

**Ensign United States Drilling Inc.**

**Cafeteria Plan**

**Plan Document**

**Amended and Restated as of January 1, 2025, unless otherwise noted**

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# Ensign United States Drilling Inc.

## Cafeteria Plan

### ARTICLE I

#### Introduction

1.1 Purpose of Plan. The purpose of this Plan is to provide eligible employees of Ensign United States Drilling Inc. a choice between cash and benefits under one or more Qualified Benefit Plans.

1.2 Plan Status. This Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code of 1986, as amended from time to time (the "Code"). The plan was established effective January 1, 2008 and amended and restated effective January 1, 2025.

### ARTICLE II

#### Participation

2.1 Commencement of Participation. Each regular full-time and part-time employee who is regularly scheduled to work for the Plan Sponsor at least 25 hours per week is eligible to participate in the Health Care FSA Program and the Dependent Care FSA Program on the first day of the month following or coinciding with his or her date of hire. For all other Qualified Benefit Plans, each Employee will be eligible to participate in the Plan on the first day on which he or she meets the eligibility requirements of any Qualified Benefit Plan. An Employee will become a Participant upon making an appropriate election in accordance with the provisions of Section 3.3.

2.2 Cessation of Participation. Subject to the rights of a Participant or his or her spouse and/or Dependents to elect continuation of health care coverage under Code Section 4980B, a Participant will cease to be a Participant in the Plan as of the earlier of (i) the date on which this Plan terminates or (ii) the date on which he or she dies, terminates employment with the Plan Sponsor, or ceases to be an Employee eligible to participate under Section 2.1.

2.3 Reinstatement of Former Participant. A former Participant will again become a Participant if and when he or she first meets the eligibility requirements of Section 2.1.

2.4 Participation During FMLA and Uniformed Services Leave of Absence; Similar State Leaves. Any Employee who is absent from work due to (i) an FMLA Leave; (ii) a period of duty in the Uniformed Services; or (iii) leave under a similar or equivalent, applicable state family and medical leave law that required health benefits continuation, will have the right to continue participation in any Qualified Benefit Plan to the extent, and for the time period, required by law. The Employee's right to maintain coverage while on a leave of absence (other than COBRA continuation coverage) is conditioned on the Employee's continuing to have an employment relationship with the Plan Sponsor and making the required contributions as provided in Section 3.9, as applicable.

### ARTICLE III

#### Optional Benefits

3.1 Contributions; Benefit Options.

(a) Employee Contributions. A Participant may elect under this Plan to receive his or her full Compensation for any Plan Year in cash or to have a portion of his or her Compensation applied by the Plan Sponsor to the payment of Flexible Benefit Contributions or Employee Provided Premiums, as the case may be, under any one or more Qualified Benefit Plan(s). A Participant may elect to make pre-tax contributions to the HSA to cover "qualified eligible medical expenses," as set forth in Code Section 223(d)(2), subject to the limitations set forth in Appendix A.

3.2 Receipt of Benefits other than Cash. While the election to receive benefits under one or more Qualified Benefit Plans in lieu of cash is made under this Plan, benefits will be provided under the applicable Qualified Benefit Plan. The options available under each such plan, the requirements for participating in such options, the amount of premiums, deductibles and co-payments (if any), the amount, timing and conditions for the receipt of benefits and all other terms and conditions of eligibility, coverage and benefits under such options are set forth in the Qualified Benefit Plans. Any claim which arises under a Qualified Benefit Plan will be subject to review under the Qualified Benefit Plan and not under this Plan. Notwithstanding the foregoing, all benefits, terms, conditions and claims with respect to the Health

Care FSA Program or Dependent Care FSA Program are provided under this Plan.

### 3.3 Election of Benefits.

(a) With the exception of the Health Care FSA Program and the Dependent Care FSA Program, once a Participant enrolls in any one or more of the Qualified Benefit Plans, he or she will be deemed to have elected to have his or her Compensation reduced to the extent necessary to satisfy the Participant's Employee Provided Premiums due under such Qualified Benefit Plans, unless by written notice (on forms provided by the Plan Sponsor) to the Administrator prior to the start of any Coverage Period, a Participant elects not to have any Compensation reductions contributed to the Employee Provided Premiums under one or more Qualified Benefit Plans.

(b) If a Participant enrolls in the Health Care FSA Program and Dependent Care FSA Program, then the Participant must file a written election or elections with the Administrator (on forms provided by the Plan Sponsor) to receive his or her Compensation in cash or to have such Compensation reduced by the amount of the Flexible Benefit Contributions. Such election must be made not later than (i) the first day of the Coverage Period to which such election relates (in the case of an existing Employee) or (ii) the first day of the first pay period to which such election relates (in the case of a newly eligible Employee), or such earlier time as determined by the Administrator.

### 3.4 Irrevocability of Election by the Participant.

(a) Any election made under the Plan (including an election made through inaction under Section 3.3) shall be irrevocable by the Participant during the Plan Year except as otherwise provided in (b) through (j) below. Notwithstanding the foregoing, an Employee may elect to increase, decrease or revoke a pre-tax election to make contributions for the HSA Program described in Appendix A at any time on a prospective basis. Any change in an HSA election shall become effective as soon as administratively practicable following the Plan Sponsor's receipt of a completed election change form. No other election changes under the Plan can occur as a result of a change in an HSA election except as otherwise described in this Article III.

(b) With respect to any Qualified Benefit Plan, a Participant may revoke an election in writing for the balance of the Plan Year and, if desired, file a new election in writing if, under the facts and circumstances, (i) a change in status occurs, and (ii) the requested revocation and new election satisfy the consistency requirements in Section 3.5 below. For this purpose, a change in status includes the following events:

(i) Legal Marital Status. An event that changes a Participant's legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.

(ii) Number of Dependents. An event that changes a Participant's number of Dependents who may be eligible for coverage under a Qualified Benefit Plan, including birth, death, adoption or placement for adoption.

(iii) Employment Status. An event that changes the employment status of the Participant or the Participant's spouse or Dependent, including termination or commencement of employment, a strike or lockout, a commencement or return from an unpaid leave of absence, and a change in worksite, as well as any other change in the individual's employment status that results in the individual becoming (or ceasing to be) eligible under a benefit plan of his or her employer.

(iv) Requirements for Unmarried Dependents. An event that causes a Dependent to satisfy or cease to satisfy the requirements for coverage on account of attainment of age, student status, or any similar circumstance.

(v) Residence. A change in the place of residence of the Participant, his or her spouse or Dependent.

(vi) Other. Such other events that the Administrator determines will permit the revocation of an election (and, if applicable, the filing of a new election) during a Plan Year under regulations and rulings of the Internal Revenue Service.

(c) In the case of coverage under a Qualified Benefit Plan that is a group health plan, a Participant may revoke an election in writing for the balance of the Plan Year and file a new election in writing that corresponds with the special enrollment rights provided in Code Section 9801(f), whether or not the change in election is permitted under Section 3.4(b).

(d) In the case of a judgment, decree or order resulting from a divorce, legal separation, annulment, or change in legal custody (including a qualified medical child support order) that requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change his or her election (i) in order to provide coverage for the child under a group health plan that is a Qualified Benefit Plan if the order so requires, or (ii) in order to cancel health coverage under a group health plan that is a Qualified Benefit Plan for the Participant's child if such order requires the Participant's spouse or former spouse or another individual to provide coverage for the child and that coverage is, in fact, provided.

(e) In the case of coverage under a group health plan that is a Qualified Benefit Plan, a Participant may revoke an election for the balance of the Plan Year and file a new election in order to cancel or reduce such medical coverage for the Participant or any covered Dependent of the Participant to the extent that the Participant or Dependent becomes entitled to coverage under Part A or Part B of Title XVIII of the Social Security Act (Medicare) or Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines). In addition, if the Participant or any eligible Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may file a new election for the balance of the Plan Year to commence or increase coverage under another group health plan that is a Qualified Benefit Plan.

(f) If the Participants' share of the cost of coverage under a Qualified Benefit Plan significantly increases or significantly decreases during the Plan Year, a Participant may make a corresponding change in election under the Plan for the balance of the Plan Year, which will include (but not be limited to) the following:

- (i) For a significant cost increase, Participants electing such coverage for the Plan Year may revoke their election and either elect a similar coverage under another Qualified Benefit Plan for the balance of the Plan Year, or drop such coverage if there is no similar coverage under a Qualified Benefit Plan; or
- (ii) For a significant cost decrease, Participants may elect to commence participation under certain options under a Qualified Benefit Plan with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

This Section 3.4(f) shall apply to the Dependent Care FSA Program only if the significant cost change is imposed by a dependent care provider who is not a relative of the Participant. No election change may be made as to the Health Care FSA Program on account of a significant cost change. Despite any other contrary provision of the Plan, for any insignificant changes in the costs of any Qualified Benefit Plans, the Administrator shall automatically change Participants' elections to account for such changes in cost.

(g) If the Participant or his or her spouse or Dependents experience a significant curtailment in coverage under a Qualified Benefit Plan other than the Health Care FSA Program during the Plan Year, the Participant may make a corresponding change in election under the Plan for the balance of the Plan Year as follows:

- (i) For a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his or her election and elect a similar coverage under another Qualified Benefit Plan for the balance of the Plan Year; or
- (ii) For a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his or her election and either elect similar coverage under another Qualified Benefit Plan for the balance of the Plan Year, or drop such coverage if there is no similar coverage under a Qualified Benefit Plan.

(h) If during the Plan Year a new Qualified Benefit Plan, or option under a Qualified Benefit Plan, becomes available, or an existing Qualified Benefit Plan, or option under a Qualified Benefit Plan, is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year, provided that no such election change may be made as to the Health Care FSA Program.

(i) If a Participant's spouse or Dependent makes an election change under a plan maintained by his or her employer, the Administrator may permit the Participant to revoke an election, other than an election for the Health Care FSA Program, under this Plan and make a new election for the balance of the Plan Year that is on account of and corresponds with the election change made by the Participant's spouse or Dependent, if:

- (i) The election change made by the Participant's spouse or Dependent under his or her employer's plan

satisfies the regulations and rulings under Code Section 125; or

(ii) The period of coverage under the plan maintained by the employer of the Participant's spouse or Dependent does not correspond with the Plan Year of this Plan.

(j) If a Participant or his or her spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect health coverage under one or more Qualified Benefit Plan(s) for the balance of the Plan Year for the Participant, his or her spouse or Dependent. No change is permitted with regard to the Health Care FSA Program and the Dependent Care FSA Program available under the plan.

(k) If a Participant and/or any of a Participant's related individuals enrolls in or intends to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Administrator may permit the Participant to revoke an election under the Plan that is on account of and corresponds with:

(i) the Participant's

(ii) the Participant's related individual or related individuals', or

(iii) both the Participant's and the Participant's related individuals'

enrollment in a Marketplace plan effective immediately following the revocation. If the Participant does not enroll in Marketplace coverage, the Participant must elect self-only coverage (or family coverage including one or more already-covered related individuals) under the group health plan. Coverage may only be terminated for those covered individuals who are enrolling or intend to enroll in Marketplace coverage during open enrollment or pursuant to a Marketplace special enrollment period.

The Administrator may rely on the reasonable representation of the Participant that the Participant and/or the Participant's related individual or related individuals have enrolled or intend to enroll in a Marketplace plan that is effective immediately following the revocation. No change is permitted with regard to non-health benefits including the Health Care FSA Program benefits and Dependent Care FSA Program benefits available under the Plan.

(l) If a Participant who was reasonably expected to average 30 hours of service or more per week experiences an employment status change such that he or she is reasonably expected to average less than 30 hours of service per week may prospectively revoke his or her election under the Plan, provided that the Participant certifies to the Administrator that he or she and any related individuals whose coverage is being revoked have enrolled or intend to enroll in another plan providing "minimum essential coverage" (as defined under the Affordable Care Act) for coverage that is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked. No change is permitted with regard to non-health benefits, including the Health Care FSA Program benefits or Dependent Care FSA Program benefits available under the Plan.

(m) Any application for a revocation and new election under this Section 3.4 must be made within 30 days following the date of the actual event, or within 60 days of the occurrence of one of the following events: (i) a Participant's or Dependent's coverage under a Medicaid plan or state children's health insurance program is terminated as a result of loss of eligibility for such coverage; or (ii) the Participant or Dependent becomes eligible for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan, and shall be effective at such time as the Administrator shall prescribe, unless otherwise required by law.

**3.5 Consistency Rules.** A Participant's requested revocation and new election under Section 3.4(b) will be consistent with a change in status (i) if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a Qualified Benefit Plan or under a plan maintained by the employer of the Participant's spouse or Dependent, and (ii) with respect to Dependent Care FSA Program, if the election change is on account of and corresponds with a change in status that affects expenses described in Code Section 129 (including employment-related expenses as defined in Code Section 21(b)(2)). A change in status that affects the eligibility under an employer's plan shall include a change in status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the plan.

**3.6 Automatic Termination of Election.** Elections made or deemed to be made under Section 3.3 will automatically terminate on the date on which the Participant (i) terminates employment with the Plan Sponsor, (ii) loses eligibility

under the terms of a Qualified Benefit Plan, or (iii) elects under Section 3.3 or 3.4 to receive cash in lieu of benefits under the Qualified Benefit Plans, although coverage or benefits under the Medical Plans and/or the Health Care FSA Program may continue if and to the extent provided by such plan or as required by law. Despite any other contrary provision of the Plan, if a Participant's employment with the Plan Sponsor terminates and the Participant returns to employment with the Plan Sponsor within thirty (30) days of such termination and within the same Plan Year of the Participant's date of termination, then the Participant's pre-termination elections under the Plan will be automatically reinstated, and no election changes shall be permitted unless otherwise specified by Section 3.4. If a Participant's employment with the Plan Sponsor terminates and the Participant returns to employment with the Plan Sponsor more than thirty (30) days or more after such termination, but within the same Plan Year of the Participant's date of termination, the Participant may make new elections; however, the Participant's elections for the Health Care FSA Program or Dependent Care FSA Program may not exceed the maximum annual contributions as set forth in Sections 4.3 and 5.3 of this Plan and applicable law.

3.7 Changes by Administrator. If the Administrator determines, at any time, that the Plan may fail to satisfy any nondiscrimination requirements imposed by the Code with respect to benefits provided to highly compensated individuals (as defined in Code Section 105(h)), highly compensated employees (as defined in Code Section 414(q)) or key employees (as defined in Code Section 416(i)(1)), the Administrator will take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to assure compliance with such requirements. Such action may include, without limitation, a modification of elections by such highly compensated individuals, highly compensated employees or key employees with or without their consent.

3.8 Maximum Contributions. The maximum amount of the contributions under this Plan for any Participant in any Plan Year will be the sum of the Flexible Benefit Contributions (subject to the Maximum Contributions applicable to each of the Flexible Benefits as described in Articles IV and V of this Plan), and the Employee Provided Premiums, as amended from time to time, of the most expensive benefits available to the Participant under each Qualified Benefit Plan for such Plan Year, plus, for Participants in the Plan Sponsor's HSA Program, the Annual Contribution Limit, determined in accordance with Section 3.2 of Appendix A.

3.9 Premium Payments by Employees on FMLA and Uniformed Services Leave of Absence. Any Employee who elects to maintain coverage under Section 2.4 while on an FMLA Leave or while absent from work for more than 31 days for duty in the Uniformed Services must continue to make any required contributions specified in Section 3.3. During such absence, an Employee may choose to make such contributions by (i) remitting payment to the Plan Sponsor on or before each pay period for which the contributions would have been deducted from the Employee's paycheck if leave had not been taken, provided that any delinquent payments must be made within 30 days of their due date, or (ii) at the Employee's written election (on forms furnished by and delivered to the Administrator not less than 30 days prior to prepayment), prepaying the amounts that will become due during such leave out of one or more of the Employee's paychecks preceding such leave. The Plan Sponsor, in its sole discretion, may agree with the Employee to fund the Employee's required contributions under Section 3.3 during the leave of absence, as long as the Employee agrees (on forms furnished by and delivered to the Administrator not less than 30 days prior to commencement of such leave of absence) to commence remitting payment to the Plan Sponsor upon the Employee's return to active employment with the Plan Sponsor following the leave of absence of all amounts paid by the Plan Sponsor on the Employee's behalf to maintain coverage under Section 2.4; provided, however, if an Employee fails to return to active employment with the Plan Sponsor following the leave of absence, then the Employee shall reimburse the Plan Sponsor for such advances made on the Employee's behalf within thirty (30) days following the Plan Sponsor's written demand for such reimbursement. Despite the foregoing, an Employee who is absent from work for any paid leave of absence must continue any and all benefits elected under this Plan (unless the same is prohibited by any insurance policy provision requiring an insured to be actively at work), and Employee contributions for those benefits that the Employee elected under this Plan will continue to be deducted from the Employee's paycheck in such absence.

## ARTICLE IV

### Health Care Flexible Spending Program

4.1 Purpose of Health Care FSA Program. The Health Care FSA Program is intended to qualify as a health care reimbursement plan under Code Section 105(b). The purpose of the Health Care FSA Program is to enable Participants to elect to receive payments or reimbursements for Qualifying Medical Care Expenses that are excludable from Participants' gross income under Code Section 105(b).

4.2 Establishment of Accounts. The Plan Sponsor will establish and maintain on its books a Health Care Flexible

Spending Account for each Plan Year with respect to each Participant who has elected under the Plan to receive reimbursement of Qualifying Medical Care Expenses incurred during the Plan Year.

#### 4.3 Health Care Flexible Spending Account Maximum and Minimum Contribution.

(a) Notwithstanding any other provision of the Plan to the contrary, the maximum amount which the Participant may elect to receive under this Plan in the form of payments or reimbursements for Qualifying Medical Care Expenses incurred in any Plan Year is the statutory amount under Section 125(i)(2) of the Code in effect on January 1st of the same calendar year in which the Plan Year begins, as indexed for cost of living increases for any Plan Year beginning with or within such calendar year.

(b) Carryover. Notwithstanding any other provision of the Plan to the contrary, a Participant may carry over an amount not to exceed twenty percent (20%) of the of the indexed maximum amount permitted under Section 125(i) of the Code which is unused as of the end of the Plan Year to pay or reimburse Qualifying Medical Care Expenses incurred during the next Plan Year . For purposes of the carryover, the following applies:

(i) The amount remaining unused after the Plan Year is the amount remaining after Qualifying Medical Care Expenses are reimbursed at the end of the deadline for seeking reimbursement for the Plan Year.

(ii) Any amount carried over will not count towards the maximum limit on annual salary reductions for Qualifying Medical Care Expenses.

(iii) Qualifying Medical Expenses incurred during the Plan Year will be reimbursed from the Participant's unused balance for the current Plan Year, and then from any unused amounts carried over from the prior Plan Year.

4.4 Crediting of Accounts. As of the first day of each Plan Year, there will be credited to a Participant's Health Care Flexible Spending Account the full amount of the contributions, if any, to be made to such account for the Plan Year in accordance with the Participant's elections and compensation reduction agreement under the Plan. All amounts credited to each such Health Care Flexible Spending Account will be the property of the Plan Sponsor until paid out pursuant to Section 4.8.

4.5 Debiting of Accounts. A Participant's Health Care Flexible Spending Account for each Plan Year will be debited from time to time, but not below zero, in the amount of any payment under Section 4.8 to or for the benefit of the Participant for Qualifying Medical Care Expenses incurred during such Plan Year. As set forth in Section 10.10, the Administrator has, in its discretion, established a debit card or reimbursement program for purposes of tracking debits from a Participant's Health Care Flexible Spending Account.

4.6 Forfeiture of Accounts. The amount credited to a Participant's Health Care Flexible Spending Account for any Plan Year will be used only to reimburse the Participant for Qualifying Medical Care Expenses incurred during such Plan Year except that if the Participant carries over unused funds pursuant to Section 4.3 of this Plan, such funds may be used to reimburse Qualifying Medical Care Expenses in the next Plan Year. A Participant must apply for reimbursement on or before 90 days immediately following the end of the Plan Year. Any balance remaining in a Participant's Health Care Flexible Spending Account at the end of the Plan Year, after payment of all reimbursements under this Health Care FSA Program, will remain the property of the Plan Sponsor, and the Participant will forfeit all rights with respect to such balance, except that if a Participant carries over unused funds pursuant to Section 4.3(c) of this Plan, such funds may be used to reimburse Qualifying Medical Plan Expenses in the next Plan Year.

4.7 Claims for Reimbursement. A Participant who has elected to receive medical care reimbursements for the applicable Plan Year may apply for reimbursement of Qualifying Medical Care Expenses incurred by the Participant during the Plan Year by submitting an application in writing to the Plan Sponsor, on forms furnished by and delivered to the Plan Sponsor, setting forth:

(a) the amount, date and nature of the expense with respect to which benefit is requested;

(b) the name of the person, organization or entity to which the expense was or is to be paid;

(c) the name of the person for whom the expense was incurred and, if such person is not the Participant requesting the benefit, the relationship of such person to the Participant; and

(d) the amount recovered or expected to be recovered under any insurance arrangement or other plan with respect to the expense.

Such application must be submitted no later than 90 days immediately following the close of the Plan Year and must be accompanied by invoices, receipts, cancelled checks or other statements showing the amounts of such expenses, together with any additional documentation which the Administrator may reasonably request.

Despite any provision of this Section 4.7 to the contrary, if the Administrator hires a third-party administrator to process reimbursement claims under the Health Care FSA Program, including, without limitation, the administration of a debit card program established by the Administrator, then a Participant must apply for reimbursements in accordance with the policies and procedures established by such third-party administrator in order to receive reimbursements for Qualifying Medical Care Expenses.

4.8 Disbursement or Payment of Expenses. The Plan Sponsor, or the Plan's third-party administrator (if applicable), will reimburse the Participant from the Participant's Health Care Flexible Spending Account for Qualifying Medical Care Expenses incurred during the Plan Year for which the Participant submits for reimbursement in accordance with Section 4.7. The Plan Sponsor, or the Plan's third-party administrator (if applicable), may, at its option, pay any such Qualifying Medical Care Expenses directly to the person providing or supplying medical care through a debit card program or otherwise in lieu of reimbursing the Participant. Expenses are incurred at the point in time when the care giving rise to the Qualifying Medical Expense is provided to, or received by, an individual, not the date an individual is required to pay for such medical care or is billed after the receipt of medical care.

4.9 Limits on Reimbursements. Despite any other provision of the Health Care FSA Program to the contrary, no amount will be reimbursed under this Health Care FSA Program if such amount is payable or reimbursable under any other plan or policy of insurance.

## ARTICLE V

### Dependent Care Assistance Program

5.1 Purpose of Dependent Care FSA Program. This Dependent Care FSA Program is intended to qualify as a dependent care assistance plan under Code Section 129. The purpose of the Dependent Care FSA Program is to enable Participants to elect to receive payments or reimbursements for their Dependent Care Expenses that are excludable from the Participants' gross income under Code Section 129.

5.2 Establishment of Accounts. The Plan Sponsor will establish and maintain on its books a Dependent Care Assistance Account for each Plan Year with respect to each Participant who has elected to receive dependent care assistance for the Plan Year.

5.3 Maximum and Minimum Contribution. Notwithstanding any other provision of the Plan to the contrary, the maximum amount which the Participant may receive in any taxable year in the form of payments or reimbursements for Dependent Care Expenses will be the lesser of (i) the Participant's earned income for the taxable year (after all reductions in compensation including the reduction related to dependent care assistance), or (ii) the actual or deemed earned income of the Participant's spouse for the taxable year, or (iii) \$2,500 if married and filing separate returns, or (iv) \$5,000 if single, or married and filing joint returns. In the case of a spouse who is a full-time student at an educational institution or is physically or mentally incapable of caring for himself, such spouse will be deemed to have earned income of not less than \$250 per month if the Participant has one Dependent and \$500 per month if the Participant has two or more Dependents.

5.4 Crediting of Accounts. There will be credited to a Participant's Dependent Care Assistance Account for each Plan Year an amount equal to the contributions, if any, to be made to such account for the Plan Year in accordance with the Participant's election and compensation reduction agreement under the Dependent Care FSA Program. All amounts credited to each such Dependent Care Assistance Account will be the property of the Plan Sponsor until paid out pursuant to Section 5.9.

5.5 Debiting of Accounts. A Participant's Dependent Care Assistance Account for each Plan Year will be debited from time to time in the amount of any payment under Section 5.9 to or for the benefit of the Participant for Dependent Care Expenses incurred during such Plan Year or Grace Period, as applicable. As set forth in Section 5.8, the Administrator has, in its discretion, established a debit card or reimbursement program for purposes of tracking debits from a Participant's Dependent Care Assistance Account.

5.6 Grace Period. Notwithstanding any other provision of the Plan to the contrary, Participant Dependent Care

Expenses paid or reimbursed from benefits or contributions remaining unused at the end of the Plan Year may be paid or reimbursed from any unused benefits or contributions remaining after the end of the Plan Year until up to the fifteenth day of the 3rd month following the end of the Plan Year.

5.7 Forfeiture of Accounts. The amount credited to a Participant's Dependent Care Assistance Account for any Plan Year, including the Grace Period will be used only to reimburse the Participant for Dependent Care Expenses incurred during such Plan Year, and applicable Grace Period, and only if the Participant applies for reimbursement on or before 90 days immediately following the end of the Plan Year. Any balance remaining in a Participant's Dependent Care Assistance Account at the end of the Plan Year, and applicable Grace Period, after payment of all reimbursements under this Plan, will remain the property of the Plan Sponsor, and the Participant will forfeit all rights with respect to such balance.

5.8 Claims for Reimbursement. A Participant who has elected to receive dependent care assistance for a Plan Year may apply to the Plan Sponsor for reimbursement of Dependent Care Expenses which the Participant incurs during the Plan Year and applicable Grace Period by submitting an application in writing to the Plan Sponsor on such forms as the Plan Sponsor may prescribe, setting forth (a) the amount, date and nature of the expense with respect to which benefit is requested, (b) the name of the person, organization or entity to which the expense was or is to be paid, and (c) such other information as the Plan Sponsor may from time to time require. Such application must be submitted no later than 90 days immediately following the close of the Plan Year or Grace Period and must be accompanied by invoices, receipts, cancelled checks or other statements showing the amounts of such expenses, together with any additional documentation which the Administrator may reasonably request.

Despite any provision of this Section 5.8 to the contrary, if the Administrator hires a third-party administrator to process reimbursement claims under the Plan, including, without limitation, the administration of a debit card program established by the Administrator, then a Participant must apply for reimbursements in accordance with the policies and procedures established by such third-party administrator in order to receive reimbursements for Dependent Care Expenses.

5.9 Reimbursement or Payment of Expenses. The Plan Sponsor, or the Plan's third-party administrator (if applicable), will reimburse the Participant from the Participant's Dependent Care Assistance Account for Dependent Care Expenses incurred during the Plan Year, including the Grace Period, for which the Participant submits documentation in accordance with Section 5.8. The Plan Sponsor, or the Plan's third-party administrator (if applicable), may, at its option, pay any such Dependent Care Expenses directly to the Dependent Care Service Provider through a debit card program or otherwise in lieu of reimbursing the Participant. No reimbursement or payment under this Section 5.9 of expenses incurred during a Plan Year or Grace Period will at any time exceed the balance of the Participant's Dependent Care Assistance Account for the Plan Year at the time of the reimbursement or payment.

5.10 Report to Participants. On or before January 31 following each calendar year, the Administrator will furnish to each Participant who has received dependent care assistance during the previous calendar year a written statement showing the amount of such assistance paid during such year with respect to the Participant.

## ARTICLE VI

### Termination of Participation

If a Participant ceases to be a Participant for any reason, any election to receive reimbursements for Qualifying Medical Care Expenses and/or Dependent Care Expenses, and any related elections and compensation reduction agreements made under the Plan will terminate. The Participant or his or her personal representative will be entitled to reimbursement only for Qualifying Medical Care Expenses and/or Dependent Care Expenses, as applicable, incurred within the Plan Year in which termination occurs and prior to the date participation is terminated, and only if the Participant or his or her personal representative applies for such reimbursement in a manner consistent with the provisions of Section 4.7 or 5.7, as applicable. No such reimbursement will exceed the remaining balance, if any, in the Participant's Health Care Flexible Spending Account and/or Dependent Care Assistance Account for the Plan Year in which the expenses were incurred.

## ARTICLE VII

### Administration

7.1 Plan Administration. The administration of the Plan will be under the supervision of the Administrator. It will be a

duty of the Administrator to ensure that the Plan is carried out, in accordance with its terms and in a nondiscriminatory manner, for the exclusive benefit of Participants and their beneficiaries. The Administrator will have the power to administer the Plan, subject to applicable requirements of law. The Administrator's powers include, but are not limited to, discretionary authority to:

- (a) make and enforce such rules and regulations as the Administrator deems necessary or appropriate for the efficient administration of the Plan;
- (b) interpret the Plan (such interpretation will be final, binding and conclusive with respect to all claims arising under this Plan);
- (c) decide all questions concerning the eligibility of any person to participate in and to receive benefits under the Plan, and to make all factual determinations;
- (d) provide Employees with a reasonable and timely notification of benefit options available under the Plan;
- (e) authorize the payment of benefits, which will be paid only if the Administrator decides in its sole discretion that the Participant or applicant is entitled to them; and
- (f) appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

7.2 Payment of Expenses. Administrative expenses will be paid by the Plan Sponsor unless the Plan Sponsor determines that administrative costs will be borne by the Participants under the Plan. The Administrator may impose reasonable conditions for payments, provided that such conditions do not discriminate in favor of Participants who are highly compensated employees or key employees.

7.3 Examination of Records. The Administrator will make available to each Participant his or her records under this Plan for examination at reasonable times during normal business hours.

7.4 Reliance on Tables, Etc. In administering the Plan, the Administrator will be entitled to rely conclusively on all tables, valuations, certificates, opinions and reports furnished by, or in accordance with the instructions of, any insurer, or by accountants, counsel or other experts employed or engaged by the Administrator.

7.5 Indemnification of Administrator. The Plan Sponsor agrees to indemnify, hold harmless and defend any Employee serving as the Administrator or as a member of a committee designated as the Administrator (including any Employee or former Employee who previously served as the Administrator or as a member of such committee) against all liabilities, damages, costs and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Plan Sponsor) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

7.6 Insurance Contracts Control. Despite any other provision of this Plan, if the terms of this Plan and the terms of an insurance contract which funds a Qualified Benefit Plan (as applicable) conflict, the terms of such insurance contract will control unless contrary to law.

7.7 Named Fiduciary. The Administrator will be a "named fiduciary" for purposes of Section 402(a)(1) of ERISA with authority to control and manage the operation and administration of the Plan, and will be responsible for complying with all of the reporting and disclosure requirements of Part 1 of Subtitle B of Title I of ERISA.

7.8 COBRA Compliance. Unless otherwise required under the Code or the regulations promulgated thereunder, notwithstanding the provisions of Article VII, if a Participant or Qualified Beneficiary experiences a Qualifying Event, then, at the Participant's and/or Qualified Beneficiary's election, coverage under the Health Care FSA Program will continue until the end of the Plan Year in which the Qualifying Event occurs by paying to the Administrator, on an after-tax basis, 102% of the monthly amount of the Participant's compensation reduction election under Section 4.3 that is applicable to the Health Care FSA Program.

7.9 HIPAA Privacy and Security Provisions. With respect to the Health Care FSA Program, the following provisions shall apply.

- (a) The Plan Sponsor may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §160.103) as permitted by the "Standards for Privacy of Individually Identifiable Health Information"

under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, as amended by the Health Information Technology for Economic and Clinical Health Act ("HITECH Act") portion of the American Recovery and Reinvestment Act of 2009, and applicable guidance (the "Privacy Rule").

(b) The Plan will disclose Protected Health Information to the Plan Sponsor only upon its receipt of a certification by the Plan Sponsor that the Plan Sponsor agrees to:

- Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;
- Ensure that any agents, including subcontractors, to whom it provides Protected Health Information and electronic Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
- Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- Report to the Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Privacy Rule of which it becomes aware;
- Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. §164.524;
- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528, including an accounting of disclosures of any electronic health record (as defined in HIPAA);
- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;
- If feasible, return or destroy all Protected Health Information received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- Ensure that adequate separation of the Plan and the Plan Sponsor is established as required by 45 C.F.R. 164.504(f)(2)(iii) as described below.

(c) Certification of the Plan Sponsor

The Plan (or a health insurance issuer or HMO with respect to the Plan, if applicable) will disclose Protected Health Information to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 C.F.R. §164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 7.9(a) and (b). The Plan will not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Plan Sponsor as otherwise permitted herein unless the statement required by 45 C.F.R. §164.520(b)(1)(iii)(C) is included in the appropriate notice. The Plan Sponsor hereby certifies that this Section 7.9 constitutes an amendment of the governing Plan documents that complies with HIPAA and that the Plan Sponsor will comply with the conditions of disclosure set forth herein.

(d) Separation of Plan and the Plan Sponsor

(i) Only designated employees in the Benefits Department, Payroll Department, Human Resources Department, Office Administrator and Assistant, Workers Compensation Supervisor, US Operations Executive Vice President department(s) or position(s), as applicable, of the Plan Sponsor ("Permitted Employees") will be given access to the Protected Health Information. Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees.

(ii) The Permitted Employees may only use the Protected Health Information for Plan administrative functions that the Plan Sponsor performs for the Plan.

(e) Security of Electronic Protected Health Information

In accordance with 45 C.F.R. §164.314(b)(2), to the extent as may be required by law, the Plan Sponsor agrees to:

- (i) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that the Plan Sponsor may create, receive, maintain, or transmit on behalf of the Plan;
- (ii) Ensure that the adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- (iii) Ensure that any agents, including subcontractors, to whom it provides electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect the information; and
- (iv) Report to the Plan any security incident of which it becomes aware with respect to electronic Protected Health Information.

## **ARTICLE VIII**

### **Amendment and Termination**

8.1 Amendment of Plan. The Plan Sponsor reserves the right to amend this Plan at any time without the consent of any Employee or Participant.

8.2 Termination of Plan. It is the expectation of the Plan Sponsor that it will continue this Plan indefinitely, but the continuance of this Plan is not assumed as a contractual obligation of the Plan Sponsor, and the right is reserved to the Plan Sponsor at any time to terminate this Plan without liability. Upon termination of the Plan, all elections and reductions in Compensation relating to the Plan will terminate.

8.3 Legal Enforceability of Provisions. The Plan and the provisions hereof constitute a legally enforceable agreement between the Plan Sponsor and a Participant.

## **ARTICLE IX**

### **Claims Provisions**

9.1 General Claims Procedures. Any claim made in connection with a Qualified Benefit Plan, other than the Health Care FSA Program or Dependent Care FSA Program will be subject to review under such Qualified Benefit Plan, and will not be subject to review under this Article IX. The following procedures set forth in this Section 9.1 will govern the processing of claims under the Dependent Care FSA Program, provided, however, to the extent that these procedures are inconsistent with the claims procedures in effect with any third-party administrator hired by the Administrator to assist with processing claims under the Dependent Care FSA Program, the third-party administrator's claims procedures will supersede these procedures as long as such other claims procedures comply with applicable law. The Administrator's refusal to make payment for or debit a Participant's Dependent Care Assistance Account for Dependent Care Expenses through a debit card program, if any, established by the Administrator for such purpose shall be a denial of a claim.

(a) Claims Procedure. If any claim made under the Dependent Care FSA Program are wholly or partially denied, the Administrator will notify the person making such claim (the "claimant") of his or her decision in writing. Such notification will be written in a manner calculated to be understood by the claimant and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary and (iv) information as to the steps to be taken if the claimant wishes to submit a request for review, including a statement that the claimant may bring a civil action after an adverse benefit determination on review. Such notification will be given within 90 days after the claim is received by the Administrator (or within 180 days, if special circumstances require an extension and if written notice of such extension is given to the claimant within the initial 90-day period). If such notification is not given within such period, the claim will be considered denied as of the last day of such period and the claimant may request review thereof.

(b) Review Procedure. Within 60 days after the date on which the claimant receives a written notice of a denied claim (or, if applicable, within 60 days after the date on which such denial is considered to have occurred) the

claimant may (i) file a written request with the Administrator for a review of the denied claim and (ii) submit written comments to the Administrator. The Administrator will notify the claimant of his or her decision in writing. Such notification will be written in a manner calculated to be understood by the claimant and will contain specific reasons for the decision as well as specific references to pertinent Plan provisions. In addition, such notification will include a statement that, upon request and free of charge, the claimant shall be entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, and a statement that the claimant may bring a civil action after an adverse benefit determination on review. The decision on review will be made within 60 days after the request for review is received by the Administrator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Administrator to hold a hearing, and if written notice of such extension and circumstances is given to the claimant within the initial 60-day period). If the decision on review is not made within such period, the claim will be considered denied.

9.2 Health Claim Procedures. The following procedures set forth in this Section 9.2 will govern the processing of claims under the Health Care FSA Program, provided, however, to the extent that these procedures are inconsistent with the claims procedures in effect with any third-party administrator hired by the Administrator to assist with processing claims under the Health Care FSA Program, the third-party administrator's claims procedures will supersede these procedures as long as such other claims procedures comply with applicable law and regulations. The Administrator's refusal to make payment for or debit a Participant's Health Care Flexible Spending Account for a Qualifying Medical Care Expense through a debit card program established by the Administrator, if any, for such purpose shall be a denial of a claim.

(a) Incomplete Benefit Claims. If a Pre-Service Claim (or Urgent Care Claim) does not include substantially all of the information required in Section 4.7, the Administrator shall notify the Claimant of the informational or procedural deficiency and how it may be cured within five days (or within 24 hours, in the case of an Urgent Care Claim).

(b) Notifications of Decisions on Benefit Claims.

(i) Urgent Care Claims. Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you file an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information.

(ii) Pre-Service Claims. Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim is a Pre-Service Claim, and it is submitted improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 5 days. If your Pre-Service Claim is submitted properly with all needed information, you will receive written notice of the claim decision from the Plan Administrator within 15 days of receipt of the claim. The Plan Administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

(iii) Concurrent Care Claims. If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above. If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

(iv) Post-Service Claims. Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30- day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

(c) Adverse Benefits Determination Notice. Any notice of the denial of a claim for benefits shall be given the claimant in written form. The notice of denial must include:

- (i) the specific reason(s) for your adverse benefit determination;
- (ii) reference to the specific Plan provision on which the determination is based;
- (iii) a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- (iv) a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- (v) either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- (vi) if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and
- (vii) in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

(d) How to Appeal a Claim Decision. If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- (i) The patient's name;
- (ii) The date(s) of health care service(s).
- (iii) The provider's name.
- (iv) The reason you believe the claim should be paid.
- (v) Any documentation or other written information to support your request for claim payment.

Your first appeal request must be submitted to the Plan Administrator within 180 days after you receive the claim denial.

(e) Decision on Appeal of Disputed Claims.

(i) Upon its receipt of a notice for a request for a review, the Administrator shall make a prompt decision on the review. The individual who conducts the review shall not be the same individual who made the initial adverse benefit determination. If the adverse benefit determination is appealed on the basis of a medical judgment, the Administrator shall consult with an independent health care professional who is qualified in the areas of dispute who shall not have been involved in the initial claim denial.

(ii) Appeals of adverse benefit determinations shall be decided, and notice of the decision on appeal shall be given to the claimant, according to the following timetable:

(A) Urgent Care Claims. An appeal of an adverse benefit determination involving an Urgent Care Claim shall be decided and notice issued to the claimant as soon as possible, but in no event later than 72 hours, after the Administrator has received the request for the review on appeal.

(B) Pre-Service Claims. An appeal of an adverse benefit determination of a Pre-Service Claim shall be decided and notice issued to the claimant within a reasonable period, but not more than 30 days, after the Administrator has received the request for the review on appeal.

(C) Post-Service Claims. An appeal of an adverse benefit determination of a Post-Service Claim shall be decided and notice issued to the claimant within a reasonable period, but not more than 60 days, after the Administrator has received the request for the review on appeal.

(D) Concurrent Care Claims. An appeal of an adverse benefit determination involving concurrent care by a claimant shall be decided and notice issued to the claimant as soon as possible, but in no event later than 72 hours after the Administrator has received the request for the review on appeal if the claim involves Urgent Care, 30 days in the case of a Pre-Service Claim, or 60 days in the case of a Post-Service Claim.

(f) Contents of Notice of Decision on Appeal. The Administrator shall provide the claimant with written notice of the Administrator's benefit determination on review in accordance with the applicable time frames set out in Section 9.2(e). In the case of an adverse benefit determination, the notice shall set forth, in a manner calculated to be understood by the Claimant:

(i) the specific reason or reasons for the adverse determination;

(ii) reference to the specific Plan provisions on which the benefit determination is based;

(iii) a statement that the claimant is entitled to receive, without charge, reasonable access to any document (A) relied on in making the determination, (B) submitted, considered or generated in the course of making the benefit determination, (C) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (D) that constitutes a statement of policy or guidance with respect to this Plan concerning the denied treatment without regard to whether the statement was relied on;

(iv) if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of this Plan to the claimant's medical condition, or a statement that such explanation will be provided without charge on request;

(v) a statement describing the Plan's optional appeals procedures, and the claimant's right to receive information about the procedures as well as the claimant's right to bring a civil action under ERISA § 502(a); and

(vi) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

9.3 Preservation of Other Remedies. After exhaustion of the claims procedures provided under this Article IX, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

## ARTICLE X

### Miscellaneous

10.1 Communication to Employees. Promptly after the Plan is made effective, the Plan Sponsor will notify all Employees of its availability and terms. The Plan Sponsor will notify each new Employee of the availability and terms of the Plan as soon as practicable following the date the Employee commences his or her employment with the Plan Sponsor. Within a reasonable period of time prior to the commencement of each Plan Year, or, in the case of a newly eligible Employee, as soon as practicable following the date on which he or she commences his or her employment with the Plan Sponsor, the Plan Sponsor will provide to Employees (i) booklets, brochures, or other explanatory items which describe the material provisions of the Plan (to the extent the same have not been previously furnished), including benefits, enrollment procedures, timing of elections and the consequences of failing to make a timely election and (ii) such enrollment forms and salary reduction agreements as may be required to make, change or revoke elections under this Plan.

10.2 Participant's Rights. This Plan will not be deemed to constitute an employment contract between the Plan Sponsor and any Participant or to be in consideration of or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan will be deemed to give any Participant or Employee the right to be retained in the service of the Plan Sponsor or to interfere with the right of the Plan Sponsor to discharge any Participant or Employee at any time regardless of the effect which such discharge will have upon him as a Participant in this Plan.

### 10.3 Protective Clauses.

(a) If a Participant fails to obtain coverage under any insured Qualified Benefit Plan (whether as a result of the negligence or gross neglect of the Plan Sponsor or otherwise), such Participant's sole and exclusive remedy will be the return of the amount of the Employee Provided Premiums actually paid by such Participant in the Plan Year(s) for which coverage was not obtained.

(b) If and to the extent payments or reimbursements due under an insured Qualified Benefit Plan are required to be paid to the Plan Sponsor, as agent for a Participant or the spouse, Dependent or other beneficiary of such Participant or otherwise, the Plan Sponsor's liability for any claim brought by a Participant or by the spouse, Dependent or other beneficiary of a Participant with respect to such payment or reimbursements will be limited to the amount of the payments or reimbursements, if any, actually received by the Plan Sponsor thereunder in connection with such claim. If payments or reimbursements under an insured Qualified Benefit Plan are not timely received by the Plan Sponsor following the submission of a claim, the Plan Sponsor will so notify the Participant. Thereafter, the Plan Sponsor will have no obligation to pursue such claim, and the Participant may pursue, settle or compromise such claim as the Participant, in the sole exercise of his or her discretion, sees fit.

(c) The Plan Sponsor will not be responsible for the validity of any insurance contract which funds an insured Qualified Benefit Plan or for the failure of an insurer to make payments provided for thereunder, or for the action of any person which may cause any such insurance contract to be rendered null and void or unenforceable, in whole or in part.

(d) Once coverage under an insured Qualified Benefit Plan is applied for and obtained, the Plan Sponsor will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Plan Sponsor. Where premium notices are timely received by the Plan Sponsor, the Plan Sponsor's liability for the payment of premiums corresponding to such notices will be limited to the dollar amount of such premiums and will not include liability for any other loss which may result from the failure to pay such premiums.

(e) The Plan Sponsor will not be liable for the payment of any premium due under a Qualified Benefit Plan or any loss which may result from the failure to pay such premium if the amounts deferred under Section 3.3 are insufficient to provide for the payment of the Employee Provided Premium of a Qualified Benefit Plan at the time such premium is due. The Plan Sponsor will notify a Participant if such amounts are insufficient to pay such premiums but will not be liable for any failure to make such notification. Such premiums may be paid (i) if permitted under Code Section 125, pursuant to an amendment to a Participant's agreement to defer a portion of his or her Compensation under Section 3.3 or (ii) otherwise, by a cash contribution of the Participant.

10.4 No Guarantee of Tax Consequences. Neither the Administrator nor the Plan Sponsor makes any representation or warranty that any amount paid as premiums or distributed as benefits under any Qualified Benefit Plan will be excludable from the gross income of a Participant for federal or state income tax purposes. It will be the obligation of each Participant to determine whether payments are excludable from the Participant's gross income for federal and state income tax purposes.

10.5 Indemnification of the Plan Sponsor by Participants. If any Participant receives payments or reimbursements which do not qualify for exclusion from gross income, such Participant will indemnify and reimburse the Plan Sponsor for any liability it may incur for failure to withhold federal or state tax from such payments or reimbursements, provided however that such indemnification and reimbursement will not exceed the amount of additional federal and state tax (together with any interest and penalties) that the Participant would have owed if the payments or reimbursements had been made to the Participant as regular cash compensation, less any such additional tax actually paid by the Participant.

10.6 Nonassignability of Rights. The right of any Participant to receive any amount under the Plan will not be alienable by the Participant by assignment or any other method, and will not be subject to the rights of creditors, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

10.7 Limitation of Rights. Neither the establishment of the Plan nor any amendment thereof, nor the payment of any benefits under this Plan, will be construed as giving to any Participant or other person any legal or equitable right against the Plan Sponsor or Administrator, except as provided herein.

10.8 Governing Law. This Plan will be construed, administered and enforced according to the laws of State of Texas and the provisions of the Code and any other applicable federal law.

10.9 Funding. Unless otherwise required by law, (i) contributions to the Plan will be deemed general assets of the Plan Sponsor until the amount thereof has been paid over to or under a Qualified Benefit Plan and (ii) nothing herein contained will be construed to require the Plan Sponsor or the Administrator to maintain any fund or segregate any amount, in trust or otherwise, 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 asset of the Plan Sponsor from which any payment under the Plan may be made.

10.10 Debit Card or Other Stored Value Cards. The Plan Administrator has established a debit card or other stored value card program ("debit card") for the reimbursement of Qualifying Medical Care Expenses and Qualifying Dependent Care Expenses which provides for reimbursement by paying a provider directly for a Participant's Qualifying Medical Care Expenses or Dependent Care Expenses with a debit card provided by the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. The debit card will be funded on a Participant's effective date of participation during the Plan Year in the amount elected by the Participant, and the account balance will be reduced in amounts equal to reimbursed Qualifying Medical Care Expenses or Dependent Care Expenses, respectively. Except as otherwise provided herein, if a provider does not accept payment with a debit card or the debit card is used for items sold, or services provided, by a provider or merchant not approved by the Plan Administrator pursuant to applicable IRS guidance, then a Participant shall generally make a claim for Plan benefits by filing a written request with the Plan Administrator upon a form furnished by the Administrator for such purpose pursuant to Sections 4.7 and 5.7, as applicable. In any case, subject to the following provisions, reimbursement will generally be made within thirty (30) days after the claim has been filed and approved for payment by the Administrator.

(a) The Participant must certify upon enrollment, and at each annual enrollment thereafter, that (i) any debit card provided to the Participant pursuant to this Plan will be used only for Qualifying Medical Care Expenses and Dependent Care Expenses for the Participant, and their spouse or Dependents, as applicable, (ii) any Qualifying Medical Care Expenses and Dependent Care Expenses for which the debit card is used have not been reimbursed in any other manner, (iii) the Participant will not seek reimbursement under any other plan, (iv) he or she understands that such certification is reaffirmed each time the card is used, and (v) he or she will retain sufficient documentation for any Qualifying Medical Care Expenses and Dependent Care Expenses paid with the card, including invoices, receipts, bills, or other similar statements that show the date the sale or service was rendered, a description of the item sold or service rendered, and the amount of the item or service as such may be required.

(b) Upon a Participant's termination from the Plan the Participant's debit card service will be deactivated. At such time the Participant must submit any remaining claims, as applicable, for Qualifying Medical Care Expenses and Dependent Care Expenses using one of the other methods for submitting claims provided for in this Plan.

(c) The Plan Administrator reserves the right to recover payments for claims paid using a debit card that is subsequently determined to not qualify as a Qualifying Health Care Expense, or claims paid using a debit card that are not substantiated. Failure to substantiate a claim will result in the deactivation of the debit card, and may result in taxable income to a Participant if not corrected using one of the methods described in this Section 9.10. The

Plan Administrator may use one or more of the below correction methods to make the Plan whole:

- (i) Demand a Participant repay the improper amount;
- (ii) Withhold the improper payment from a Participant's wages or other compensation to the extent permissible under applicable state and federal law; or
- (iii) Offset the improper payment against a Participant's future claims.

10.11 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 125 or the regulations issues thereunder, cause to be allocated or cause to withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Employer.

10.12 Right to Offset Future Payments. In the event a reimbursement or the amount of a reimbursement is made erroneously to an individual, the Plan shall have the right to reduce future reimbursements to or on behalf of such individual by the amount of the erroneous or excess reimbursement. This right to offset shall not limit the right of the Plan to recover an erroneous or excess reimbursement in any other or correction methods permitted under applicable IRS guidance.

10.13 Right to Recover Payments. Whenever a reimbursement has been made by the Plan, including erroneous reimbursement, in a total amount in excess of the amount that may be reimbursed under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such reimbursements, to the extent of the excess, from the person to or for whom the payment was made using any method permitted under applicable IRS guidance.

10.14 Savings Clause. If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

10.15 Forfeitures. As a condition of entitlement to a qualified benefit under this Plan, you and your covered dependents must keep the claims administrator or the Plan Administrator, as applicable, informed of your current mailing address and other relevant contact information. If the Plan is unable to locate any individual otherwise entitled to a benefit payment for any of the qualified benefits hereunder, after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator), to the extent not otherwise specified in the applicable plan materials for any health and welfare plans for which the individual pays a premium, the individual is not entitled to a qualified benefit hereunder and forfeits any rights to any qualified benefit. In the event that a check issued by a Claims Administrator for a self-insured qualified benefit is not cashed within 12 months from the date of issue, the check will be voided and the check will be applied to the payment of current qualified benefits and administrative fees under the Plan. In the event that a participant or other beneficiary as defined by ERISA does not receive a check that was issued and requests payment within one year of the amounts in the issued check, the Claims Administrator will make payment under the terms and conditions of the Plan as in effect when the claim was originally processed. Unclaimed funds may be applied only to the delivery of benefits (including administrative fees) under the Plan to the extent required by ERISA. The Plan shall have no liability for checks not cashed within one year; the amount of the check will be deemed a forfeiture, and no funds shall escheat to any state.

## **ARTICLE XI**

### **Definitions**

As used herein, unless the context clearly indicates otherwise, the following words and phrases have the meanings herein specified. A pronoun or adjective in the masculine gender includes the feminine and neuter genders, and the singular includes the plural, unless the context clearly indicates a different meaning.

11.1 "Administrator" means the Plan Sponsor or such other person or committee as may be appointed from time to time by the Plan Sponsor to supervise the administration of the Plan.

11.2 "COBRA" means the provisions requiring continuation of employer-sponsored group health coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985.

11.3 "Code" means the Internal Revenue Code of 1986, as amended.

11.4 "Compensation" means the total cash remuneration received by a Participant from the Plan Sponsor or Participating Employer as designated in Schedule B, if any, during a Plan Year prior to any reductions under Section 3.3. Compensation includes overtime, commissions and bonuses.

11.5 "Contract Year" means the 12-month period ending with or within the Plan Year which will be designated by the Administrator for purposes of making or changing benefit elections under this Plan, except as provided in Section 3.3(a) (relating to the election of benefits by a newly eligible Employee).

11.6 "Dependent" means for purposes of the Health Care FSA Program, or other Qualified Benefit Plans which provides accident or health coverage for which a premium is required, a "dependent" is your child (as defined in Code Section 152(f)(1)) who has not attained age 27 by the end of the calendar year, and any individual who is a tax dependent of yours as defined in Code Section 152 (determined without regard to Sections 152(b)(1), (b)(2) and (d)(1)(B)). For purposes of the HSA Program, a Dependent means any person who falls within the definition of dependent under Code Section 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof. Notwithstanding anything in the Plan to the contrary, any pre-tax payments made pursuant to the Plan with respect to a domestic partner and/or the child of a domestic partner who does not qualify as the Employee's Dependent, if any, shall be treated as taxable compensation. This taxable compensation shall be treated as wages reportable on the Employee's Form W-2 and shall be subject to income tax and social security tax withholding. For purposes of the Dependent Care FSA Program, "Dependent" means any individual who is (i) a dependent (as defined under Section 152(a)(1)) of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Code Section 151(c), or (ii) a dependent (as defined under Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof) or spouse of the Participant who is physically or mentally incapable of caring for himself and who has the same principal place of abode as the Participant for more than one-half of the taxable year.

11.7 "Dependent Care Assistance Account" means the account described in Article V.

11.8 "Dependent Care FSA Program" means the dependent care assistance program described in Article V.

11.9 "Dependent Care Expenses" mean expenses incurred by a Participant which (i) are incurred for the care of a Dependent of the Participant or for related household services, (ii) are paid or payable to a Dependent Care Service Provider, and (iii) are incurred to enable the Participant to be gainfully employed for any period for which there are one or more Dependents with respect to the Participant. "Dependent Care Expenses" do not include expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in 11.5(i) or regularly spends at least 8 hours each day in the Participant's household. Dependent Care Expenses will be deemed to be incurred at the time the services to which the related expenses are rendered.

11.10 "Dependent Care Service Provider" means a person who provides care or other services described in 11.8(i), but does not include (i) a dependent care center, as defined in Code Section 21(b)(2)(D), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (ii) a related individual described in Code Section 129(c).

11.11 "Effective Date" means the original effective date of the plan, which is January 1, 2008, as amended and restated effective January 1, 2025.

11.12 "Employee" means any individual employed by the Plan Sponsor. However, only those individuals classified as "employees" by the Plan Sponsor shall be eligible to participate, including any leased employees within the meaning of Code Section 414(n)(2). Independent contractors, freelancers and individuals hired through staffing firms shall not be eligible to participate in the Plan even if they are subsequently determined to be common law employees for any purpose, including without limitation, for wage, labor or tax purposes by either the Internal Revenue Service, Department of Labor or any other Federal or state agency, administrative body or court. An employee shall not include any self-employed individual, partner in a partnership, and more-than 2% shareholder in a Subchapter S corporation.

11.13 "Employee Provided Premium" means the sum of (i) that portion of the total premium cost of a Medical Plan and/or any other Qualified Benefit Plan that requires payment of premiums, which is required to be paid by the Employee, either by law or by agreement, and depending on what options exist under such plan (e.g., to the extent applicable, individual or family coverage, high or low deductibles, etc.), as adjusted from time to time to reflect changes, if any, in the percentage of such premiums paid by the Employee and/or changes in the total amount of such premiums, and (ii) a pro rata share of the costs of the administration of the Plan (allocated on a uniform basis) to the extent that the Plan Sponsor determines that such costs will be borne by Participants pursuant to Section 7.2.

11.14 "ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time.

11.15 "Flexible Benefit Contributions" means the aggregate of all amounts deferred pursuant to an election made under this Plan to participate in the Health Care FSA Program and/or the Dependent Care FSA Program.

11.16 "FMLA" means the Family and Medical Leave Act of 1993.

11.17 "FMLA Leave" means a leave of absence that the Plan Sponsor is required to extend to an Employee under the provisions of the FMLA.

11.18 "Grace Period" means the two-and-a-half (2<sup>1/2</sup>) month period immediately following the end of each Plan Year, during which to the extent that a Participant has a balance in the Participant's Health Care Flexible Spending Account or Dependent Care Assistance Account at the end of a Plan Year, the Participant may continue to incur Qualifying Medical Care Expenses or Dependent Care Expenses during the Grace Period and be reimbursed for such expenses up to the amount remaining in the Participant's Health Care Flexible Spending Account or Dependent Care Assistance Account as of the end of the preceding Plan Year.

11.19 "Health Care Flexible Spending Account" means the account described in Article IV.

11.20 "Health Care FSA Program" means the health care flexible spending program described in Article IV.

11.21 Health Savings Account/HSA means a health savings account within the meaning of Code Section 223.

11.22 Health Savings Account Program/HSA Program is the plan set forth in Appendix A. The HSA Program is established primarily for the purpose of permitting an HSA-Eligible Employee to receive, in lieu of taxable compensation, reimbursement by the HSA of "qualified medical expenses" (as defined in Code Section 223(d)(2)) incurred by the Employee, the Employee's Spouse and/or Dependents.

11.23 High Deductible Health Plan/HDHP means a high deductible health plan offered by the Plan Sponsor that is intended to qualify as a high deductible health plan under Code Section 223(c)(2), as described in materials provided separately by the Plan Sponsor. A High Deductible Health Plan may or may not be the sole medical insurance plan eligible for pre-tax salary reduction funding hereunder.

11.24 HSA-Eligible Employee means an individual who is eligible to contribute to an HSA under Code Section 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Plan Sponsor and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Plan Sponsor or any other employer.

11.25 "Medical Plans" means the group health insurance and/or self-funded plans, if any, designated from time to time by the Plan Sponsor, and communicated in writing to Participants, for purposes of providing various benefits under this Plan.

11.26 "Participant" means an Employee who participates in the Plan in accordance with Article II.

11.27 "Plan" means the Ensign United States Drilling Inc. Cafeteria Plan as set forth herein, together with all amendments and restatements.

11.28 "Plan Sponsor" means Ensign United States Drilling Inc. and any Affiliated Employer who adopts the Plan pursuant to authorization provided by the Plan Sponsor. Notwithstanding the previous sentence when the Plan provides that the Plan Sponsor has a certain power (e.g., the appointment of a third party administrator, entering into a contract with a third party insurer, or amendment or termination of the Plan) the term "Plan Sponsor" shall mean only Ensign United States Drilling Inc.. Affiliated Employers who adopt the Plan shall be bound by the Plan as adopted and subsequently amended unless they clearly withdraw from participation herein. Affiliated Employers who have adopted the Plan are set forth in Appendix B.

11.29 "Plan Year" means the twelve-month period ending each December 31st.

11.30 "Post-Service Claim" means any benefit claim that is not a Pre-Service Claim or an Urgent Care Claim.

11.31 "Pre-Service Claim" means any benefit claim with respect to which the terms of this Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

11.32 "Qualified Beneficiary" means any individual eligible to continue health care coverage under COBRA as a result

of a Qualifying Event.

11.33 "Qualified Benefit Plan" refers to the Health Care FSA Program and the Dependent Care FSA Program, any of the Medical Plans and/or any other employer-sponsored welfare benefit plans, if any, designated from time to time by the Plan Sponsor, and communicated in writing to Participants, for purposes of providing various benefits under this Plan.

11.34 "Qualifying Event" means any event described in Code Section 4980B which gives a Qualified Beneficiary the right to continue health care coverage under COBRA.

11.35 "Qualifying Medical Care Expense" means any expense incurred by a Participant, or by the spouse or Dependent of such Participant, for medical care as defined in Code Section 213(d)(including without limitation amounts paid for hospital bills, doctor and dental bills, and drugs), but only to the extent that the expense is not reimbursable to the Participant or other person incurring the expense through insurance or otherwise (other than under the Plan). Qualifying Medical Expenses do not include "qualified long term care services" as defined in Section 7702B(c) of the Code or premiums paid for health care coverage sponsored by the Plan Sponsor, any other employer, Medicare, or for individual coverage.

11.36 "Urgent Care" means a medical situation where failing to make a determination quickly could seriously harm a claimant's life, health, or ability to regain maximum function or could subject a claimant to severe pain that could not be managed without the requested treatment, as may be determined by a physician, and "Urgent Care Claim" shall mean a claim involving Urgent Care.

11.37 "Uniformed Services" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated as such by the President of the United States in time of war or emergency.

Executed this 30 day of May, 2025.

Ensign United States Drilling Inc.

By: *Cheryl Feinstein*

Name: Cheryl Feinstein

Title: Benefits Manager, US

**APPENDIX A**  
**THE HEALTH SAVINGS ACCOUNT PROGRAM**  
**ARTICLE I**  
**PLAN ESTABLISHMENT**

**1.1 Purpose**

The purpose of this Appendix A is to set forth the provisions governing the Health Savings Account (HSA) Program. The HSA Program is created exclusively to permit an HSA-Eligible Employee to make contributions to an Eligible HSA.

**1.2 Qualification**

The HSA Program is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The HSA Program is an elective pre-tax option under the Plan, and is intended to constitute accident and health plan coverage under Code Section 106.

**1.3 Incorporation By Reference**

The terms of the Plan are incorporated by reference wherever they apply to the HSA Program's operation.

**1.4 Duration**

The HSA Program is established with the intent of being maintained for an indefinite period of time; however, the Plan Sponsor, in its sole and absolute discretion, and in accordance with the provisions of Article X of the Plan, may amend or terminate the HSA Program or any of the provisions herein.

**1.5 Use of Terms**

Terms used in this Appendix A shall have the same meanings as the terms defined in Article XI of the Plan, unless separately defined in this Appendix A. All of the terms and provisions in Articles I through XI of the Plan shall apply to this Appendix A, except that where the provisions of this Appendix A and Articles I through XI of the Plan conflict, the provisions of this Appendix A shall govern.

**ARTICLE II**  
**DEFINITIONS**

**2.1 Eligible HSA**

An Eligible HSA, as used in this Appendix A, means an HSA that is established and maintained by an HSA-Eligible Employee through the HSA trustee or custodian selected by the Plan Sponsor and offered in conjunction with the Employee's enrollment in a High Deductible Health Plan sponsored by the Plan Sponsor.

**ARTICLE III**  
**PARTICIPATION AND TERMS**

**3.1 Participation, Contributions and Elections**

HSA-Eligible Employees may elect to contribute to the HSA Program on a prospective basis by enrolling under the terms of Section 3.1 of the Plan. As described in Section 3.4(a) of the Plan, such election can be increased or decreased prospectively during the Plan Year, effective no later than the next available payroll date following the Plan Sponsor's receipt of a completed election change form. Subject to the terms and conditions of Articles I through XI of the Plan and this Appendix A, as part of an Employee's participation under the terms of Article III of the Plan, any HSA-Eligible Employee may elect to contribute an amount to an Eligible HSA.

**3.2 Annual Contribution Limits**

The maximum amount that an HSA-Eligible Employee may elect to contribute to an Eligible HSA during the Plan Year is the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made, determined pursuant to Code Section 223(b)(2).

If the HSA-Eligible Employee attains (or will attain) age 55 by the end of any calendar year, the annual contribution limit is increased by the catch-up limit applicable for that calendar year (as determined pursuant to Code Section 223(b)(3)) (currently \$1,000).

The annual contribution limit shall be reduced by any HSA contributions made by the Plan Sponsor on behalf of the HSA-Eligible Employee. For Employees who elect to participate in the Plan Sponsor's Blue Cross Blue Shield High Deductible Health Plan, the Plan Sponsor will contribute up to \$750 (for individual coverage) and up to \$1,500 (for two-person or family coverage) to the Employee's HSA, or such other amount as provided in the initial and annual open enrollment materials furnished to Employees, which contributions shall be credited to the Employee's HSA Monthly. For Employees who elect to participate in the Plan Sponsor's Kaiser High Deductible Health Plan, the Plan Sponsor will contribute up to \$500 (for individual coverage) and up to \$1,000 (for two-person or family coverage) to the Employee's HSA, or such other amount as provided in the initial and annual open enrollment materials furnished to Employees, which contributions shall be credited to the Employee's HSA Monthly. The annual contribution limit (and the catch-up limit, if applicable) will be prorated by the number of months during the Plan Year in which the Employee is an HSA-Eligible Employee unless the HSA-Eligible Employee is enrolled in a High Deductible Health Plan on December 1 of a given year, in which case the Employee may elect the entire annual contribution limit (including the catch-up contribution, if otherwise eligible); however, in order for such Employee's contribution to retain its tax-favored status, the Employee must remain eligible for an HSA through the end of the following calendar year.

**ARTICLE IV**  
**MISCELLANEOUS**

**4.1 Administration of the HSA Program**

The Plan Sponsor shall transfer any pre-tax HSA contribution amounts elected by an HSA-Eligible Employee directly to the HSA trustee or custodian. The Plan Administrator shall maintain records of such HSA contribution amounts, and shall provide this information to the Plan Sponsor so that the Plan Sponsor may appropriately report this information on the Employee's Form W-2. The Plan Sponsor shall have no responsibility, authority or control over such HSA contribution amounts once such amounts are transferred to the HSA trustee or custodian.

**4.2 HSA Program and ERISA**

The HSA benefits under this Plan consist solely of the ability to make contributions to the HSA on a pre-tax salary reduction basis and any Plan Sponsor contributions to such HSA as set forth in Section 3.2. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claim procedures, etc.) shall be provided and are set forth in the HSA, not this Plan. The HSA Program is not an employer-sponsored employee welfare benefit plan within the meaning of Section 3(1) of ERISA. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code Section 223(d)(2). The Plan Sponsor's only involvement with the HSA Program is to forward to the HSA provider(s) contributions that Employees make via pre-tax salary reductions and that the Plan Sponsor contributes on behalf of Employees, and to select an HSA trustee or custodian to facilitate the establishment of an HSA by HSA-Eligible Employees who enroll in a High Deductible Health Plan sponsored by the Plan Sponsor. The Plan Sponsor shall maintain records to keep track of HSA contributions Employees make via pre-tax salary reductions and that the Plan Sponsor contributes on behalf of Employees, but it shall not create a separate fund or otherwise segregate assets for this purpose. The Plan Sponsor has no authority or control over the funds deposited into an HSA.

#### **4.3 Amount Payable**

The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223 and the laws of any applicable state or local jurisdiction.

Executed this 30 day of May, 2025.

Ensign United States Drilling Inc.

By: *Cheryl Feinstein*

Name: Cheryl Feinstein

Title: Benefits Manager, US

**APPENDIX B**  
**PARTICIPATING EMPLOYERS**

**As of January 1, 2025**

- Ensign United States Drilling (California) - EIN: 95-2223221

**SUMMARY PLAN DESCRIPTION**  
**For**  
**ENSIGN UNITED STATES DRILLING INC.**  
**CAFETERIA PLAN**

Amended and Restated as of January 1, 2025, unless otherwise noted

**The Plan Sponsor reserves the right to amend this Plan, in its sole discretion, at any time without the consent of any employee, former employee, or participant. The benefits provided under the Plan are not guaranteed benefits for covered persons or for their dependents. The Plan Sponsor reserves the right, in its sole discretion, to terminate the Plan or any Plan feature or component at any time and for any reason without liability.**

**The terms "you" and "your" as used in this document refer to an individual who is otherwise eligible to participate in the Plan. Receipt of this document does not guarantee that the recipient is in fact eligible to participate in the Plan or any Plan feature or component.**

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# ENSIGN UNITED STATES DRILLING INC. CAFETERIA PLAN SUMMARY PLAN DESCRIPTION

## INTRODUCTION

We are pleased to announce that we have established a Flexible Benefits Plan (the "Plan") under which you may choose to redirect a portion of your wages to pay for your share of the costs of available health and welfare plans that we sponsor and/or set aside money to pay for unreimbursed medical expenses (Health Care Flexible Spending Account) and/or dependent care expenses (Dependent Care Assistance Account), all with pre-tax dollars. This means that you will pay less in taxes each year.

Read this Summary Plan Description carefully so that you understand the provisions of the Plan and the benefits you will receive. We want you to be fully informed of the benefits available to you under the Plan both before you enroll and while you are a participant. You should direct any questions you have to the Plan Administrator. There are Plan documents available upon request for your review.

**IF THERE IS A CONFLICT BETWEEN THIS SUMMARY PLAN DESCRIPTION AND THE PLAN DOCUMENTS, THE PLAN DOCUMENTS WILL PREVAIL. IF THERE IS A CONFLICT BETWEEN AN INSURANCE CONTRACT WHICH FUNDS BENEFITS AND EITHER THE PLAN DOCUMENTS OR THIS SUMMARY PLAN DESCRIPTION, THE INSURANCE CONTRACT WILL PREVAIL.**

## I. ELIGIBILITY

### 1.1 When Will I Become Eligible To Participate In This Plan?

You will become eligible to participate in this Plan when you become eligible to participate, and you enroll, in any of the Plan Sponsor's health and welfare plans available under this Plan, the Health Care Flexible Spending Account Program and/or the Dependent Care Assistance Account Program.

For eligibility rules concerning the Plan Sponsor's health and welfare plans for which you pay a premium, please see the summary plan description or plan document for each. You should ask the Plan Administrator for copies of such documents if you need them.

If you are a regular full-time and part-time employee who is regularly scheduled to work for the Plan Sponsor at least 25 hours per week, you will be eligible to participate in the Health Care Flexible Spending Account Program and/or the Dependent Care Assistance Account Program as of the first day of the month following or coinciding with your date of hire.

Please note that if you are initially classified as an independent contractor (or any other non-employee designation) by your Employer and are subsequently determined to be a common law employee for any purpose, including without limitation, for wage, labor or tax purposes by either the Internal Revenue Service, Department of Labor or any other Federal or state agency, administrative body or court, you will still be ineligible for participation in the Plan for the period during which you were a non-employee. Unless otherwise noted herein, an employee shall not include any self-employed individual, partner in a partnership, and more-than-2% shareholder in a Subchapter S corporation.

### 1.2 What Must I Do To Enroll In The Plan?

If you are newly eligible for the Plan and enroll in any one or more of the qualified benefits that are part of this Plan, other than the Health Care Flexible Benefit Plan and/or Dependent Care Flexible Benefit Plan, you must complete an enrollment form/salary reduction agreement; however, even if you do not complete an enrollment form/salary reduction agreement, you will automatically be enrolled in this Plan once you enroll in any one or more of those qualified benefits. Further, if you are an existing employee, your elections for this Plan will continue until the next Plan Year if you remain covered under the qualified benefit plan as of the last day of the plan year for that plan. If you don't intend to participate in the Plan the next Plan Year, you must notify the Plan Sponsor in writing during open enrollment that you no longer intend to participate in the Plan.

If you are newly eligible for the Plan and elect to make contributions to the Health Care Flexible Benefit Plan and/or Dependent Care Flexible Benefit Plan you must complete an enrollment form/salary reduction agreement to

participate within the time periods specified in Article III of this SPD. You must complete an enrollment form/salary reduction agreement each Plan Year to participate in the Health Care Flexible Benefit Plan and/or Dependent Care Flexible Benefit Plan.

## II. OPERATION

### 2.1 How Does The Plan Operate?

Before the start of each Plan Year (as defined below), you may elect to have a portion of your salary or wages deducted on a pre-tax basis, and allocate your salary reductions to pay for the cost of the employee portion of the premiums due under any of the health and welfare plans available under the Plan, and fund the Health Care Flexible Spending Account and/or Dependent Care Assistance Account.

Your salary or wages will be deducted on a pre-tax basis, and your salary reductions allocated to pay for the cost of the employee portion of the premiums due under any of the health and welfare plans available under the Plan initially upon enrollment (for new employees) and each year thereafter (for current employees); however you must make a new election each year to have a portion of your salary or wages deducted on a pre-tax basis to fund a Health Care Flexible Spending Account and/or Dependent Care Assistance Account.

### 2.2 Who Is a Dependent?

For purposes of the Health Care Flexible Spending Account Program, or other Qualified Benefit Plans which provides accident or health coverage for which a premium is required, a "dependent" is your child (as defined in Code Section 152(f)(1)) who has not attained age 27 by the end of the calendar year, and any individual who is a tax dependent of yours as defined in Code Section 152 (determined without regard to Sections 152(b)(1), (b)(2) and (d)(1) (B)).

For purposes of the Dependent Care Assistance Account Program, please see Section 6.2 below for more information about who is an "eligible dependent" for reimbursement of dependent care expenses.

NOTE THAT THE HEALTH AND WELFARE PLANS MAY HAVE DIFFERENT DEFINITIONS OF "DEPENDENT" FOR PURPOSES OF COVERAGE AND ELIGIBILITY FOR BENEFITS. AS A RESULT, FOR TAX PURPOSES, IF YOU ARE COVERING AN ELIGIBLE DEPENDENT UNDER A HEALTH AND WELFARE PLAN WHO DOES NOT MEET THE DEFINITIONS ABOVE, THEN THE BENEFITS FOR SUCH DEPENDENTS MAY BE TAXABLE TO YOU.

NOTE: Please see the Plan Administrator if you have any questions about the "dependent" status of any individual in your family and/or whether or not coverage for certain dependents may be taxable to you.

## III. CONTRIBUTIONS

### 3.1 How Is My Compensation Measured Under The Plan?

Compensation under the Plan means the total cash amount that is paid to you each year.

### 3.2 What Contributions Are Made To The Plan?

Except for the funds you elect to contribute to fund a Health Care Flexible Spending Account and/or Dependent Care Assistance Account, by enrolling in any of the underlying health and welfare benefits, your salary or wages are reduced by a certain amount that represents your share of the cost of such benefits and are contributed to the Plan.

NOTE THAT THE AMOUNT OF THE EMPLOYER CONTRIBUTIONS MADE TO THE PLAN ON YOUR BEHALF ARE WITHIN THE SOLE DISCRETION OF THE EMPLOYER, AND YOU HAVE NO CONTRACTUAL RIGHT TO ANY EMPLOYER CONTRIBUTIONS. YOUR EMPLOYER MAY INCREASE, DECREASE OR ELIMINATE SUCH CONTRIBUTIONS AT ANY TIME WITHIN ITS SOLE DISCRETION.

### 3.3 What Happens To Contributions That Are Made To The Plan?

All contributions to the Plan, including your salary or wage reductions, may be used to pay for benefits under the Plan in any way that you want (as long as such benefits are covered under the Plan).

By your election, contributions that you defer are set aside into your Health Care Flexible Spending Account and/or Dependent Care Assistance Account only to be reimbursed for eligible expenses, and/or used to pay the cost of the employee portion of applicable premiums in the health and welfare plans you choose.

### **3.4 When Must I Decide What Coverage I Want?**

Except as described in Section 3.6 below, you may elect benefits under the Plan only during the "election period."

### **3.5 When Is The Election Period For The Plan?**

If you are a newly eligible Employee, the election period for the Plan will be the thirty (30) day period prior to the date you become eligible to participate in the Plan. See the Plan Administrator if you have any questions about the dates you become eligible to participate in the Plan.

For existing employees, with the exception of the Health Care Flexible Spending Account and/or Dependent Care Assistance Account you will be provided an opportunity to elect any underlying qualified health and welfare benefits in accordance with the terms of the plans for those benefits. However, once you are enrolled in those benefits, you will be deemed to have elected to enroll in this plan and your compensation will be reduced to make pre-tax contributions for your share of the premiums for any benefits you elect, as described above in Section 1.2. For the Health Care Flexible Spending Account and/or Dependent Care Assistance Account the Plan Administrator will establish an election period for a reasonable period of time prior to the beginning of each Plan Year, and such election period will be communicated to you in advance.

### **3.6 May I Change My Elections During The Plan Year?**

Generally, no. You cannot change the elections you have made after the beginning of the Plan Year. However, you are permitted to change certain elections if you experience an IRS defined "change in status" and/or other special events as described below. Also, you may elect to increase, decrease or revoke a pre-tax election to make contributions to your health savings account (HSA) at any time on a prospective basis. Any change in an HSA election shall become effective as soon as administratively practicable following the Employer's receipt of a completed election change form.

Examples of status changes include these events:

- (i) marriage;
- (ii) divorce, legal separation or annulment;
- (iii) death of your spouse or dependent child;
- (iv) birth, adoption or placement for adoption of a child;
- (v) termination of the employment of your spouse or dependent child;
- (vi) commencement of the employment of your spouse or dependent child;
- (vii) your or your spouse's or dependent child's commencement or return from an unpaid leave of absence from employment;
- (viii) adjustment to your or your spouse's or dependent child's work schedule, such as a switch between part-time and full-time work, a strike, a lockout or an increase or reduction in hours of employment, that causes a loss of coverage;
- (ix) a change in your or your spouse's or dependent child's worksite or residence that causes a loss of current coverage eligibility;
- (x) adjustments in dependent status through satisfying or ceasing to satisfy the age, student status or other requirements to qualify as a dependent under the Plan;
- (xi) significant change in your or your spouse's health coverage attributable to the spouse's employment; and
- (xii) leave of absence under the Family and Medical Leave Act.

Your election may also be changed if one of these special events occurs:

(i) the issuance of a judgment, decree or order that requires accident or health coverage for your dependent child.

(ii) your or your spouse's or dependent child's entitlement to Medicare or Medicaid that causes a loss of coverage.

(iii) your or your spouse's or dependent child's loss of eligibility for Medicare or Medicaid.

(iv) a "significant" increase in the cost of any benefit under the Plan; provided that for the Dependent Care Assistance Account program, the increase in cost is imposed by a dependent care giver who is not your relative. No election change may be made as to the Health Care FSA Program on account of a significant cost change.

*\*Note: If the cost of a health and welfare plan increases or decreases during the Plan Year, this Plan may, on a reasonable and consistent basis, automatically change your premium contributions in response to the change in cost.*

(v) "significant" improvement in coverage, such as the addition of new benefit plan, or significant improvement in coverage offered under an existing benefit plan. You may cancel your election and receive coverage under the new or improved benefit option. No election change may be made as to the Health Care FSA Program on account of a significant improvement in coverage.

(vi) elimination or "significant" cutback in coverage provided by an insurance company or other third party. You may cancel your election and receive coverage under a similar plan, provided both plans agree to make the change. No election change may be made as to the Health Care FSA Program on account of a significant cutback in coverage.

(vii) your failure to make the required premium payment. Your election will be canceled but you will not be able to make a new election for the rest of the Plan Year.

(viii) your separation from service. If you terminate employment, you may cancel your election for any remaining period of coverage.

(ix) your loss of group health coverage sponsored by a governmental or educational institution. No election change may be made as to the Health Care FSA Program and the Dependent Care FSA Program loss of such coverage.

(x) your spouse or dependent makes an election change under a plan maintained by his or her employer that has a different period of coverage than this Plan. No election change may be made as to the Health Care FSA Program for this reason.

(xi) your enrollment and/or or a related individuals' enrollment in Marketplace coverage. If you and/or a related individual enroll or intend to enroll in Marketplace coverage during the Marketplace's annual open enrollment period or during a special enrollment period, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you and/or the related individual or related individuals who cease coverage due to the revocation enroll in a Marketplace plan effective immediately following the revocation. If only a related individual or related individuals enroll or intend to enroll in Marketplace coverage, you will be transitioned to self-only coverage (or family coverage including one or more already-covered related individuals) under the Employer's health benefits. Coverage may only be terminated for those covered individuals who are enrolling or intend to enroll in Marketplace coverage during open enrollment or pursuant to a Marketplace special enrollment period. No change is permitted with regard to non-health benefits including the Health Care Flexible Spending Account Program and Dependent Care Flexible Spending Account Program available under the Plan.

(xii) your permanent reduction of hours. If you were reasonably expected to average 30 hours of service or more per week and experience an employment status change such that you are no longer reasonably expected to average 30 hours of service or more per week, the Administrator may permit you to cancel your election for any remaining period of coverage, provided that you (and any related individuals who cease coverage due to the revocation) enroll or intend to enroll in another plan no later than the first day of the second full month following the revocation. No change is permitted with regard to non-health benefits including the Health Care Flexible Spending Account Program and Dependent Care Flexible Spending Account Program available under the Plan.

If you have a status change and you want to cancel or modify your election for a Plan Year, you must file a written application with the Plan Administrator within 30 days of the event, or within 60 days in the case of a special

enrollment right due to the loss of eligibility for Medicaid or state children's health insurance program coverage, or eligibility for a state premium assistance subsidy from a Medicaid plan or through a state children's health insurance program with respect to coverage under the group health plan. Keep in mind that any change to your election must be consistent with your status change. The Plan Administrator will consider your application and inform you of the decision.

Elections made under this Plan automatically terminate on the date on which you cease to be a participant in the Plan, although coverage or benefits under the Medical Plans and/or the Health Care Flexible Spending Account Program may continue if and to the extent provided by such plan or as required by law. In the event you become a participant again within 30 days of the date you stopped being a participant and before the end of the same Plan Year, the elections you previously had in effect shall automatically be reinstated for the balance of the Plan Year. If you become a participant 30 days or more after the date you stopped being a participant and before the end of the Same Plan year, you may make new elections; however your elections for the Health Care Flexible Spending Account and Dependent Care Flexible Spending Account may not exceed the maximum annual contributions as set forth Sections 5.1 and 6.1 herein and applicable law.

### **3.7 May I Make New Elections In Future Plan Years?**

Yes, you may. If you want to participate in the Health Care Flexible Spending Account Program and/or the Dependent Care Assistance Account Program for an upcoming Plan Year, you must complete a new enrollment form/salary reduction agreement in order to participate for that Plan Year, regardless of whether or not you are making changes in your elections. Further, you will be provided an opportunity to change your elections for the underlying health and welfare benefits for which you pay pre-tax premiums prior to the beginning of each Plan Year, but do not need to renew your elections to participate in this Plan each year. So long as you remain enrolled in any underlying health and welfare benefits immediately prior to the Plan Year, you will be deemed to have elected to enroll in this plan for the following Plan Year and your compensation will be reduced to make pre-tax contributions for your share of the premiums for any underlying health and benefits you elect for the following Plan Year. However, if you wish to change any elections under this Plan in future years, you must notify the Administrator during open enrollment prior to the beginning of the next Plan Year of your intent not to participate.

## **IV. BENEFITS**

### **4.1 What Benefits Are Available Under The Plan?**

Under the Plan, you may choose to receive your entire compensation in cash or use a portion to pay for any of the nontaxable benefits available under the Plan.

The nontaxable benefits under the Plan include:

- (i) Pre-tax premium contributions provided under the Plan Sponsor's health and welfare plans available under this Plan, as designated and announced by the Plan Sponsor from time to time;
- (ii) Pre-tax contributions to your Health Savings Account (HSA) established with the HSA custodian or trustee as designated and announced by the Plan Sponsor from time to time;
- (iii) The Plan Sponsor's Health Care Flexible Spending Account program, the details of which are described below;
- (iv) The Plan Sponsor's Dependent Care Assistance Account program, the details of which are described below;

In the case of insured benefits, certain limits may apply on the amount of coverage that we obtain on your behalf. For example, it is possible, though unlikely, that even if you are a participant in the Plan, you might fail to qualify for coverage under the insured benefits offered under the Plan. Here, it is the insurance contracts, and not the terms of the Plan, which will dictate.

The Plan Sponsor may terminate or modify Plan benefits at any time, subject to the provisions of any insurance contracts. We will not be liable to you if an insurance company fails to provide any of the benefits described above, even if the failure to provide benefits is due to our gross negligence (for example, if we fail to enroll you or pay premiums). In the case of health benefits, you may have a right by law to continue your benefits that would otherwise terminate when (i) you leave employment, (ii) you are no longer eligible under the terms of any group health plan or

insurance policy, or (iii) when insurance coverage terminates.

Any benefits to be provided by insurance will be provided only after you have furnished the Plan Administrator with the necessary enrollment forms.

## **V. HEALTH CARE FLEXIBLE SPENDING ACCOUNT PROGRAM**

### **5.1 What Is A Health Care Flexible Spending Account?**

The Health Care Flexible Spending Account (HFSA), is intended to pay for health care expenses not covered by your group health plans and/or deductibles and other out-of-pocket expenses associated with your group health plans.

The HFSA is a tax savings vehicle which enables you to take money pre-tax from your salary to pay for certain unreimbursed medical expenses. Then, as you incur eligible expenses, you are reimbursed from your account. The maximum amount you can elect to contribute to your HFSA is limited to the statutory amount under Section 125(i)(2) of the Code in effect on January 1st of the same calendar year in which the Plan Year begins, as indexed for cost of living increases for any Plan Year beginning with or within such calendar year, which has been communicated to you by the Plan Sponsor separately. The maximum amount is available to you as of the first day of the Plan Year. These limits will be reviewed annually and adjusted as experience indicates.

### **5.2 What Health Care Expenses Can Be Reimbursed?**

Only "qualifying health care expenses" can be reimbursed. To be eligible an expense must:

- (i) be for medical care incurred within the Plan Year;
- (ii) not be reimbursable from another source;
- (iii) be incurred by you or your spouse or dependents; and
- (iv) not be claimed as a tax deduction.

A more detailed description of qualifying health care expenses is set forth in Appendix A to this Summary Plan Description.

### **5.3 How Does The Health Care Flexible Spending Account Work?**

You elect to participate in the HFSA by providing a source of pre-tax funds to reimburse yourself for your qualifying health care expenses by entering into an election form/salary reduction agreement with your Employer. Under that agreement, you agree to a salary reduction to fund the HFSA instead of receiving a corresponding amount of your regular pay.

As you incur qualifying health care expenses, you may obtain reimbursement by submitting a claim form to the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. (See Section 12.2 of this Summary Plan Description.) The Plan Administrator offers a debit card program for the reimbursement of qualifying health care expenses. Therefore, you may also obtain reimbursement by paying the provider directly for your qualifying health care expenses with a debit card that is provided to you by the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. The debit card will be funded with the amount of funds in your account, and the account balance will be reduced in amounts equal to your reimbursed health care expenses. You are still required to meet any applicable substantiation requirements if you use a debit card, as communicated by the Plan Administrator. If any expenses reimbursed by your debit card are subsequently determined to be non-qualifying health care expenses, the Plan Administrator may use methods permitted under applicable law or the Plan to recover such funds. If the provider does not accept payment with your debit card, then you should submit a paper claim form to the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. You should contact the Plan Administrator if you need a paper claim form.

**EMPLOYEES WHO FAIL TO USE (SPEND) 100% OF THE AMOUNT CREDITED TO THE HFSA FOR A CERTAIN PLAN YEAR WILL FORFEIT THE UNUSED PORTION AT THE END OF THE PLAN YEAR YOU MAY CARRY OVER AN AMOUNT NOT TO EXCEED TWENTY PERCENT (20%) OF THE OF THE INDEXED MAXIMUM AMOUNT PERMITTED UNDER SECTION 125(I) OF THE CODE AS OF THE END OF**

THE PLAN YEAR TO PAY OR REIMBURSE QUALIFYING MEDICAL CARE EXPENSES INCURRED DURING THE NEXT PLAN YEAR. THE PLAN SPONSOR WILL NOTIFY YOU OF THE EXACT AMOUNT THAT MAY BE CARRIED OVER BEFORE ANY ENROLLMENT PERIOD.

#### **5.4 Is My Health Information Protected?**

This Plan will operate in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), including, but not limited to, the privacy and security regulations with respect to protected health information to the fullest extent required by law. A description of the HIPAA privacy rights of each person covered under the Plan is contained in the Privacy Notice which has been provided to you. If you need a copy of the Privacy Notice or if you have any complaints, questions or concerns about anything addressed in the Privacy Notice, please see your Human Resources representative.

#### **5.5 What If My Coverage Under The Health Care Flexible Spending Account Program Is Terminated?**

##### Introduction

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 to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage (including coverage under the Health Care Flexible Spending Account program). The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the Plan and under Federal law, you should ask the Plan Administrator

The Plan Administrator is responsible for administering COBRA continuation coverage, but the Plan Administrator may delegate its administrative duties to a third-party administrator from time to time. The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

Wex Health Inc.  
1 Hancock Street  
Portland, ME 04101  
(866) 451-3399

##### COBRA Continuation Coverage

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." COBRA applies to each group health plan under the Plan. Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage because either one of the following qualifying events happens:

- (i) Your hours of employment are reduced; or
- (ii) Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage because any of the following qualifying events happens:

- (i) Your spouse dies;
- (ii) Your spouse's hours of employment are reduced;
- (iii) Your spouse's employment ends for any reason other than his or her gross misconduct;

- (iv) Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- (v) You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage because any of the following qualifying events happens:

- (i) The parent-employee dies;
- (ii) The parent-employee's hours of employment are reduced;
- (iii) The parent-employee's employment ends for any reason other than his or her gross misconduct;
- (iv) The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- (v) The parents become divorced or legally separated; or
- (vi) The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator (or a third-party COBRA administrator, as applicable) has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or entitlement of the employee to Medicare (Part A, Part B, or both), your Employer must notify the Plan Administrator (or a third-party COBRA administrator, as applicable) of the qualifying event within 30 days after the event or when you would otherwise lose coverage under the plan.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator (or a third-party COBRA administrator, as applicable). The Plan requires you to notify the Plan Administrator (or a third-party COBRA administrator, as applicable) within 60 days after the qualifying event occurs or the date you would otherwise lose coverage due to a qualifying event, whichever is later. You must send this notice to the Plan Administrator (or a third-party COBRA administrator, as applicable) in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that group health plan coverage would otherwise have been lost.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, entitlement of the employee to Medicare (Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. However, with respect to the extension of coverage under the Health Care flexible spending account, if available, continuation coverage will extend only until the end of the plan year in which the qualifying event occurs except where the Plan allows you to carryover a limited amount of unused funds to the next plan year without making a new election.

Generally, continuation coverage for a Health Care Flexible Spending Account will only be available if you have what is known as an "underspent" Health Care Flexible Spending Account, meaning if the amount you elected to contribute to your Health Care Flexible Spending Account exceeds the amount you have available to reimburse Qualifying Health Care Expenses at the time you terminate.

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

#### ***Disability extension of 18-month period of continuation coverage***

If you or anyone in your family covered under the group health plan is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator

is notified of the SSA's determination within 60 days after the later of: (i) the date of the SSA determination; (ii) the date of a qualifying event; or (iii) the date you lose coverage under the plan. This notice should be sent to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

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

If your family experiences another qualifying event while receiving COBRA continuation coverage, and such event would result in loss of health coverage if the first qualifying event had not already occurred, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, becomes entitled to Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the group health plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days after the later of (i) the date of the second qualifying event, or (ii) the date coverage under the plan would have been lost if the first qualifying event had not occurred. This notice must be sent to the Plan Administrator in accordance with the procedures set forth below under "Furnishing Notice to Plan Administrator."

### ***Furnishing Notice to Plan Administrator***

**YOU SHOULD FOLLOW THESE PROCEDURES WHEN NOTIFYING THE PLAN ADMINISTRATOR (OR THIRD-PARTY COBRA ADMINISTRATOR, AS APPLICABLE) OF A QUALIFYING EVENT. FAILURE TO FOLLOW THESE PROCEDURES MAY CAUSE LOSS OF COVERAGE.**

Unless the Plan has a third-party COBRA administrator, in which case qualified beneficiaries should follow the notice procedures established by the third-party COBRA administrator, when furnishing a notice to the Plan Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices will be delivered to the human resources department of the Plan Administrator (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail, or (iii) by registered or certified mail, return receipt requested. Such notices will include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the Plan Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

### **End of Continuation Coverage**

Continuation coverage will end earlier than the period elected if:

- Timely payment of premiums for the continuation coverage is not made;
- The qualified beneficiary first becomes covered under any other group health plan, after the COBRA election, as an employee or otherwise;
- The qualified beneficiary first becomes entitled to benefits under Medicare, after the COBRA election;
- The Plan Sponsor ceases to provide any group health plan to any employee;
- You, as the covered employee, cease to be disabled, if continuation coverage is due to your disability; or
- The period of continuation coverage expires.

### **Health Insurance Marketplace**

You may have other options available to you when you lose group health 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 generally doesn't accept late enrollees. For more information about the Marketplace, visit [www.healthcare.gov](http://www.healthcare.gov).

### **Medicare**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed,

after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>.

### Other Coverage Options

You may also be eligible for Medicaid or Children's Health Insurance Program (CHIP), which, if eligible, may be a coverage option in lieu of COBRA and may cost less than COBRA continuation coverage. You can learn more about these options at: [www.healthcare.gov](http://www.healthcare.gov) or <https://www.healthcare.gov/medicaid-chip/childrens-health-insurance-program/>.

### *If you have questions*

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

### *Keep your plan informed of address changes*

In order to protect your family's rights, you should keep the Plan Administrator (or third-party COBRA Administrator, as applicable) informed of 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.

## **VI. DEPENDENT CARE ASSISTANCE ACCOUNT**

### **6.1 What Is A Dependent Care Assistance Account?**

A Dependent Care Assistance Account (DCAP) allows eligible employees to set aside, on a pre-tax basis, monies to pay for qualifying dependent care expenses, which include expenses incurred for the care of an "eligible dependent," or for related household services, and are incurred to enable you and your spouse (if applicable, unless your spouse is a full-time student or disabled) to be gainfully employed.

To be a qualifying dependent care expense, the money must be paid to any individual or organization other than your spouse, your child under age 19 at calendar year end, your dependent for income tax purposes, an overnight camp, or a childcare facility caring for more than 6 persons but not complying with all state or local requirements.

### **6.2 Who Is An Eligible Dependent?**

An "eligible dependent" must be one of the following:

- (i) a person who is your dependent child under the age of 13, who lives in your home for more than half the year, and who receives more than half of his or her support from you for the year; or
- (ii) a person who is your disabled dependent (other than as set forth in (i) above), who lives in your home for

more than half the year, who receives more than half of his or her support from you for the year, and who regularly spends at least 8 hours a day in your home; or

(iii) a person who is your disabled spouse, who lives in your home for more than half the year, and who regularly spends at least 8 hours a day in your home.

### **6.3 What Limits Apply?**

There is a \$5,000 limit per family, except that if you are married and file separate tax returns, the limit is \$2,500 per person. In addition, for each Plan Year, you are not entitled to any DCAP reimbursement in excess of your taxable compensation or your spouse's taxable compensation. .

Any expenses reimbursed from your DCAP cannot be used for Federal Child and Dependent Care tax credit, as described later.

### **6.4 How Does The Dependent Care Assistance Account Work?**

You elect to participate in the DCAP by providing a source of pre-tax funds to reimburse yourself for your qualifying dependent care expenses by entering into an election form/salary reduction agreement with your Employer. Under that agreement, you agree to a salary reduction to fund the DCAP instead of receiving a corresponding amount of your regular pay.

As you incur qualifying dependent care expenses, you may obtain reimbursement by submitting a claim form to the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. (See Section 11.2 of this Summary Plan Description.) The Plan Administrator offers a debit card program for the reimbursement of qualifying dependent care expenses. Under the debit card program, you can also be reimbursed by paying the provider directly for your qualifying dependent care expenses with a debit card that will be provided to you by the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. The debit card will be funded with the amount of funds in your account, and the account balance will be reduced in amounts equal to your reimbursed dependent care expenses. You are still required to meet any applicable substantiation requirements if you use a debit card, as communicated by the Plan Administrator. If any expenses reimbursed by your debit card are subsequently determined to be non-qualifying dependent care expenses, the Plan Administrator may use methods permitted under applicable law or the Plan to recover such funds. If the provider does not accept payment with your debit card, then you should submit a paper claim form to the Plan Administrator, or if applicable, a third-party administrator designated by the Plan Administrator from time to time. You should contact the Plan Administrator if you need a paper claim form.

EMPLOYEES WHO FAIL TO USE (SPEND) 100% OF THE AMOUNT CREDITED TO THE DCAP FOR A CERTAIN PLAN YEAR WILL FORFEIT THE UNUSED PORTION AT THE END OF THE PLAN YEAR OR, IF APPLICABLE, THE END OF THE 2<sup>1/2</sup> MONTH GRACE PERIOD FOLLOWING THE END OF THE PLAN YEAR.

### **6.5 What Is The Dependent Care Tax Credit**

Currently, the amount of federal income taxes (but not FICA) you owe may be reduced by a percentage of the money you have spent on qualifying dependent care expenses. This is called a Dependent Care Tax Credit. The percentage varies depending on the combined income of you and your spouse. The total amount of expenses eligible for the credit is \$3,000 for one qualifying dependent and to \$6,000 for two or more dependents.

These expenses are also eligible for payment through a DCAP. Note that you are not permitted to use both the Dependent Care Tax Credit and the DCAP, so you should evaluate both possibilities. A full explanation of the tax laws as they relate to dependent care expenses is beyond the scope of this Summary Plan Description. We encourage you to seek the assistance of a competent tax advisor if you are unsure about how to proceed.

## **VII. PREMIUM DEDUCTIONS**

### **7.1 How Are Employee Premiums For Health And Welfare Plans Paid?**

Upon your enrollment in the Employer's group health plan(s), you are automatically enrolled in the Plan and your regular compensation will be reduced on a pre-tax basis by the amount of your premium payment (to the extent

applicable) for the coverage selected under such plan(s) unless you notify the Employer promptly, in a manner or on a form as prescribed by the Plan Administrator, that you do not wish to participate. Such notice must be provided at least 30 days prior to start of any Plan Year, or within seven days of the date you first participate in the group health plan(s), as applicable.

## VIII. TERMINATION OF EMPLOYMENT

### 8.1 What Happens If My Employment is Terminated During the Plan Year?

If your employment is terminated during the Plan Year, you will remain covered by the Plan Sponsor's health and welfare plans, but only to the extent permitted under each such plan and only for the period for which premiums have been paid prior to your termination.

You will remain eligible for reimbursement for all qualified expenses incurred under your Health Care Flexible Spending Account and/or Dependent Care Assistance Account until the following:

- **Health Care Flexible Spending Account:** Up to the date your employment is terminated, provided that you make proper claims for reimbursement on or before 90 days immediately following the close of the Plan Year.
- **Dependent Care Flexible Spending Account:** Up to the date your employment is terminated, provided that you make proper claims for reimbursement on or before 90 days immediately following the close of the Plan Year.

Under federal law, you, your spouse and your dependents may be entitled to continuation of health care coverage. (See Section 5.5 of this Summary Plan Description.)

## IX. HIGHLY COMPENSATED AND KEY EMPLOYEES

### 9.1 Do Limitations Apply To Those Who Are Highly Compensated?

Under the Internal Revenue Code, "highly compensated individuals," "highly compensated employees" and "key employees" are Participants who are generally highly paid employees. If you are within these categories, the amount of your contributions and benefits may be limited so that the Plan as a whole does not unfairly favor those who are highly paid. Plan experience will dictate whether contribution limitations on "highly compensated individuals," "highly compensated employees" or "key employees" will apply. You will be notified of these limitations if you are affected.

## X. GENERAL INFORMATION ABOUT THE PLAN

**This section contains certain general information which you may need to know about the Plan.**

### 10.1 General Plan Information

The name of the Plan is the Ensign United States Drilling Inc. Cafeteria Plan.

The Plan Sponsor has assigned Plan Number 501 to your Plan, and the Plan has been made part of the Plan Sponsor's Employee Benefits Plan for Employees of Ensign United States Drilling Inc. for annual reporting purposes.

The Plan is effective January 1, 2008 amended and restated effective January 1, 2025.

Your Plan's records are maintained on a fiscal period known as the Plan Year. Each Plan Year will run from January 1 through December 31.

### 10.2 Employer Information

The Plan Sponsor's name, address, and identification number are:

Ensign United States Drilling Inc.  
15015 Vickery Drive  
HOUSTON, Texas 77032  
E.I.N.: 84-1281167

### 10.3 Plan Administrator Information

The name, title, address, and business telephone number of your Plan Administrator is:

The name, title, address, and business telephone number of your Plan Administrator is:

Ensign United States Drilling Inc.  
15015 Vickery Drive  
HOUSTON, TX 77032  
(832) 431-4700

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

#### **10.4 Service Of Legal Process**

The name and address of the Plan's agent for service of legal process is:

Ensign United States Drilling Inc.  
15015 Vickery Drive  
HOUSTON, TX 77032

#### **10.5 Type Of Administration**

The Plan is administered by the Plan Administrator, who may delegate administrative duties to a third-party administrator from time to time. As applicable, the Plan Administrator will notify you who the third-party administrator is, and any applicable contact information, when you join the Plan. The Plan Administrator may change the third-party administrator from time to time, and you will be notified of any such change. The third-party administrator designated by the Plan Administrator is:

Wex Health Inc  
1 Hancock Street  
Portland, ME 04101  
Telephone: (866) 451-3399

### **XI. ADDITIONAL PLAN INFORMATION**

#### **11.1 ERISA Rights And Protections**

##### *Your Rights Under ERISA*

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

- (i) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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.
- (ii) Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- (iii) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report

In addition, you may continue coverage under the Health Care Flexible Spending Account program for yourself, spouse or dependents if there is a loss of coverage under the Health Care Flexible Spending Account program as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this Summary Plan Description and the documents governing the Health Care Flexible Spending Account program on the rules governing your COBRA continuation coverage rights.

*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 an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants. 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.

### *Enforce Your Rights*

If your claim for a benefit is denied or ignored, 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 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 thirty (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 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 Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

### *Assistance with Your Questions*

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area 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. You may also visit their website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**For all non-health care claims under the Plan, the following procedures set forth in Sections 11.2 through 11.5 will apply. For all health care claims under your health flexible spending account, Article XII of this Summary Plan Description will apply. Despite any other provision of the Plan, the claims procedures of any third-party administrator of the Plan will supersede the procedures set forth below as long as such procedures comply with applicable law.**

## **11.2 Filing A Claim**

- (i) All claims for reimbursement from your Dependent Care spending accounts must be submitted during the Plan Year in which the expenses were incurred on or before 90 days immediately following the close of the Plan Year.
- (ii) With the claim form, you must submit a bill or receipt from the provider which gives the following information:
  - (a) name and address of the provider and - in some cases - the provider's taxpayer identification number and signature;
  - (b) the date(s) services were provided;
  - (c) the type of service provided; and
  - (d) who received the service.
- (iii) Instead of submitting a claim as set forth in (ii) above, the Plan Administrator has established a debit card

program for the processing and reimbursement of all eligible dependent care benefits, and the details of such program will be explained to you if and when the program is established.

### **11.3 Notification Of Your Claim**

If any claim made under this Plan is wholly or partially denied, the Administrator will notify the person making such claim (the "claimant") of his or her decision in writing. You will receive a response to your claim within 90 days after your claim is submitted. More time may be required if there are special circumstances. If so, the Plan Administrator will contact you within the 90-day period. This notice will include an explanation as to why extra time is required and the date you can expect a decision. The extension will not exceed an additional 90 days.

If the Plan Administrator fails to notify you within the designated time period, your claim will be considered to have been denied. Despite the foregoing, any claim made in connection with a Qualified Benefit Plan other than the Dependent Care Flexible Spending Account will be subject to review thereunder as required in Section 3.2 and will not be subject to review under this Article.

### **11.4 Claim Denial**

If all or part of your claim is denied, you will receive written notification explaining the reasons for the denial, reference to specific Plan provisions on which the denial is based, a description of any additional information or material needed to complete your claim and an explanation of why the information is necessary, and appropriate information about the Plan's claims review procedures, including a statement of your right to bring a lawsuit following a denial on review.

### **11.5 Appealing A Denied Claim**

If your claim is denied and you wish to appeal, you must file your appeal with the Plan Administrator within 60 days after you receive the denial. Your appeal should include any additional information that you wish the Plan Administrator to consider. If your appeal is not filed within this 60-day period, you will not be able to appeal your claim.

The Plan Administrator will notify you in writing within 60 days after your appeal is received. If there are special circumstances, more time may be necessary to review your appeal. You may be asked to wait an additional 60 days for a decision. If all or part of your claim on appeal is denied, you will receive written notification explaining the reasons for the denial and reference to the specific Plan provisions on which the denial is based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim, and a statement of your right to bring a lawsuit following a denial on review. The decision will be final and binding on all parties. If you do not receive a written response from the Plan Administrator within the designated time period, your appeal will be considered to have been denied.

If you are dissatisfied with the decision after you have pursued these steps, you have the right to file a lawsuit in a state or federal court.

## **XII. HEALTH CARE CLAIM PROCEDURES**

**For all non-health care claims under the Plan, the following procedures set forth in Sections 11.2 through 11.5 will apply. For all health care claims relating to your Health Care Flexible Spending Account, this Article XII will apply. Despite any other provision of the Plan, the claims procedures of any third-party administrator of the Plan will supersede the procedures set forth below as long as such procedures comply with applicable law.**

### **12.1 Health Care Claim Definition**

How you file a health care claim for benefits depends on the type of claim it is. There are several categories of benefits:

- (i) A "concurrent care claim" is a claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim.
- (ii) A "pre-service care claim" is a claim for a benefit under the Plan with respect to which the terms of the Plan require approval (usually referred to as precertification) of the benefit in advance of obtaining medical care.

(iii) A "post-service care claim" is a claim for a benefit under the Plan after medical care has been rendered.

(iv) An "urgent care claim" is a claim for medical care or treatment that requires notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. This type of claim generally includes those situations commonly treated as emergencies.

## 12.2 Filing A Health Care Claim

If you wish to designate an authorized representative to act on your behalf with respect to your claim for benefits, you must do so in writing. Please be advised that no rights under the Plan, including but not limited to the right to receive any benefit or any right to pursue a claim or cause of action, are assignable. Any payment by the Plan directly to a provider pursuant to a written election or purported assignments submitted by a participant or a dependent is provided at the discretion of the Plan Administrator as a convenience to the participant or dependent and does not imply an enforceable assignment of any benefits or the right to pursue a claim or cause of action.

The Plan Administrator has established a debit card program for the processing and reimbursement of all eligible health care expenses, and the details of such program will be explained to you if and when the program is established. However, in the absence of a debit card program established under this Plan or if a provider will not accept payment from a debit card under this Plan, all claims must be filed using a written form supplied by the Plan Administrator and may be submitted by U.S. Mail, by hand delivery or by facsimile.

The Plan Administrator or its delegee provides forms for filing claims and authorized representative designations under the Plan that must be filed in writing. All claims from your Health Care Flexible Spending Account must be submitted during the Plan Year in which the expenses were incurred. Any claims not submitted on or before 90 days immediately following the close of the Plan Year will be rejected.

Your claim for benefits should include the following:

- (i) the amount and nature of the qualifying health care expense (as described elsewhere in this Summary Plan Description under "Health Care Flexible Spending Account Program") for which you want to be reimbursed;
- (ii) the date that the care giving rise to the qualifying health care expense was provided;
- (iii) the name of the person receiving the care if such person is not you, and the relationship of such person to you;
- (iv) the name of the person to whom, or organization to which, the qualifying health care expense was incurred;
- (v) that the qualifying health care expense has not been reimbursed, or is not reimbursable, under any other health plan coverage; and
- (vi) a written statement or receipt from an independent third party that the qualifying health care expense has been incurred and the amount of such qualifying health care expense.

## 12.3 Notification Of Your Health Care Claim

### *Post-Service Claims*

If your Post-Service Claim is denied, you will receive a written notice from the Plan Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Plan Administrator will notify you within this 30- day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the Plan Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

### *Pre-Service Claims*

If your claim is a Pre-Service Claim, and it is submitted improperly, the Plan Administrator will notify you of the

improper filing and how to correct it within 5 days. If your Pre-Service Claim is submitted properly with all needed information, you will receive written notice of the claim decision from the Plan Administrator within 15 days of receipt of the claim. The Plan Administrator will notify you within this 15-day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Plan Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

### *Urgent Claims*

If your claim is an Urgent Care Claim:

- You will receive notice of the benefit determination in writing or electronically within 72 hours after the Plan Administrator receives all necessary information, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.

If you file an Urgent Care Claim improperly, the Plan Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim is received. If additional information is needed to process the claim, the Plan Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Plan Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information.

### *Concurrent Care Claim*

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The claims administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

## **12.4 Health Care Claim Denial**

The Plan Administrator will provide you with written notice of the denial of your claim. Such notice will include the following:

- (i) the specific reason(s) for your adverse benefit determination;
- (ii) reference to the specific Plan provision on which the determination is based;
- (iii) a description of any additional material or information necessary for you to fix your claim and an explanation of why such material or information is necessary;
- (iv) a description of the review procedures, including a statement of your right to bring a lawsuit following an adverse benefit determination on review;
- (v) either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- (vi) if the adverse benefit determination is based on a medical judgment, either an explanation of such judgment, or a statement that such explanation will be provided to you free of charge upon request; and

(vii) in the case of an Urgent Care Claim, a description of the expedited review process to which you may be entitled.

## 12.5 Appealing A Denied Health Care Claim

You have 180 days after the receipt of the denial notice to request a review of the denial. Your request for a review must be in writing unless your claim involves urgent care, in which case the request may be made orally.

If you disagree with a claim determination, you can contact the Plan Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name and the identification number from the ID card, if any.
- The date(s) of health care service(s).
- The provider's name.
- The reason you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Plan Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. You consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

### *Appeal Determination Notice*

#### Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of Post-Service Claims, the first level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Plan Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

For procedures associated with Urgent Claims, see "Urgent Claim Appeals" below.

If you are not satisfied with the first level appeal decision of the Plan Administrator, you have the right to request a second level appeal from the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from receipt of first level appeal decision.

Please note that the Plan Administrator's decision is based only on whether or not benefits are available under the group health plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

#### Urgent Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the Plan Administrator as soon as possible, and provide the Plan Administrator with the information identified above under "How to Appeal a Claim Decision." The Plan Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

- (i) Urgent Care Claims - not later than 72 hours after receiving your request for a review.
- (ii) Pre-Service Claims - not later than 30 days after receiving your request for a review.
- (iii) Post-Service Claims - not later than 60 days after receiving your request for a review.

Similar to the initial claim determination period, these review periods may be extended. If these periods are extended, you will be notified by the Plan Administrator.

#### *Appeal Determination Notice*

If denied, your review decision on appeal will include:

- the specific reason(s) for the adverse determination;
- reference to the specific Plan provision on which the benefit determination is based;
- a statement that you are entitled to receive, without charge, reasonable access to any document (i) relied on in making the determination, (ii) submitted, considered, or generated in the course of making the benefit determination, (iii) that demonstrates compliance with the administrative processes and safeguards required in making the determination, or (iv) that constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment without regard to whether the statement was relied on;
- either the specific rule or guideline used in making your benefits determination or a statement that such a rule or guideline was relied upon in making the determination and that a copy of such rule or guideline will be provided free of charge upon request;
- if the adverse determination is based on medical necessity or experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment applying the terms of the Plan to your medical condition, or a statement that such explanation will be provided without charge on request;
- a statement describing the Plan's optional appeals procedures, and your right to receive information about such procedures, as well as your right to bring a lawsuit; and
- the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If you file an internal appeal for medical benefits, you will continue to be covered pending the outcome of the internal appeal. This means that the Plan shall not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

## APPENDIX A

### Qualifying Health Care Expenses

Under the Plan, you will be reimbursed only for those types of medical expenses normally deductible on your federal income tax return (without regard to the 7.5% of adjusted gross income limitation). They include, for example, expenses you have incurred for:

- (i) Medicine, drugs, birth control pills, vaccines, and vitamins you are prescribed by your physician.
- (ii) Over the counter drugs deemed qualifying by the Internal Revenue Service under Code §213 (e.g., antacids, cold medicine, pain relievers and allergy medicine).
- (iii) Personal protective equipment ("PPE"), such as masks, hand sanitizer and sanitizing wipes, for the primary purpose of preventing the spread of the Coronavirus Disease 2019 (COVID-19 PPE).
- (iv) Menstrual care products.
- (v) Medical doctors, dentists, eye doctors, chiropractors, osteopaths, podiatrists, psychiatrists, psychologists, physical therapists, acupuncturists and psychoanalysts (medical care only).
- (vi) Medical examination, X-ray and laboratory service, insulin treatment, and whirlpool baths the doctor ordered.
- (vii) Nursing help. If you pay someone to do both nursing and housework, you can be reimbursed only for the cost of the nursing help.
- (viii) Hospital care (including meals and lodging), clinic costs, lab fees.
- (ix) Medical treatment at a center for drug addicts or alcoholics.
- (x) Medical aids such as hearing aids (and batteries), false teeth, eyeglasses, contact lenses, braces, orthopedic shoes, crutches, wheelchairs, guide dogs and the cost of maintaining them.
- (xi) Ambulance service and other travel costs to get medical care. If you use your own car, you can claim what you spend for gas and oil to go to and from the place you received the care; or you can claim the per-mile reimbursement rate established by the Internal Revenue Service as in effect at the time the travel costs are incurred. Add parking and tolls to the amount you claim under either method.

You **cannot** obtain reimbursement for:

- (i) Expenses for which reimbursements are already available under another group health plan.
- (ii) Premiums paid for health coverage under any plan maintained by your Employer or any other employer.
- (iii) The basic cost of Medicare insurance (Medicare A).
- (iv) Life insurance or income protection policies.
- (v) The hospital insurance benefits tax withheld from your pay as part of the social security tax or paid as part of social security self-employment tax.
- (vi) Maternity clothes.
- (vii) Diaper service.
- (viii) Nursing care for a healthy baby.
- (ix) Illegal operations or drugs.
- (x) Travel your doctor told you to take for rest or change.
- (xi) Funeral expenses.

Qualifying medical expenses include only those expenses incurred for:

- (i) Yourself.

(ii) Your spouse.

(iii) All dependents you list on your federal income tax return.

(iv) If you are divorced or separated, any child of yours that is listed as a dependent on his or her other parent's federal income tax return (and certain other individuals in the case of a multiple support agreement).

IRS Publication 502, Medical and Dental Expenses, has a checklist of medical expenses that can be deducted and therefore reimbursed under this Plan, and those that cannot.

**ENSIGN UNITED STATES DRILLING INC.  
CAFETERIA PLAN**

**Schedule A - Participating Employers**

**As of January 1, 2025, unless otherwise noted**

Each entity listed below has sufficient common ownership with the Employer so as to constitute a member of a commonly controlled group as described in Code §414(b), (c), (m), and (o) and has adopted the Plan with the consent of the Plan Sponsor.

- Ensign United States Drilling (California) - EIN: 95-2223221