JM FAMILY ENTERPRISES, INC.

RETIREE HEALTH REIMBURSEMENT ARRANGEMENT

SUMMARY PLAN DESCRIPTION

EFFECTIVE DATE: January 1, 2016

AMENDED AND RESTATED: September 27, 2023

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INTRODUCTION

JM Family Enterprises, Inc. (the "Employer") has established the Health Reimbursement Arrangement (the “HRA”). The JM Family Enterprises, Inc. Retiree Medical Plan Retirement Option (MPRO) and the JM Family Enterprises, Inc. Healthcash benefits are intended to be components of this HRA. Despite the fact that the MPRO and Healthcash historically provided different types of benefits, this Summary Plan Description, as well as the HRA plan document will serve as the governing plan documents for both the MPRO and Healthcash benefits. We will refer to the MPRO and Healthcash benefits as separate "Benefit Options" throughout the plan documents.

Upon meeting the eligibility criteria established by the Employer, you may be eligible to participate in either the MPRO or the Healthcash Benefit Option. To avoid confusion, and to provide you with information about the Benefit Option that you are eligible for, your Employer will determine which Benefit Option you are eligible for, and will provide you with the appropriate Appendix based on that determination. If you are eligible for the MPRO Benefit Option, you will receive the MPRO Benefit Option Appendix with your SPD. If you are eligible for the Healthcash Benefit Option, you will receive Healthcash Benefit Option Appendix with your SPD. If you would like to review the Appendix for the other Benefit Option, copies may be obtained from the Plan Administrator whose contact information is contained in this SPD.

This HRA is intended to be a component of the JM Family Enterprises, Inc. Your Choice Plan and shall be administered accordingly. The purpose of this HRA is to reimburse certain participating Retirees (and in some cases, the Surviving Spouse or Dependents of the Retiree) (“Participants”) for certain unreimbursed medical expenses (“Eligible Medical Expenses”) incurred by the Participant or their Spouse or Dependents. The HRA is intended to qualify as a medical expense reimbursement plan and meet the requirements for qualification under Code Section 105(b) and Section 106(a), and that benefits paid Retirees hereunder be excludible from their gross incomes by virtue of Section 105(b) and Section 106(a).

This Summary Plan Description, or “SPD,” describes the basic features of the HRA, including the rights and responsibilities of Participants, the former Employer, and the Plan Administrator. Benefits Option The SPD and/or its Appendices may be amended or replaced from time to time to reflect changes made to the Plan. You should contact your former Employer if you have concerns that the SPD or Appendices you have are outdated. The appendices referenced in this SPD should be considered a part of the SPD.

This HRA has been established and is operated in accordance with both this SPD and the official Plan Document. This SPD (including the applicable appendices) has been incorporated into and made a part of the official Plan Document (i.e., the official Plan Document and this SPD together constitute the Plan Document for this HRA). Although the SPD has been incorporated into and made a part of the Plan Document, the terms of the official Plan Document will control if there is a conflict between this SPD and the official Plan Document.

PART I: General Information about the Plan

**You will notice that certain terms and/or phrases are capitalized throughout this SPD. These terms and/or phrases are important and you should remember them. The capitalized terms and phrases are defined either in this SPD or in the official plan document in which this SPD is incorporated.*

Q-1. What is the HRA?

The HRA is an Employer provided reimbursement account. The HRA works as follows:

- The Employer establishes a notional account called a Health Reimbursement Arrangement ("Reimbursement Account") for each Participant (see Q-2 for more information on how to become a Participant).
- The Employer allocates a specified amount of employer contributions, called "HRA Dollars," to each Participant's Reimbursement Account for reimbursement of Eligible Medical Expenses.
- You do not forfeit HRA dollars that you do not use during a Plan Year.
- Since the HRA is Employer funded, you do not make contributions to this account, nor do you have to pay for your HRA coverage (unless you elect COBRA continuation coverage under the COBRA Continuation of Coverage Appendix).

Q-2. Who can participate in the HRA?

You are eligible to participate in this HRA if you satisfy the Retiree eligibility requirements for at least one of the two (2) Benefit Options as described in the Eligibility Criteria Appendix of this SPD. Eligible Retirees who become covered under this HRA are called "Participants." **Despite anything in this SPD to the contrary, you may participate in one of the Benefit Options or the other but not both**.

Q-3. How do I know if I satisfy the eligibility requirements for one of the Benefit Options?

You may consult the eligibility criteria for each of the two HRA Benefit Options described in the Eligibility Criteria Appendix of this SPD.

Q-4. Can I use my HRA Dollars to reimburse the Eligible Medical Expenses of my Spouse and Dependents?

If you become a Participant, you may choose to use your HRA Dollars to reimburse the Eligible Medical Expenses of your Spouse and Dependents. If you choose to use your HRA Dollars to reimburse the Eligible Medical Expenses of your Spouse and Dependents, you may be required to periodically provide proof of their Spouse and/or Dependent status upon request by the Plan Administrator (or its designee). Failure to provide such proof may result in a delay in coverage under this HRA or termination of coverage.

In some circumstances, the HRA may reimburse the Eligible Medical Expenses of a child of yours (as defined by applicable state law) in accordance with a Qualified Medical Child Support Order ("QMCSO") to the extent the QMCSO does not require coverage not otherwise offered under this HRA.

You may request a copy of the Plan's QMCSO procedures, free of charge, by contacting the Plan Administrator of this HRA (as identified in the Plan Information Appendix).

Q-5. What is the effective date of coverage under this HRA?

Coverage under this HRA for an individual who is a Retiree on or any time leading up to the HRA's Effective Date (January 1, 2016), and who satisfies the eligibility requirements for at least one Benefits Option as discussed in the Eligibility Criteria Appendix of this SPD, begins on the Effective Date.

Coverage for an individual, who is an Associate on or at any time following the Effective Date and who incurs a Termination of Employment after the Effective Date will begin on the later of: the day the former Associate satisfies the eligibility requirements for at least one Benefits Option as discussed in the Eligibility Criteria Appendix of this SPD, or the first day of the calendar month following the calendar month in which the former Associate's Termination of Employment occurred. In no event will the coverage under this HRA begin before the earlier of the Effective Date of this HRA. The effective date of this HRA is identified in the Plan Information Appendix.

Q-6. When does coverage under this HRA end?

Coverage ends on the earlier of:

(a) the date of your death (however, please review the applicable MPRO or Healthcash Benefit Option Appendix that has been provided to you to identify situations in which coverage may continue for your Spouse or Dependents after your death);

(b) the date you elect to permanently opt out of and waive future reimbursements from your Reimbursement Account;

(c) if you are a Participant in the Healthcash Benefit Option, the date that there are no HRA Dollars remaining in your Reimbursement Account;

(d) the date an adopting Affiliate Employer of the Retiree withdraws from participation in the Plan; or

(e) the date that this Plan is terminated by the Company.

All HRA Dollars that are not applied towards Eligible Medical Expenses incurred before your coverage termination date are forfeited, except as otherwise described in the applicable MPRO or Healthcash Benefit Option Appendix of this SPD.

Q-7. How do I enroll in the HRA?

Generally, once you satisfy the eligibility requirements discussed in the Eligibility Criteria Appendix of this SPD, you will receive notice from the Third Party Administrator that you are eligible to participate in the Plan, unless you affirmatively elect to opt out of and waive coverage under the Plan. However, there are certain circumstances in which your participation in the Plan may/will be delayed. Please see the applicable MPRO or Healthcash Benefit Option Appendix of this SPD to determine when you will begin participating in the Plan.

Q-8. What is an "Eligible Medical Expense?"

"Eligible Medical Expenses" vary based on whether the Participant is eligible for the MPRO or the Healthcash Benefit Option. Please see the applicable MPRO or Healthcash Benefit Option Appendix of this SPD to identify the Eligible Medical Expenses for your Benefit Option.

Q-9. What is a Reimbursement Account?

Once you become a Participant, the Employer establishes a Reimbursement Account for you. The Reimbursement Account is a notional bookkeeping account that keeps a record of HRA Dollars allocated to your account and reimbursements made to you under this HRA. You have no property rights in the Reimbursement Account.

Q-10. Who contributes to my Reimbursement Account?

While you are enrolled in the Plan as a Participant, the Employer allocates HRA Dollars to your Reimbursement Account. The amount and frequency of the HRA Dollar allocations will depend on whether you are eligible for the MPRO or the Healthcash Benefit Options. You do not contribute to your Reimbursement Account, nor do you pay for this coverage. However, your Spouse or Dependents may be required to pay the "applicable premium" for continuation of HRA coverage under COBRA (please refer to the COBRA Continuation of Coverage Appendix for more information regarding COBRA continuation coverage).

Q-11. How are HRA Dollars allocated to my Reimbursement Account?

The Employer will allocate a specified amount of HRA Dollars to your Reimbursement Account, based on your Benefit Option. Please see the applicable MPRO or Healthcash Benefit Option Appendix of this SPD for an explanation of when the "HRA Dollars" will be allocated to your Reimbursement Account (i.e., on a one-time or annual basis).

These Appendices will also provide information about the amount of HRA Dollars that will be contributed to your Reimbursement Account. The amount of HRA Dollars allocated to your Reimbursement Account is determined in the sole discretion of the Employer in a uniform and non-discriminatory manner and may vary depending on circumstances, including but not limited to, Benefit Option and family status.

Q-12. What happens if I do not use all of the HRA Dollars allocated to my Reimbursement Account during the Plan Year?

If you do not use all of the HRA Dollars allocated to your Reimbursement Account, the HRA Dollars remain in your Reimbursement Account for reimbursement of Eligible Medical Expenses during a subsequent Plan Year (to the extent you remain covered under the Plan).

When your coverage terminates under the Plan, any HRA dollars remaining in your Reimbursement Account will be forfeited and returned to the Employer, unless your Spouse and/or Dependents may continue to receive Plan benefits, as described in the applicable MPRO or Healthcash Benefit Option Appendix of this SPD.

Q-13. Is there a limit on how much can be allocated to my Reimbursement Account?

The amount of HRA Dollars that will be allocated to your Reimbursement Account will vary based on the Benefit Option that you are eligible to participate in. Please see the applicable MPRO or Healthcash Benefit Option Appendix of this SPD. There is no limit on the balance that you may maintain in your Reimbursement Account at any given time.

Q-14. What is the maximum amount of reimbursement that I may receive under the HRA?

The maximum reimbursement amount that you can receive is equal to your Reimbursement Account balance at the time the request for reimbursement is processed. Any portion of a claim for reimbursement that exceeds the maximum reimbursement amount will be pended and processed if and when the Reimbursement Account becomes sufficient. Pended claims will be processed and, if appropriate, paid before any new claims are processed and paid.

Q-15. Will a change in status cause the amount of HRA Dollars allocated to my Reimbursement Account to change during the Plan Year?

In some instances, the gain or loss of a Spouse, or your return to work for the Employer may cause your HRA Dollar allocation to be adjusted to the extent described in the applicable MPRO or Healthcash Benefit Option Appendix of this SPD. All adjustments (if any) will be applied only prospectively.

Q-16. How do I receive reimbursement under the HRA?

Under this HRA, your reimbursement options will vary based on the Benefit Option that you are eligible for. Please consult the applicable MPRO or Healthcash Benefit Option Appendix of this SPD for more information about the reimbursement options for your Benefit Option.

Q-17. What happens if my claim for benefits is denied?

If you are denied a benefit under the Plan, you should proceed in accordance with the following procedures contained in the Appeal Procedures Appendix of this SPD.

Q-18. What happens if I receive overpayments or reimbursements made in error from this HRA?

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error (i.e., you were reimbursed for an expense under the HRA that is later paid for by another health plan), you will be required to refund the overpayment or erroneous reimbursement to the HRA.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Plan Administrator may consider the payment to be taxable income to you. In addition, if the Plan Administrator determines that you have submitted a fraudulent claim, the Plan Administrator may terminate your coverage under this HRA.

Q-19. How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan indefinitely, it has the right to modify or terminate the Plan at any time for any reason.

Q-20. Does the Plan coordinate benefits with other Medical Benefits?

Generally, only medical care expenses that have not been or will not be reimbursed by any other source may be Eligible Medical Expenses (to the extent all other conditions for Eligible Medical Expenses have been satisfied). As such, this HRA does not coordinate benefits with any other group or individual health coverage except to the extent required by Medicare secondary payer rules.

Q-21. Who do I contact if I have questions about the HRA?

If you have any questions about the HRA, you should contact the Third Party Administrator or the Plan Administrator. Contact information for the Third Party Administrator and the Plan Administrator is provided in the Plan Information Appendix.

PART II: ERISA Rights

This HRA is a welfare benefit plan as defined in the Employee Retirement Income Security Act (ERISA). ERISA provides that you, as a Plan Participant, will be entitled to:

1. Receive Information about Your Plan and Benefits

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

- Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated Summary Plan Description. The Plan Administrator may apply a reasonable charge for the copies.

- The Plan Administrator is required by law to furnish each participant with a copy of the summary annual report.

2. Continue Plan Coverage

- Please refer to the COBRA Continuation of Coverage Appendix of this SPD for more information regarding the right to continue coverage under the Plan as a result of a qualifying event.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the 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 welfare benefit from the Plan, or from exercising your rights under ERISA.

4. Enforcement of Your Rights

If your claim for a welfare benefit under an ERISA-covered plan is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits that 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 (i.e., if it finds your claim is frivolous).

5. Assistance with Your Questions

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 obtaining documents from the Plan Administrator, you should contact the nearest office of the U.S. Department of Labor, Employee Benefits Security Administration listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Ave., 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.

PART III: Appendices

PLAN INFORMATION APPENDIX

This Appendix provides information specific to the above-named Employer's Health Reimbursement Arrangement for Retirees.

**The effective date of this amended Plan Information Appendix is September 27, 2023.*

GENERAL PLAN INFORMATION

1. Name, Address, and Telephone Number of the Employer/Plan Sponsor:	JM Family Enterprises, Inc. 100 Jim Moran Boulevard Deerfield Beach, FL 33442 954-429-2000
2. Name, Address, and telephone Number of the Plan Administrator: The Plan Administrator shall have the exclusive right to interpret the Plan and to decide all matters arising under the Plan, including the right to make determinations of fact, and construe and interpret possible ambiguities, inconsistencies, or omissions in the Plan and the SPD issued in connection with the Plan. The Plan Administrator may delegate one or more of its responsibilities to one or more committees or third parties.	JM Family Enterprises, Inc. Benefits Committee JM Family Enterprises, Inc. 100 Jim Moran Boulevard Deerfield Beach, FL 33442 954-429-2000
3. Address for Service of Legal Process:	JM Family Legal Department 100 Jim Moran Boulevard Deerfield Beach, FL 33442
4. Employer's Federal Tax Identification Number:	59-1390794
5. Plan Number:	503

6. Original Effective Date of the HRA:	January 1, 2016
7. Plan Year:	January 1 through December 31
8. Affiliated Employers participating in the Plan:	Century Warranty Services, Inc. Courtesy Insurance Company Fidelity Warranty Services, Inc. Jim Moran & Associates, Inc. JM Family Enterprises, Inc. SET Services Group LLC Southeast Toyota Distributors, LLC and its Vehicle Processing division Southeast Transportation Systems, Inc. World Omni Financial Corp.; and effective September 1, 2016, its DataScan division
9. Third Party Administrator: The Plan Administrator has delegated certain day-to-day ministerial administrative duties such as claims processing to the Third Party Administrator. The Third Party Administrator processes claims and performs other administrative duties in accordance with the terms of the Plan and/or the Plan Administrator's instructions. In addition, the Third Party Administrator may rely on guidance from applicable regulatory agencies to assist it in administering the Plan in accordance with its terms.	HealthEquity www.healthequity.com/wageworks 877-924-3967 Hearing Impaired (TTY): 866-353-8058 International resident: 262-238-4000
10. COBRA Administrator	JM Family Enterprises, Inc. 100 Jim Moran Boulevard Deerfield Beach, FL 33442 Phone: 954-420-3366 Fax: 954-363-4146

11. How is the HRA funded?	General Assets
12. Payment Claim Date	Any unclaimed reimbursement amounts (i.e., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) within 120 days after the check is issued.

ELIGIBILITY CRITERIA APPENDIX

ELIGIBILITY FOR MEDICAL PLAN RETIREMENT OPTION (MPRO) BENEFIT OPTION

As explained earlier in this SPD, capitalized terms used throughout this document, including the terms "Years of Service" and "Disabled Associate" used within this Appendix, shall have the same meaning prescribed to it in the official plan document. For your convenience, "Years of Service" are determined in accordance with the Vesting Years of Service provisions under the JM Family Enterprises, Inc. Associates' Retirement Plan (but in no case do references to "Years of Service" in this Appendix bestow eligibility on a Retiree not otherwise eligible to participate in the Retirement Plan), and "Disabled Associate" means an individual receiving benefits under a long-term disability insurance policy sponsored by the Employer.

You will be eligible to participate in the MPRO Benefits Option of the HRA if you satisfy the following eligibility criteria:

A. Prior to January 1, 2006, you:

1. attained age fifty-five (55), and

2. accrued ten (10) or more Years of Service; and

3. then experienced a Termination of Employment; **OR**

B. You:

1. attained age fifty (50) as of December 31, 2005, and

2. experience(d) a Termination of Employment after 2005, and

3. at the time of your Termination of Employment, you had:

   i. attained age fifty-five; and

   ii. accrued ten (10) or more Years of Service, and

4. you did not waive participation in the MPRO Benefits Option (or its predecessor benefit plan) in favor of the Healthcash Benefit Option (or its predecessor benefit plan) in the time leading up to January 1, 2006, the date the predecessor Healthcash Plan first became effective, in the manner prescribed by applicable administrative procedures; **OR**

C. You:

1. were a Disabled Associate who attained age fifty (50) as of December 31, 2005, and

2. while a Disabled Associate, you:

i. attained age fifty-five; and

ii. accrued ten (10) or more Years of Service, and:

3. you did not waive participation in the MPRO Benefits Option (or its predecessor benefit plan) in favor of the Healthcash Benefits Option (or its predecessor benefit plan) in the time leading up to January 1, 2006, the date of predecessor Healthcash Plan first became effective, in the manner prescribed by applicable administrative procedures; **OR**

D. You:

1. experienced a Termination of Employment or became a Disabled Associate prior to the Effective Date of this Plan; and

2. despite the fact that you satisfied the criteria under sections A., B. or C. above, you elected not to receive MPRO Benefits; and

3. as part of the one-time Lookback Group election, you affirmatively elected to opt into the Plan on or about the Plan's Effective Date.

If you satisfy the eligibility criteria under Sections A.,B., C., or D. above, you will be eligible to participate in the MPRO Benefit Option of the HRA. Information about this Benefit Option can be found in the MPRO Benefit Option Appendix of this SPD.

ELIGIBILITY FOR HEALTHCASH BENEFIT OPTION

You will be eligible to participate in the Healthcash Benefits Option of the HRA if you satisfy the following eligibility criteria:

A. After 2005, you:

1. attained age fifty (50) and experienced a Termination of Employment, and

2. at the time of your Termination of Employment, you had:

i. attained age fifty-five (55); and

ii. accrued ten (10) or more Years of Service, **OR**

B. You:

1. satisfied the criteria in subsections B.1-3 or C. 1-2 under Eligibility for MPRO Benefit Option, and

2. waived participation in the MPRO Benefits Option (or its predecessor plan) in favor of the Healthcash Benefits Option (or its predecessor plan) in the time leading up to January 1, 2006, the date the predecessor Healthcash plan first became effective, in the manner prescribed by applicable administrative procedures; **OR**

C. You:

1. are a Disabled Associate who attained age fifty (50) after 2005, and

2. while a Disabled Associate, you have:

   i. attained the age of fifty-five (55), and

   ii. accrued ten (10) or more Years of Service.

If you meet the eligibility criteria contained in paragraphs A., B., or C. above, you will be eligible to participate in the Healthcash Benefit Option of the HRA. Information about this Benefit Option can be found in the Healthcash Benefit Option Appendix of this SPD.

APPEAL PROCEDURES APPENDIX

Step 1: *Notice is received from Third Party Administrator.* If your claim is denied, you will receive written notice from the Third Party Administrator that your claim is denied as soon as reasonably possible, but no later than 30 days after receipt of the claim. For reasons beyond the control of the Third Party Administrator, the Third Party Administrator may take up to an additional 15 days to review your claim. You will be provided written notice of the need for additional time prior to the end of the 30-day period. If the reason for the additional time is that you need to provide additional information, you will have 45 days from the notice of the extension to provide that information. The time period during which the Third Party Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the 45-day period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Third Party Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a right to request all documentation relevant to your claim.

Step 3: *If you disagree with the decision, file an appeal.* If you do not agree with the decision of the Third Party Administrator, you may file a written appeal. You should file your appeal no later than 180 days after receipt of the notice described in Step 1. The Plan has established two levels of appeal; therefore, you should file your first-level appeal with the Third Party Administrator. You should submit all information identified in the notice of denial, as necessary, to perfect your appeal and any additional information that you believe would support your appeal to: Health Equity, Attn: Reimbursement Accounts, 15 W. Scenic Pointe Dr., Draper, UT 84020

A first-level claims appeal form is available online at the following address:
https://resources.healthequity.com/Forms/Claims_Appeal_Form.pdf

Step 4: *Notice of Denial is received from claims reviewer.* If the claim is again denied on first-level appeal, you will be notified in writing no later than 30 days after receipt of the appeal by the Third Party Administrator.

Step 5: *Review your Second Notice of Denial carefully.* You should review the *second* Notice of Denial carefully. The second Notice will contain the same type of information that is provided in the first Notice of Denial provided by the Third Party Administrator.

Step 6: *If you still disagree with the Third Party Administrator's decision, file a 2nd Level Appeal with the Plan Administrator.* If you still do not agree with the Third Party Administrator's decision, you may file a written second-level appeal with the Plan Administrator within 60 days after receiving the first level appeal denial notice from the Third Party Administrator. You should gather any additional information that is identified in the second Notice of Denial as necessary to perfect your second-level appeal and any other information that you believe would support your appeal. Send your second level appeal to: Appeals

Committee, JM Family Enterprises, Inc., Attn: Retiree Medical/Administrative Committee 100 Jim Moran Blvd., Deerfield Beach, FL, 33442.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information; and
- You cannot file suit in federal court until you have exhausted these appeal procedures.

COBRA CONTINUATION OF COVERAGE APPENDIX

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a "qualifying event" (defined below). The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should contact the Plan Administrator.

Upon becoming eligible for the HRA, you will have certain COBRA continuation coverage rights and responsibilities. **Please review this appendix carefully and maintain it in your records, as it provides important information regarding COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it**. In addition to this appendix, you will be provided an election notice that gives more detailed information regarding your continuation coverage rights following a qualifying event. If you believe you have experienced a qualifying event and do not receive an election notice, you should contact the Plan Administrator or the designated Third Party Administrator immediately.

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

<u>When Coverage May Be Continued Under COBRA</u>

Only “Qualified Beneficiaries” may elect COBRA continuation coverage. A Qualified Beneficiary with respect to this Plan is you, a Spouse, and/or Dependent child who lose coverage as a result of one of the following Qualifying Events:

For you:

- Commencement of a proceeding in bankruptcy with respect to the Employer

For your Spouse:

- Divorce or legal separation
- Death of the Participant (however, please review the applicable MPRO or Healthcash Benefit Option Appendix that has been provided to you to identify situations in which coverage may continue for your Spouse or Dependents after your death)
- Commencement of a proceeding in bankruptcy with respect to the Employer

For your Dependent:

- Child ceasing to be a Dependent (as defined by the Plan)
- Death of the Participant (however, please review the applicable MPRO or Healthcash Benefit Option Appendix that has been provided to you to identify situations in which coverage may continue for your Spouse or Dependents after your death)
- Commencement of a proceeding in bankruptcy with respect to the Employer

Required Notice

A Qualified Beneficiary must provide notice to the designated COBRA Administrator (identified in the Plan Information Appendix) within 60 days of the later of the date of the Qualifying Event or the date coverage is lost as a result of the Qualifying Event. A Qualified Beneficiary can call, fax or mail this information to the designated COBRA Administrator.

Following the date that the COBRA Administrator has received notice that you have experienced a Qualifying Event (as required above) the Qualified Beneficiary(ies) will receive an Election Notice. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. The Qualified Beneficiary must complete the Election Notice and return it to the COBRA Administrator no later than 60 days from the later of the date of the Qualifying Event or the date the Election Notice is received from the COBRA Administrator. The right to continuation coverage will be lost if the Election Notice is not returned to the COBRA Administrator within the 60-day period. Each Qualified Beneficiary has an independent right to elect continuation coverage. A Qualified Beneficiary can call, fax or mail the Election Notice to the COBRA Administrator.

Paying for Coverage

Qualified Beneficiaries are required to pay the entire cost of continuation coverage (as determined by the COBRA Administrator or its designee) plus a two percent administrative fee. The monthly contribution amount will be provided in the Election Notice.

The first contribution is due 45 days after the date the Qualified Beneficiary sends the Election Notice to the COBRA Administrator. The first contribution covers the period beginning on the date that coverage is lost to the end of the month in which you are sending you payment. All subsequent contributions are due the first of each month that continuation coverage is in effect. Failure to make the subsequent contribution payments within 30 days of the due date will cause continuation coverage to terminate retroactive to the end of the month in which the last full payment was received. Additional information about making contribution payments will be sent with the Election Notice.

Type of Coverage

If you choose continuation coverage, you are entitled to the level of coverage under the HRA in effect for you immediately preceding the qualifying event. At the beginning of each plan year that COBRA is in effect, you will be entitled to an increase in your Reimbursement Account Balance equal to the sum of the HRA Dollars allocated to similarly situated Participants in the same Benefit Option (subject to any restrictions applicable to similarly situated Participants) so long as you continue to pay the applicable premium.

When Continuation Coverage Ends

Continuation coverage will generally end on the earlier of the first to occur:

- 18 months from the date of the Qualifying Event
- The end of the month in which you last made a timely and complete contribution payment
- The Qualified Beneficiary becomes entitled to Medicare
- The Qualified Beneficiary becomes covered by another group health plan after electing continuation coverage to the extent that the Qualified Beneficiary is not subject to a pre-existing condition exclusion period
- The Employer terminates all Plan coverage
- For any reason that coverage for a non-Qualified Beneficiary might end (i.e., submission of fraudulent claims)
- Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or your Spouse or Dependents covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

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

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children

getting COBRA continuation coverage if you die; become entitled to Medicare benefits (under Part A, Part B, or both); get divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Obtaining Individual Coverage

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

General Information

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator using the contact information found in the Plan Information Appendix. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

MPRO BENEFIT OPTION APPENDIX

This Section only applies to Retirees that satisfy the eligibility criteria for the MPRO Benefit Option as described in the Eligibility Criteria Appendix of this SPD. If you do not meet the eligibility criteria for the MPRO Benefit Option, this information will not apply to your coverage under the HRA Plan.

I. HRA Dollars

Prior to January 1, 2019, you received HRA Dollar credits to your HRA account on a monthly basis ($650 per month if you were not yet eligible for Medicare, and $300 per month if you were enrolled in Medicare).

Effective, January 1, 2019, if you are not yet eligible for Medicare, you will receive a $7,800 HRA Dollar credit to your HRA account on the first day of the Plan Year. If you have enrolled in Medicare, you will receive a $3,600 HRA Dollar credit to your HRA account on the first day of the Plan Year.

Similarly, if you have a Spouse that is not eligible for Medicare (as of the first day of the Plan Year), you will receive an additional $7,800 HRA Dollar to your HRA account on the first day of the Plan Year, and if you have a Spouse that has enrolled in Medicare (as of the first day of the Plan Year), you will receive an additional $3,600 HRA Dollar credit to your HRA account on the first day of the Plan Year.

If your Spouse is an Associate or former Associate and is eligible to participate in this MPRO Benefit Option as a Participant, you will not receive a credit to your HRA account for your Spouse. Rather, your Spouse will be permitted to enroll in the Plan and receive credits as a Participant, however he or she will also not receive a spousal credit due to your participation in the Plan.

If your Spouse is an Associate or former Associate who may become eligible to participate in the Healthcash Benefit Option, you will only receive a credit to your HRA account for your Spouse if he or she is not eligible to receive benefits under the Plan upon termination.

For purposes of this Appendix, a Participant and his/her Spouse will be deemed to have enrolled in Medicare on the first day of the calendar month in which the Participant and/or his/her Spouse attains age sixty-five (65). Notwithstanding the foregoing, a Participant and his/her Spouse may be deemed to have enrolled in Medicare prior to attaining age sixty-five (65) as a result of certain disabilities. The Participant is responsible for informing the Employer if either the Participant, or the Participant's Spouse enrolls in Medicare either prior to, or after, the first day of the calendar month in which the Participant or the Participant's Spouse attains age sixty-five (65).

HRA Dollars may only be used to pay for Eligible Medical Expenses. If the HRA Dollar credit amount changes, you will be notified by the Plan Administrator.

II. Eligible Medical Expense

As a Participant in the MPRO Benefit Option of the HRA, you will be eligible to use your HRA Dollars to pay for any Eligible Medical Expenses. "Eligible Medical Expenses" are medical care expenses incurred by you, your Spouse, or your Dependents that are for "medical care" as defined in Internal Revenue Code Section 213(d). "Incurred" means the date the service or treatment is provided; not when the expense arising from the service or treatment is paid. Thus, an expense that has been paid but not incurred (i.e., pre-payment to a physician) will not be reimbursed until the services or treatment giving rise to the expense has been provided. Also, an otherwise Eligible Medical Expense will not be reimbursed unless the requirements described in Section IV below have been satisfied.

Eligible Medical Expenses include, but are not limited to, the following:

A. Health plan premiums, including for medical, dental, or vision coverage;

B. out of pocket expenses for prescription drugs;

C. hospital bills;

D. dental treatments;

E. long-term care insurance premiums;

F. eyeglasses;

G. co-pays; and

H. medical equipment.

You may allocate the HRA Dollars in your HRA account to pay for Eligible Medical Expenses for you, your Spouse, or your Dependents, as you see fit.

Despite the above, the determination of whether an expense is an Eligible Medical Expense is determined within the sole discretion of the Third Party Administrator, subordinate to the Plan Administrator.

III. Participation in the MPRO Benefit Option

Generally, you (and your Spouse and/or Dependents) will become eligible for coverage under this Plan, and will be required to enroll in the Plan immediately following your Entry Date. However, in some circumstances, you (and your Spouse and/or Dependents) may be permitted to delay your enrollment in the Plan.

A. Extended Coverage Under JM Family Medical Plan through Medicare Eligibility, or December 31, 2022, Whichever Comes First

1. Retirees Participating in the Plan on December 31, 2017

If on December 31, 2017, you (and your Spouse): (i) are enrolled in this Plan, and (ii) have not yet attained Medicare eligibility, you will be given the opportunity to waive coverage under this Plan for you (and your Spouse), and instead enroll in the JM Family Medical Plan that is offered to active associates.

If on December 31, 2017: (i) you (and your Spouse) are enrolled in this Plan, and (ii) you (but not your Spouse) have attained Medicare eligibility, your Spouse will be given the opportunity to waive coverage under this Plan, and instead enroll in the JM Family Medical Plan that is offered to active associates.

Enrollment by you and/or your Spouse, as applicable, in the JM Family Medical Plan will be contingent upon the completion of your timely enrollment election as required by the JM Family Medical Plan Administrator, and the payment of all required premiums. If you (and/or your Spouse) satisfy the conditions outlined in this Section III.A.I. of this MPRO Benefit Option Appendix and successfully enroll in the JM Family Medical Plan, you and/or your Spouse will be deemed to have postponed your participation in this Plan until such time that your (and/or your Spouse's) eligibility for coverage under the JM Family Medical Plan ends.

2. Retirees Eligible for the Plan On or After January 1, 2018

If you become eligible for this Plan for the first time on or after January 1, 2018, you (and/or your Spouse) will be deemed to have postponed participation in this Plan provided that: (i) you (and/or your Spouse) have not yet attained Medicare eligibility, and (ii) you (and/or your Spouse) remain enrolled in the JM Family Medical Plan, until such time that your (and/or your Spouse's) eligibility for coverage under the JM Family Medical Plan ends.

B. Additional Delays in Enrollment Permitted

In addition to the delays in enrollment permitted if you (and/or your Spouse) are eligible for extended coverage under the JM Family Medical Plan as described in Section Section III.A. of this MPRO Benefit Option Appendix, there are a number of other circumstances that will allow you and/or your Spouse to postpone your participation in this Plan.

These circumstances include:

- if your Spouse and/or Dependents are covered under the group health plan offered by your Spouse's employer, provided that such employer may not be JM Family Enterprises, Inc. or any of its affiliates;

- if you joined the Plan as part of the one-time Lookback Group election, but had previously enrolled in a Medicare plan that restricted your ability to drop such coverage;

- if your Spouse and/or Dependents receives medical coverage as a result of prior military service (including TRICARE, or coverage from the Veterans Administration (VA) for a service-connected condition);

- for any period during which you receive Employer-paid coverage following your Termination From Employment (including as a result of a separation agreement, retention agreement, or some form of severance package);

provided that you must provide the Plan Administrator with notice of the circumstance which allow you to delay your enrollment in coverage under the Plan. You must also notify the Plan Administrator if there is a change in your circumstances which allowed you to delay enrollment in the Plan no more than 30 calendar days following the change.

In addition to the circumstances listed above during which you may/must delay your enrollment in coverage through the Plan, you may also elect to suspend your benefits under the HRA for a Plan Year in which you receive a Federal Premium Subsidy. You will be required to affirmatively request that the Plan Administrator suspend your benefits prior to the start of the Plan Year in question. Please contact the Plan Administrator for more details.

Notwithstanding the special delays in enrollment if: (i) you are eligible for extended coverage in the JM Family Medical Plan, as described in Section III.A. above of this MPRO Benefit Option Appendix, and/or (ii) you receive Employer-paid coverage following your Termination From Employment, as described in Section III.B. above of this MPRO Benefit Option Appendix; you will not be permitted to delay your enrollment in this Plan as a result of your voluntary enrollment in COBRA continuation coverage under

the JM Family Medical Plan. Therefore, absent one of the two specific circumstances described in the prior sentence, an election to voluntarily enroll in COBRA continuation coverage after your Termination From Employment will result in the forfeiture of your eligibility and entitlement to benefits under this Plan.

IV. Benefit Claim Information

You will receive information from the Third Party Administrator regarding how you may use your HRA Dollars to pay for Eligible Medical Expenses. You will also receive information from the Third Party Administrator regarding the claims substantiation proof that must be provided with each request for reimbursement. For substantiation for Eligible Medical Expenses, you must provide as much information as the Third Party Administrator (or the Plan Administrator, as the case may be) determines necessary to substantiate the nature, amount, and timeliness of any expenses that may be reimbursed.

If your claim for reimbursement is approved, you will be provided reimbursement as soon as reasonably possible following the determination. Any unclaimed reimbursement amount (i.e., failing to cash a reimbursement check) will be forfeited and returned to the Employer if not claimed (or cashed) by the "Payment Claim Date" identified in the Plan Information Index. If your claim for reimbursement is denied, in whole or in part, you will be notified according to the HRA's claims review procedures described in Q-17 in the SPD above.

Death of Participant

In the event of a Participant's death, HRA Dollar contributions to the Participant's HRA account that are made on behalf of the Participant will end. Notwithstanding the foregoing, if the Participant was married on the date of his or her death, HRA Dollar contributions may continue on behalf of his or her Spouse as discussed in greater detail below.

If the Participant was unmarried on the date of his or her death, the Participant's coverage will terminate under the HRA and there will be no new HRA Dollar contributions to the Participant's HRA account, and any remaining balance will be forfeited according to Q-12 of the SPD.

If the Participant was married on the date of his or her death, there will be no new HRA Dollar contributions to the Participant's HRA account on behalf of the Participant. However, any balance in the Participant's HRA account on the date of his or her death will remain, and HRA Dollar contributions will continue to be made on behalf of the Participant's Spouse on an annual basis in the amount of the Spouse Contribution. The Participant's Spouse will then be treated as if he or she were the Participant, for purposes of reimbursing Eligible Medical Expenses. Upon the death of the Participant's Spouse, regardless of whether the deceased Participant or the deceased Participant's Spouse have surviving Dependents, coverage under the HRA will terminate. Any remaining balance in the HRA account deposited in the Plan Year of the Participant’s Spouse’s death in the Participant's HRA account will be forfeited according to Q-12 of the SPD.

In the event that a married Associate dies prior to his or her Termination of Employment, if the married Associate would otherwise have been eligible to participate in the MPRO Benefits Option on the date of

his or her death if he or she had retired on the day preceding his/her death, the deceased Associate's Spouse will still be eligible to receive annual HRA Dollar contributions in the amount of the Spouse Contribution. The deceased Associate's Spouse will then be treated as if he or she was the Participant, for purposes of reimbursing Eligible Medical Expenses. Upon the death of the deceased Associate's Spouse, regardless of whether the deceased Associate or deceased Associate's Spouse have surviving Dependents, coverage under the HRA will terminate. Any remaining balance in the HRA account deposited in the Plan Year of the Participant's Spouse's death in the Participant's HRA account will be forfeited according to Q-12 of the SPD.

In the event that an unmarried Associate dies prior to his or her Termination of Employment, and who would otherwise have been eligible to participate in the MPRO Benefits Option on the date of his or her death, regardless of whether the unmarried Associate has surviving Dependents, no HRA Dollar contributions will be made under the MPRO Benefits Option on behalf of the deceased Associate.

In the event that the Employer erroneously credits a Participant's HRA account after the death of the Participant and/or the Participant's Spouse, the Participant's HRA account will be forfeited according to Q-12 of the SPD.