FLEXIBLE BENEFIT PLAN

with General & Limited Medical FSA on the Beniversal® MasterCard®

PLAN HIGHLIGHTS*

A. General Plan Information

1. Employer name: AMG Vanadium LLC.
2. Plan name: AMG Vanadium Flexible Benefit Plan.
3. Plan type: The Plan is a welfare plan designed to provide benefits permitted under Section 125 of the Internal Revenue Code (IRC). The Plan name and Plan number should be used in any formal correspondence relating to the Plan.
4. Eligibility requirements: Must be an employee of AMG Vanadium LLC and:
   - For Insurance Premiums, General Medical Flexible Spending Account (General Medical FSA) and Dependent Care Flexible Spending Account (Dependent Care FSA): who works at least 40 hours per week.
     - *If you or your spouse is reporting contributions to a Health Savings Account (HSA), you are not eligible for a General Medical FSA.*
   - For a Limited Medical FSA: who works at least 40 hours per week and does not participate in a General Medical FSA.
5. The effective date on which you can begin participating in the Plan: Once the eligibility requirements have been met.
6. Kinds of group insurance for which you can pay your share of premiums through the Plan: Medical Insurance.
7. The Plan Year begins on January 1 and ends on December 31.
8. Plan effective date: January 1, 2022.
9. Plan number: 501.
10. Employer ID number: 20-2931565.
11. Name, address and telephone number of the Plan Administrator:
    AMG Vanadium LLC
    60790 Southgate Road
    Cambridge, OH 43725
    (740) 435-5937
12. Agent for service of process: AMG Vanadium LLC.

B. Flexible Spending Accounts (FSAs)

1. Types of FSAs

<u>General Medical FSA</u>

(a) Maximum amount you can set aside per Plan Year for reimbursement of eligible medical expenses as defined by IRC Section 213(d) except for insurance premiums: $3,050.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year or during the 2 ½ month grace period following the end of the Plan Year. The grace period ends March 15.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan,
  - during the Plan Year and
  - prior to the date on which you become ineligible.
- The Beniversal Card may no longer be used to access General Medical FSA funds. You may submit a claim for reimbursement of eligible expenses.

<u>Limited Medical FSA</u>

(a) Maximum amount you can set aside per Plan Year for reimbursement of eligible vision care and dental care expenses as defined by IRC Section 213(d): $3,050.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year or during the 2 ½ month grace period following the end of the Plan Year. The grace period ends March 15.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan,
  - during the Plan Year and
  - prior to the date on which you become ineligible.

- The Beniversal Card may no longer be used to access Limited Medical FSA funds. You may submit a claim for reimbursement of eligible expenses.

Dependent Care FSA

(a) Maximum amount you can set aside per calendar year for reimbursement of eligible dependent care services, as defined by IRC Section 21(b), is limited to the smallest of the following amounts:
- $5,000 if single or if married and filing jointly; $2,500 if married and filing separately.
- The earned income of the participant.
- The earned income of the participant's spouse.

(b) For active participants:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year or the 2 ½ month grace period following the end of the Plan Year. The grace period ends March 15.

(c) If you become ineligible (including termination of employment) during the Plan Year:
- Eligible services must be provided:
  - after your effective date in the Plan and
  - during the Plan Year in which you become ineligible.

2. Claims for FSAs

Claim submission time frames for eligible participants

(a) Claims must be received by Benefit Resource, LLC before the end of the 15 day run-out that follows the grace period.
(b) Claims denied during the run-out may be resubmitted, but must be received by Benefit Resource within 21 days after the run-out ends.
(c) Any funds remaining in your account after this will be forfeited.

Claim submission time frames for ineligible participants

(a) Claims must be received by Benefit Resource, LLC before the end of the 30 day run-out after the end of the Plan Year.
(b) Claims denied during the run-out may be resubmitted, but must be received by Benefit Resource within 21 days after the run-out ends.
(c) Any funds remaining in your account after this will be forfeited.

Claim reimbursements

(a) Complete your claim following all instructions.
(b) Claims received with proper documentation will be processed within 5 business days.
(c) Claim reimbursements are processed daily.
(d) There is a minimum reimbursement amount of $15 (except during the run-out after the end of the Plan Year).
(e) A claim should never be submitted for an expense that has been paid for with a Beniversal Card or reimbursed from any other source.

3. Beniversal Card for General, Limited Medical or Dependent Care FSA

(a) The Beniversal Card allows you to access General, Limited and Dependent Care FSA funds to pay for eligible services at qualified merchants.
(b) The card may only be used to pay for eligible services after they have been provided. The IRS allows one exception: eligibility of orthodontia expenses can be based on either date of payment, date of service or payment due date on coupons/statements.
(c) Once a new Plan Year begins, you can access your General, Limited and Dependent Care FSA funds associated with the new Plan Year and any General, Limited and Dependent Care FSA funds remaining from your prior Plan Year on your Beniversal Card:
- Prior Plan Year General, Limited and Dependent Care FSA funds can be accessed through the 2 ½ month grace period following the end of the Plan Year *(refer to Section B. 1)*.
- Unused prior Plan Year General, Limited and Dependent Care FSA funds are forfeited after the end of the run-out that follows the grace period *(refer to Section B.2)*.

(d) You are advised to save all documentation related to eligible expenses paid with your card, as IRS regulations require all FSA transactions to be verified for eligibility.
(e) If a card transaction cannot be automatically verified, you will be contacted to submit documentation for that transaction.
(f) Medical and Dependent Care expenses paid with the card should never be submitted for claim reimbursement.