plan Administrator must be notified in writing within 31 days of the date you wish to make such a change (adding or dropping dependents, for example)***. See the rules in the box above, under the heading entitled, "Notice Procedures," for an explanation regarding how your notice should be made.

Children Born to or Placed for Adoption with the Covered Employee During COBRA Period. A child born to, adopted by or placed for adoption with a covered employee during a period of continuation coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA continuation coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, age requirements). ***Be sure to promptly notify the Plan Administrator if you need to make a change to your COBRA coverage. The Plan Administrator must be notified in writing within 31 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

Alternate Recipients Under Qualified Medical Child Support Orders. A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment with the employer is entitled the same rights under COBRA as an eligible child of the covered employee, regardless of whether that child would otherwise be considered a dependent. ***Be sure to promptly notify the Plan Administrator if you need to make a change to your COBRA coverage. The Plan Administrator must be notified <u>in writing</u> within 31 days of the date you wish to make such a change.*** See the rules in the box above, under the heading entitled, *"Notice Procedures,"* for an explanation regarding how your notice should be made.

If You Have Questions

Questions concerning your Plan or your COBRA continuation 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 or 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). Addresses and phone

numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

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 and Plan Contact Information

Plan Name:

Parsons Corporation Health & Welfare Plan

Plan Contact Information:

WEX Health, Inc.
P.O. Box 2079
Omaha, NE 68103
866-451-3399

SAMPLE Notice for California Employees
GENERAL NOTICE
REQUIRED BY CALIFORNIA ASSEMBLY BILL NO. 1554

This Appendix provides notice required by California Assembly Bill No. 1554.

If you choose to participate in the Dependent Care FSA, Medical FSA, or an adoption assistance plan, if applicable, and your coverage terminates prior to the end of the Plan Year due to termination of employment or loss of eligibility, you may be required to submit claims for reimbursement of expenses prior to the end of the Plan Year and prior to the normal deadline for submitting claims (i.e., the normal run-out period). For more information, please contact the Plan Administrator.

PLAN SPONSOR ADOPTION PAGE

The undersigned, on behalf of **Parsons Corporation** hereby adopts the amended and restated **PARSONS CORPORATION** FLEXIBLE BENEFITS PLAN AND SUMMARY PLAN DESCRIPTION, in the form attached hereto, effective as of January 1, 2023.

PARSONS CORPORATION

By: Patti B. Hahn

Title: Vice President, Global Benefits

Date: 07/20/2023