TRICO COMPANIES, LLC

HEALTH REIMBURSEMENT ARRANGEMENT (HRA) PLAN DOCUMENT

Effective January 01, 2022

TRICO COMPANIES, LLC
HEALTH REIMBURSEMENT ARRANGEMENT
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TRICO COMPANIES, LLC
HEALTH REIMBURSEMENT ARRANGEMENT

TRICO Companies, LLC (the "Employer") hereby sets forth the TRICO Companies, LLC Health Reimbursement Arrangement (the "Plan"), as in effect January 01, 2022.

ARTICLE I

Purpose

The purpose of this Plan is to reimburse Participants for certain Medical Care Expenses, which are covered under the Employer's Group Health Plan but are under the Group Health Plan's deductible limit or are required as co-payments, on a nontaxable basis. "Medical Care Expenses" include dental and vision care expenses, as defined in Code Section 213(d). This Plan is funded solely by the Employer and reimburses qualified Medical Care expenses of a Participant and his or her Dependents, up to a maximum amount established by the Employer. Amounts remaining at the end of the year may be available to reimburse Medical Care expenses incurred during future years, and may be subject to any Employer-imposed cap, if applicable. The Plan is offeredas a supplement to the Employer's primary Group Health Plan coverage, which includes dental and vision benefits. A Participant must be enrolled in the Employer's non-HRA Group Health Plan, or another non-HRA Group Health Plan that otherwise meets the applicable federal integration requirements under the ACA, as a condition of participating in this Plan.

This Plan is intended to qualify as a Health Reimbursement Arrangement as defined by IRS Notice 2002-45, and as an employer-provided medical reimbursement plan under Sections 105 and 106 of the Internal Revenue Code of 1986, as amended ("the Code"), and the regulations issued thereunder.

ARTICLE II

Definitions

2.1 "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended from time to time.

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

2.3 "Dependent" means an Employee's Spouse (as defined in Section 2.17) and the Employee's child(ren) if under age 27 as of the end of the taxable year (or such other age as determined by the Plan Administrator and permitted by applicable law).

2.4 "Eligible Employee" means any person providing services to the Employer as a common-law employee, who is expected to work at least 30 hours per week and who either: (i) is enrolled in the Employer's Group Health Plan; or (ii) has non-HRA Group Health Plan coverage that otherwise meets the applicable federal integration requirements under the ACA. Non-resident aliens, independent contractors (even if re-characterized by the Internal Revenue Service

as employees), leased employees within the meaning of Sections 414(n)(2) and 414(o)(2) of the Code, and individuals designated by the Employer or Participating Employer as temporary employees shall not be Eligible Employees for purposes of this Plan.

2.5 "Employer" means TRICO Companies, LLC, and any entity which succeeds to the business and assumes the obligations of the Employer.

2.6 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

2.7 "Group Health Plan" means a group health plan which meets the rules contained in the ACA for integration with a health reimbursement account.

2.8 "HRA Account" means an account maintained on the books of the Employer for each Participant for the purpose of recording the Health Reimbursement Account credits and Health Reimbursement Account benefits of the Participant.

2.9 "Highly Compensated Participant" means a Participant who is described in Section 105(h)(5) of the Code.

2.10 "Medical Care" means medical care as defined in Code Section 213(d), which includes amounts incurred by the Participant, Spouse or Dependent(s) for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body; for transportation primarily for and essential to Medical Care; and for health insurance co-pays and deductibles.

However, Medical Care shall not include individual health insurance premiums for major medical coverage; or medical care expenses that have already been reimbursed, or are eligible to be reimbursed, by insurance or otherwise, among other exclusions. For expenses incurred prior to Jan. 1, 2020, Medical Care shall not include expenses incurred for any medicine or drug (other than insulin) that is not "prescribed" within the meaning of Code Section 106(f).

2.11 "Participant" means an Eligible Employee who has satisfied the requirements of Article III; and whose participation has not terminated under Article III, Section 3.4.

2.12 "Participating Employer" means any member of the following group including the Employer, if such member adopts the Plan with the Employer's authorization as provided in Article XI, Section 11.1 and meets the definition of an Employer as described in Section 2.5: (i) a controlled group of corporations, within the meaning of Section 414(b) of the Code; (ii) a group of trades or businesses under common control, within the meaning of Section 414(c) of the Code; (iii) an affiliated service group, within the meaning of Section 414(m) of the Code; or (iv) a trade or business required to be aggregated pursuant to Section 414(o) of the Code. Each Participating Employer is identified in Appendix A. The Employer shall amend Appendix A as needed to reflect a Participating Employer's adoption of or withdrawal from the Plan without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized

officer or representative of the Employer and shall not require approval of the Board of Directors.

2.13 "Period of Coverage" means the Plan Year; provided, however, that with respect to a Participant who commences participation after the beginning of the Plan Year, the initial Period of Coverage shall run from the effective date of the Participant's coverage to the end of that Plan Year.

2.14 "Plan" means this TRICO Companies, LLC Health Reimbursement Account Plan as set forth herein and as amended from time to time.

2.15 "Plan Administrator" means the Employer or such other individual, committee or firm as the Employer shall designate from time to time.

2.16 "Plan Year" means the twelve consecutive month period ending on December 31.

2.17 "Spouse" means an individual who is treated as a spouse under federal tax law.

ARTICLE III

Eligibility and Participation

3.1 Eligibility Requirements. All Eligible Employees, as defined in Article II, Section 2.4, are eligible to participate in the Plan.

3.2 Determination of Eligibility. The determination of eligibility to become and continue as a Participant in the Plan shall be made by the Plan Administrator from the Employer's records, and the Plan Administrator's determination shall be binding and conclusive upon all persons.

3.3 Enrollment. An Eligible Employee must properly complete any enrollment form required by the Plan Administrator to enroll in the Plan and commence participation in the Plan. Such enrollment form must be completed, executed, and returned to the Plan Administrator by the applicable deadline. Such coverage will be effective as soon as administratively possible after the completed enrollment form is received.

Notwithstanding the preceding sentence, if required by the Internal Revenue Service, each Eligible Employee must be given the opportunity to opt out of the Plan and waive future benefits at least annually and, upon termination of employment, to waive any future reimbursements from the Plan.

3.4 Termination of Participation. A Participant will cease to be a Participant in this Plan upon the earlier of the termination of the Plan or the date on which the Participant ceases to be an Eligible Employee (because of retirement, termination of employment, layoff, reduction in hours, or any other reason). However, Participation may continue beyond such date under generally applicable criteria determined in the sole discretion of the Plan Administrator.

3.5 Reimbursements After Termination. If a Participant terminates participation for any reason, including, without limitation, termination of employment, retirement, reduction of hours, death, disability or leave of absence, the Participant (or his or her estate) shall continue to be entitled to payment of HRA Account benefits for eligible Medical Care Expenses incurred during such Plan Year prior to the termination of participation if the Participant files a claim within 90 calendar days from the date he or she ceases to be a Participant. If any balance remains in the Participant's HRA Account after payment of all HRA Account benefits for which the Participant is entitled to payment under the preceding sentence, such remaining balance shall be forfeited by the Participant unless the Participant elects to continue coverage in accordance with Article VIII, Section 8.5.

ARTICLE IV

Accounts and Funding

4.1 HRA Account. Prior to the beginning of each Plan Year, the Employer shall, in its sole discretion, determine the amount it will credit to each Participant's HRA Account for the Plan Year. The amount shall be calculated for each Plan Year in a uniform and nondiscriminatory manner. Amounts credited to an HRA Account are available to pay eligible Medical Care Expenses. For purposes of reimbursement, the Plan Administrator reserves the right to define eligible Medical Care Expenses more narrowly, which may be outlined in a separate communication.

The amount credited by the Employer may vary year to year. This amount may be prorated by the Employer on a monthly basis or if a Participant is not employed by the Employer for the entire Plan Year.

All amounts credited to an HRA Account shall remain the property of the Employer until paid out pursuant to the Plan. In no event shall any interest or other income be allocated to an HRA Account. Amounts remaining at the end of the year may be available to reimburse Medical Care expenses incurred during future years, and may be subject to any Employer-imposed cap, if applicable.

The Plan Administrator will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account will merely be a recordkeeping account with the purpose of tracking contributions and available reimbursement amounts.

In no event shall benefits be provided other than for reimbursement for eligible Medical Care expenses.

4.2 Funding. The HRA Account shall be funded only by the Employer. Participants are not permitted to contribute to their accounts directly or via salary reduction agreement.

4.3 Reimbursement Limits. The Plan Administrator shall communicate to Participants any maximum dollar limit for reimbursements from the Participant's HRA Account.

Such amount may be changed at any time by the Plan Administrator, and any such changes shall be communicated to Participants.

Total reimbursements will also be limited to the amount currently credited to a Participant in his or her HRA Account. However, unreimbursed Medical Care Expenses may be paid with additional HRA Account credits made during the same Plan Year in which the Medical Care Expenses were incurred.

4.4 Highly Compensated Participants. Highly Compensated Participants shall be required to include in their gross incomes for federal income tax purposes HRA Account reimbursements that are excess reimbursements as defined in Section 105(h) of the Code if the Plan fails to satisfy the nondiscrimination requirements of Section 105(h) of the Code with respect to eligibility or benefits.

ARTICLE V

Claims Procedure

5.1 Expense Reimbursement Procedure. Reimbursement of Medical Care expenses shall be made in accordance with the following rules:

(a) To receive reimbursement for Medical Care expenses from his or her account, a Participant must submit a written application not later than 30 days following the end of the Plan Year in which such Medical Care expenses were incurred or billed to the Participant, in accordance with such rules, practices and procedures as the Plan Administrator may specify, in its discretion, for the reimbursement of Medical Care expenses from the Participant's account, including rules that do not invalidate an application that is submitted later than 30 days following the end of the Plan Year provided the application is filed as soon as reasonably possible.

(b) The Plan Administrator reserves the right to verify to its satisfaction all claimed Medical Care expenses prior to reimbursement. Each request for reimbursement shall include such substantiation as required by the Plan Administrator, which may include the following information:

(i) the name, Social Security number, and address of the employee;

(ii) the name and date of birth of the person for whom the Medical Care expense was incurred and, if such person is not the Participant requesting reimbursement, the relationship of the person to such Participant and a statement that such person is a Dependent of such Participant;

(iii) the name and address of the person, organization or other provider to whom the Medical Care expense was or is to be paid;

(iv) a written statement from an independent third party setting forth the type, purpose, date and amount of the Medical Care expense for which reimbursement is requested; and

(v) a statement that the Participant has not been reimbursed and that the Medical Care expense is not reimbursable by insurance or otherwise.

(c) The Plan Administrator may require the Participant to furnish a bill, receipt, canceled check, or other written evidence of obligation to pay Medical Care expenses. The Plan Administrator reserves the right to require the Participant to provide, to the Plan Administrator's satisfaction, further proof of any of the above-described information and other information reasonably necessary to determine the eligibility for and amount of any reimbursement from the Participant's account. The Plan Administrator may require the Participant to provide written authorization to obtain information from any group medical, HMO, dental, vision care, prescription drug, or other health benefit plans in which Participant or his or her Dependents are enrolled.

(d) Expenses eligible for coverage under any group medical, HMO, dental, vision care, prescription drug, or other health plans or insurance coverage in which the Participant or his or her Dependents are enrolled must be submitted first to all such plans or insurers in accordance with the rules of those plans or insurers, and be finally adjudicated under those plans or insurers, before submitting the expenses to the Employer for reimbursement under the Plan.

(e) Subject to applicable law, the Plan Administrator may establish such rules as it deems desirable regarding the frequency of reimbursement of Medical Care expenses and the minimum dollar amount that may be requested for reimbursement.

5.2 Claims for Reimbursement.

(a) In General. This Section is intended to comply with Department of Labor Regulations 2560.503-1 and 2590.715-2719, and shall apply specifically to claims under a group health plan as defined in Department of Labor Regulation 2560.503-1.

(b) Written Claim for Benefits. If a claimant asserts a right to any benefit under the Plan, the claimant must file a written claim for such benefit with the Plan Administrator (as defined in Section 2.15 of this plan document). For purposes of this Section, claimant shall mean any Participant, Spouse, Dependent, or Beneficiary or authorized representative who files a claim for benefits.

(c) Upon the denial of a claim, the Plan Administrator shall notify the claimant in writing of such denial within 30 days of receipt of the claim. The Plan Administrator shall be permitted one 15-day extension to the 30-day claim determination period, provided that the Plan Administrator determines that such extension is necessary due to matters beyond the Plan's control and notifies the claimant before the end of the initial 30-day period of the circumstances necessitating the extension of time and the date by which the Plan intends to

render a decision. If such extension is required due to the claimant's failure to submit all information necessary to decide the claim, the extension notification must specifically describe the required information and the claimant shall have 45 days from receipt of the notice to provide the requested information. Failure by the claimant to provide requested information shall result in the denial of the claim. A denial notice shall explain the reason(s) for denial, refer to the Section(s) of the Plan on which the denial is based, and provide the claim appeal procedures. The denial notice must also comply with any additional requirements described in Department of Labor Regulation 2590.715-2719.

(d) Appeal of Claim Denial.

(i) Any claimant shall have the right to appeal an "adverse benefit determination" as defined in Department of Labor Regulation 2590.715-2719 within 180 days of receipt of such adverse benefit determination. Any appeal shall be submitted to the Plan Administrator in writing. If the appeal relates to a claim for payment, the claimant's request should include: the patient's name and plan identification number; the date(s) of health care service(s); the provider's name; the reason(s) the claimant believes the claim should be paid; and any documentation or other written information to support the claimant's request for claim payment.

(ii) An appeal shall be determined by an individual who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of that individual. If the appeal is related to medical matters, the appeal shall be reviewed in consultation with an independent and impartial health care professional who has appropriate training and experience in the particular field of medicine in order to make the health care judgment and who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, independent and impartial medical experts as part of the appeal resolution process. The claimant consents to this referral and the sharing of pertinent health claim information. Upon request and free of charge the claimant has the right to reasonable access to and copies of, all documents, records, and other information relevant to the claimant's claim for benefits.

(iii) Upon being notified of an adverse determination under an appeal, the claimant shall be permitted, within 60 days of receiving notice of such determination, to submit notice of a "second-level appeal" to the Plan Administrator. A second-level appeal shall be decided in accordance with the rules in paragraph (ii).

(e) Timeframes for Appeals Determinations.

The Plan Administrator shall have 30 days, upon receiving notice of appeal (or second-level appeal) of the denial of benefits, to notify the claimant electronically or in writing of the appeal determination.

The Plan Administrator has the exclusive right to interpret and administer the provisions of the Plan and its decisions with respect to claims are conclusive and binding.

(f) External Appeals.

If required by applicable law, when a Participant exhausts all internal appeals procedures, the Participant may commence an external review. The external review process will comply with applicable state or federal law and other rules and procedures as prescribed in Department of Labor Regulation 2590.715-2719.

ARTICLE VI

Payment of Benefits

6.1 Assignment of Benefits. Except to the extent provided in this Plan, no benefit payable at any time shall be assignable, transferable, or subject to any lien, in whole or in part, either directly or by operation of law, or otherwise, and none of the following shall be liable for, or subject to, any obligation or liability of any Participant (*e.g.*, through garnishment, attachment, pledge or bankruptcy): the Plan, the Plan Administrator, or the Employer.

6.2 Payment to Representative. In the event that a guardian, conservator or other legal representative has been duly appointed for a Participant entitled to any payment under this Plan, any payment due the Participant may be made to the legal representative making the claim. If a Participant dies while benefits under the Plan remain unpaid, the Plan Administrator may make payment to the executors or administrators of the Participant's estate. Payment in the manner described above shall be in complete discharge of the liabilities of this Plan and the obligations of the Plan Administrator and the Employer.

6.3 Responsibility for Payment. It is the Participant's responsibility, in all cases, to pay for Medical Care expenses. Any benefit payment made directly to a Participant or the Participant's representative for a Medical Care expense shall completely discharge all liability of this Plan, the Plan Administrator, and the Employer with respect to such expense.

6.4 Overpayments. If, for any reason, any benefit is erroneously paid or exceeds the amount payable on account of a Participant's Medical Care expenses, the Participant shall be responsible for refunding the overpayment to the Plan. The refund shall be in the form of a lump-sum payment, a reduction of the amount of future benefits otherwise payable under the Plan, or any other method as the Plan Administrator, in its sole discretion, may require.

6.5 Coordination with Other Sources. Reimbursement of Medical Care expenses under this Plan shall be permitted only to the extent that such Medical Care expenses have not been previously reimbursed or are not reimbursable from another source. To the extent that a Medical Care expense is partially reimbursable from another source, the other source shall provide reimbursement prior to any reimbursement from the Plan.

6.6 Participant's Responsibilities. Each Participant shall be responsible for providing the Plan Administrator with his or her current address. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The Plan Administrator and the Employer shall have no obligation or duty to locate a Participant who does not provide a

current address. In the event a Participant becomes entitled to payment under this Plan and such payment cannot be made, for any reason, the amount of such payment, if and when made, shall be determined under the provisions of the Plan without any consideration to interest payments which may have accrued.

6.7 Missing Person. If, within one year after any amount becomes payable under this Plan to a Participant, the Participant has not accepted or been available to receive the reimbursement, the amount shall be forfeited to the Employer and shall cease to be a liability of this Plan, provided an appropriate level of care shall have been exercised by the Plan Administrator in attempting to make such payment.

ARTICLE VII

Amendment and Termination

7.1 Amendment. The Employer has the right to amend the Plan at any time to the extent that it may deem advisable subject to applicable law. Any amendment shall be at the direction of an authorized officer of the Employer or an authorized designee.

7.2 Termination. The Employer has established the Plan with the *bona fide* intention and expectation that it will be continued indefinitely, but the Employer is not and shall not be under any obligation or liability whatsoever to maintain the Plan for any given length of time and may, in its sole and absolute discretion, discontinue or terminate the Plan, in whole or in part, at any time, at the direction of an authorized officer of the Employer or an authorized designee.

ARTICLE VIII

Special Compliance Provisions

8.1 Use and Disclosure of Protected Health Information. Unless the Plan is self-administered and has fewer than 50 Participants, the Plan shall use protected health information ("PHI") only to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). For purposes of this Section, health plan shall have the meaning as defined in HIPAA. Specifically, any health plan shall use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations, as those terms are defined in HIPAA Regulation 45 C.F.R. § 164.501.

(a) An HRA Account will use and disclose PHI as required by law and as permitted by authorization of the Participant or other covered individual. With an authorization, an HRA Account shall disclose PHI to pension plans, disability plans, reciprocal benefit plans, and workers' compensation insurers, for purposes related to administration of the HRA Account.

(b) An HRA Account shall disclose PHI to the Employer only upon receipt of a certification from the Employer that the HRA Account documents have been amended to incorporate the following provisions and that the Employer agrees to:

(i) not use or further disclose PHI other than as permitted or required by the HRA plan document or as required by law;

(ii) ensure that any agents, including subcontractors, to whom the Employer provides PHI received from an HRA Account agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(iii) not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

(iv) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

(v) report to the HRA Account's designee any PHI use or disclosure that it becomes aware of which is inconsistent with the uses or disclosures provided for;

(vi) make PHI available to an individual in accordance with HIPAA's access requirements;

(vii) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(viii) make available the information required to provide an accounting of disclosures;

(ix) make the Employer's internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services for the purposes of determining the HRA Account's compliance with HIPAA;

(x) ensure that adequate separation between the HRA Account and the Employer is established as required by HIPAA; and

(xi) if feasible, return or destroy all PHI received from the HRA Account that the Employer maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction not feasible).

(c) Only those employees or classes of employees identified in the Plan's privacy policies and procedures may have access to and use and disclose PHI for plan administration functions that the Employer performs for the HRA Account. If such individuals do not comply with this plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

(d) Security. The Employer shall implement security measures with respect to PHI to the extent of and in accordance with the security rules implemented by HIPAA. Specifically, the Employer shall:

(i) implement administrative, physical and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the plan;

(ii) ensure the adequate separation between the Plan and the Employer is supported by reasonable and appropriate security measures;

(iii) ensure that any agent, including a subcontractor, to whom it provides information agrees to implement reasonable and appropriate security measures to protect the information (*e.g.*, in the event the Employer provides information to the broker for renewal bids); and

(iv) report to the Plan any security incident of which it becomes aware.

8.2 Special Enrollment Rights. (a) In accordance with the HIPAA special enrollment rules, if an eligible Employee declines coverage in a group health plan for himself or herself and/or the Employee's Spouse and Dependents because of other health insurance coverage, they may be able to enroll in the Plan's coverage upon loss of eligibility for the other coverage, provided that the Participant requests enrollment within 30 days after the other coverage ends.

If a Participant gains a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and the Participant's Spouse and Dependents in the HRA Account provided that enrollment is requested within 30 days after the marriage, birth, adoption, or placement for adoption.

(b) Employees, Spouses and Dependents who are eligible but not enrolled in the HRA may enroll when:

(i) The Employee's, Spouse's or Dependent's Medicaid or Children's Health Insurance Program ("CHIP") coverage is terminated as a result of loss of eligibility and the eligible Employee requests coverage within 60 days after the termination, or

(ii) The Employee, Spouse or Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the eligible Employee requests coverage within 60 days after eligibility is determined.

8.3 Coverage During FMLA Leave. A Participant on a leave of absence that qualifies as leave under the Family and Medical Leave Act of 1993 ("FMLA") may continue to receive the maximum reimbursement amount available under this Plan for Medical Expenses incurred during such leave, along with his or her eligible Spouse and Dependents, if such Participant remains an Eligible Employee and did not experience an interruption in employment until the

end of such FMLA leave period, or, if earlier, the date the Participant gives notice that he or she does not intend to return to work at the end of the FMLA period.

If a Participant does not continue coverage in the Plan but returns to work before the expiration of FMLA leave, he or she will be reinstated in his or her benefit coverage at the same level and under the same conditions as if the leave had not occurred. However, in this instance, the Participant will not be reimbursed for Medical Expenses incurred during FMLA leave and credits to his or her HRA Account may be pro-rated based on absence to the extent permitted by law.

8.4 Military Leave. A Participant's right to elect continued participation in a group health plan available under this Plan for himself or herself, the Participant's Spouse and Dependents during a leave of absence for active military duty is protected by the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

In no event shall benefits available under this Plan during a period of USERRA qualified military leave be less generous than those benefits available during other comparable employer approved leave periods (*e.g.*, family and medical leave).

8.5 COBRA. Notwithstanding any provision in this Plan to the contrary, a Participant, Spouse or Dependent who loses coverage under the Plan due to a qualifying event as defined in the Consolidated Omnibus Budget Reconciliation Act ("COBRA") and Section 4980B of the Code shall be entitled, to the extent required by law, to elect to continue the same coverage maximum reimbursement amount he or she had on the day before the qualifying event. The maximum reimbursement amount will increase at the same time and by the same increment that it is increased for similarly situated non-COBRA beneficiaries (as will decreases for claims reimbursed). Qualified beneficiaries who elect to continue coverage may submit claims for Medical Care expenses incurred after the qualifying event and before the end of such COBRA continuation coverage.

8.6 Genetic Information Nondiscrimination Act of 2008 ("GINA"). (a) Unless otherwise permitted, the Employer may not request or require any genetic information from an Employee or family member of the Employee.

(a) "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

(b) The Employer shall not request any genetic information when requesting health-related information.

(c) The Employer will not request, require or purchase genetic information in violation of GINA. If the Employer intentionally or unintentionally obtains genetic information pertaining to an Employee or a family member of the Employee, the Employer will not use such

genetic information in violation of GINA. Any genetic information received by the Employer that pertains to an Employee or a family member of the Employee, shall be maintained on forms and in medical files that are separate from personnel files, and shall be treated as confidential medical records.

8.7 Health-Related Factors. The Plan will not discriminate against any Participant or Dependent in terms of eligibility to participate in the Plan based on a health-related factor. In addition, benefits provided under the Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

8.8 Mental Health Parity Act. The Plan must generally comply with the provisions of the Mental Health Parity and Addiction Equity Act of 2008, including that the Plan's financial requirements and treatment limitations that are applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

ARTICLE IX

Plan Administration and Fiduciary Duties

9.1 Named Fiduciary. The Plan Administrator shall be the "named fiduciary" of the Plan, as defined in Section 402(a)(2) of ERISA, unless the Employer appoints a replacement.

9.2 Plan Administration.

(a) The Plan Administrator shall have sole discretion and authority to control and manage the operation and administration of the Plan.

(b) The Plan Administrator shall have complete discretion to interpret the provisions of the Plan, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Employer made in good faith pursuant to the Plan shall be final, conclusive and binding on all persons, subject only to the claims procedure, and may not be overturned unless found by a court to be arbitrary and capricious.

(c) The Plan Administrator shall have all other powers necessary to administer the Plan, including, but not limited to, the following:

(i) To prescribe procedures to be followed by Participants in filing claims under the Plan;

(ii) To prepare and distribute information explaining the Plan to Participants;

(iii) To receive from the Employer, Participants and Dependents, such information as shall be necessary or desirable for the proper administration of the Plan;

(iv) To keep records of claims and disbursements for claims under the Plan, and such other information as may be required by the Code;

(v) To appoint individuals or committees to assist in the administration of the Plan and to engage any other agents it deems advisable;

(vi) To accept, modify or reject Employee enrollment under the Plan;

(vii) To promulgate enrollment forms and claims forms to be used by Participants;

(viii) To prepare and file any reports or returns with respect to the Plan required by the Code or any other laws;

(ix) To determine and enforce any limits on benefits elected hereunder;

(x) To correct errors and make equitable adjustments for mistakes made in the administration of the Plan; specifically, and without limitation, to recover erroneous overpayments made from the Plan to a Participant or Dependent, in whatever manner the Employer determines is appropriate, including suspensions or recoupment of, or offsets against, future payments due that Participant or Dependent.

9.3 Delegation of Duties. The Plan Administrator may delegate responsibilities for the operation and administration of this HRA, may designate fiduciaries other than those named in the HRA, and may appoint one or more claim administrators to process all or a designated portion of claims under this HRA in accordance with its terms. The person, persons, entity or entities serving as claim administrator shall serve at the pleasure of the Plan Administrator.

9.4 Fiduciary Duties and Responsibilities. Each Plan fiduciary shall discharge his or her duties with respect to the HRA solely in the interest of each Participant, Spouse, Dependent and Beneficiary; for the exclusive purpose of providing benefits to such individuals and defraying reasonable expenses of administering the Plan; and in accordance with the terms of the HRA. Each fiduciary, in carrying out such duties, shall act with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in exercising such authority. A fiduciary may serve in more than one fiduciary capacity. Unless liability is otherwise provided under Section 405 of ERISA, a named fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a named fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

ARTICLE X

Miscellaneous

10.1 Limitation of Rights. Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed as to:

(a) give any person any legal or equitable right against the Employer or Plan Administrator except as expressly provided herein or required by law, or

(b) create a contract of employment with any Employee, obligate the Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way.

10.2 Benefits Solely from General Assets. The benefits provided hereunder will be paid solely from the general assets of the Employer. Nothing herein will be construed to require the Employer to maintain any fund or segregate any amount for the benefit of any Participant from the Employer's general assets, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under the Plan may be made.

10.3 Governing Laws and Jurisdiction and Venue. The Plan shall be construed and enforced according to the laws of the state of Washington, to the extent not preempted by federal law which shall otherwise control. Exclusive jurisdiction and venue of all disputes arising out of or relating to this Plan shall be in any court of appropriate jurisdiction in the state of Washington.

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

10.5 Construction. The captions contained herein are inserted only as a matter of convenience and reference, and in no way define, limit, enlarge or describe the scope or intent of the Plan, nor in any way shall affect the Plan or the construction of any provision thereof. Any terms expressed in the singular form shall be construed as though they also include the plural, where applicable, and references to the masculine, feminine, and the neuter are interchangeable.

10.6 Titles. The titles of the Articles and Sections hereof are included for convenience only and shall not be construed as part of this Plan or in any respect affecting or modifying its provisions. Such words in this Plan as "herein," "hereinafter," "hereof" and "hereunder" refer to this instrument as a whole and not merely to the subdivision in which said words appear.

10.7 Expenses. All expenses incurred in establishing and operating the Plan, including, without limiting the generality of the foregoing, legal fees, accounting fees, administrative expenses and the like, shall be paid by the Employer.

ARTICLE XI

Participating Employers

11.1 Adoption of the Plan. This Plan may be adopted by a Participating Employer, provided that such adoption is with the approval of the Employer and the Participating Employer meets the definition of an Employer as described in Article II, Section 2.5. Such adoption shall be by resolution of the Participating Employer's governing body.

11.2 Administration. As a condition to adopting the Plan, and except as otherwise provided herein, each Participating Employer shall be deemed to have authorized the Plan Administrator to act for it in all matters arising under or with respect to the Plan and shall comply with such other terms and conditions as may be imposed by the Plan Administrator.

11.3 Termination of Participation. Each Participating Employer may cease to participate in the Plan with respect to its Employees or former Employees by resolution of its governing body.

ARTICLE XII

Effective Date

This plan document sets forth the terms of the Plan as in effect January 01, 2022.

IN WITNESS WHEREOF, the Employer has caused this document to be duly executed in its name and on its behalf as of the date set forth below.

TRICO Companies, LLC

By:_________________________________

Date: _______________________________

ATTEST:

____

APPENDIX A
TRICO COMPANIES, LLC

PARTICIPATING EMPLOYERS

In addition to TRICO Companies, LLC, the following Participating Employers have adopted the Plan pursuant to Article XI, Section 11.1:

There are no other employers participating in the Plan.