

**BRUBACHER EXCAVATING, INC. WELFARE
BENEFIT PLAN**

As Amended and Restated Effective December 1, 2024

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GENERAL INFORMATION

Name of the Plan:

Brubacher Excavating, Inc. Welfare Benefit Plan

Company Identification Number:

23-2073860

Employer and Plan Sponsor:

Brubacher Excavating, Inc.
P.O. Box 528
Bowmansville, PA 17507

Plan Number:

501

Type of Plan:

Health and Welfare (See attached Schedule B)

Type of Administration:

See attached Schedule B.

Plan Administrator:

Brubacher Excavating, Inc.
P.O. Box 528
Bowmansville, PA 17507

Named Fiduciary for Claim Determination:

Brubacher Excavating, Inc.
P.O. Box 528
Bowmansville, PA 17507

Agent for Service of Legal Process:

Brubacher Excavating, Inc.
P.O. Box 528
Bowmansville, PA 17507

End of Plan Year:

October 31

Source of Contributions:

See attached Schedule C

ARTICLE 1. EFFECTIVE DATE

1.01 Effective Date The Plan was originally effective as of June 1, 1988. Unless otherwise stated herein, this Amended and Restated Plan, is effective November 1, 2022. This document amends and restates the previous amended and restated plan and incorporates both discretionary amendments and legally required amendments needed in order to comply with various federal laws. Provisions relating to COBRA, FMLA, HIPAA, MHPA, NMHPA, USERRA, GINA, HITECH, MHPAEA, Michelle's Law, WHCRA, Qualified Medical Child Support Orders, and PPACA became effective as required by law.

ARTICLE 2. INTRODUCTION

2.01 Purpose The Company sponsors various benefit programs (the "Programs") for the exclusive benefit of Participants. The Programs are intended to conform to the written plan document and other requirements of ERISA. Any assets of the Programs shall be held for the exclusive purposes of providing benefits to the Programs' Participants and their beneficiaries and for defraying reasonable expenses in administering the Programs. This document, the Insurance Contract, Summary Information and Summary Booklet are intended to constitute one single plan for purposes of the reporting and disclosure requirements of ERISA and the IRC. This instrument, together with the attached documents, constitute the written Plan document and Summary Plan Description required by ERISA.

The Company has established the Brubacher Excavating, Inc. Welfare Benefit Plan (the "Plan") contained herein to provide certain uniform rules and policies among all of the Programs. The purpose of the Plan is to set forth those uniform rules and policies. The terms of the Plan and the documents of all the Programs included herein shall, until amendment or termination, be legally enforceable by Participants of the Programs.

ARTICLE 3. GENERAL PROVISIONS AND DEFINITIONS

3.01 "COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time. Reference to a specific provision of COBRA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.02 "Company"

shall mean Brubacher Excavating, Inc., a corporation organized and existing under the laws of the Commonwealth of Pennsylvania, or any successor(s) thereto, whether by merger, consolidation or otherwise.

3.03 “Continuation Coverage” shall mean health coverage which is elected by an Employee or a covered Dependent where, as a result of the:

- (a) Death of the Employee;
- (b) Divorce or legal separation of the Employee from the Employee’s spouse;
- (c) Dependent’s ceasing to be a dependent child as defined under Section 3.05 of the Plan;
- (d) Dependent’s loss of eligibility under the Plan because the Participant becomes entitled to benefits under Medicare;
- (e) Termination (other than by gross misconduct), or reduction of hours, of the Employee’s employment; or
- (f) Spouse ceasing to be a Dependent as defined under Section 3.05 of the Plan;

the Employee’s or Dependent’s coverage under the Plan would have been terminated. A person who elects Continuation Coverage is required to pay a premium equal to 102% of the full cost of the elected coverage under the Plan. Continuation Coverage is provided for a limited period of time depending on the purpose of the Continuation Coverage.

3.04 “Day or Date” shall mean a twenty-four (24) hour period beginning at 12:01 A.M. and ending at that next following 12:00 A.M.

3.05 “Dependent” shall mean, with respect to a Program that is a Health Plan, unless otherwise stated in an applicable Insurance Contract, Summary Supplement, Summary Booklet or Summary Information and except in cases where a benefit is provided through insurance and applicable state law mandates a more expansive definition of “Dependent,” an individual who is:

- (a) the Spouse of a Participant in a legally valid, existing marriage;
- (b) a natural or adopted child, a stepchild, foster child or a legal ward (guardianship) of a Participant who is:
 - (i) for purposes of the medical benefits, under the age of 26, or
 - (ii) for purposes of other benefits, below the limiting age defined in the governing document for the respective benefit.
- (c) If both spouses are eligible Employees: (i) neither spouse may be covered under the Plan as both a Dependent and a Participant, and (ii) coverage will not be duplicated for an eligible Dependent of both spouses.

3.06 “Eligible Employee” shall mean an Employee eligible to participate under Section 4.01.

3.07 “Employee” shall mean any person employed by the Company or any Participating Employer.

3.08 “ERISA” shall mean the Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to a specific provision of ERISA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.09 “FMLA” shall mean the Family and Medical Leave Act of 1993, as amended from time to time. Reference to a specific provision of FMLA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.10 “GINA” shall mean the Genetic Information Nondiscrimination Act of 2008.

3.11 “Group Health Plan” shall mean a group health plan within the meaning of section 733(a) of ERISA.

3.12 “Health Plan” shall mean that portion of the Plan that is intended to qualify as a Group Health Plan.

3.13 “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, as amended from time to time. Reference to a specific provision of HIPAA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.14 “HITECH” shall mean the Health Information Technology for Economic and Clinical Health Act

3.15 “Insurance Contract” shall mean the Group Policy(ies) and/or insurance certificate of the Insurer, or any replacement or substitution thereof. The Company may from time to time and at its discretion substitute other insurance contracts entered into with the Insurer or with other insurance companies. In that event and without the need for Plan amendment, such contract or contracts shall be considered incorporated by reference in the Plan document.

3.16 “IRC” shall mean the Internal Revenue Code of 1986, as amended from time to time. Reference to a specific provision of the IRC shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.17 “Medical Child Support Order” shall mean any court judgment, decree, or order (including a court’s approval of a domestic relations settlement agreement) that:

(a) orders child support related to the provision of health benefits to a child of a person covered by the Plan, or requires the Plan to provide health benefit coverage to a child, pursuant to a state domestic relations law, or

(b) enforces a state medical child support law enacted under the Social Security Act.

3.18 “MHPA”

shall mean the Mental Health Parity Act of 1996, as amended from time to time. Reference to a specific provision of MHPA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.19 “MHPAEA”

shall mean the Mental Health Parity Addiction Equity Act.

3.20 “NMHPA”

shall mean the Newborns’ and Mothers’ Health Protection Act of 1996, as amended from time to time. Reference to a specific provision of NMHPA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.21 “Participant”

shall mean any Eligible Employee who is participating in a Program in accordance with the terms and conditions established for that Program, and has not for any reason become ineligible to participate further in that Program. An Employee shall be a Participant in the Plan if and only if he/she elects or receives coverage under one or more Programs. Any additional participation policy for each Program is set forth in the Programs referred to in Schedule B. “Participant” shall also mean a former Employee or his/her Dependent who is participating in the Plan through Continuation Coverage.

3.22 “Participating Employer”

shall mean the Company or any other entity that adopts the Plan. An entity’s participation in the Plan requires the approval of the Company and of such other entity, which approval shall be given by execution of documents evidencing such intent and consent. “Participating Employer” includes any successor(s) to a Participating Employer, whether by merger, consolidation or otherwise. All current Participating Employers are listed in Schedule A.

3.23 “PPACA”

shall mean the Patient Protection and Affordable Care Act, as amended from time to time. Reference to a specific provision of PPACA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.24 “Plan”

shall mean the Brubacher Excavating, Inc. Welfare Benefit Plan as it shall be amended from time to time. The Plan shall consist of this document, the group insurance contracts and the summary of benefits materials referenced herein.

3.25 “Plan Administrator”

shall mean the party or parties named or appointed pursuant to Article Five.

3.26 “Plan Year”

shall be the twelve month period beginning on November 1 and ending on October 31 in the following year.

3.27 “Programs” shall mean the programs which are governed by the terms and conditions herein contained as set forth in Schedule B and in this document, the Insurance Contract, Summary Information, Summary Booklet and the summary of benefits materials, incorporated herein by reference. The Section 125 Plan, as covered by Article Nine of this Plan Document, is also a Program. Once a Participating Employer has adopted the Plan, it is up to the discretion of that Participating Employer, with the consent of the Company, to designate the Programs the Participating Employer shall offer to its employees through the Plan. The Programs that each Participating Employer has selected to offer to its employees are set forth in Schedule B. These same Programs may be changed from time to time by the Company or any Participating Employer with the consent of the Company.

3.28 “Qualified Medical Child Support Order” or “QMCSO”

shall mean a Medical Child Support Order that either creates or recognizes the right of an alternate recipient, or assigns to the alternate recipient the right, to receive medical benefits under the Plan for which a person covered by the Plan is entitled. A QMCSO must conform to the requirements of 29 CFR 2590.609-2. An alternate recipient includes any child of a person covered by the Plan who is recognized under a Medical Child Support Order as being entitled to enrollment in the Plan.

3.29 “Qualifying Exigencies” shall mean short notice military deployment, military events and related activities, childcare and school activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and other additional activities, each as described under 29 C.F.R. section 825.126.

3.30 “Spouse” shall mean a Participant’s spouse under a legally valid existing marriage.

3.31 “Summary Booklet” shall mean any individual booklet that shall summarize the benefits under the self-funded options to which the covered person is entitled, and the provisions of this Plan principally affecting the covered person, and which shall along with this Plan document constitute a Summary Plan Description as required under ERISA Section 102.

3.32 “Summary Information” shall mean any individual booklet that shall summarize the benefits under the fringe benefit programs and payroll practices to which the covered person

is entitled, and the provisions of this Plan principally affecting the covered person, and which shall constitute a written plan document to the extent one is required under the IRC.

3.33 USERRA” shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time. Reference to a specific provision of USERRA shall include such provision, any valid regulation or ruling promulgated thereunder and any comparable provision of future law that amends, supplements or supersedes such provision.

3.34 “WHCRA”shall mean the Women’s Health and Cancer Rights Act of 1998.

ARTICLE 4. TERMS OF THE PLAN

4.01 Employee Eligibility: See Schedule D for a description of the various Programs’ eligibility criteria under the terms thereof set forth herein or in the Summary Information, Insurance Booklet, Insurance Contract, summary of benefit materials, or employee handbook, whichever is applicable. Following are some additional eligibility rules for the Plan.

(a) Coverage of Dependents:

(i) Dependents of Eligible Employees: Except as provided below, Dependents of an Eligible Employee may be covered under any Program on the Date that the Employee becomes a Participant, or the Date that the dependent becomes a Dependent, whichever is later, provided that the Participant agrees to contribute toward Dependent coverage according to the cost schedule provided to him/her.

(ii) Proof of Eligibility: Spouses and children are eligible to participate in the Plan only to the extent that the Employee has provided proper proof of the individual’s relationship to the Employee by the deadline established by the Plan Administrator.

(iii) Eligibility of Spouses: Spouses are eligible to participate in the medical benefit under the Plan only if they are not eligible for other employer-sponsored medical coverage.

(iv) Qualified Medical Child Support Order: This Plan, as determined by the Plan Administrator, will provide benefits in accordance with the applicable requirements of any QMCSO. Where there is a QMCSO, coverage for a Dependent child will become effective on the Date that the court order is determined by the Plan Administrator to be a qualified order.

(b) **Termination of Coverage:** Coverage under the Plan (other than Continuation Coverage under Section 4.08) will terminate for both an Employee and his or her Dependents on the earliest of the following Dates:

- (i) The Date of termination of the Plan;
- (ii) The Date an Employee ceases to be eligible for coverage under the Plan except, for purposes of medical benefits, as provided in Schedule E;
- (iii) The Date an Employee becomes a Full-Time member of the Armed Forces of any country, except as otherwise required under an applicable federal or state law and as described in the Company's Military Leave Policy;
- (iv) The Date provided for in Schedule D;
- (v) The Date that an Employee ceases to be actively at work; except that an Employee may continue coverage as described in Schedule F. Coverage will be continued for benefits in accordance with the provisions of Schedule F so long as the Employee pays the required premium contribution as described in Schedule F;
- (vi) The Date on which an Employee fails to make any required contribution(s) necessary to maintain his/her coverage;

(c) **Termination of Coverage as a Dependent:** A Dependent's coverage under the Plan (other than Continuation Coverage under Section 4.08) will terminate on the earliest of the following Dates:

- (i) The Date of termination of the Plan;
- (ii) The Date the Dependent ceases to meet the definition of a Dependent;
- (iii) The Date specified by the Plan Administrator that coverage will terminate if the Employee does not provide proof of the Dependent's relationship to the Employee;
- (iv) The Date a Spouse becomes eligible for other employer-sponsored coverage;
- (v) The Date the Dependent becomes a Full-Time member of the Armed Forces of any country, except as otherwise required under an applicable federal or state law;
- (vi) The Date on which the Employee's coverage is terminated; or
- (vii) The Date on which there is a failure to make any required contribution(s) necessary to maintain the Dependent's coverage.

(d) **Individuals Not Eligible to Participate.** Except as otherwise provided in Schedule E for purposes of medical benefit eligibility, and notwithstanding the prior subsections, a leased employee, temporary employee, independent contractor or similar worker will not be considered to be an Eligible Employee unless considered a common law employee (for purposes of medical coverage) or unless clearly designated as such under one or more Programs.

No individual whose employer does not regard him/her as being an Employee shall be eligible to participate retroactively in the Plan even if it is later determined by a court of law, the Internal Revenue Service, the Social Security Administration, or any other government agency that he/she should have been an Employee.

(e) **Insurance Policies.** If a benefit is provided through insurance, an individual must be an Eligible Employee or a covered Dependent under the terms of this Section and must be eligible for benefits under the terms of the Insurance Contract in order to be entitled to benefits. However, the eligibility of unmarried Dependent children for dependent life insurance coverage shall be determined in accordance with the Insurance Contract.

(f) **Cost-Sharing.** Notwithstanding the above, an Employee is eligible for coverage under the Plan only if, and to the extent that, he/she pays his/her share of the cost of coverage as set forth in Schedule C (as amended from year to year) and/or in a notice provided to Employees annually. Unless otherwise indicated in Schedule C, an Employee may pay for his/her share of the cost of coverage only through a cafeteria plan (meeting the requirements under IRC §125). Therefore, if an Employee refuses to make a salary reduction election under a cafeteria plan sponsored by a Participating Employer, he/she may not be eligible to participate in one or more of the Programs under the Plan.

(g) **Special Enrollment.** If an Employee declines enrollment for himself/herself and his/her Dependents under the Plan or a Program which is a “group health plan” as defined under IRC §5000(b)(1) because the Employee or the Employee’s Dependents had other medical, dental, vision or prescription drug coverage, the Employee may later be able to enroll himself/herself and his/her Dependents in the medical / prescription drug, dental or vision coverage option(s) available under the Plan if the other medical, dental, vision or prescription drug coverage, or the employer contributions for the coverage, ends. In addition, if an Employee gains a new Dependent as a result of marriage, birth, adoption or placement for adoption, the Employee may be able to enroll himself/herself and his/her Dependents in the medical/prescription drug, dental or vision coverage option(s) available under the Plan at the time the relevant event occurs. An Employee must request enrollment not later than thirty (30) Days after the termination of coverage or relevant event. Coverage will take effect as follows:

(i) With respect to those who lose other coverage, the Date on which the other coverage was lost; and

(ii) With respect to new Dependents due to marriage, birth, adoption or placement for adoption, the Date on which the relevant event occurred.

This subsection (m) does not limit, preclude or apply to an enrollment mid-Plan Year when the Plan Administrator is presented with a QMCSO.

Notwithstanding the forgoing, in the event an Employee or his or her eligible Dependent (1) loses coverage under Medicaid or a state child health program, or (2) becomes eligible for state assistance with respect to paying his or her contributions to the Plan, he or she may change an election for accident or health coverage during a Plan Year and make a new election that corresponds with the special enrollment rights provided in Code Section 9801(f), including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009; provided that such Employee meets the sixty (60) day notice requirement imposed by Code Section 9801(f) (or such longer period as may be permitted by the Plan and communicated to Employees). Such change shall take place on a prospective basis, unless otherwise required by Code Section 9801(f) to be retroactive.

See Schedule D for a summary of the various Programs' eligibility criteria.

4.02 Insuring and Funding Benefits Funding for the Plan shall consist of an aggregation of the funding for all Programs. The Company shall have the right to insure any benefits under the Plan or to establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as the Company deems advisable. In addition, the Company shall have the right to alter, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or insurance policy. The funding policy for each Program shall be established under the Programs referred to in Schedule B.

If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier. To the extent funds are transferred to or accumulated in a trust to provide any self-funded benefit, that benefit will be payable from the assets of such trust. Neither the Company nor any Participating Employer shall have any further responsibility to pay such benefit. Insurance premiums shall be paid either from the Company's general assets or from the pre-tax payroll contributions of Participants as indicated on Schedule C.

Each Participating Employer shall, upon demand from the Company, reimburse the Company for the Participating Employer's appropriate share of any insurance premiums or plan funding necessary to provide benefits under the Plan.

4.03 Benefits and Termination of Rights to Benefits The benefits available under the Plan shall consist of an aggregation of the benefits available under each Program, including all limitations and exclusions with respect to each Program's benefits. The benefits available under each Program are set forth in the Programs referred to in Schedule B. The Company reserves the right to change insurance carriers, coverage and other features of any Program provided through the Plan.

A Participant's right to benefits under the Plan shall consist of, and be limited to, his/her right to benefits under each Program in which he/she is a Participant as set forth in the Plan document and in those materials provided by the relevant insurer or third party administrator. Any termination or cessation of a Participant's rights or coverage under a Program shall be considered a termination or cessation of those same rights under the Plan. The Plan provides for no rights other than those rights provided for under each Program.

4.04 Payment of BenefitsThe benefits provided under the Plan shall be payable according to the payment policy of each Program. The payment policy for benefits under each Program is set forth in Schedule B, except that the Plan explicitly excludes any and all coverage for services rendered in connection with a voluntary abortion.

4.05 Procedures for the Submission and Review of ClaimsThe procedure to be followed for submitting and reviewing claims under the Plan shall correspond to the claims procedure for the Program under which the claim is being or was originally submitted.

All claims should be reported promptly. Unless otherwise provided by a specific Program, the deadline for filing a claim for any benefits is ninety (90) days after the date of the loss causing the claim. If, through no fault of the participant, the participant is unable to meet the deadline for filing a claim, the claim will still be accepted if the participant files as soon as possible. Unless the participant is legally incapacitated, late claims will not be covered if they are filed more than two (2) years after the deadline. The time periods for responding to and appealing claims determinations differ based on the type of claim being filed.

4.06 Inspection of DocumentsThe Plan, the Programs, and any relevant insurance contracts shall be available for inspection during normal business hours at the personnel office of the Company or at its plant locations. Participants shall have the right to obtain copies of such documents from the Plan Administrator and, except as otherwise provided in the claims and appeals procedures referred to in Section 4.05, the Plan Administrator shall have the authority to charge a reasonable fee for the costs associated with their duplication (e.g., copy costs) or retrieval (e.g., hourly rate for the labor involved in locating requested information).

4.07 FMLA CoverageNotwithstanding any other provision of the Plan, any Participant on a leave of absence covered under the FMLA shall continue to participate and be eligible to receive benefits under the Plan in accordance with the FMLA rules and regulations.

FMLA leave includes leave for any of the following reasons:

- (a) the birth of a son or daughter, and to care for the newborn child;
- (b) the pregnancy of the Employee if such condition prevents the Employee from performing the functions of their job;
- (c) the placement with the Employee of a son or daughter for adoption or foster care;
- (d) the care of the Employee's spouse, son, daughter, or parent with a serious health condition;
- (e) For "Qualified Exigencies"
- (f) Care for a covered servicemember who is undergoing medical treatment or recuperation or therapy as a result of a serious injury or illness incurred in the line of duty (as defined under the FMLA); or

(g) the serious health condition of the Employee which prevents the Employee from performing the functions of their job.

If a Participant is eligible for a leave of absence under the FMLA, the Company (or the Participating Employer) will maintain the required coverage for the Participant and his/her Dependents during the period that the Participant is on FMLA leave as long as he/she continues to pay his/her share of the cost of coverage. The Participant should contact the personnel office to make arrangements for paying his/her share of premiums while on leave. Upon his/her return from FMLA leave, the Participant will immediately become eligible for coverage under the applicable Programs regardless of whether the Participant continued coverage during his/her leave. In some instances, if the Participant fails to return to work from FMLA leave, his/her Participating Employer may bill him/her for the portion of the cost of his/her coverage that it may have paid to maintain his/her coverage during his/her leave.

4.08 Continuation Coverage All persons whose health benefits would otherwise terminate may have rights to Continuation Coverage at their own expense due to a qualifying event described in Section 3.03 and or IRC §4980B. To the extent that the law or regulations require Continuation Coverage under the Plan:

(a) Any Participant who becomes eligible for Continuation Coverage will be notified of such eligibility within 44 Days of the occurrence of the qualifying event, unless the qualifying event is one described in Section 3.03(b), (c) or (f) for which the Participant or Dependent must notify the Plan Administrator, in which case the Participant will be notified by regular mail to the last address of record with the Company of such eligibility within 14 days of the Plan Administrator being notified of the occurrence of the qualifying event. The Participant must elect, in writing, whether to continue coverage within sixty (60) Days following the later of the Date of the qualifying event and the Date the Plan Administrator informs a person of any rights under this Section, whichever is the later.

(b) Continuation Coverage shall terminate at the earliest of the following dates:

(i) except as extended in subsection (iii), (ix) or (x), the end of an 18-month period after the Date of the qualifying event if the qualifying event is one described in Section 3.03(e);

(ii) the end of a 36-month period after the Date of the qualifying event if the qualifying event is one described in Section 3.03(a), (b), (c) (d) or (f);

(iii) the end of a 29-month period after the Date of the qualifying event, but only if the qualifying event is one described in Section 3.03(e) and both within sixty (60) Days after the Date the determination is issued and prior to the end of the 18-month period described in subsection (i) above, written notice is provided to the Plan Administrator, that a person has been determined to have been disabled under Title II or XVI of the Social Security Act during the first sixty (60) Days of such qualifying event. Coverage may be continued for this period for the individual determined to be disabled and all other qualified beneficiaries associated with such individual;

(iv) the Date that the Company discontinues benefits in its entirety as to health expense coverage. Continuation Coverage may be available under another group health plan sponsored by the Company, if such a plan exists;

(v) the Date any required contributions are not made (as extended for any applicable grace period);

(vi) the first Day after the Date of the election that the individual is covered under another group health plan. However, Continuation Coverage will not terminate until such time that the individual is no longer affected by a preexisting condition exclusion or limitation under such other group health plan. To the extent permitted by law, coverage under the new group health plan will be the primary coverage for those benefits not affected by a preexisting condition exclusion or limitation;

(vii) the Date the individual becomes entitled to benefits under Medicare. This will not apply if it is contrary to the provisions of the Medicare Secondary Payer Rules or other federal law;

(viii) in the case of a qualified beneficiary who is disabled at any time during the first sixty (60) Days of Continuation Coverage, the first Day of the month that begins more than thirty (30) Days after the Date of the final determination under Title II or XVI of the Social Security Act that the individual whose coverage is being continued for a 29-month period is no longer disabled;

(ix) the end of a 36-month period after the Date of the qualifying event if the qualifying event is one described in Section 3.03(e) and a second qualifying event occurs during the 18-month period described in subsection (i) above;

(x) the end of the later of: (a) 36 months after the date the Participant became entitled to Medicare benefits or (b) 18 months (or 29 months, if subsection (iii) above applies) after the Date of a qualifying event described in Section 3.03(e), if the Participant becomes entitled to Medicare under Title XVIII of the Social Security Act before experiencing a qualifying event described in Section 3.03(e); or

(xi) such other time period provided for under IRC §4980B(f)(2)(B)(i).

(c) Premium costs will equal 102% (in the case of a disability extension of the maximum coverage period, the Plan may increase the charge to 150% of the applicable premium for certain qualified beneficiaries) of the full cost to the Plan of this continued coverage.

The Participant or Dependent must notify the Plan Administrator of the occurrence of a qualifying event described in Sections 3.03(b), (c) or (f) within sixty (60) days of the occurrence of the event. The Participant or Dependent must also notify the Plan Administrator if a person is eligible for an extended Continuation Coverage period under Section 4.08(b)(iii) within sixty (60) Days after the Date of the determination, and within thirty (30) Days after the Date of any final determination that the Participant or Dependent is no longer disabled. If notice is not provided within this time period, continuation under this Section 4.08 will not be available.

4.09 NMHPA To the extent that a Program is subject to NMHPA, no Program may restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child in a manner that does not meet the terms and conditions mandated by NMHPA.

In the event of an inpatient confinement, pregnancy coverage will be payable for inpatient care of the covered person and any newborn child for a minimum of 48 hours following a vaginal delivery and a minimum of 96 hours following a cesarean delivery. Notwithstanding the foregoing, the minimum stay periods shall not be applicable in any case in which the decision to discharge the mother or her newborn child prior to the expiration thereof is made by an attending provider in consultation with the mother. If a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider made within a reasonable time thereafter.

4.10 MHPA/ MHPAEA To the extent a Program is subject to MHPA/MHPAEA, no Program that provides both medical and surgical benefits and mental health benefits (including substance disorder benefits if covered under the Program) may impose an aggregate lifetime limit or an annual limit on mental health benefits that is less than the comparable limit on medical and surgical benefits in accordance with the provisions of MHPA/MHPAEA.

4.11 GINA To the extent a Program is subject to GINA, no Program that provides health benefits shall use genetic information for adjusting group premium or contribution amounts on the basis of genetic information; requesting or requiring an individual or an individual's family members to undergo genetic testing; or requesting, requiring, or purchasing genetic information for underwriting purposes.

ARTICLE 5. ADMINISTRATION OF PLAN

5.01 Plan Administrator The Company shall be the Plan Administrator (unless it appoints one or more persons in that position). The Plan Administrator shall administer the Plan and shall be the “named fiduciary” for the Plan.

The Plan Administrator, or such person or committee delegated by the Plan Administrator, shall have control of the day-to-day administration of the Plan, and shall serve without additional remuneration if an employee of the Company, except for reimbursement of out-of-pocket expenses, and for so long as it is mutually agreeable to the Plan Administrator and to the Company. If the Company appoints one or more persons or a committee as Plan Administrator, the Company shall have no duty or responsibility with respect to the administration of the Plan related to that duty other than the appointment or removal of the Plan Administrator.

5.02 Duties and Powers of the Plan Administrator With respect to the administration of the Plan, the Plan Administrator shall have the duties, responsibilities and authority:

(a) To construe and interpret the Plan including, without limitation, the authority to determine an Employee’s eligibility to participate in and receive benefits under one or more Programs, to correct any defect, and to reconcile any inconsistency;

(b) To prescribe uniform procedures to be followed by Eligible Employees and Participants in making elections, filing claims and any other administrative procedures necessary to properly administer any or all of the Programs;

(c) To prepare and distribute information explaining the Plan to Eligible Employees and Participants;

(d) To receive from the Company, Eligible Employees and Participants such information as may be necessary or desirable for the proper administration of the Plan;

(e) To employ such persons, including, but not limited to, actuaries, accountants, claims administrators, and counsel, as it deems appropriate, to perform such duties as may from time to time be required either by administrative convenience or necessity or under ERISA, IRC or other applicable law and to render advice upon request with regard to any matters arising under the Plan;

(f) To prepare and file any reports or returns with respect to the Plan required under applicable law;

(g) To take all other steps deemed necessary or appropriate to properly administer the Plan in accordance with its terms and the requirements of applicable law; and

(h) To act in accordance with all applicable laws governing fiduciary standards.

To the extent that the administrative procedures or duties of the Plan Administrator conflict with the provisions of any insurance contracts providing Plan benefits, the insurance contracts shall govern.

5.03 Qualified Medical Child Support OrdersThe Plan Administrator shall establish reasonable procedures to determine whether Medical Child Support Orders are Qualified Medical Child Support Orders and to administer the provision of benefits under such Qualified Medical Child Support Orders. Such procedures:

- (a) Shall be in writing;
- (b) Shall provide for the prompt notification to each person specified in a Medical Child Support Order as eligible to receive benefits under the Plan (at the address included in the order) of such procedures upon receipt by the Plan of the order; and
- (c) Shall permit an alternate recipient (as defined in ERISA §609(a)(2)(C)) to designate a representative for receipt of copies of notices that are sent to the alternate recipient with respect to a Medical Child Support Order.

5.04 Rules and DecisionsThe Plan Administrator (or committee delegated by the Plan Administrator) shall decide any matter, and may adopt any rule or procedure, regarding eligibility, benefits, claims, or any other issue arising under the Plan that it deems necessary, desirable or appropriate in the administration of the Plan, including factual determinations. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Eligible Employees and Participants in similar circumstances and shall be conclusive and binding on all persons having an interest in the Plan. When making any decision or determination, the Plan Administrator shall be entitled to rely upon, without further inquiry, such information as may be furnished to it by an Eligible Employee or Participant, the Company, legal counsel, or the administrator of any Program or another plan.

5.05 Delegation and Allocation of Responsibility of the Plan Administrator

(a) The Plan Administrator may allocate or delegate any responsibility regarding the Plan provided to it under the Plan among one or more persons or a committee, which persons may be either named fiduciaries or persons other than fiduciaries. Any such allocation or designation shall be approved by the Plan Administrator in writing and shall:

- (i) Specifically identify the person, persons or committee to whom a responsibility is allocated or delegated; and
- (ii) Specifically identify the nature and scope of the responsibility allocated.

(b) The named fiduciary or other person, persons or committee to whom a responsibility of the Plan Administrator is allocated or delegated in accordance with subsection 5.05(a) shall be responsible only for the performance of that responsibility according to the terms of the delegation or allocation, and, in accordance with ERISA §405(a), such person shall not be liable for the act or omission of any other person with respect thereto unless:

(i) By his/her failure to properly administer the specific responsibility he/she has enabled such other person to commit a breach of fiduciary responsibility; or

(ii) He/she knowingly participates in, or knowingly undertakes to conceal, an act or omission of another person, knowing such act or omission to be a breach; or

(iii) Having knowledge of the breach of another, he/she fails to make reasonable efforts under the circumstances to remedy said breach.

(c) Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan.

5.06 Representations to Fiduciaries Any person who is a fiduciary with respect to the Plan shall be entitled to rely on representations made by Eligible Employees, Participants, Employees, former Employees, and beneficiaries with respect to age, marital status and other personal facts, unless said fiduciary has actual knowledge that said representations are false.

5.07 Indemnification To the full extent allowed by law, each Participating Employer, jointly and severally, shall indemnify each past, present and future Plan Administrator and each other Employee who acts in the capacity of an agent, delegate or representative of the Plan Administrator or the Participating Employer under the Plan (collectively, each such Plan Administrator and each such other Employee who acts in the capacity of an agent, delegate or representative of the Plan Administrator or the Participating Employer under the Plan shall be referred to in this Section as a “Plan Administration Employee”), and each Plan Administration Employee shall be entitled without further act on his/her part to indemnity from each Participating Employer, jointly and severally, for any and all losses, liabilities, costs and expenses (including the amount of judgments, court costs, reasonable attorneys’ fees, and the amount of approved settlements made with a view to the curtailment of costs of litigation, other than amounts paid to a Participating Employer) incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened or anticipated possible action, suit, or other proceeding, including any investigation that might lead to such a proceeding in which he/she is or may be involved by reason of, or in connection with, his/her being or having been a Plan Administration Employee. This indemnity obligation indemnifies the Plan Administration Employee against the consequences of his/her active, passive, concurrent or partial negligence; provided, however, such indemnity shall not include any losses, liabilities, costs and expenses incurred by such Plan Administration Employee:

(a) With respect to matters as to which he/she is finally adjudged in any such action, suit or proceeding to have been guilty of gross negligence or willful misconduct in the performance of his/her duties of Plan Administration Employee; or

(b) With respect to any matter to the extent that a settlement thereof is affected in an amount in excess of the amount approved by the Company (which approval shall not be unreasonably withheld).

No right of indemnification hereunder shall be available to, or enforceable by, any such Plan Administration Employee unless, within forty-five (45) Days after his/her receipt of notice or, if applicable, service of process in any such potential or actual action, suit or other proceeding (or such longer period as may be approved by the Company), he/she shall have offered the Company, in writing, the opportunity to handle and defend same at its sole expense, and the decision by the Company to handle the proceeding shall conclusively determine that the Plan Administration Employee is entitled to the indemnity provided herein unless he/she then expressly agrees otherwise.

Until and unless a final judicial determination has been made that indemnity is not applicable, all reasonable costs and expenses of the Plan Administration Employee shall be promptly and fully paid or reimbursed by a Participating Employer, upon demand.

The foregoing right of indemnification shall inure to the benefit of the heirs, executors, administrators and personal representatives of each Plan Administration Employee, and shall be in addition to all other rights to which he/she may be entitled as a matter of law, contract, or otherwise.

5.08 Participating Employer's Protective Clauses Upon the failure of either the Participant or the Participating Employer to obtain the insurance contemplated by the Plan (whether a result of negligence, gross neglect, or otherwise), the benefits payable to the Participant shall be limited to the insurance premium, if any, that remains unpaid for the period in question and the actual insurance proceeds, if any, received by the Participating Employer or the Participant as a result of the Participant's claim.

For benefits provided under a fully-insured Program, the liability of the Participating Employer shall only extend to and shall be limited to any payment actually received by the Participating Employer from the insurance carrier. In the event that the full insurance benefit contemplated is not promptly received by the Participating Employer within a reasonable time after submission of a claim, the Participating Employer shall notify the Participant of such facts, and the Participating Employer shall no longer have any legal obligation whatsoever (except to execute any document called for by a settlement reached by the Participant). The Participant shall be free to settle compromise or refuse to pursue the claim as the Participant, in his/her sole discretion, shall see fit.

The Participating Employer shall not be responsible for the validity of any insurance policy issued hereunder or for the failure on the part of this insurance carrier to make payments provided for under any insurance policy. Once insurance is applied for or obtained, the Participating Employer shall not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Participating Employer.

5.09 Agents and Expenses The Plan Administrator may employ others to assist it in its duties and may rely upon the written certificates of any agent, counsel, accountant, investment

manager, actuary or physician. The Plan Administrator shall be entitled to reimbursement by the Participating Employers for all proper charges and expenses incurred in carrying out its duties under the Plan, including compensation of agents.

5.10 Reliance on Tables, Etc. In administering the Plan, the Plan Administrator will be entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by, or in accordance with the instructions of, the administrator of any Program, or by accountants, counsel or other experts employed or engaged by the Plan Administrator.

5.11 No Guarantee of Tax Consequences Neither the Plan Administrator, the Company, nor the Participating Employers make any commitment or guarantee that any amounts paid to or for the benefit of a Participant under the Plan will be excludable from the Participant's gross income for federal or state income tax purposes, or that any other federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for federal and state income tax purposes and to notify the Participating Employer if the Participant has any reason to believe that any such payment is not so excludable.

ARTICLE 6. AMENDMENT OR TERMINATION

6.01 Amendment or Termination The Plan is established with the intention of being maintained for an indefinite period of time. However, the Company, shall have the sole right to alter, amend or terminate the Plan (including all Schedules and Appendices) or any Program listed in Schedule B, in whole or in part, at any time it determines to be appropriate, without notice. The Company may amend or substitute any set of Program terms without affecting other Plan provisions. Except to comply with applicable laws (including, without limitation, the IRC and ERISA), the Company shall not retroactively amend, alter, or terminate the Plan or any Program in a manner that would reduce a Participant's right to receive benefits which, because of the incurred provision of a covered service, are already payable upon submission of a claim; provided, however, that this sentence should not be interpreted to restrict the rights of the Company to amend or terminate the Plan or any Program to the extent not inconsistent with ERISA or other controlling law.

ARTICLE 7. PARTICIPANT RIGHTS, RESPONSIBILITIES AND LIMITATIONS

7.01 No Enlargement of Employee Rights Nothing contained in the Plan shall be deemed to give an Eligible Employee, Participant, or employee of the Company or any Participating Employer the right to be retained in the service of the Company or a Participating Employer or to interfere with the right of the Company or a Participating Employer to discharge or retire such person at any time.

7.02 No Assignment Except as may otherwise be specifically provided in the Plan, the Programs, the insurance contracts, or applicable law, a Participant's rights, interests or benefits

under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution or levy of any kind, either voluntary or involuntary, prior to being received by the persons entitled thereto under the terms of the Plan and/or the Programs, and any such attempt shall be void.

7.03 Subrogation:

(a) **Generally:** If, in the event of accidental bodily injury for which a Participant will have a claim against the general assets of a Participating Employer for benefits under the Plan, a Participant acquires any right or action against a third party for such accidental bodily injury (including lost wages), the Participant shall, if requested by the Participating Employer, assign and transfer such claim or right of action to the Participating Employer. In the alternative, at the Participating Employer's option, the Participant shall execute and deliver to the Participating Employer the customary form of loan receipt upon receiving an advance of funds in respect of the benefits paid in the treatment of such accidental bodily injury, and shall subrogate the Participating Employer to, or shall hold in trust for the Participating Employer, all such rights of action to the extent of the amount paid or advanced.

In the event of any direct conflict between this Section and the subrogation provisions in materials of any Program, the subrogation provisions in the Program shall control.

In addition, the Participant shall permit suit to be brought in the Participant's name under the direction of, and at the expense of, the Participating Employer. Advancement of any monies shall be contingent upon the receipt of a signed and dated subrogation agreement by the Plan Administrator (or its delegate).

(b) **Subrogation Rights Not Affected By Payment:** The Plan's subrogation rights shall not be affected if benefits are paid before the Participating Employer obtains any additional agreement from the Eligible Employee (or from any other payee). The failure or refusal of an Eligible Employee (or other payee, if applicable) to sign an agreement at the request of the Participating Employer recognizing the Plan's subrogation rights shall result in a forfeiture of all benefits payable to that Eligible Employee (or other payee), even if such benefits have already been paid, and the Company shall retain a right to recover paid benefits which are forfeited in such a manner.

(c) **Lien on Proceeds:** The Company, on behalf of the Plan, shall have a lien against the proceeds of any settlement, award or judgment which results from a claim or lawsuit by, or on behalf of, an Eligible Employee who received benefits under the Plan that were paid from the general assets of a Participating Employer. Notice of the lien is sufficient to establish the Plan's lien against the third party or insurance carrier. The Company shall be entitled to deduct the amount of the lien from any future claims payable to or on behalf of the Eligible Employee if:

- (i) The lien is not repaid or otherwise recovered by the Company; or
- (ii) The Eligible Employee or other claimant fails to promptly notify the Participating Employer of a payment received from a third party or insurance carrier that is subject to the Plan's subrogation rights.

(d) **Recovery From Third Party:** In the event that the Participating Employer obtains a recovery against a third party in excess of payments made to or on behalf of the Participant and reasonable out of pocket expenses of the recovery, then the Participating Employer shall pay over to the Participant that excess amount recovered by the Participating Employer.

(e) **No Assignment to a Third Party:** This Section 7.03 provides subrogation rights to the Plan Administrator and the Participating Employers only. Except as otherwise set forth in the Programs, other third parties, including insurers, have no subrogation rights under the Plan.

7.04 Right to Receive and Release Necessary Information For the purpose of determining the applicability and implementation of the terms of the Plan and to the extent permitted by law, the Plan Administrator (or its delegate) may, without the consent of or notice to any person, release or obtain from any other organization or person any information with respect to any person that it deems to be necessary or desirable for these purposes. Any person claiming benefits under the Plan shall furnish to the Plan Administrator (or its delegate) any information requested to implement the Plan or the relevant Program.

7.05 Notice of Address Each person entitled to benefits under one or more Programs must file with the Company or the appropriate Participating Employer, in writing, his/her mailing address and each change of mailing address. Any communication, statement or notice addressed to such person at such address shall be deemed sufficient for all purposes of the Plan, and there shall be no obligation on the part of the Company, the Plan Administrator (or its delegate), or any insurer to search for or to ascertain the location of such person.

ARTICLE 8.

GOVERNING TERMS AND APPLICABLE LAW

8.01 Severability If any provision of the Plan is held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions hereof shall continue to be fully effective.

8.02 Conflicts of Terms In the event of a conflict of terms between an insurance company contract or other provider contract providing for benefits under the Plan and the Plan document (including the Programs referred to in Schedule B), the Plan document shall govern. However, notwithstanding the terms of the insurance company contract or other provider contract, no individual who is neither an Eligible Employee or a Dependent (as defined under Sections 3.05 and 3.06 of the Plan) shall be eligible for benefits.

8.03 Corporate Actions Any action required to be taken by the Company or a Participating Employer under the Plan may be taken by any officer of the Company or a Participating Employer acting under authority of the board of directors, as constituted from time to time, or comparable governing body charged with management of the organization, unless otherwise specified or delegated.

8.04 Prohibition of Discrimination Any discretionary acts to be taken under the terms and provisions of the Plan by the Plan Administrator shall be uniform in their nature and in their application to all those similarly situated, and no discretionary acts shall be taken that would be discriminatory under the provisions of the IRC relating from time to time to welfare plans.

8.05 Titles and Headings The titles and headings of the sections and articles of this instrument appear for convenience of reference only, and in the case of any conflicts, the text of this instrument, rather than the titles or headings, shall control.

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

8.07 Application of State Law The Plan shall be administered, construed, and enforced according to the laws of the Commonwealth of Pennsylvania and in courts situated in that Commonwealth, except as preempted by ERISA.

8.08 Plan and Programs Wherever the Plan refers to the eligibility, coverage or benefits of the Plan, it shall be construed as referring to the eligibility, coverage and benefits of the particular Program to which the eligibility, coverage or benefit applies.

ARTICLE 9.

SECTION 125 PROGRAM

9.01 Section 125 Benefits

(a) **Purpose of Section 125 Program:** The Brubacher Excavating, Inc. Section 125 Program (referred to as the “Cafeteria Plan”) is intended to qualify as a “cafeteria plan” within the meaning of the Code Section 125 so that certain benefits which a Participant elects to receive under the Plan will be eligible for exclusion from the Participant’s income for federal and state income tax purposes.

(b) **Documentation for Cafeteria Plan:** The Cafeteria Plan is described in a separate document (“Cafeteria Plan Documentation”). Such document shall cover eligible individuals as of their enrollment. The provisions, limitations, and conditions of the Cafeteria Plan Documentation shall govern the Cafeteria Plan, including which individuals are eligible for the described benefits. Said Documentation shall contain such provisions as the Company deems appropriate, and shall be amended, discontinued, or replaced by the Company as deemed appropriate.

ARTICLE 10.
HIPAA PRIVACY: COMPANY AND OTHER DISCLOSURES
OF PROTECTED HEALTH INFORMATION

10.01 Introduction The Plan recognizes that it is a group health plan which qualifies it as a Covered Entity under the HIPAA Privacy Provisions.

10.02 Definitions For purposes of this Section, the following terms have the definitions set forth below:

(a) **“HIPAA Privacy Provisions” or “HIPAA”** The federal law commonly known as the Health Insurance Portability and Accountability Act of 1996, 45 C.F.R., Parts 160 through 164, as amended.

(b) **“Plan Administration Functions”** These are activities listed under the definitions of Payment or Health Care Operations as defined by HIPAA § 164.501, but do not include functions to modify, amend, or terminate the Covered Health Plan or solicit bids from prospective issuers. Covered Health Plan Administration Functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans. Plan Administration Functions do not include any employment-related functions or functions in connection with any other benefits or benefit plans, and the Covered Health Plan may not disclose information for such purposes absent an authorization from an individual for whom the information pertains. In addition, enrollment functions performed by the Company are not considered Plan Administration Functions.

(c) **“PHI” or “Protected Health Information”** Information that is created or received by a health plan, employer, health care provider, or health care clearinghouse and includes information that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual. In addition, either the information must identify the individual, or there must be a reasonable basis to believe the information can be used to identify the individual. This information may be maintained or transmitted either electronically or in any other form or medium.

(d) **“Privacy Policy”** This is the HIPAA Privacy Policies and Procedures for the Covered Health Plan under the Brubacher Excavating, Inc. Welfare Benefit Plan, including any amendments or modifications thereto as may be approved by the Plan Administrator, the HIPAA privacy official or any other authorized person.

(e) **“Summary Health Information”** This is information that may be individually identifiable health information, and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Company has provided health benefits under the Covered Health Plan; and from which the following information has been deleted, except that the geographic information described in subsection (ii) below need only be aggregated to the level of a five digit zip code:

(i) Names;

(ii) All geographic subdivisions smaller than a State, including street address, city, county, precinct, zip code, and their equivalent geocodes, except for the initial three digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

- The geographic unit formed by combining all zip codes with the same three initial digits contains more than 20,000 people; and
- The initial three digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

(iii) All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

- (iv) Telephone numbers;
- (v) Fax numbers;
- (vi) Electronic mail addresses;
- (vii) Social security numbers;
- (viii) Medical record numbers;
- (ix) Health plan beneficiary numbers;
- (x) Account numbers;
- (xi) Certificate/license numbers;
- (xii) Vehicle identifiers and serial numbers, including license plate numbers;
- (xiii) Device identifiers and serial numbers;
- (xiv) Web Universal Resource Locators (URLs);
- (xv) Biometric identifiers, including finger and voice prints;
- (xvi) Full face photographic images and any comparable images; and
- (xvii) Any other unique identifying number, characteristic or code.

10.03 Disclosure of Summary Health Information to the Company In accordance with the HIPAA Privacy Provisions, the Covered Health Plan may disclose Summary Health

Information to the Company, if the Company requests the Summary Health Information for the purpose of:

- (a) Obtaining premium bids from health plans for providing health insurance coverage under the Covered Health Plan; or
- (b) Modifying, amending or terminating the Covered Health Plan.

10.04 Disclosure of Certain Enrollment Information to the CompanyPursuant to HIPAA §164.504(f)(1)(iii), the Covered Health Plan may disclose to the Company information on whether an individual is participating in the Covered Health Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Covered Health Plan to the Company.

10.05 Disclosure of PHI to Obtain Stop-loss or Excess Loss CoverageThe Company hereby authorizes and directs the Covered Health Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Covered Health Plan. Such disclosures shall be made in accordance with the HIPAA Privacy Provisions. In addition, to the extent allowable under the HIPAA Privacy Provisions, the Covered Health Plan may disclose this information to the Company for purposes of Plan Administration Functions.

10.06 Other Disclosures of Protected Health Information (“PHI”) to the Company for Plan Administration FunctionsIn order that the Company may receive and use PHI for Plan Administration Functions other than those set forth above, the Company agrees to:

- (a) Not use or further disclose PHI other than as permitted or required by the Covered Health Plan Document or as Required by Law (as defined in the HIPAA Privacy);
- (b) Ensure that any agents, including a subcontractor, to whom the Company provides PHI received from the Covered Health Plan agree to the same restrictions and conditions that apply to the Company with respect to such PHI and agree to implement reasonable and appropriate security measures to protect electronic PHI;
- (c) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company, except pursuant to an authorization which meets the requirements of the HIPAA Privacy Provisions;
- (d) Report to the Covered Health Plan any security incident or any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for and of which the Company becomes aware;
- (e) Make available PHI to the appropriate individual where approved by the Covered Health Plan and requested by a Participant in accordance with HIPAA §164.524 and consistent with the Privacy Policy;

(f) Make available PHI for amendment or incorporation of amendments by a Participant where approved by the Covered Health Plan and requested by a Participant in accordance with HIPAA §164.526 and consistent with the Privacy Policy;

(g) Make available the information required to provide an accounting of disclosures by the Company, where approved by the Covered Health Plan and requested by the Participant in accordance with the rights and administrative requirements of HIPAA §164.528 and consistent with the Privacy Policy;

(h) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Covered Health Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Covered Health Plan with Part 164, Subpart E, of the HIPAA Privacy Provisions;

(i) If feasible, return or destroy all PHI received from the Covered Health Plan that the Company still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

(j) Ensure that adequate separation between the Covered Health Plan and the Company, as required in HIPAA §164.504(f)(2)(iii), is established as follows:

(i) The following employees, or classes of employees, or other persons under control of the Company, shall be given access to the PHI to be disclosed:

Human Resources Director
HR Department Staff
IT Personnel
Plan Auditor
Payroll Staff
Finance Department

(ii) The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration Functions that the Company performs for the Covered Health Plan.

(iii) In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Covered Health Plan’s documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, reassignment of duties and discharge), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

(iv) The adequate separation will be supported by reasonable and appropriate security measures.

(k) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan as required under the Security Standards for the Protection of Electronic Protected Health Information by HIPAA §164.300 et.al.

10.07 Certification of AmendmentThe Covered Health Plan shall disclose PHI to the Company only upon receipt of a certification by the Company that:

(a) The Covered Health Plan's documents have been amended to incorporate the above provisions; and

(b) The Company agrees to comply with such provisions.

10.08 Other Disclosures and Uses of PHIAll other required and permitted uses and disclosures of PHI to the Company or other individual or entity are set forth and governed by the provisions of the Privacy Policy.

ARTICLE 11.

STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (“ERISA”). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits.

You have a right to:

Examine, without charge, at the Plan Administrator’s office and at other work locations, all Plan documents, including insurance contracts, collective bargaining agreements (if any) and copies of all documents filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as annual reports and Plan descriptions.

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

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

Continue Group Health Plan Coverage.

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the health provisions of the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate 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 the Company, a labor 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 is denied 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 make a written request for materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to a \$110.00 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may seek a review of the matter with the Plan Administrator. If your claim is still denied upon review, you may file suit in the appropriate court.

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

Assistance with Your Questions.

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

In Witness Whereof, we have set our hands and seal on this ____ day of _____, _____ to be effective as of November 1, 2022.

BRUBACHER EXCAVATING, INC.

By: _____

SCHEDULE A

PARTICIPATING EMPLOYERS

Brubacher Excavating, Inc.
M³ Explo LLC

SCHEDULE B

ADDITIONAL GENERAL INFORMATION ABOUT THE PLAN

Type of Plan:	Welfare plan providing medical/prescription drug, dental, vision, accidental death and dismemberment and group term life
Funding Medium and Type of Plan Administration:	Benefits under the Plan are funded through insurance contracts, or through self-funding from the general assets of the Plan Sponsor or through a trust. The Medical Program includes coverage that is self-funded by the Employer through the Brubacher Excavating, Inc. Medical Plan Trust. Employees also contribute to the cost of medical coverage with pre-tax and after-tax payroll deductions. The Basic Group Term Life Program, Voluntary Life Program, Long Term Disability Program, Dental Program, AD&D Program and Short Term Disability Program are fully insured by New York Life Insurance Company.. The Vision Program is fully insured by National Vision Administrators, LLC. The insurance companies, not the Employer, are responsible for paying claims with respect to these fully insured programs. The Company and the insurance companies share responsibility for administering these program benefits. Insurance premiums for employees and their eligible family members for insured benefits are paid in part by the Employer out of its general assets, and in part by employees' pre-tax and after-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and upon request. Employees may also participate in an Employee Assistance Program, which is administered through Personal Assistance Services (PAS), and paid by the Employer from its general assets; and a Wellness Program, which is administered and paid by the Employer.
Insurance Companies:	The Guardian Life Insurance Company National Vision Administrators, LLC
Third Party Administrators:	Medical: Allied Benefit Systems, LLC

COBRA:
Isolved, Inc.

Employee Assistance Program:
Personal Assistance Service

See the Benefits Booklets and Benefits Summaries for the addresses, phone numbers and websites of the insurance companies and Third Party Administrators.

SCHEDULE C

EMPLOYEE COSTS

Medical	Set by Company each year
Basic Group Term Life	100% paid by Company
Dental	100% paid by Participant
Voluntary Life	100% paid by Participant
Vision	100% paid by Participant
Long Term Disability	100% paid by Participant
Short Term Disability	100% paid by Company
AD&D Program	100% paid by Company
Wellness	100% paid by Company
Employee Assistance Program	100% paid by Company
LegalShield	100% paid by Employee

The specific costs for each Program will be provided each year during open enrollment.

SCHEDULE E

SCHEDULE D ELIGIBILITY CRITERIA*

Summary of Eligibility and Participation Provisions	Who Is Eligible and When Participation Begins (subject to enrollment within the required period of time)	When Coverage Ends
Medical	Employee eligibility and termination information for medical benefits are set forth in the <i>Brubacher Excavating Policy for Determining Eligibility for and Termination of Health Plan Coverage</i> , which is attached to and incorporated into the Summary Plan Description as Schedule E. Coverage for new Employees who are reasonably expected to work an average of 30 hours per week begins sixty (60) days after date of hire.	Coverage ends on the date employment is terminated (except to the extent COBRA is elected)
Basic Group Term Life	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins on hire date.	Coverage ends on the date employment is terminated.
Dental	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins sixty (60) Days after hire date. The Company founder and spouse shall also be eligible for coverage under the Dental Program. Notwithstanding the foregoing, all full-time Employees will be eligible for coverage immediately upon returning to work following a temporary layoff.	Coverage ends on the date employment is terminated (except to the extent COBRA is elected)
Voluntary Life	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins sixty (60) Days after hire date.	Coverage ends on the date employment is terminated.
Vision	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins sixty (60) Days after hire date. The Company founder and spouse shall also be eligible for coverage under the Vision Program. Notwithstanding the foregoing, all full-time Employees will be eligible for coverage immediately upon returning to work following a temporary layoff.	Coverage ends on the date employment is terminated (except to the extent COBRA is elected) .

Summary of Eligibility and Participation Provisions	Who Is Eligible and When Participation Begins (subject to enrollment within the required period of time)	When Coverage Ends
Long Term Disability	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins sixty (60) Days after hire date.	Coverage ends on the date employment is terminated.
Short Term Disability	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins sixty (60) Days after hire date for non-executive employees.	Coverage ends on the date employment is terminated.
AD&D Program	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins on hire date.	Coverage ends on the date employment is terminated.
Wellness	Every Employee of the Company who is eligible for the Medical benefits and covered Spouses.	Coverage ends on the date the individual is no longer eligible for Medical benefits.
Employee Assistance Program	Administered through Personal Assistance Services (PAS) and is offered to every employee on the date of hire.	Coverage ends on the date employment is terminated (except to the extent COBRA is elected).
LegalShield	Every full-time Employee of the Company who is regularly scheduled to work at least thirty (30) hours per week. Coverage begins sixty (60) Days after hire date.	Coverage ends on the date employment is terminated.

See also Schedule E with respect to eligibility and termination of health benefits, and Schedule F with respect to continuation of benefits during absences from active work.

BRUBACHER EXCAVATING, INC.
POLICY FOR DETERMINING ELIGIBILITY FOR AND TERMINATION
OF HEALTH PLAN COVERAGE

PURPOSE

This Policy for Determining Eligibility for and Termination of Health Plan Coverage (the “Policy”) is adopted by the Employer in compliance with Internal Revenue Code § 4980H (the “Policy”) and sets forth the policy of Brubacher Excavating, Inc. (the “Employer”) for determining full-time employment status under Internal Revenue Code § 4980H. The Policy applies to the following benefits (the “Benefits”) that are offered to full-time employees under the Brubacher Excavating, Inc. Welfare Benefit Plan (the “Plan”): medical. The Policy is intended to set forth the methods by which the Employer will determine whether an Employee is a Full-Time Employee under Internal Revenue Code (“Code”) § 4980H for purposes of:

- (i) Meeting the Employer’s reporting obligations under Code § 6056; and
- (ii) Determining eligibility for the Benefits.

The Policy is also intended to describe the termination of coverage under the Benefits for Employees who are covered under the Plan, but who are no longer working due to disability or other leave of absence.

This Policy is part of, and incorporated by reference into, the Plan.

POLICY

An Employee who is determined by the Employer to be a Full-Time Employee during a Measurement Period shall be considered a Full-Time Employee during the corresponding Stability Period under Code § 6056. Unless otherwise excluded under the terms of the Health Plan, such Full-Time Employee will also have an opportunity to elect, change, or decline Health Plan coverage for himself or herself and his or her dependents during the related Administrative Period.

This Policy is intended to satisfy the regulations under Treasury Regulation § 54.4980H-3 (the “Rule”), will be interpreted consistently with the Rule, and will be revised to conform to changes that may be made by any subsequent guidance.

EFFECTIVE DATE

This Policy is effective November 1, 2022.

DEFINITIONS

Any capitalized terms in this Policy have the following meanings:

- **Administrative Period** – The period immediately following a Measurement Period during which the Employer identifies which Employees are Full-Time Employees and conducts enrollment under the Plan.
 - For a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee, the initial Administrative Period is 30 days.
 - For Ongoing Employees, the Administrative Period is the 45 day period immediately following the standard Measurement Period
- **Eligible Employee** – An Eligible Employee under the Plan is any Full-Time Employee and includes the following employees:
 - A newly hired employee who the Employer designates as Full Time;
 - A newly hired employee who the Employer reasonably expects to work an average 30 or more Hours of Service per week; or
 - An employee who averages 30 or more Hours of Service during the Initial Measurement Period or any Standard Measurement Period.
- **Employee** – A common law employee of the Employer.
- **Employment Break Period** – A period of at least thirteen consecutive weeks during which an Employee of the Employer is not credited with any Hours of Service. In addition, Employees who are not credited with an Hour of Service for a period of at least four weeks that is longer than the period of employment preceding the break will be considered to have an Employment Break Period. Such Employees will be treated as new Employees upon the resumption of their services for the Employer under this Policy.
- **Full-Time Employee** – An Employee who, when hired, is reasonably expected to work an average of 30 or more Hours of Service per week until the end of the first Standard Measurement Period during which the Employee worked the entire time; and an Employee who has worked an average of 30 hours per week during an Initial or Standard Measurement Period.
- **Health Benefit Plans** – the medical benefits offered under the Brubacher Excavating, Inc. Welfare Benefit Plan, which has been established and is maintained by the Employer, and amended from time to time.
- **Hour of Service** –
 - each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and
 - each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation,

holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b-2(a))

Notwithstanding the preceding, an Hour of Service shall not include any hour for services:

- performed as a bona fide volunteer; or
 - performed outside of the United States.
- **Initial Measurement Period** – The period used by the Employer to determine whether an Employee is a Full-Time Employee. The Initial Measurement Period is applied to new Variable Hour, Seasonal, and Part-Time Employees and is the Employee's first 12 months of employment. The Initial Measurement Period begins on the first day of the first payroll period beginning after the Employee's date of hire. At such time that a new Variable Hour, Seasonal, or Part-Time Employee has been employed for an entire Standard Measurement Period, he or she will be tested under that Standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees.
 - **Ongoing Employee** – An Employee who has been employed by the Employer for at least one complete Standard Measurement Period.
 - **Part-Time Employee** – A new Employee who the Employer reasonably expects to be employed on average less than 30 Hours of Service per week during the Initial Measurement Period, based on the facts and circumstances at the Employee's start date.
 - **Rehired Employee** - After an employee becomes covered under the Plan, if their employment ends and they are rehired by the Employer within 13 weeks after the termination date for purposes of the Affordable Care Act, coverage will take effect on the day the employee reports for employment with the Employer. If coverage resumes within the same Plan Year, the Plan will consider coverage continuously in force for purposes of applying the Deductible, Out-of-Pocket Maximum, and Plan maximums. If the employee was not covered under the Plan on the date of the termination or they are rehired by the Employer more than 13 weeks after the termination date, they will be treated as a new Employee.
 - **Seasonal Employee** – An Employee who is hired into a position for which the customary annual employment is six months or less. Customary annual employment means that by the nature of the position, an Employee in this position typically works for a period of six months or less, and that period begins each calendar year in approximately the same part of the year, such as summer or winter.
 - **Special Unpaid Leave** – Unpaid leave under the Family and Medical Leave Act and unpaid leave subject to the Uniformed Services Employment and Reemployment Rights Act.

- **Stability Period** – The period that follows, and is associated with, an Initial or Standard Measurement Period (and related Administrative Period) during which an Employee’s status as a Full-Time Employee (or not as a Full-Time Employee, as the case may be) will continue.
 - For a new Variable Hour, Seasonal, or Part-Time Employee, the Stability Period is the 12- month period following the Employee’s Initial Measurement Period and related Administrative Period. Thereafter, such Employee will have the same Stability Period as an Ongoing Employee.
 - For Ongoing Employees, the initial Stability Period is the 12-month period following the Standard Measurement Period and related Administrative Period. The initial Stability Period for Ongoing Employees begins each year on November 1st. There is a second Stability Period of May 1 – October 31 if an employee is not determined to be a Full-Time employee during the initial Measurement Period.
- **Standard Measurement Period** - For Ongoing Employees, the standard Measurement Period is the 6-month period that begins each year on March 15th and ends on September 14th . There is a second Measurement Period of September 15 – March 14 if an employee is not determined to be a Full-Time employee during the initial Measurement Period.
- **Variable Hour Employee** – A new Employee for whom, based on the facts and circumstances at the Employee’s hire date, the Employer cannot determine whether the Employee is reasonably expected to be employed on average at least 30 Hours of Service per week during the initial Measurement Period because the Employee’s hours are variable or otherwise uncertain.
- **Waiting Period** – The period of time that must elapse before coverage begins for an otherwise eligible individual. Generally, medical coverage for newly hired full time employees will begin on the 60th day of employment.

PROCEDURES FOR COUNTING AND CREDITING HOURS OF SERVICE

- **Hourly Employees** – The Employer will calculate actual Hours of Service from records of hours worked and hours for which payment is made or due for all Employees who are paid by the Employer on an hourly basis.
- **Salaried Employees** – The Employer will calculate Hours of Service for salaried employees using an equivalency rather than tracking and calculating actual hours worked. This means that for each day worked a salaried employee will be credited with 8 hours.
- **Counting Hours for Ongoing Employees**
 - An Ongoing Employee is a Full-Time Employee for a Stability Period if, during the preceding Standard Measurement Period, the Ongoing Employee was credited with an average of 30 or more Hours of Service

per week. Unless otherwise excluded under the terms of the Benefit Plans, such Full-Time Employee will have an opportunity to elect, change, or decline coverage for himself or herself and his or her dependents during the related Administrative Period.

- An Ongoing Employee who is not credited with at least 30 Hours of Service per week over a Standard Measurement Period is not a Full-Time Employee for the subsequent Stability Period (unless the Ongoing Employee is determined to work an average of 30 or more hours per week during a second 6-month period from September 15th through March 14th). If an Ongoing Employee is determined to be Full-Time based on this second Standard Measurement Period, the Employee will be offered coverage to begin on May 1st.

- **Counting Hours for New Full-Time Employees**

- A new Employee who is reasonably expected at the Employee's start date to work an average of 30 or more Hours of Service per week (and who is not a Variable Hour, Part-Time, or Seasonal Employee) will be eligible for coverage in the Benefit Plans on the first day of the calendar month after the Waiting Period.
- If a new Employee who is reasonably expected at the Employee's start date to work 30 or more Hours of Service per week changes employment status before the Employee has completed a full Standard Measurement Period, the Employee will no longer be eligible for coverage as of the first day of the month following the change. If the Employee's Hours of Service increase again before the end of the first Standard Measurement Period during which the Employee worked for the Employer during the entire period, the Employee will become eligible again and will be offered coverage.

- **Counting Hours for New Variable Hour Employees, Seasonal Employees, and Part-Time Employees**

- New Variable Hour, Seasonal, and Part-Time Employees will be tested under an Initial Measurement Period to determine whether they are Full-Time Employees.
- A new Variable Hour, Seasonal, or Part-Time Employee who is credited with an average of at least 30 Hours of Service per week over his or her Initial Measurement Period will be a Full-Time Employee for his or her initial Stability Period. Such Employee will have an opportunity to elect Plan coverage for himself or herself and his or her dependents (if dependent coverage is available for the Benefit) during the related initial Administrative Period.

- A new Variable Hour Employee, Seasonal Employee, or Part-Time Employee who is not credited with an average of at least 30 Hours of Service per week over his or her Initial Measurement Period will not be a Full-Time Employee for his or her initial Stability Period.
- At such time that a new Variable Hour Employee, Seasonal Employee, or Part-Time Employee has been employed for an entire Standard Measurement Period, he or she will be tested under that Standard Measurement Period at the same time and under the same conditions as apply to other Ongoing Employees. If the Employee was determined to not be a Full-Time Employee during the Initial Measurement Period, but is determined to be a Full-Time Employee during an overlapping Standard Measurement Period, coverage will be offered as of the first day of the Stability Period corresponding to the Standard Measurement Period. If the Employee was determined to be Full-Time during the Initial Measurement Period, he or she will remain eligible for coverage until the end of the corresponding initial Stability Period regardless of the results of the testing during the Standard Measurement Period.

For example: an Employee is hired on July 15, 2021 as a Variable Hour Employee. The employee's Initial Measurement Period starts on August 1, 2021 and ends on July 31, 2022. The Employee's initial Administrative Period Begins on August 1, 2022 and coverage will be offered to be effective on September 1, 2022 if the Employee is determined to have worked or been paid for an average of 30 or more hours per week during the Initial Measurement Period.

- If a new Variable Hour, Seasonal, or Part-Time Employee materially changes employment status before the end of the Initial Measurement Period in such a way that, if the Employee had begun employment in the new position, the Employee would have reasonably been expected to work 30 or more hours per week, the Employer will treat the Employee as a Full-Time Employee on the first day of the fourth month following the change in employment status or, if earlier and the Employee averages more than 30 Hours of Service per week during the Initial Measurement Period, the first day of the first month following the end of the Initial Measurement Period and related Administrative Period.

For example: an Employee is hired on July 15, 2022 as a Variable Hour Employee. The employee's Initial Measurement Period starts on August 1, 2022 and ends on July 31, 2023. The Employee's initial Administrative Period Begins on August 1, 2023 and coverage will be offered to be effective on September 1, 2023 if the Employee is credited with an average of 30 or more hours per week during the Initial Measurement Period. On March 6, 2023, the Employee accepts a full-time position. Because of this change in status, the Employee will be offered coverage that will become effective as of July 1, 2023.

SPECIAL RULES

- **Factors for Determining Employee Status** – For purposes of determining whether an Employee is reasonably expected at his or her start date to be a Full-Time Employee (who is not a Seasonal Employee), a Part-Time Employee, or a Variable Hour Employee, the Employer will consider all of the facts and circumstances, including the following factors:
 - whether the Employee is replacing an Employee who was (or was not) a Full-Time Employee or a Variable Hour Employee;
 - the extent to which other Employee in the same or comparable positions are considered Full-Time Employees; and
 - whether the position was advertised, or otherwise communicated to the new Employee or otherwise documented (for example, through a contract or job description), as requiring 30 or more Hours of Service per week, less than 30 Hours of Service per week, or may vary above and below an average of 30 Hours of Service per week.

No single factor is determinative. In determining an Employee's status, the Employer will not take into account the likelihood that the Employee may terminate employment with the Employer before the end of an Initial Measurement Period, or the potential for, or likelihood of, an Employment Break Period in determining the Employer's expectation of future Hours of Service.

- **Use of Payroll Periods** - For purposes of measuring the beginning and end of a Measurement Period with respect to Employees who are paid on a weekly, bi-weekly, or semi-monthly basis, the Employer will treat as a Measurement Period a period that:
 - (i) Begins on the first day of the weekly, bi-weekly, or semi-monthly payroll period, as applicable, that follows the payroll period that includes the date that would otherwise be the first day of the Measurement Period, and
 - (ii) Ends on the last day of the weekly, bi-weekly, or semi-monthly payroll period, as applicable, that includes the date that would otherwise be the last day of the Measurement Period.

This special rule does not apply with respect to Employees who are paid on a monthly basis.

- **Exclusion of Special Unpaid Leave.** The Employer will determine an Employee's average Hours of Service for an Initial or Standard Measurement Period by (i) computing the average after excluding any Special Unpaid Leave during that Measurement Period and (ii) by using that average as the average for the entire Measurement Period.
- **Employment Break Periods.** Employees who have an Employment Break Period will be considered a New Employee upon returning to work. If the Employee is hired into a Full-

Time position, the Employee will be offered coverage that will become effective at the end of the Waiting Period. If the Employee is hired to work in a Part-Time, Variable Hour or Seasonal position, an Initial Measurement Period may be applied.

- **Material Changes in Employment Status**

- (i) If an ongoing Employee was a Full-Time Employee and was offered minimum value coverage from the date of hire, and that Employee experiences a material change in employment status to a position that is part-time, variable hour, or seasonal, the Employer will begin to determine the Employee's eligibility on a monthly basis beginning on the first day of the fourth month following the change in status.
- (ii) If an ongoing Variable Hour, Seasonal, or Part-Time Hourly Employee experiences a material change in employment status before the end of a Measurement Period in such a way that, if the Employee had begun employment in the new position, the Employee would have been classified as Full-Time and would have satisfied the Waiting Period, the Employer will designate the Employee as a Full-Time Employee on the date of the change in status, or if earlier and the Employee averages more than 30 Hours of Service per week during a Measurement Period, the first day of the first month following the end of the next applicable Stability Period.

TERMINATION OF COVERAGE FOR EMPLOYEES ON LEAVE OF ABSENCE

When an Employee is no longer actively working due to a disability or other leave of absence, coverage will continue as described in Schedule F. At any time that the Employee's employment terminates, coverage will terminate immediately following the termination of employment. If the Employee is in a Stability Period during reduction in hours, remains employed and continues to have Hours of Service, was eligible for and enrolled in coverage, the coverage will not terminate until the end of the Stability Period.

If the Stability Period ends during the leave of absence and the Employee is no longer eligible for coverage due to the average hours worked during the Measurement Period, coverage will continue beyond the end of the Stability Period as required by the Family and Medical Leave Act (the "FMLA"), to the extent that the leave is covered by the FMLA.

In addition, if the Employee was determined to work an average of 30 or more hours per week during the prior Standard Measurement Period, the Employee will be offered coverage during open enrollment and may continue to be covered by the Plan until his or her employment terminates.

For example: An employee has been working for the Employer as a Full-Time Employee for the last 7 years. On September 15th, the employee begins a medical leave of absence that is covered by the FMLA. The FMLA leave is not expected to end until December 10th. During open enrollment in November, the Employee is offered coverage to begin on December 1st because

the Employee worked an average of 40 hours during the prior Measurement Period. The employee enrolls. A new Stability Period begins on December 1st. If the Employee does not return to work at the end of the FMLA period or notifies the Employer of his or her intent not to return to work, his or her employment may be terminated, at which time coverage under the Benefits will also terminate.

If instead, the Employee had been a Variable Hour Employee who began a non-FMLA covered leave on September 15th, the Employer would not have to offer coverage to the Employee during the open enrollment period if the Employee did not work or get paid for an average of 30 hours per week during the prior Standard Measurement Period.

ADMINISTRATION, REVIEW AND AMENDMENT OF POLICY

The Employer will administer Measurement Periods for new and Ongoing Employees, determine whether an Employee meets the qualifications to be a Full-Time Employee during Administrative Periods, and offer coverage under the Plan during Stability Periods to Eligible Employees determined to be Full-Time Employees, all in accordance with this Policy and the terms of the Brubacher Excavating, Inc. Welfare Benefit Plan. The Employer has full and absolute discretionary authority to interpret the terms of this Policy to determine whether its Eligible Employees are Full-Time Employees.

The Employer will periodically review this Policy for compliance under applicable regulations and other guidance. The Employer has the right, in its sole and absolute discretion, to revise this Policy at any time to ensure legal compliance and to further the goals of the Employer.

SCHEDULE F

BRUBACHER EXCAVATING, INC. BENEFIT CONTINUATION POLICY

POLICY

The following Policy describes situations during which coverage for specified benefits will continue under certain defined conditions.

EFFECTIVE DATE

This Policy is effective November 1, 2022 and amended December 1, 2024.

TEMPORARY LAYOFF

When notified of a temporary layoff, employees will have the option to continue benefits or terminate benefits during that layoff period. Employees who choose to terminate benefits during the layoff (other than basic life, which will be paid by the employer and short term disability which will automatically terminate), will have their benefits reinstated immediately upon return to work. Continued coverage for employees who choose not to terminate their benefits will continue as follows:

- Basic Life/AD&D Insurance – Benefits will continue for up to 4 months; during this time, Brubacher will continue to pay the monthly premium.
- Voluntary Life/AD&D Insurance will be treated as active employees for up to 4 months. During this time, the employees will be required to pay their premium contributions or use credits obtained from medical contributions as described below.
- Short Term Disability – Coverage will end on the temporary layoff effective date. Upon the return to work date, coverage will be reinstated immediately.
- Long Term Disability – Coverage may continue for up to 1 month. During this time, employees will be required to pay their premium contributions.
- Dental – Employees will be treated as active employees for up to 4 months. During this time, employees will be required to pay their premium contributions or use credits obtained from medical contributions as described below. Following the layoff, if the employees do not return to work, dental benefits will terminate and Brubacher will offer COBRA.
- Vision - Employees will be treated as active employees for up to 4 months. During this time, the employees will be required to pay their premium contributions or use credits obtained from medical contributions as described below. Following the layoff, if the employee does not return to work, medical benefits will terminate and Brubacher will offer COBRA.
- Medical - Employees will be treated as active employees for up to 4 months. During this time, the employees will be required to pay their premium contributions or will be credited with the payment amount if they work less than an average of 20 hours per week over the prior 4 weeks as calculated on the first day of each month.

This calculation and credit is available only for the first quarter – January through March and will be calculated on February 1st, March 1st and April 1st. This credit will be applied to contributions due for all benefits. Following the layoff, if the employee does not return to work, medical benefits will terminate and Brubacher will offer COBRA.

PAYMENTS DURING TEMPORARY LAYOFF

- During temporary layoff, payment for contributions is due each week in the amount that would have been deducted from pay. There is a 4-week grace period to make these payments.
- If the employee works any hours during the temporary layoff, contributions will be deducted from that pay.
- If the employee receives a credit towards the payment for contributions that credit will be applied to the weekly payments starting with the oldest due date.
- Benefits will be terminated only if a payment is not paid or credited within 4 weeks of when it was due.

SHORT TERM DISABILITY

Brubacher will continue all coverage for up to 6 months from date of disability according to the same contribution schedule as would apply during active employment. Employees will be required to continue making their regular contributions towards benefits during the leave period and should make payment arrangements with Brubacher prior to beginning leave or as soon as possible thereafter. After 6 months of leave, all benefits will be terminated and COBRA will be offered for applicable benefits.

PERSONAL LEAVE OF ABSENCE

Brubacher will continue all coverage for up to 30 days from the commencement date of an approved personal leave of absence according to the same contribution schedule as would apply during active employment. Employees will be required to continue making their regular contributions towards benefits during the leave period and should make payment arrangements with Brubacher prior to beginning leave or as soon as possible thereafter. After 30 days of leave, benefits will be terminated and COBRA will be offered for applicable benefits.

FMLA

Benefits will be continued during FMLA leave as required by law.

COVERAGE FOR PART TIME TO FULL TIME

Upon a change in status from part-time to full-time, coverage will be effective immediately. If an employee had continuous service since the date of hire, Brubacher will credit the employee's prior service towards the applicable eligibility waiting period.

TEMPORARY TO FULL TIME

Upon a change in status from temporary to full-time, Brubacher will credit prior service and benefits will be effective immediately if the employee has satisfied the applicable waiting period. The temporary service date will be used for eligibility.

FULL TIME REDUCED HOURS

Upon a reduction of working hours for a Full Time Employee, Brubacher is in compliance with Internal Revenue Code § 4980H (the "Policy"). This allows a member to remain enrolled in The Plan through the end of the current Stability Period , as long as the Employee remains employed and continues to have Hours of Service, was eligible and enrolled in coverage, and pays the required premium amounts. There is a 4-week grace period to make these payments before coverage is terminated and COBRA offered.

MILITARY

Refer to the Company's Military Leave Policy for more information.