IRONROAD WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Effective January 2023

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ARTICLE I.
INTRODUCTION

IronRoad, Inc. (the "Employer") maintains the IronRoad Welfare Benefit Plan (the "Plan") for the exclusive benefit of and to provide welfare benefits to its eligible employees, their eligible spouses, and eligible dependents.

The welfare benefits provided under the Plan include the following coverages: medical, prescription drug, dental, vision, life and accidental death and dismemberment (AD&D), voluntary life, long-term disability (LTD), voluntary LTD, short-term disability (STD), voluntary STD, voluntary accident, voluntary critical illness, flexible spending account, voluntary whole life, and certain wellness benefits including employee critical illness plus, employee life option plus, advantage life, group accident and group hospital confinement benefits.

This Summary Plan Description ("SPD") is being distributed to supplement the benefit booklets, certificates, summary plan descriptions, and/or benefit summaries (which we will refer to as "Booklets") in order to provide you with a complete description of the Benefits available under the Plan. You should keep this SPD with the underlying Booklets by the various Claims Administrators and Insurers for each plan, which documents describe your Benefits with greater specificity. This document, together with the underlying Booklets issued by Claims Administrators and the Insurers constitute the Summary Plan Description required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

Please note that:

A. This SPD does not fully describe the benefits provided under the Plan. Rather this SPD describes the general provisions with respect to the benefits offered under the Plan. For details on the benefits provided through the Plan, please refer to the underlying Booklets which are the binding documents with respect to Benefits.

B. If there are any discrepancies between benefits described in this SPD and the underlying Booklets then the provisions of the underlying Booklets will prevail in determining the Benefits provided under the Plan.

ARTICLE II.
ELIGIBILITY

The Employees eligible to participate in a Benefit, as well as the waiting periods and effective dates of coverage for a Benefit are generally described in the Booklets. Generally, Employees eligible to participate in these benefits are regular, full-time employee of the Employer or Participating Employer is regularly scheduled to work the number of hours set out in Attachment C, but certain exceptions may apply, as outlined in the Booklets. A brief summary of conditions on eligibility for Benefits is provided in Attachment C.

Notwithstanding the information provided in the Booklets for health Benefits:

A. a dependent as defined by the health Booklet is eligible for coverage for health Benefits until age 26 regardless of whether the dependent is married, or meets student status, residency (except United States residency) or financial dependency requirements;

B. any lifetime limits imposed on the dollar value of health Benefits will not apply to any health Benefits that are determined to be essential health benefits as defined by the Patient Protection and Affordable Care Act (ACA) and any implementing regulations;

C. no annual limit on the dollar value of health Benefits that are determined to be essential health benefits will apply; and

D. no preexisting condition limitations apply to health Benefits.

Starting March 1, 2020, the Employer will continue coverage under a Benefit for a period of up to 12 weeks from the start of a furlough, even if you would otherwise lose that coverage based on that furlough, if the furlough is due to the Covid-19 outbreak. If you pay your required share of premiums at the time and in the manner specified by the Employer, coverage during the Covid-19 furlough will continue until the earliest of: (1) the end of 12 weeks after the start of the furlough, (2) the end of the furlough or your employment, and (3) the date the insurer end their extension of coverage based on Covid-19.

ARTICLE III.
TERMINATION OF PARTICIPATION

Section 3.1 Termination of Coverage. Coverage under a Benefit ends at the times described in the Booklets. Coverage for health Benefits may be rescinded, that is, retroactively cancelled or terminated, only in the event of your (i) fraud, (ii) intentional misrepresentation of a material fact, or (iii) failure to timely pay required premiums. If your coverage for health Benefits is rescinded, the Plan will provide you with at least 30 calendar days advance notice. In some instances, you may be able to elect to convert your coverage to an individual policy of insurance. Please refer to the applicable Booklets for more information. Also, if your coverage under a Group Health Plan ends, you may be eligible to elect COBRA continuation coverage, as described later in this SPD.

Section 3.2 Termination Due to Fraud or Intentional Misrepresentation. Coverage under the Plan will be terminated immediately upon finding that you have committed, participated in, or are participating in the commission of fraud against the Plan or underlying benefit plan. Such fraud includes, but is not limited to:

A. furnishing or participating in furnishing fraudulent information to the Plan or underlying benefit plan for the purpose of obtaining coverage under the Plan (i.e., false health-related treatment claims);

B. permitting improper use of an identification card; and

C. use of another Participant's identification card.

Coverage under the underlying medical plan of the Plan may be rescinded (that is canceled or discontinued on a retroactive basis) if you perform an act, practice, or omission that constitutes fraud or make an intentional misrepresentation of a material fact. You and/or your dependents, as applicable, will receive at least 30 days advance notice before the coverage is rescinded.

ARTICLE IV.
LEAVES OF ABSENCE

Section 4.1 Family and Medical Leaves. If you are absent from work for a family or medical leave covered by the Family and Medical Leave Act ("FMLA"), you may revoke your election of coverage under a Group Health Plan and reinstate coverage when you return from the FMLA leave.

If you elect to maintain your Group Health Plan and/or other Plan coverage during your absence and your leave is a paid leave, payroll deductions will continue in accordance with your election. If you wish to maintain your coverage under these programs and your leave is unpaid, you must pay the premiums for the coverage using one of the following methods:

A. Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you are subject to this method, you will be invoiced and have to reimburse the Company at regular intervals from your after-tax funds for the premiums that come due during the leave. Your coverage will end if you fail to make the payments required under this option.

B. Catch-up Payments. The amount of your salary reduction may be increased when you return to work to catch up on the premiums that were due during the leave of absence if you are not subject to the pay-as-you-go payment method.

If you are absent from work on unpaid leave for any reason and you remain covered under a Benefit, any required premium for coverage will be paid by the Employer or Participating Employer during the unpaid leave and deductions will be withheld from your first paycheck upon your return to employment. In the alternative, the employee and the Employer may agree to another payment schedule, at the Employer's or Participating Employer's discretion.

Section 4.2 Military Leaves. If you are absent from work for active military duty that is covered by the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"), your right to continued participation in the Plan will be as follows:

A. If you are absent from work for less than 31 days, your coverage under a Group Health Plan will be continued at active employee rates.

B. If you are absent for more than 30 days, you may elect to continue coverage under a Group Health Plan for up to 24 months or the period of your military service, whichever is shorter. You may be required to pay up to 102% of the normal premium for this continued coverage. If you elect not to continue coverage under a Group Health Plan, your coverage will be reinstated to the extent required under USERRA upon your return to employment.

ARTICLE V.
ENROLLMENT PROCEDURES

If you are eligible for and wish to become covered under a Benefit, you must complete the required enrollment process no later than (i) the date of your fulfillment of the eligibility requirements set forth above (for new hires) and (ii) during the annual enrollment period announced by the Employer or Participating Employer or during the life event change period (for ongoing employees).

The Booklet for the Group Health Plan describes special enrollment rights under HIPAA. Also, a special enrollment period is available into the Group Health Plan for the Family Premium Glitch Fix or if you, your spouse or your dependent child's coverage under Medicaid or under the Children's Health Insurance Program (CHIP) terminates due to loss of eligibility; or you, your spouse or your dependent child becomes eligible for a CHIP premium assistance subsidy. This special enrollment period is available for 60 days following the date of the event. You, your spouse or your dependent child must request special enrollment by contacting the Plan Administrator within 60 days of the occurrence of one of these events. Contact information for the Plan Administrator is located in Section 10.1 below.

ARTICLE VI.
BENEFITS AND COSTS OF COVERAGE

The benefits provided under a Benefit are described in detail in the Booklets. To the extent any Benefit provides for a lower cost by using a network provider, a list of participating medical providers is available and will be provided to you automatically, free of charge upon your request. Please reference the applicable Booklet for details.

Benefits are provided either through (i) contracts of insurance with insurance companies (the "Insurers") in return for premium payments paid to the Insurers and (ii) self-funded through the Employer's or Participating Employer's general assets. The Employer and Participating Employer pays the cost of certain Benefits, while the cost of other Benefits are shared by the Employer and Participating Employer and you or are paid entirely by you. The Employer or Participating Employer forwards all contributions that it or eligible Employees make for coverage under a Benefit directly to the Insurers as premium payments, when the Benefit is provided under a contract of insurance.

The cost of coverage under a Benefit may change from time to time. The current cost for coverage under a Benefit will be communicated to you and the Employer or Participating Employer will inform you of any change in the cost of a Benefit.

Such coverage is subject to all the terms described in this SPD, including relevant deductibles and coinsurance provisions.

ARTICLE VII.
CLAIMS AND APPEAL PROCEDURES

Section 7.1 Claims and Appeals. A claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's procedure

for making benefit claims. The claims procedures for the Plan are contained in the underlying benefit summaries issued by the Claims Administrator(s) and/or the Insurers, and are intended to comply with regulations governing claims procedures contained in Department of Labor Regulations Section 2560.503-1. The Plan's claims procedures must be exhausted prior to any lawsuit for Plan benefits.

ARTICLE VIII.
CONTINUATION COVERAGE (COBRA)

The Booklets for a Group Health Plan generally describe rights to continuation coverage under COBRA. However, the notice procedures in this document supplement and take precedence over any conflicting notice procedures in the Booklets.

Section 8.1 General. If you are a Qualified Beneficiary, you have the right to continue your coverage under a Group Health Plan if you lose that coverage due to a Qualifying Event. If you are an employee, you are a Qualified Beneficiary if you are covered by the Group Health Plan on the day prior to a Qualifying Event that is your termination of employment (for reasons other than gross misconduct) or a reduction in your hours of employment. If you are the spouse or dependent child of an employee, you are a Qualified Beneficiary if you are covered by the Group Health Plan on the day prior to a Qualifying Event. A child born to or placed for adoption with an employee during a period of COBRA coverage is also a Qualified Beneficiary. Employees who are nonresident aliens with no U.S.-source income, and the spouse or dependent children of such employees, are not Qualified Beneficiaries.

A Qualifying Event means each of the following events, if it causes a Qualified Beneficiary to lose coverage under a Group Health Plan:

A. The employee's hours of employment are reduced;

B. The employee's employment ends for any reason other than gross misconduct (as defined below);

C. The death of the employee;

D. The employee's entitlement to Medicare benefits;

E. Divorce or legal separation between the employee and his or her spouse; or

F. For a dependent child, the child's ceasing to satisfy the definition of a dependent under the terms of the applicable program.

If you are a Qualified Beneficiary and you lose coverage under a Group Health Plan due to the first four Qualifying Events listed above, you will automatically receive a Qualifying Event notice from the Plan Administrator or its designee of your right to elect COBRA continuation coverage. **However, if you are a Qualified Beneficiary and you lose coverage under a Group**

Health Plan due to a divorce or legal separation, or due to a child's loss of dependency status, <u>you must notify the Plan Administrator or its designee of the event within 60 days after the Qualifying Event occurs</u> or you will lose your right to elect COBRA continuation coverage.

As indicated previously, an employee's termination of employment for gross misconduct is not considered a Qualifying Event. Gross misconduct means conduct that could have an adverse impact on the business of the Employer or Participating Employer, including but not limited to theft, embezzlement, and serious violations of Employer or Participating Employer policy that subject an employee to dismissal.

Section 8.2 Electing COBRA Coverage. If you are a Qualified Beneficiary and you experience a Qualifying Event, you will receive a Qualifying Event notice from the Plan Administrator or its designee describing your rights to elect COBRA continuation coverage, as well as an election form you can use to apply for that coverage. Remember, if the Qualifying Event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the Plan Administrator or its designee of the event before this notice will be sent to you. If you do not receive a Qualifying Event notice and election form within 30 days of your Qualifying Event (or within 14 days of the date you notified the Plan Administrator or its designee of a Qualifying Event, if applicable), you should contact the Plan Administrator or its designee.

Although each Qualified Beneficiary has an independent right to elect COBRA coverage, the Qualifying Event notice and election form will usually only be sent to the employee and spouse, at the employee's address shown in the records of the Group Health Plan. However, if the records of the Group Health Plan show that the employee and spouse live at different locations, or that a dependent child lives at a different location, separate notices will be sent. For this reason, it is very important that you keep the Plan Administrator or its designee informed of your current address and the addresses of your spouse and covered dependents. Again, each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA coverage will be provided only if it is elected by a Qualified Beneficiary during the COBRA election period. The COBRA election period begins on the date of the Qualifying Event and ends 60 days after the date a Qualifying Event Notice is sent to the Qualified Beneficiary or, if later, the date the Qualified Beneficiary would otherwise lose coverage as a result of the Qualifying Event. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost. The Group Health Plan does not permit you to waive COBRA coverage during the election period and then revoke the waiver before the end of the election period in order to elect coverage as of a date other than the date coverage was initially lost.

Prior to the time a Qualified Beneficiary elects COBRA coverage, his or her coverage under the Group Health Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a timely election of COBRA coverage and the timely payment by the Qualified Beneficiary of the first premium payment. This means that, until

you elect COBRA coverage, any provider who asks will be told that your coverage has been terminated, but may be retroactively reinstated if you timely elect and pay for COBRA coverage.

Section 8.3 Paying for COBRA Coverage. Qualified Beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the Qualifying Event, through the end of the month in which the Qualifying Event occurred.

The cost for each one-month period of COBRA coverage depends on the type of coverage that is being continued. The cost will be communicated to you in the Qualifying Event notice sent to you by the Plan Administrator or its designee. The cost may change at the beginning of each Plan Year. Any changes will be communicated to you.

The first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage. The first payment must include payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received. If the payment is not postmarked or received within 45 days of the date you elected COBRA coverage, you will lose your right to COBRA coverage.

Payments for subsequent one-month periods are due on the first day of those periods and should be sent to the Plan Administrator or its designee. You will have a 30-day grace period to send in these payments, but they must be postmarked or received no later than 30 days after the first day of the coverage period or your COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. Any payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. In some cases, however, if your payment is not significantly less than the applicable premium, you will have 30 days following the date you are notified of the shortfall to make up the balance.

If payment for a period of COBRA coverage is made after the first day of that period, your coverage will be continued but will be subject to retroactive termination if payment for that period is not received during the grace period. However, any claims incurred prior to payment will not be processed until payment is made. This means that, until you pay for COBRA coverage, any health care provider who asks will be told that your coverage is in force, but may be retroactively terminated if you do not timely pay for COBRA coverage. In addition, you will be required to reimburse the Plan for any claims that are paid if you do not subsequently send in timely payment.

Section 8.4 Duration of COBRA Coverage. COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before

the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

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

If you or anyone in your family covered under a Group Health Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator or its designee in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator or its designee is notified of the SSA's determination before the end of the 18-month period of COBRA continuation coverage and not later than 60 days after the latest of (i) the date of the disability determination by the SSA, (ii) the date on which a Qualifying Event occurs, or (iii) the date on which you or another Qualified Beneficiary loses (or would lose) coverage under the program as a result of the Qualifying Event. If a Qualified Beneficiary who was previously determined by the SSA to be disabled is subsequently determined by the SSA to be no longer disabled, you must notify the Plan Administrator of that determination within 30 days of the date you receive the determination from the SSA.

In addition, if your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, you must make sure that the Plan Administrator or its designee is notified of the second Qualifying Event within 60 days of the event. Only individuals who were Qualified Beneficiaries in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event are eligible for this extension.

COBRA coverage will end prior to the 18-, 29- or 36-month period described above under the following circumstances:

A. the first day of a coverage period for which timely payment is not made;

B. the date the Employer or Participating Employer ceases to provide any group health plan to you;

C. the date, after the date a COBRA election is made, upon which the Qualified Beneficiary first becomes covered under another group health plan;

D. the date, after the date a COBRA election is made, upon which a Qualified Beneficiary first becomes entitled to Medicare benefits;

E. the first day of the coverage period that is more than 30 days after the date a Qualified Beneficiary entitled to a disability extension is finally determined to not be disabled; or

F. the date coverage is terminated for cause.

If the COBRA coverage of a Qualified Beneficiary terminates early, the Plan Administrator or its designee will send a notice regarding the termination of COBRA Coverage to you as soon as practicable.

Section 8.5 How to Notify the Plan Administrator. You must send written notice of a Qualifying Event that is a divorce, a legal separation, or a child's loss of dependent status, to the Plan Administrator or its designee within 60 days of the event. Also, if you elect COBRA coverage and you are eligible for an 11-month extension of that coverage due to the disability of a Qualified Beneficiary, or for an 18-month extension of that coverage due to the occurrence of a second Qualifying Event, you must provide written notice of the disability determination or the second Qualifying Event to the Plan Administrator or its designee. Notice must be sent by first class mail or other nationally-recognized courier service, by fax, e-mail or by hand-delivery. Oral notice will not be accepted. Your notice must include your name and the names of other affected family members, the type of Qualifying Event and written documentation of the event that identifies the date on which the event occurred. You should keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

Any notices required to be provided to the Plan Administrator or its designee may be provided by the employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same Qualifying Event.

Section 8.6 If You Have Questions. Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

ARTICLE IX.
QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Any Benefit which is a Group Health Plan will provide benefits to a child of an eligible employee in accordance with a Qualified Medical Child Support Order ("QMCSO"), as defined

in ERISA § 609. You may obtain a copy of the Group Health Plan's Qualified Medical Child Support Order Procedures, free of charge, upon written request to the Plan Administrator.

ARTICLE X.
PLAN ADMINISTRATION

Section 10.1 Plan Administration. The administration of the Plan is under the supervision of the Plan Administrator. The Employer or Participating Employer acts on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan without discrimination among them.

The Employer or Participating Employer bears the incidental costs of administering the Plan.

Certain vision, life, AD&D, LTD, STD, and voluntary benefits are administered by the applicable Insurers and certain medical, prescription drug, dental, and health flexible spending account benefits are administered by the applicable Claims Administrators. Claims for these benefits are sent to the Insurers or the Claims Administrators as applicable. Unless otherwise provided in the underlying benefit summaries, the Employer is responsible for determining eligibility, while the Insurer is responsible for determining the amount of any benefits payable under the underlying plan, prescribing claims procedures to be followed, and paying claims. The Insurers and the Claims Administrators as applicable, also have the authority to require employees and their covered dependents to furnish them with such information as they determine necessary for the proper administration of the Plan.

If you have any general questions regarding the Plan, please contact the Plan Administrator or the Claims Administrator (as set forth in the attached Schedule A) who administers a benefit, as applicable. However, if you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the Insurers that insures the particular benefit.

Section 10.2 Fiduciary and Named Fiduciary. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan, or has discretionary authority or responsibility in the administration of the Plan.

The "named fiduciary" is the one named in the Plan, which is the Plan Administrator. The named fiduciary can appoint others to carry out fiduciary responsibilities under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will generally not be liable for any act or omission of such person.

ARTICLE XI.
COMPLIANCE WITH FEDERAL LAWS

The terms of the Plan will be construed and administered in a manner calculated to meet the requirements of the following laws, as the laws are applicable to this Plan:

A. Americans with Disabilities Act of 1990, as amended;

B. Health Insurance Portability and Accountability Act of 1996, as amended;

C. Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

D. The Newborns' and Mothers' Health Protection Act of 1996;

E. The Mental Health Parity Act of 1996, as amended;

F. The Women's Health and Cancer Rights Act of 1998;

G. The Mental Health Parity and Addiction Equity Act of 2008;

H. The Genetic Non-Discrimination Act of 2008;

I. The Children's Health Insurance Program Reauthorization Act of 2009;

J. The American Reinvestment and Recovery Act of 2009;

K. The Patient Protection and Affordable Care Act of 2010;

L. Health Care and Education Reconciliation Act of 2012; and

M. Any other federal law or applicable guidance that may apply to the Plan.

To the extent a Plan provision is contrary to or fails to address the minimum requirements of these laws, the Plan will provide the coverage or benefit necessary to comply with the minimum requirements thereof.

ARTICLE XII.
GENERAL PROVISIONS

Section 12.1 Future of the Plan. The continued maintenance of the Plan is completely voluntary on the part of the Employer and neither its existence nor its continuation will be construed as creating any contractual right to or obligation for its future continuation. While the Employer intends to continue the Plan indefinitely, it reserves the right at any time and for any reason, in its sole and absolute discretion, to curtail benefits under, or otherwise amend or terminate the Plan or any portion thereof, including, without limitation, those portions of the Plan outlining the benefits provided or the classes of employees or dependents eligible for benefits under the Plan. If the Plan is terminated, the rights of the Plan participants are limited to expenses incurred before termination.

Section 12.2 Cost of Administration. The costs and expenses incurred by the Plan Administrator in administering the Plan may be paid by the Employer as may be determined by the Plan Administrator.

Section 12.3 Funding and Payment of Benefits. The Benefits provided under the Plan will be paid from insurance contracts and funded through the Employer's or Participating Employer's general assets. Benefits may be paid in part through contributions made to the Plan

by the Employer or Participating Employer or by Participants on either a pre-tax or after-tax basis. Nothing herein will be construed to require the Employer or Participating Employer to maintain any fund or segregate any amount for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any fund, account or asset of the Employer or Participating Employer from which any payment under the Plan may be made, unless required by applicable law.

ARTICLE XIII.
STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

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

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

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

D. 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.

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 your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file a suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the

materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the 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.

ARTICLE XIV.
GENERAL PLAN INFORMATION

Plan Name:	IronRoad Welfare Benefit Plan
Plan Number:	506
Employer Identification Number:	84-3944510
Plan Year:	Each 12 consecutive month period beginning on January 1 and ending on the next following December 31; provided however each Benefit plan may have various contract years associated with their insurance policies.
Type of Plan:	Welfare Plan providing medical, prescription drug, dental, vision, life and accidental death and dismemberment, long-term disability, short-term disability, health flexible spending account, voluntary whole life, voluntary critical illness, voluntary accident, and other wellness benefits including employee critical illness, employee life option plus, advantage life, group accident, and hospital confinement benefits.
Name and Address	IronRoad, Inc., 9435 Waterstone Blvd., Suite 250, Cincinnati, OH 45249

Plan Administrator:	IronRoad, Inc., 9435 Waterstone Blvd., Suite 250, Cincinnati, OH 45249 Please note that the Insurers are the claim fiduciaries for all Benefits under the Plan which are provided through contracts of insurance. The name, address and phone number of the Insurers are described in the Booklets.
Type of Administration:	Fully insured and self-insured benefits, with certain duties contracted to outside third parties administrators.
Agent for Service of Legal Process	Service of legal process may be made upon the Employer or the Plan Administrator at the address described above.

ARTICLE XV.
DEFINITIONS

A. **Booklets** mean the insurance policies, plan documents, benefit booklets, summary plan descriptions, and certificates of insurance that describe the Benefits that are incorporated as part of this SPD.

B. **Claims Administrator** means any third party engaged by the Employer to process claims under the Plan where Benefits are not provided under a contract of insurance.

C. **Employee** means any person employed by the Employer or Participating Employer as a common law employee, other than: (i) any leased employee or any person classified as a leased employee by the Employer or Participating Employer regardless of whether such person is later determined, whether by the Employer or Participating Employer or otherwise, to be a common law employee of the Employer or Participating Employer; (ii) any person who is classified by the Employer or Participating Employer (as a signatory to a contract, letter of agreement, or other document) as an independent contractor or sub-contractor not entitled to benefits under the Plan for purposes of withholding and payment of employment taxes, even if such person is later determined, whether by the Employer or Participating Employer or otherwise, to be a common law employee of the Employer or Participating Employer; or (iii) a nonresident alien with no income from sources within the United States.

D. **ERISA** means the Employee Retirement Income Security Act of 1974, as amended.

E. **FMLA** means the Family and Medical Leave Act, as amended.

F. **Group Health** Plan means a plan or program that provides health care benefits to Employees. The medical, prescription drug, dental, vision, and health flexible spending account benefits are offered under plans that are considered Group Health Plan.

G. **HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

H. **Insurer** means an insurance company that has issued an insurance contract through which one or more Benefits are provided. The name, address and phone number of each Insurer providing a benefit is described in the Booklets. The Insurers are responsible for financing all insured Benefits in exchange for payment of insurance premiums, and are also responsible for processing and deciding all claims for insured Benefits.

I. **Participant** means an Employee who has satisfied the eligibility and enrollment requirements applicable to a covered benefit and has not ceased to be eligible for coverage with respect to such covered benefit.

J. **Plan** means the IronRoad Welfare Benefit Plan.

K. **Plan Administrato**r means the Employer.

ATTACHMENT A

BENEFITS PROVIDED UNDER THE PLAN Effective in January 1, 2022

Benefit Program	Insured/Self-Insured Documents Received
Medical Plan (PPO and HDHP options)	Self-Insured - UMR
Prescription Drug Plan	Self-Insured - RxBenefits
Dental Plan	Self-Insured - UMR
Vision Insurance Policy	Insured - EyeMed
Group Life and AD&D Insurance Policy	Insured – United of Omaha Life Insurance Company
Voluntary Life and Accident Insurance Policy	Insured – United of Omaha Life Insurance Company
Long-Term Disability and Voluntary Long-Term Disability Insurance Policies	Insured – United of Omaha Life Insurance Company
Short-Term Disability and Voluntary Short-Term Disability Insurance Policies	Insured – United of Omaha Life Insurance Company
Section 125 Cafeteria Plan (pre-tax premium, health flexible spending account, dependent care flexible spending account, and health savings account)	Self-Insured - TASC
Voluntary Critical Illness Insurance Policy	Insured – United of Omaha Life Insurance Company
Voluntary Accident Insurance Policy	Insured - United of Omaha Life Insurance Company

Attachment B
LISTING OF ADOPTING COMPANIES Effective in January 1, 2023

None

Attachment C
BENEFIT ELIGIBILITY
Effective in January 1, 2023

Eligibility Group ID - 445
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plan H and Minimum Essential Coverage plan, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident

Eligibility Group ID - 492
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plan H and Minimum Essential Coverage plan, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident

Eligibility Group ID - 510
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans C & H, Dental, Vision

Eligibility Group ID - 459
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plan E & H

Eligibility Group ID - 006
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident, Group Term Life at $15,000

Eligibility Group ID - 331
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life at $15,000

Eligibility Group ID - 444
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 451
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available – Medical Plans C, I, H & K, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 350
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following date of hire
Options Available -Medical Plans C, H & I, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 446
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plan H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident

Eligibility Group ID - 486
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Voluntary Coverages: Life, Long-Term Disability, Critical Illness, Accident. Group Term Life $50,000.

Eligibility Group ID - 100
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Dental, Vision, Voluntary Coverages: Life, Critical Illness, Accident. Group Term Life $15,000. Company Paid Disability.

Eligibility Group ID - 457
Full Time Hour Requirement –37.5 Hours
Waiting Period – Date of Hire
Options Available -Medical Plans C, E & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000. Company paid LTD.

Eligibility Group ID - 341
Full Time Hour Requirement –25 Hours
Waiting Period – first of the month following 60
Options Available –Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 314
Full Time Hour Requirement –25 Hours
Waiting Period – first of the month following Date of Hire
Options Available – Medical Plans B & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 499
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following Date of Hire
Options Available -Medical Plans C& E, Dental, Vision, Company Paid Disability, Group Term Life: 1x annual salary.

Eligibility Group ID - 508
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plan H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident

Eligibility Group ID -102
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plans A, B, H & I, Dental, Vision, Voluntary Coverages: Life, , Critical Illness, Accident. Group Term Life $15,000. Company Paid Disability.

Eligibility Group ID - 419
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following Date of Hire
Options Available -Medical Plans G & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life: 1x annual salary.

Eligibility Group ID - 363
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans E & H, Dental, Voluntary Coverages: Life,Critical Illness, Accident. Group Term Life 2x annual salary. Company Paid Disability.

Eligibility Group ID - 388
Full Time Hour Requirement –30 Hours
Waiting Period – 30 days after hire date
Options Available - Voluntary Coverages: Life, Disability, Critical Illness, Accident

Eligibility Group ID – 334
Full Time Hour Requirement –25 Hours
Waiting Period – Date of Hire
Options Available -Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident

Eligibility Group ID - 509
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 316
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plans A, B, E & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID – 487
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available Dental, Vision, Voluntary Coverages: Life, Critical Illness, Accident. Group Term Life $15,000. Company Paid Disability.

Eligibility Group ID - 468
Full Time Hour Requirement –30 Hours
Waiting Period – Date of Hire
Options Available -Medical Plans E & H, Dental, Vision, Voluntary Coverages: Life, Critical Illness, Accident, Group Term Life $50,000. Company Paid Disability.

Eligibility Group ID - 325
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans B and H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 421
Full Time Hour Requirement –30 Hours
Waiting Period – 30th day of employment
Options Available -Dental, Vision, Voluntary Coverages: Life

Eligibility Group ID - 407
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans B, H & D, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 402
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans A, B, C & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life Class 1: $50,000, Class 2 $308,000

Eligibility Group ID -087
Full Time Hour Requirement –30 Hours
Waiting Period – 90th day of Employment
Options Available -Medical Plan E , Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life $15,000.

Eligibility Group ID - 395
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 30
Options Available -Medical Plans C, E, H & I, Dental, Vision, Voluntary Coverages: Life, Long-Term Disability, Critical Illness, Accident. Group Term Life $35,000. Company Paid STD.

Eligibility Group ID - 299
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans C, E & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident. Group Term Life : $15,000 (Employees), $35,000 (Managers), $50,000 (Owners)

Eligibility Group ID - 532
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans C, D, E, & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident, Group Term Life : $50,000

Eligibility Group ID - 528
Full Time Hour Requirement –30 Hours
Waiting Period – first of the month following 60
Options Available -Medical Plans B, E, & H, Dental, Vision, Voluntary Coverages: Life, Disability, Critical Illness, Accident,

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