Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2025

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2025 or fiscal plan year beginning 01/01/2025 and ending 12/31/2025

A This return/report is for:
- [ ] a multiemployer plan
- [ ] a multiple-employer plan (Filers checking this box must provide participating employer information in accordance with the form instructions.)
- [X] a single-employer plan
- [ ] a DFE (specify) _____

B This return/report is:
- [X] the first return/report
- [ ] the final return/report
- [ ] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [ ] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan
GRACE FRANCHISE OPERATING COMPANY, INC. EXCEPTED BENEFIT HEALTH REIMBURSEMENT ARRANGEMENT (EBHRA)

1b Three-digit plan number (PN) ▶ 502

1c Effective date of plan 01/01/2023

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
GRACE FRANCHISE OPERATING COMPANY

6525 CROWN BLVD # 41446
SAN JOSE, CA 95120-2904

6525 CROWN BLVD # 41446
SAN JOSE, CA 95120-2904

2b Employer Identification Number (EIN)
27-0856386

2c Plan Sponsor's telephone number

2d Business code (see instructions)
812112

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	07/30/2026	ALYSIA HOREN
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE	Filed with authorized/valid electronic signature.	07/30/2026	ALYSIA HOREN
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a Plan administrator's name and address [X] Same as Plan Sponsor

3b Administrator's EIN

3c Administrator's telephone number

4 If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:

a Sponsor's name

4b EIN

c Plan Name

4d PN

5	Total number of participants at the beginning of the plan year	**5**	141
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	141
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	139
b	Retired or separated participants receiving benefits	**6b**	
c	Other retired or separated participants entitled to future benefits	**6c**	
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**.	**6d**	139
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	139
g(1)	Number of participants with account balances as of the beginning of the plan year (only defined contribution plans complete this item)	**6g(1)**	
g(2)	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g(2)**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested.	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristic Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristic Codes in the instructions:

4A

9a Plan funding arrangement (check all that apply)

- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

9b Plan benefit arrangement (check all that apply)

- **(1)** [ ] Insurance
- **(2)** [ ] Code section 412(e)(3) insurance contracts
- **(3)** [ ] Trust
- **(4)** [X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary
- **(4)** [ ] **DCG** (Individual Plan Information) – Number Attached _____
- **(5)** [ ] **MEP** (Multiple-Employer Retirement Plan Information)

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [ ] **A** (Insurance Information) – Number Attached _____
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... ☐ Yes ☒ No

11c Enter the Receipt Confirmation Code for the 2025 Form M-1 annual report. If the plan was not required to file the 2025 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code_____

Grace Franchise Operating Company, Inc. Excepted Benefit Health Reimbursement Arrangement (EBHRA) Summary Plan Description

Introduction

Your employer (the Employer) is pleased to provide the Grace Franchise Operating Company, Inc. Excepted Benefit Health Reimbursement Arrangement (EBHRA) Plan (the EBHRA Plan) for Eligible Employees. Under federal tax law, the EBHRA Plan is known as an "Excepted Benefit Health Reimbursement Arrangement" or " EBHRA" plan. Grace Franchise Operating Company, Inc. also offers the Grace Franchise Operating Company, Inc. Medical Plan (the "Medical Plan"). Only Eligible Employees who are eligible for coverage under the Medical Plan can become Participants in the EBHRA Plan and receive credits to their EBHRA Accounts. Eligible Employees do not need to *enroll* for coverage in the Medical Plan to participate in the EBHRA Plan; they must be *offered* other Medical Plan coverage sponsored by the employer. The Employee may waive coverage.

This booklet describes the basic features of the EBHRA Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the EBHRA Plan and a brief description of your rights as a Participant. If there is a conflict between the official, complete EBHRA Plan document and this booklet, the official EBHRA Plan document will control. Definitions of capitalized terms used in this booklet are contained in Part V.

PART I. General Information About the Plan

I-1. What is the purpose of the EBHRA Plan?

The purpose of the EBHRA Plan is to reimburse Participants, up to certain limits, for their own and their covered Spouses' and Dependents' Medical Care Expenses. Reimbursements for Medical Care Expenses paid by the EBHRA Plan generally are excludable from taxable income.

I-2. When did the EBHRA Plan take effect?

The EBHRA Plan became effective January 1, 2023. It was amended effective January 1, 2026.

I-3. Who can become a participant in the EBHRA Plan?

If you are an Employee who works 10 or more hours per week, has been employed by the Employer for a period of at least one month, and you are eligible for and offered coverage in the Medical Plan, you are an Eligible Employee and may become a Participant in the EBHRA Plan. If you meet all of these requirements other than the "10 or more hours per week" requirement and if you qualify as a "full-time" employee under the federal "employer shared responsibility" provisions, then you will also be eligible to participate. If your employment terminates for any reason and you are not rehired within 30 days, or you fail to qualify as an Eligible Employee for any other reason for more than 30 days, your service before the loss of Eligible Employee status will be disregarded when determining whether you are entitled to Eligible Employee status at a later date.

I-4. What Benefits are offered through the EBHRA Plan?

Once you become a Participant, the EBHRA Plan will maintain an "EBHRA Account" in your name to keep a record of the amounts available to you for the reimbursement of eligible Medical Care Expenses. Your EBHRA Account is merely a recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer), and it does not bear interest or accrue earnings of any kind. Benefits must first be reimbursed from the Medical Plan and any secondary health insurance coverage (as well as the Employer's Health FSA, which will provide reimbursements before the EBHRA Plan) before any Benefits are payable from this Plan.

Before the start of each subsequent Plan Year, the Employer will determine the maximum annual amount that may be credited during that Plan Year to Participants' EBHRA Accounts. For each calendar month that you are a Participant, your EBHRA Account will be credited with a pro rata portion of the maximum annual amount, so long as you are an Eligible Employee on the first day of that month. For example, starting in 2026 at the beginning of each calendar month during which you are a Participant, your account will be credited monthly with a prorated amount as follows: $2,200 for Salaried employees, $1,500 for Full time employees, and $750 for all part time employees. However, no credit will be given for a month if you fail to qualify as an Eligible Employee on the first day of that month. Your EBHRA Account will be reduced by any amount paid to you, or for your benefit, for eligible Medical Care Expenses incurred by you, your Spouse, or your Dependents. The amount available for reimbursement of Medical Care Expenses as of any given date will be the total amount credited to your EBHRA Account as of such date, reduced by any prior reimbursements made to you as of that date.

After the end of the Plan Year, the unused amount (if any) in your EBHRA Account will be forfeited.

I-5. How will the EBHRA Plan work?

The EBHRA Plan will reimburse you for eligible Medical Care Expenses to the extent that you have a positive balance in your EBHRA Account. The following procedure should be followed:

- You must submit a claim to the Administrator and provide any additional information requested by the Administrator;
- A request for payment must relate to Medical Care Expenses incurred by you, your Spouse, or your Dependent during the time you were a Participant under this Plan; and
- A request for payment must be submitted by January 31 following the close of the Plan Year in which the Medical Care Expense was incurred.

Claims must be submitted in writing. The Administrator may require that Participants submit claims on a form provided by the Administrator. The claim must set forth-

- The individual(s) on whose behalf the Medical Care Expenses were incurred;
- The nature and date of the Medical Care Expenses so incurred;
- The amount of the requested reimbursement; and
- A statement that such Medical Care Expenses have not otherwise been reimbursed and are not reimbursable through any other source and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

Each claim must be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and showing the amounts of such Medical Care Expenses, along with any additional documentation that the Administrator may request (including, but not limited to, proof of a prescription). Generally, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $25, although there is an exception made for the final reimbursement claim for a Plan Year. If the Employer implements an electronic payment card program (debit card, credit card, or similar method) to pay expenses from the EBHRA Plan, some expenses may be validated at the time the expense is incurred (like copays for medical care). For other expenses, the card

payment is only conditional, and you will still have to submit supporting documents. You will receive more information from the Employer about what you must do to obtain reimbursement if such a system is implemented.

I-6. Are there any limitations on Benefits available from the EBHRA Plan?

Premiums and Medical Care Expenses are covered by the EBHRA Plan. A Medical Care Expense is an expense that is related to the diagnosis, care, mitigation, treatment, or prevention of disease. Some examples of eligible Medical Care Expenses are (a) insulin; (b) prescribed and over-the-counter drugs and medicines; (c) medical devices such as crutches, bandages, and diagnostic devices such as blood-sugar test kits; (d) dental expenses; (e) dermatology; (f) physical therapy; and (g) contact lenses or glasses used to correct a vision impairment. Your Employer or Administrator can provide you with more information about which expenses are eligible for reimbursement.

Some examples of expenses that are not Medical Care Expenses and are not eligible for reimbursement include the following:

- Health insurance premiums for any other plan (including the Medical Plan).
- Long-term care services.
- Cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease. "Cosmetic surgery" means any procedure that is directed at improving the patient's appearance and that does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
- The salary expenses of a nurse to care for a healthy newborn at home.
- Funeral and burial expenses.
- Household and domestic help (even if recommended by a qualified physician due to an Employee's, Spouse's, or Dependent's inability to perform physical housework).
- Custodial care.
- Costs for sending a problem child to a special school for benefits that the child may receive from the course of study and disciplinary methods.

- Social activities, such as dance lessons (even if recommended by a physician for general health improvement).
- Bottled water.
- Cosmetics, toiletries, toothpaste, etc.
- Uniforms or special clothing, such as maternity clothing.
- Automobile insurance premiums.
- Transportation expenses of any sort, including transportation expenses to receive medical care.
- Marijuana and other controlled substances that are in violation of federal laws, even if prescribed by a physician.
- Any item that does not constitute "medical care" as defined under Code §213.
- Any expense incurred before you became a Participant.
- Short-term, limited-duration insurance, unless specifically approved by the Administrator on a case-by-case basis.

I-7. How do I become a Participant?

If you meet the eligibility requirements described in Section I-3, you will become a Participant in the EBHRA Plan on the first of the month following one month of employment with your submission of a properly completed enrollment form in accordance with procedures established by the Employer, but only if you are an Eligible Employee on that day.

I-8. What if I cease to be an Eligible Employee?

If you cease to be an Eligible Employee because you are no longer eligible for the Medical Plan, your participation will terminate at the end of that month or when your EBHRA Account balance is exhausted, whichever happens first. If you cease to be an Eligible Employee for any other reason (for example, if you die, retire, or terminate employment), your participation in the EBHRA Plan will terminate at the end of the month in which the terminating event occurs, unless you are eligible for and elect COBRA continuation coverage as described below. In either case, you will be reimbursed for any Medical Care Expenses prior to the date your participation terminates, up to your account balance in the EBHRA Account, provided that you comply with the reimbursement

request procedures required under the EBHRA Plan (see Section I-5 for more information on the reimbursement request process). Any unused portions will be not be available after termination of employment. However, if you are rehired within 30 days after your termination, your EBHRA Account balance will be reinstated.

I-9. What is COBRA continuation coverage? If I or my Spouse or Dependent has a COBRA Qualifying Event, can I continue to participate in the EBHRA Plan?

COBRA is a federal law that gives certain employees, spouses, and dependent children of employees the right to temporary continuation of their health care coverage under the Employer's major medical or other health insurance plan at group rates. If you, your Spouse (if applicable), or your Dependent children (if applicable) incur an event known as a "Qualifying Event," and if such individual is covered under the EBHRA Plan when the Qualifying Event occurs, then the individual incurring the Qualifying Event will be entitled under COBRA to elect to continue his or her coverage under the EBHRA Plan if he or she pays the applicable premium for such coverage. "Qualifying Events" are certain types of events that would cause, except for the application of COBRA's rules, an individual to lose his or her health insurance coverage. A Qualifying Event includes the following events:

- Your termination from employment or reduction of hours;
- Your divorce or legal separation from your Spouse;
- Your becoming eligible to receive Medicare benefits;
- Your Dependent child ceasing to qualify as a Dependent.

If the Qualifying Event is termination from employment, then the COBRA continuation coverage runs for a period of 18 months following the date that regular coverage ended. COBRA continuation coverage may be extended to 36 months if another Qualifying Event occurs during the initial 18-month period. You are responsible for informing the Administrator of the second Qualifying Event within 60 days after the second Qualifying Event occurs. COBRA continuation coverage may also be extended to 29 months in the case of an individual who becomes disabled within 60 days after the date the entitlement to COBRA continuation coverage initially arose and who continues to be disabled at the end of the 18 months. (In the event that family coverage is continued under COBRA, the Employee, Spouse, and Dependents may all extend coverage to 29 months regardless of which individual has become disabled.) In all other cases to which COBRA applies, COBRA continuation coverage shall be for a period of 36 months.

I-10. Will I have any administrative costs under the EBHRA Plan?

Generally, no. The Employer is currently bearing the entire cost of administering the EBHRA Plan while you are an Employee.

I-11. How long will the EBHRA Plan remain in effect?

Although the Employer expects to maintain the EBHRA Plan indefinitely, it has the right to terminate the EBHRA Plan at any time. The Employer also reserves the right to amend the EBHRA Plan at any time and in any manner that it deems reasonable, in its sole discretion. An amendment or termination of the Plan could result in the reduction or elimination of EBHRA Account balances under this Plan.

I-12. Are my Benefits taxable?

The EBHRA Plan is intended to meet certain requirements of existing federal tax laws, under which the Benefits that you receive under the EBHRA Plan generally are not taxable to you. However, the Employer cannot guarantee the tax treatment to any given Participant, since individual circumstances may produce differing results. If there is any doubt, you should consult your own tax advisor.

I-13. What happens if my claim for Benefits is denied?

If your claim for Benefits is denied, then you have the right to be notified of the denial and to appeal the denial, both within certain time limits. The rules regarding denied claims for Benefits under the EBHRA Plan are discussed below.

A. When must I receive a decision on my claim?

If your claim is denied in whole or in part, you will be notified in writing by the Administrator within 30 days after the date the Administrator received your claim. This time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a claim is incomplete. The

Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.

B. What information will a notice of denial of a claim contain?

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary; and
- appropriate information on the steps to be taken if you wish to appeal the Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA (where applicable) with respect to any adverse determination after appeal of your claim.

C. Do I have the right to appeal a denied claim?

If your claim is denied in whole or part, then you (or your authorized representative) may request review upon written application to the Benefits Committee that acts on behalf of the Administrator with respect to appeals (the Committee). Your appeal must be made in writing within 180 days after your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court. Your written appeal should state the reasons that you believe your claim should not have been denied. It should include any additional facts or documents that you believe support your claim. You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

D. How will my appeal be reviewed?

Appeals will be reviewed and decided by the Committee or other entity designated in the Plan in a reasonable time not later than 60 days after the Committee receives your request for review. The Committee may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- the specific reason(s) for the decision on review;
- the specific Plan provision(s) on which the decision is based;
- a statement of your right to review (upon request and at no charge) relevant documents and other information;
- if an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and
- a statement of your right to bring suit under ERISA §502(a) (where applicable).

I-14. Who is the Administrator?

The Employer is the Administrator and the named fiduciary for the EBHRA Plan.

I-15. May I elect to suspend or permanently opt out of my EBHRA Account?

Yes. If you participate in the EBHRA Plan, you will be ineligible to make health savings account (HSA) contributions. You can remove the EBHRA as an obstacle to HSA contributions for a Plan Year if you elect to "suspend" your EBHRA Account before the beginning of that Plan Year. Whether you elect to suspend your

EBHRA Account is up to you.

You may elect to suspend your EBHRA Account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. Your suspension election will remain in effect for the entire Plan Year to which it applies, and you may not modify or revoke the election during that Plan Year.

By electing to suspend your EBHRA Account for a Plan Year, you agree to permanently forgo reimbursements from your EBHRA Account for Medical Care Expenses incurred during that Plan Year. Medical Care Expenses incurred in the Plan Year before the suspended Plan Year may be reimbursed, so long as there was no suspension in effect for that prior Plan Year. You must apply for reimbursement, by submitting an application in writing to the Administrator, no later than January 31 following the close of the Plan Year in which the Medical Care Expense was incurred.

In lieu of a suspension of your EBHRA Account, you may elect to permanently opt out of and waive any right to reimbursements from your EBHRA Account for expenses incurred after the election takes effect, except for limited-scope dental or vision expenses. This opportunity will be offered at least annually by the EBHRA Plan.

The Employer will not contribute to your EBHRA Account after any opt-out election takes effect or for any Plan Year for which you have suspended your participation in the EBHRA Plan.

PART II. Administrative Information

The Administrator administers the EBHRA Plan and has the discretionary authority to interpret all EBHRA Plan provisions and to determine all issues arising under the EBHRA Plan, including issues of eligibility, coverage, and Benefits. The Administrator's failure to enforce any provision of the EBHRA Plan shall not affect its right to later enforce that provision or any other provision of the EBHRA Plan. The Administrator may delegate some of its administrative duties to agents.

General Plan Information

Name of Plan: Grace Franchise Operating Company, Inc. Excepted Benefit Health Reimbursement Arrangement (EBHRA) Plan

Plan Number: 502

Effective Date: January 1, 2023

Plan Year: January 1 to December 31. The financial records of the EBHRA Plan are kept on a Plan Year basis. The Plan Year ends on each December 31.

Type of Plan: The EBHRA Plan is intended to qualify as an employer-provided medical reimbursement plan under Code §§105 and 106 and the regulations issued thereunder, and as an excepted benefit health reimbursement arrangement as defined under Treas. Reg. 54.9831-1(c)(3)(viii), IRS Notice 2002-45, and other applicable guidance.

Sponsoring Employer Information

Name and Address: Grace Franchise Operating Company, Inc., 6525 Crown Blvd #41446, San Jose, California 95120.

Federal Employer Identification Number (EIN): 27-0856386

Plan Administrator Information

Name, Address, and Business Telephone Number: Grace Franchise Operating Company, Inc., 6525 Crown Blvd #41446, San Jose, CA 95120, Attention: Human Resources Manager, (831) 706-2500.

Agent for Service of Legal Process

The name and address of the Plan's agent for service of legal process is: Grace Franchise Operating Company, Inc., 6525 Crown Blvd #41446, San Jose, CA 95120, Attention: Human Resources Manager.

Funding Medium and Type of Plan Administration

Type of Administration: The Administrator pays applicable Benefits from the general assets of the Employer.

Funding: The EBHRA Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

Qualified Medical Child Support Order

The Plan will provide benefits as required by any qualified medical child support order (QMCSO), as defined in ERISA §609(a). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

PART III. ERISA Rights

As a Participant in the EBHRA Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act (ERISA). ERISA provides that all plan participants are entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Administrator's office and at other specified locations (such as worksites) all plan documents and copies of all documents filed by the EBHRA Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration, such as detailed annual reports, if any;
- Obtain copies of all plan documents governing the operation of the plan and other plan information upon written request to the Administrator (the Administrator may charge a reasonable amount for the copies);

and

- Receive a summary of the EBHRA Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case the Employer, as Plan Administrator, is required by law to furnish each Participant with a copy of this summary annual report.

COBRA Rights

You are entitled to continue health care coverage under COBRA for yourself, your Spouse (if applicable), or your Dependents (if applicable) if there is a loss of coverage under the EBHRA Plan as a result of a qualifying event. You, your Spouse, or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the EBHRA Plan for the rules governing your COBRA continuation 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 the employee benefits plan. The people who operate your EBHRA Plan, called "fiduciaries" of the EBHRA Plan, have a duty to do so prudently and in the interest of the EBHRA Plan Participants and beneficiaries. No one, including your Employer or any other person, may discriminate against you in any way to prevent you from obtaining a Benefit from the EBHRA Plan or from exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Benefit is ignored or denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the EBHRA Plan documents or the latest annual report (Form 5500), if any, from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the EBHRA 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 EBHRA Plan Administrator. If you have a claim for Benefits that is denied or ignored in whole or in part, and if you have

exhausted the claims procedures available to you under the EBHRA Plan, then you may file suit in state or federal court.

If it should happen that plan fiduciaries misuse the EBHRA Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees (for example, if it finds that your claim is frivolous).

Assistance With Your Questions

If you have any questions about the EBHRA Plan, you should contact the EBHRA Plan Administrator. If you have any questions about this part of the Summary Plan Description or about your rights under ERISA, or if you need assistance in obtaining documents from the EBHRA Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PART IV. HIPAA Privacy Rights

Group health plans, including the EBHRA Plan, are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You may receive a separate notice from the Employer that outlines its health privacy policies, including with regard to electronic PHI.

PART V. Definitions

In this document, the following terms, when capitalized, shall have the following meanings unless a different meaning is clearly required by the context.

- *Administrator.* The Employer.
- *Benefits.* The reimbursement benefits for Medical Care Expenses described in the EBHRA Plan.
- *COBRA.* The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- *Code.* The Internal Revenue Code of 1986, as amended.
- *Committee.* The Benefit Plan Committee of the Employer, or such other person or Committee as may be appointed by the Employer to supervise the administration of the Plan or decide appeals.
- *Compensation.* The wages or salary paid to an Employee by the Employer.
- *Dependent.* A dependent is a Participant's child as defined in Code §152(f)(1) who has not attained age 26, or a dependent as defined in Code §105(b); provided, however, that any child to whom Code §152(e) applies shall be treated as a dependent of both parents. Note that the Code §105(b) definition is similar to the Code §152 definition that is used to determine your tax dependents, except that an individual's status as a Dependent is determined without regard to the gross income limitation for a "qualifying relative" and certain other provisions of Code §152. The EBHRA Plan will provide Benefits in accordance with the applicable requirements of any qualified medical child support order, even if the child does not meet the definition of Dependent.
- *EBHRA Account.* The recordkeeping account established in your name by the Employer on the basis of which your eligible Medical Care Expenses will be paid or reimbursed.
- *EBHRA Plan.* The Grace Franchise Operating Company, Inc. Excepted Benefit Health Reimbursement Arrangement (EBHRA) Plan, as amended or restated from time to time.
- *Eligible Employee.* An Employee who works at least 20 hours per week for the Employer continuously for a period of 30 consecutive days and participates in the EBHRA Plan, or who otherwise is specified as being eligible under the EBHRA Plan document.
- *Employee.* In general, an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Certain individuals (such as leased employees; independent contractors; individuals working for a staffing agency; collectively bargained employees; self-employed individuals; partners in a partnership; and more-than-2% shareholders in a Subchapter S corporation) are not considered Employees. See the EBHRA Plan document for full details on these exclusions.
- *Employer.* Grace Franchise Operating Company, Inc. or its successor(s).
- *ERISA.* The Employee Retirement Income Security Act of 1974, as amended.
- *Health FSA.* A health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-5(a)(1).
- *HIPAA.* The Health Insurance Portability and Accountability Act of 1996, as amended.

- *Medical Care Expenses.* See Section I-6 for a description of Medical Care Expenses.
- *Medical Plan.* The Grace Franchise Operating Company, Inc. Medical Plan.
- *Participant.* An Eligible Employee who has become and not ceased to be a Participant in the Plan.
- *Plan Year.* The 12-month period ending on December 31.
- *Spouse*. An individual who is treated as a spouse for federal tax purposes.

PART VI. Miscellaneous

Effect of the EBHRA Plan on Your Employment Rights

The EBHRA Plan is not to be construed as giving you any rights against the EBHRA Plan except those expressly described in this document. The EBHRA Plan is not a contract of employment between you and the Employer.

Prohibition Against Assignment of Benefits

No Benefit payable at any time under the EBHRA Plan shall be subject in any manner to alienation, sale, transfer, assignment, pledge, attachment, or encumbrance of any kind.

Overpayments or Errors

If it is later determined that you and/or your Spouse or Dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the EBHRA Plan.

If you do not refund the overpayment or erroneous payment, the EBHRA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay.

Grace Franchise Operating Company, Inc. Excepted Benefit Health Reimbursement Arrangement (EBHRA) Plan

As Amended Effective January 1, 2026.

ARTICLE I. Introduction

1.1 Establishment of Plan

Grace Franchise Operating Company, Inc. (the Employer) hereby establishes the Grace Franchise Operating Company, Inc. Excepted Benefit Health Reimbursement Arrangement (EBHRA) Plan (the Plan) effective January 1, 2023 (the Effective Date). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Plan is intended to permit an Eligible Employee to obtain reimbursement of Medical Care Expenses on a nontaxable basis from his or her EBHRA Account.

1.2 Legal Status

This Plan is intended to be an excepted benefit health reimbursement arrangement as defined under Treas. Reg. §54.9831-1(c)(3)(viii) and other applicable guidance. The Medical Care Expenses reimbursed under the Plan are intended to be eligible for exclusion from Participants' gross income under Code §105(b). This Plan is intended to be an employer-provided medical reimbursement plan under Code §§105 and 106 and regulations issued thereunder. This Plan is not intended to be integrated with Medicare Parts B and D or a medical plan. The Plan shall be interpreted to accomplish these objectives.

ARTICLE II. Definitions

2.1 Definitions

"Administrator" means Grace Franchise Operating Company, Inc. The contact person is the Human Resources

Manager or the equivalent thereof for Grace Franchise Operating Company, Inc., who has the full authority to act on behalf of the Administrator, except with respect to appeals, for which the Committee has the full authority to act on behalf of the Administrator, as described in Section 13.1.

"Benefits" means the reimbursement benefits for Medical Care Expenses described under Article VII.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

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

"Committee" means the Benefits Committee appointed by the Board of Directors or the equivalent thereof of Grace Franchise Operating Company, Inc.

"Compensation" means the wages or salary paid to an Employee by the Employer.

"Covered Individual" means, for purposes of Article VIII, a Participant, Spouse, or Dependent.

"Dependent" means (a) any individual who is a Participant's child as defined by Code §152(f)(1) and who has not attained age 26, and (b) any tax dependent of a Participant as defined in Code §105(b) provided, however, that any child to whom Code §152(e) (regarding a child of divorced parents, etc., where one or both parents have custody of the child for more than half of the calendar year and where the parents together provide more than half of the child's support for the calendar year) applies is treated as a dependent of both parents. Notwithstanding the foregoing, the EBHRA Account will provide Benefits in accordance with the applicable requirements of any QMCSO, even if the child does not meet the definition of "Dependent."

"Effective Date" of this Plan has the meaning described in Section 1.1.

"Electronic Protected Health Information" has the meaning described in 45 CFR §160.103 and generally includes Protected Health Information that is transmitted by electronic media or maintained in electronic media. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

"Eligible Employee" means an Employee eligible to participate in this Plan, as provided in Section 3.1.

"Employee" means an individual whom the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code §414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which

such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation, including those deemed to be a more-than-2% shareholder by virtue of the Code §318 ownership attribution rules. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for Benefits in accordance with Section 3.2.

"Employer" means Grace Franchise Operating Company, Inc., and any Related Employer that adopts this Plan with the approval of Grace Franchise Operating Company, Inc. Related Employers, if any, that have adopted this Plan are listed in Appendix A to this Plan. However, for purposes of Article XIV and Section 15.3, "Employer" means only Grace Franchise Operating Company, Inc.

"Employment Commencement Date" means the first regularly scheduled working day on which the Employee first performs an hour of service for the Employer for Compensation.

"Enrollment Form" means the form provided by the Administrator for the purpose of allowing an Eligible Employee to participate in this Plan.

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

"Excepted Benefit HRA" or "EBHRA" means an HRA that satisfies the requirements specified in Treas. Reg. §54.9831-1(c)(3)(viii) or other binding regulations or guidance.

"FMLA" (where applicable) means the Family and Medical Leave Act of 1993, as amended.

"Health FSA" means a health flexible spending arrangement as defined in Prop. Treas. Reg. §1.125-5(a)(1).

"Highly Compensated Individual" means an individual defined under Code §105(h), as amended, as a "highly compensated individual."

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

"HRA" means a health reimbursement arrangement as defined in IRS Notice 2002-45. "EBHRA Account" means

the account described in Section 7.4.

"Medical Care Expenses" has the meaning defined in Section 7.2.

"Participant" means an individual who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Eligible Employees who first become Participants, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Participants who terminate participation, it shall mean the portion of the Plan Year prior to the date participation in the Plan terminates, as described in Section 3.2. A different Period of Coverage (e.g., a calendar month) may be established by the Administrator and communicated to Participants.

"Plan" means the Grace Franchise Operating Company, Inc. EBHRA Plan as set forth herein and as amended from time to time.

"Plan Year" means the calendar year (i.e., the 12-month period commencing January 1 and ending on December 31), except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"Privacy Official" shall have the meaning described in 45 CFR §164.530(a).

"Protected Health Information" shall have the meaning described in 45 CFR §160.103 and generally includes individually identifiable health information held by, or on behalf of, the Plan.

"QMCSO" means a qualified medical child support order, as defined in ERISA §609(a).

"Related Employer" means any employer affiliated with Grace Franchise Operating Company, Inc. that, under Code §§414(b), (c), or (m), is treated as a single employer with Grace Franchise Operating Company, Inc. for purposes of Code §105.

"Spouse" means an individual who is treated as a spouse for federal tax purposes.

"SPD" means the separate summary plan description describing the terms of this Plan.

"Suspension Election Form" means the form provided by the Administrator for the purpose of allowing a Participant to suspend his or her EBHRA Account for a Plan Year, as provided in Section 4.2.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

ARTICLE III. Eligibility and Participation

3.1 Eligibility to Participate

An individual is an Eligible Employee and may become a Participant in this Plan if the individual (a) is an Employee; (b) regularly works 10 hours or more per week; (c) has been employed by the Employer for one month, counting his or her Employment Commencement Date as the first day; and (d) is eligible for other group health plan coverage offered by the Employer, where such other coverage: (A) has the same plan year as this Plan; (B) is not limited to excepted benefits; and (C) is not an HRA or other account-based plan. Eligibility is determined on a month-by-month basis, as of the first day of each month, or such other period required by applicable law. In addition, an Employee who is not regularly working 10 hours or more per week, but who qualifies as a "full-time" employee under the Affordable Care Act's employer shared responsibility provisions, shall also be an Eligible Employee if the other conditions in the preceding sentence are satisfied. An Employee who becomes an Eligible Employee and who has submitted an Enrollment Form to the Administrator shall be enrolled in the Plan and become a Participant as described in Section 4.1.

3.2 Termination of Participation

An Employee will cease to be a Participant when the first of the following occurs:

- this Plan terminates; or
- the Employee ceases to be eligible under Section 3.1 or fails to satisfy any other requirement necessary to be an Eligible Employee; provided, however, that the Employee's participation may continue for purposes of COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis under Section 7.7.

If the Plan terminates, the Employee's loss of Participant status shall occur immediately upon occurrence of the termination. If an Employee ceases to be a Participant for any other reason, the Employee's loss of Participant status shall occur at the end of the month in which the applicable event occurs. Any reimbursements from the EBHRA Account after termination of participation will be made pursuant to Section 7.7 (relating to the run-out

period for submitting claims incurred prior to termination and relating to COBRA).

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days of the date of the termination of employment, the rehired Employee will be reinstated with the same EBHRA Account balance that such individual forfeited at termination, provided the individual meets the other requirements to be an Eligible Employee (disregarding the break in employment). If an Employee (whether or not a Participant) terminates employment and is not rehired within 30 days or ceases to be an Eligible Employee for any other reason for more than 30 days (including, but not limited to, a reduction in hours), the Employee's service before his or her loss of Eligible Employee status will not be taken into account when determining whether the Employee has regained Eligible Employee status, so the Employee will be required to complete the 30-day waiting period described in Section 3.1 before again becoming eligible to participate in the Plan.

3.4 FMLA and USERRA Leaves of Absence

Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under the FMLA or USERRA, then to the extent required by the FMLA or USERRA, as applicable, the Employer will continue to maintain the Participant's Benefits on the same terms and conditions as if the Participant were still an active Eligible Employee.

3.5 Non-FMLA and Non-USERRA Leaves of Absence

If a Participant goes on a leave of absence that is not subject to the FMLA or USERRA, the Participant will be treated as having terminated participation, as described above under Section 3.2.

ARTICLE IV. Method and Timing of Enrollment

4.1 Enrollment When First Eligible

An Employee who is not a Participant will commence participation in this Plan on the first day of the calendar

month immediately following the Employee's submission of a properly completed Enrollment Form to the Administrator or on the first day of such later calendar month as may properly be indicated on the Enrollment Form, provided the Employee is an Eligible Employee on the commencement date. Once the Eligible Employee is enrolled as a Participant, his or her participation will continue until his or her participation ceases pursuant to Section 3.2 (subject to any suspension). The Enrollment Form shall identify the Spouse and Dependents whose Medical Care Expenses may be submitted to the EBHRA. The Participant must promptly notify the Administrator if this information changes.

4.2 Election to Suspend EBHRA Account

A Participant may elect to suspend his or her EBHRA Account for any future Plan Year by submitting a Suspension Election Form to the Administrator before the beginning of that Plan Year. The Participant's suspension election will remain in effect for the entire Plan Year to which it applies, and the Participant may not modify or revoke the election during that Plan Year. The Participant will not receive reimbursements for any Medical Care Expenses incurred during the Plan Year to which the suspension election applies except for limited-scope dental or vision expenses that qualify as excepted benefits for HIPAA purposes.

If a Participant suspends his or her EBHRA Account for a Plan Year, the Employer will suspend contributions to the EBHRA Account for that Plan Year. Medical Care Expenses incurred before the beginning of the suspended Plan Year will be reimbursed during the suspended Plan Year, subject to the reimbursement procedures contained in Section 7.6, so long as no suspension election was in effect for the Plan Year in which such expenses were incurred.

ARTICLE V. Benefits Offered and Method of Funding

5.1 Benefits Offered

When an Eligible Employee becomes a Participant in accordance with Articles III and IV, an EBHRA Account will be established for such Participant to receive Benefits in the form of reimbursements for Medical Care Expenses, as described in Article VII. In no event shall Benefits be provided in the form of cash or any other taxable or nontaxable benefit other than reimbursement for Medical Care Expenses. In addition, benefits under the Plan shall be made available under the same terms to all similarly situated individuals, as defined in Treas. Reg.

§54.9802-1(d), regardless of any health factor (as described in Treas. Reg. §54.9802-1(a)).

5.2 Employer and Participant Contributions

(a) *Employer Contributions.* The Employer funds the full amount of the EBHRA Accounts.

(b) *Participant Contributions.* There are no Participant contributions for Benefits under the Plan, except as provided in Section 7.7 in the case of COBRA coverage.

(c) *No Funding Under Cafeteria Plan.* Under no circumstances will the Benefits be funded with salary reduction contributions, employer contributions (e.g., flex credits), or otherwise under a cafeteria plan.

5.3 Funding This Plan

All of the amounts payable under this Plan shall be paid from the general assets of the Employer. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made. There is no trust or other fund from which Benefits are paid.

ARTICLE VI. [Reserved]

ARTICLE VII. Excepted Benefit Health Reimbursement Benefits

7.1 Benefits

The Plan will reimburse Participants for Medical Care Expenses up to the unused amount in the Participant's EBHRA Account, as set forth and adjusted under Section 7.3.

7.2 Eligible Medical Care Expenses

Under the EBHRA Account, a Participant may receive reimbursement for Medical Care Expenses incurred during a Period of Coverage.

(a) *Incurred.* A Medical Care Expense is incurred at the time the medical care or service giving rise to the expense is furnished, and not when the individual incurring the expense is formally billed for, is charged for, or pays for the medical care. Medical Care Expenses incurred before a Participant first becomes covered by the Plan are not eligible.

(b) *Medical Care Expenses Generally.* "Medical Care Expenses" means expenses incurred by a Participant or a Participant's Spouse or Dependents for medical care, as defined in Code §213 (including, for example, amounts for certain hospital, doctor, and dental bills), but shall not include expenses that are described in subsection (c). Reimbursements due for Medical Care Expenses incurred by the Participant or the Participant's Spouse or Dependents shall be charged against the Participant's EBHRA Account. In order for medical expenses to be reimbursed from the EBHRA, the Participant or the Participant's Spouse or Dependents must be covered by the medical plan at the time the expense was incurred.

(c) *Medical Care Expenses Exclusions.* "Medical Care Expenses" shall not include (1) health insurance premiums for individual policies or for any other group health plan; (2) premiums for Medicare Part A, B, C, or D coverage; or (3) the expenses listed as exclusions under Appendix B to this Plan. Notwithstanding the foregoing, an EBHRA Account may reimburse COBRA premiums (or other continuation coverage premiums) that a Participant pays on an after-tax basis under any other group health plan, premiums for coverage that consists solely of excepted benefits (as defined under Treas. Reg. §54.9831-1(c)(3)(viii)), and premiums for short-term, limited-duration insurance (unless prohibited under Treas. Reg. §54.9831-1(c)(3)(viii)(F)).

(d) *Not Reimbursed or Reimbursable From Another Source.* Medical Care Expenses may be reimbursed from the Participant's EBHRA Account only to the extent that the Participant or other individual incurring the expense is not reimbursed for the expense (nor is the expense reimbursable) through other insurance, or any other accident or health plan (but see Section 7.9 if the other health plan is a Health FSA). If only a portion of a Medical Care Expense has been reimbursed elsewhere, the EBHRA Account may reimburse the remaining portion of such expense if it otherwise meets the requirements of this Article VII.

7.3 Maximum Benefits

(a) *Maximum Benefits.* The maximum dollar amount that may be newly credited to an EBHRA Account for an Employee who participates for an entire 12-month Period of Coverage is $2,200 for Salaried employees, $1,500 for Full time employees, and $750 for all part time employees, adjusted as provided under Treas. Reg. §54.9831-1(c)(3)(viii)(B)(1). This full amount will be credited on a prorated basis per-month, as specified in Section 7.4. Unused amounts may be not be carried over to the next Period of Coverage.

(b) *Changes.* For subsequent Plan Years, the maximum dollar limit may be changed by the Administrator and shall be communicated to Employees through the Enrollment Form, the SPD, or another document.

(c) *Nondiscrimination.* Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code §105(h), as may be determined by the Administrator in its sole discretion.

7.4 Establishment of Account

The Administrator will establish and maintain an EBHRA Account with respect to each Participant but will not create a separate fund or otherwise segregate assets for this purpose. The EBHRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) *Crediting of Accounts.* A Participant's EBHRA Account will be credited at the beginning of each calendar month during a Period of Coverage with an amount equal to the applicable maximum dollar limit for the Period of Coverage divided by the number of months in that Period of Coverage (e.g., divided by 12 in a 12-month Plan Year). No amount shall be credited for a calendar month, however, if the Participant is not still an Eligible Employee on the first day of that calendar month.

(b) *Debiting of Accounts.* A Participant's EBHRA Account will be debited during each Period of Coverage for any reimbursement of Medical Care Expenses incurred during the Period of Coverage.

(c) *Available Amount.* The amount available for reimbursement of Medical Care Expenses is the amount

credited to the Participant's EBHRA Account under subsection (a), reduced by prior reimbursements debited under subsection (b).

7.5 Carryover and Forfeitures

If any balance remains in the Participant's EBHRA Account for a Period of Coverage after all reimbursements have been made for the Period of Coverage, such balance shall be forfeited. If an individual ceases to be a Participant (as described in Section 3.2), expenses incurred after such time will not be reimbursed unless COBRA continuation coverage is elected as provided in Section 7.7. In addition, any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) by the close of the Plan Year following the Period of Coverage in which the Medical Care Expense was incurred shall be forfeited.

7.6 Reimbursement Procedure

(a) *Timing.* Within 30 days after receipt by the Administrator of a reimbursement claim from a Participant, the Employer will reimburse the Participant for the Participant's Medical Care Expenses (if the Administrator approves the claim), or the Administrator will notify the Participant that his or her claim has been denied (see Section 13.1 regarding procedures for claim denials and appeals procedures). The 30-day time period may be extended for an additional 15 days for matters beyond the control of the Administrator, including in cases where a reimbursement claim is incomplete. The Administrator will provide written notice of any extension, including the reasons for the extension, and will allow the Participant 45 days in which to complete an incomplete reimbursement claim.

(b) *Claims Substantiation.* A Participant who seeks Benefits may apply for reimbursement by submitting an application in writing to the Administrator in such form as the Administrator may prescribe, by no later than January 31 following the close of the Plan Year in which the Medical Care Expense was incurred, setting forth-

- the individual(s) on whose behalf Medical Care Expenses have been incurred;
- the nature and date of the Medical Care Expenses so incurred;
- the amount of the requested reimbursement; and
- a statement that such Medical Care Expenses have not otherwise been reimbursed and are not

reimbursable through any other source, and that Health FSA coverage, if any, for such Medical Care Expenses has been exhausted.

The application shall be accompanied by bills, invoices, or other statements from an independent third party (e.g., a hospital, physician, or pharmacy) showing that the Medical Care Expenses have been incurred and the amounts of such Medical Care Expenses, together with any additional documentation that the Administrator may request. Except for the final reimbursement claim for a Period of Coverage, no claim for reimbursement may be made unless and until the aggregate claims for reimbursement total at least $25. If the HRA is accessible by an electronic payment card (e.g., debit card, credit card, or similar arrangement), the Participant will be required to comply with substantiation procedures established by the Plan Administrator in accordance with Section 7.10 and applicable IRS guidance regarding electronic payment card programs.

(c) *Claims Denied.* For reimbursement claims that are wholly or partially denied, see the appeals procedure in Article XIII.

7.7 Reimbursements After Termination; COBRA

When a Participant ceases to be a Participant under Section 3.2, the Participant will not be able to receive reimbursements for Medical Care Expenses incurred after his or her participation terminates. However, such Participant (or the Participant's estate) may claim reimbursement for any Medical Care Expenses incurred during the Period of Coverage prior to termination of participation, provided that the Participant (or the Participant's estate) files a claim by March 31 following the close of the Plan Year in which the Medical Care Expense arose.

Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, the Participant and his or her Spouse and Dependents (Qualified Beneficiaries), whose coverage terminates under the EBHRA Account because of a COBRA qualifying event, shall be given the opportunity to continue (on a self-pay basis) the same coverage that he or she had under the EBHRA Account on the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA). However, in the event that such coverage is modified for all similarly situated non-COBRA Participants prior to the date continuation coverage is elected, Qualified Beneficiaries shall be eligible to continue the same coverage that is provided to similarly situated non-COBRA Participants. At the beginning of each month in the Period of Coverage, Qualified Beneficiaries shall be credited with the monthly reimbursement accrual (i.e., the maximum annual

reimbursement amount, divided by the number of months in that Period of Coverage) that is made available to similarly situated non-COBRA beneficiaries, and any unused reimbursement amounts from the previous Period of Coverage shall be carried over to the next Period of Coverage (provided that the applicable premium is paid). A premium for COBRA continuation coverage shall be charged to Qualified Beneficiaries in such amounts and shall be payable at such times as are established by the Administrator and permitted by COBRA.

7.8 Named Fiduciary; Compliance With ERISA, COBRA, HIPAA, etc.

(a) *Named Fiduciary.* Grace Franchise Operating Company, Inc. is the named fiduciary for the Plan for purposes of ERISA §402(a).

(b) *Laws Applicable to Group Health Plans.* Benefits shall be provided in compliance with ERISA, COBRA, HIPAA, FMLA, USERRA, and other group health plan laws to the extent required by such laws.

7.9 Coordination of Benefits Benefits under this Plan are solely intended to reimburse Medical Care Expenses not previously reimbursed or reimbursable elsewhere. To the extent that an otherwise eligible Medical Care Expense is payable or reimbursable from another source, that other source shall pay or reimburse prior to payment or reimbursement from this Plan.

7.10 Electronic Payment Cards

If the Employer allows payments under the Plan to be accessed by an electronic payment card (e.g., debit card, credit card, or similar arrangement), Participants will be required to comply with substantiation procedures established by the Plan Administrator in accordance with applicable IRS guidance regarding electronic payment card programs. In addition, the following provisions shall apply:

(a) *Initial and Periodic Certification.* Before receiving an electronic payment card, a Participant must certify that he or she will only use the card to pay for Medical Care Expenses, will not use the card for expenses that have already been reimbursed, will not seek reimbursement under any other health plan for

expenses paid for with the card, and will acquire and keep sufficient documentation (see subsection (d) below) for expenses paid with the card. The Participant must also agree to abide by any other terms and conditions of the card program as set forth herein and in any cardholder agreement issued in conjunction with the card, including but not limited to payment of any fees for participation in the card program and the Plan's right to recoup improper card payments by withholding amounts from Compensation and offsetting against other HRA claims. The Participant must reaffirm these agreements during each subsequent open enrollment period for the card to remain activated. In addition, these agreements are reaffirmed each time the Participant uses the card. Failure to abide by these agreements may result in deactivation of the card.

(b) *Deactivation of Card.* A Participant's card will be deactivated when participation in the HRA ceases or at other times as set forth herein (e.g., for failure to comply with the Plan's substantiation and recoupment procedures). A Participant whose card has been deactivated must request reimbursement for Medical Care Expenses through other methods (e.g., by submitting paper claims).

(c) *Merchants; Card Use.* Card use is limited to eligible merchants as provided in applicable IRS guidance and as further identified by the Plan Administrator or its designee. The card's debit balance (or credit limit, as applicable) must be limited to the amount of the Participant's available HRA balance. Each time the card is swiped, the Participant certifies to the Plan that the expense for which payment under the HRA is being made is a Medical Care Expense that has not already been reimbursed from another source and that reimbursement for the expense will not be sought from another source. Use of a card to pay for a service or product is not considered to be a claim for benefits under the Plan; a claim does not arise until a paper or electronic reimbursement request is submitted.

(d) *Documentation.* For each expense that is paid with the card, the Participant must obtain and retain a bill, invoice, or other statement from the merchant describing the service or product, the date of the service or sale, and the amount of the expense. The documentation must be retained until the close of the Plan Year following the Plan Year in which the card transaction occurred. If the Participant is asked to provide the documentation to the Plan, he or she must do so within the period specified in the request. A Participant who is unable to provide adequate or timely substantiation upon request from the Plan must repay the Plan for the unsubstantiated expense. In addition, the Participant's card may be deactivated.

(e) *Correction of Improper Payments.* Participants must repay the Plan for any improper payments that are made with their cards. Improper payments may be recouped in accordance with applicable IRS guidance. If the Plan is unable to recoup an improper payment, the Employer will treat the payment as it

would treat any other business indebtedness. If the debt is not collected and the Employer forgives the indebtedness, the payment will be treated as wages in the year in which the indebtedness was forgiven.

ARTICLE VIII-IX. [Reserved]

ARTICLE X. HIPAA Provisions

10.1 General

As a HIPAA Health Plan, the Plan shall comply with the standards for privacy of protected health information as set forth in the Privacy Rule, the security standards for the protection of Electronic PHI as set forth in the Security Rule, and the notification requirements for Breaches of Unsecured PHI under the Breach Notification Rule.

10.2 Definitions

For purposes of this Article, the following definitions shall apply:

(a) "Breach" shall mean the acquisition, access, use, or disclosure of an individual's PHI in a manner not permitted under the Privacy Rule. A Breach shall be presumed unless the Plan determines there is a low probability that the PHI has been compromised. A Breach does not include: (1) an unintentional acquisition, access, or use of PHI by a workforce member or person acting under the authority of a covered entity or business associate, if such acquisition, access, or use was in good faith and within the scope of authority and does not result in a further impermissible use or disclosure; (2) an inadvertent disclosure by a person who is authorized to access PHI to another person authorized to access PHI at the same covered entity or business associate or organized health care arrangement, and the information received is not further used or disclosed in a manner not permitted under the Privacy Rule; or (3) a disclosure of PHI where a covered entity or business associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

(b) "Breach Notification Rule" means the regulations issued under HIPAA set forth in subpart D of 45 CFR Part 164.

(c) "Electronic Protected Health Information" or "Electronic PHI" means PHI that is transmitted by or maintained in electronic media.

(d) "Health Care Operations" is as defined under 45 CFR §160.501.

(e) "HIPAA Health Plan," as defined under 45 CFR §160.103, means an individual or group plan that provides, or pays the cost of, medical care, and includes those plans and arrangements listed in 45 CFR §160.103.

(f) "Payment" is as defined under 45 CFR §160.501, and means activities undertaken by a HIPAA Health Plan to obtain contributions or to determine or fulfill its responsibility for coverage and provision of benefits, or to obtain or provide reimbursement for the provision of health care.

(g) "Privacy Policy" means the Employer HIPAA Privacy Policy.

(h) "Privacy Rule" means the regulations issued under HIPAA set forth in subpart E of 45 CFR Part 164.

(i) "Protected Health Information" or "PHI" means individually identifiable health information that (1) relates to the past, present, or future physical or mental condition of a current or former Participant, Spouse, or Dependent, provision of health care to a Participant, Spouse, or Dependent, or payment for such health care; (2) can either identify the Participant, Spouse, or Dependent, or there is a reasonable basis to believe the information can be used to identify the Participant, Spouse, or Dependent; and (3) is received or created by or on behalf of the Plan.

(j) "Responsible Employee" means an employee (including a contract, temporary, or leased employee) of the Plan or of the Employer whose duties (1) require that the employee have access to PHI for purposes of Payment or Health Care Operations; or (2) make it likely that the employee will receive or have access to PHI. Persons designated as Responsible Employees are described in Section 10.3.

(k) "Security Incident," as defined under 45 CFR §164.304, means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

(l) "Security Rule" means the regulations issued under HIPAA set forth in subpart C of 45 CFR Part 164.

10.3 Responsible Employees

Only Responsible Employees shall be permitted to use, disclose, create, receive, access, maintain, or transmit PHI or Electronic PHI on behalf of the Plan. The use or disclosure of PHI or Electronic PHI by Responsible Employees shall be restricted to the Plan administration functions that the Employer performs on behalf of the Plan pursuant to Section 10.4.

The following classes of Responsible Employees are suggestions only. Each plan sponsor will need to assess its own operating environment to determine which employees need to use and disclose PHI to perform plan administration functions. Keep in mind that access to and use of PHI by Responsible Employees must be restricted to just those administration functions that the employees perform with respect to the Plan. In addition, this section should be coordinated with the employer's HIPAA Privacy Policy, including requirements to train Responsible Employees in HIPAA compliance.]

(a) Employer employees who perform the following functions on behalf of the Plan are Responsible Employees: (1) claims determination and processing functions; (2) Plan vendor relations functions; (3) benefits education and information functions; (4) Plan administration activities; (5) legal department activities; (6) Plan compliance activities; (7) information systems support activities; (8) internal audit functions; and (9) human resources functions.

(b) In addition to those individuals described in subsection (a), the Plan HIPAA privacy official and security official, and Employer employees to whom the Plan HIPAA privacy official and security official have delegated any of the following responsibilities, shall also be Responsible Employees: (1) implementation, interpretation, and amendment of the Privacy Policy; (2) Privacy Rule, Breach Notification Rule, or Security Rule training for Employer employees; (3) investigation of and response to complaints by Participants, Spouses, Dependents, and/or employees; (4) preparation, maintenance, and distribution of the Plan's privacy notice; (5) response to requests by Participants, Spouses, or Dependents to inspect or copy PHI; (6) response to requests by Participants, Spouses, or Dependents to restrict the use or disclosure of their PHI; (7) response to requests by Participants, Spouses, or Dependents to receive communications of their PHI by alternate means or in an alternate manner; (8) amendment and response to requests to amend the PHI of Participants, Spouses, or Dependents; (9) response to requests by Participants, Spouses, or Dependents for an accounting of disclosures of their PHI; (10) response to requests for information by the Department of Health and Human Services; (11) approval of disclosures to law enforcement or to the military for government purposes; (12) maintenance of records and other documentation required by the Privacy Rule, Breach Notification Rule, or Security Rule; (13) negotiation of Privacy Rule, Breach Notification Rule, and Security Rule provisions and/or reasonable security provisions into contracts with third-party service providers; (14) maintenance of Plan PHI or Electronic PHI security documentation; or (15) approval of access to Electronic PHI by Participants, Spouses, or Dependents.

10.4 Permitted Uses and Disclosures

Responsible Employees may access, request, receive, use, disclose, create, and/or transmit PHI only to perform certain permitted and required functions on behalf of the Plan, consistent with the Privacy Policy. This includes:

(a) uses and disclosures for the Plan's own Payment and Health Care Operations functions;
(b) uses and disclosures for another HIPAA Health Plan's Payment and Health Care Operations functions;
(c) disclosures to a health care provider, as defined under 45 CFR §160.103, for the health care provider's treatment activities;
(d) disclosures to the Employer, acting in its role as Plan sponsor, of (1) summary health information for purposes of obtaining health insurance coverage or premium bids for HIPAA Health Plans or for making decisions to modify, amend, or terminate a HIPAA Health Plan; or (2) enrollment or disenrollment information;
(e) disclosures of a Participant's, Spouse's, or Dependent's PHI to the Participant or the Dependent or his or her personal representative, as defined under 45 CFR §164.502(g);
(f) disclosures to a Participant's, Spouse's, or Dependent's family members or friends involved in the Participant's, Spouse's, or Dependent's health care or payment for the Participant's, Spouse's, or Dependent's health care, or to notify a Participant's, Spouse's, or Dependent's family in the event of an emergency or disaster-relief situation;
(g) uses and disclosures to comply with workers' compensation laws;
(h) uses and disclosures for legal and law-enforcement purposes, such as to comply with a court order;
(i) disclosures to the Secretary of Health and Human Services to demonstrate the Plan's compliance with the Privacy Rule, Security Rule, or Breach Notification Rule;
(j) uses and disclosures for other governmental purposes, such as for national security purposes;
(k) uses and disclosures for certain health and safety purposes, such as to prevent or lessen a threat to public health, to report suspected cases of abuse, neglect, or domestic violence, or relating to a claim for public benefits or services;
(l) uses and disclosures to identify a decedent or cause of death, or for tissue-donation purposes;
(m) uses and disclosures required by other applicable laws; and

(n) uses and disclosures pursuant to the Participant's authorization that satisfies the requirements of 45 CFR §164.508.

10.5 Prohibited Uses and Disclosures

Notwithstanding anything in the Plan to the contrary, use or disclosure of Protected Health Information is prohibited in the following situations.

(a) *Genetic Information.* Use or disclosure of Protected Health Information that is Genetic Information about an individual for underwriting purposes shall not be a permitted use or disclosure. The term "underwriting purposes" includes determining eligibility for benefits, computation of premium or contribution amounts, or the creation, renewal, or replacement of a contract of health insurance.
(b) *Employment-Related Actions.* Use or disclosure of Protected Health Information for the purpose of employment-related actions or decisions shall not be a permitted use or disclosure.
(c) *Other Benefits.* Use or disclosure of Protected Health Information in connection with any other benefit or employee benefit plan of the Employer, except as expressly permitted in Section 10.4, shall not be a permitted use or disclosure.

10.6 Certification Requirement

The Plan shall disclose PHI, including Electronic PHI, to Responsible Employees only upon receipt of a certification by the Employer that the Employer agrees:

(a) not to use or further disclose PHI other than as permitted or required by this Article and the Privacy Policy or as required by law;
(b) to take reasonable steps to ensure that any agents to whom the Employer provides PHI or Electronic PHI received from the Plan agree: (1) to the same restrictions and conditions that apply to the Employer with respect to such PHI; and (2) to implement reasonable and appropriate security measures to protect

such Electronic PHI;

(c) not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer other than another Health Plan;

(d) to report to the Plan any use or disclosure of PHI, including Electronic PHI, that is inconsistent with the uses or disclosures described in Section 10.4, or any Security Incident, of which the Employer becomes aware;

(e) to make available PHI for inspection and copying in accordance with 45 CFR §164.524;

(f) to make available PHI for amendment, and to incorporate any amendments to PHI, in accordance with 45 CFR §164.526;

(g) to make available PHI required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

(h) to make its internal practices, books, and records relating to the use and disclosure of PHI and Electronic PHI, received on behalf of the Plan, available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule, the Breach Notification Rule, or the Security Rule;

(i) if feasible, to return or destroy all PHI and Electronic PHI received from the Plan that the Employer still maintains in any form and retain no copies of such PHI and Electronic PHI 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 PHI infeasible and Electronic PHI;

(j) to take reasonable steps to ensure that there is adequate separation between the Plan and the Employer's activities in its role as Plan sponsor and employer, and that such adequate separation is supported by reasonable and appropriate security measures; and

(k) to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic PHI that the Employer creates, receives, maintains, or transmits on behalf of the Plan.

10.7 Mitigation

In the event of noncompliance with any of the provisions set forth in this Article:

(a) The HIPAA privacy official or security official, as appropriate, shall address any complaint promptly and confidentially. The HIPAA privacy official or security official, as appropriate, first will investigate the complaint and document the investigation efforts and findings.

(b) If PHI, including Electronic PHI, has been used or disclosed in violation of the Privacy Policy or inconsistent with this Article, either the HIPAA privacy official or the security official, as appropriate, shall take immediate steps to mitigate any harm caused by the violation and to minimize the possibility that such a violation will recur.

(c) If a Responsible Employee or other Employer employee is found to have violated the Privacy Policy or policy developed under the Security Rule, such personnel shall be subject to disciplinary action up to and including termination.

10.8 Breach Notification

Following the discovery of a Breach of unsecured PHI, the Plan shall notify each individual whose unsecured PHI has been, or is reasonably believed to have been, accessed, acquired, or disclosed as a result of a Breach, in accordance with 45 CFR §164.404, and shall notify the Secretary of Health and Human Services in accordance with 45 CFR §164.408. For a breach of unsecured PHI involving more than 500 residents of a State or jurisdiction, the Plan shall notify the media in accordance with 45 CFR §164.406. "Unsecured PHI" means PHI that is not secured through the use of a technology or methodology specified in regulations or other guidance issued by the Secretary of Health and Human Services.

ARTICLE XI-XII. [Reserved]

ARTICLE XIII. Appeals Procedure

13.1 Procedure If Benefits Are Denied Under This Plan

If a claim for reimbursement under this Plan is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the SPD. The Committee acts on behalf of the Administrator with respect to appeals.

ARTICLE XIV. Recordkeeping and Administration

14.1 Administrator

The administration of this Plan shall be under the supervision of the Administrator. It is the principal duty of the Administrator to see that this Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in this Plan without discrimination among them.

14.2 Powers of the Administrator

The Administrator shall have such duties and powers as it considers necessary or appropriate to discharge its duties. It shall have the exclusive right to interpret the Plan and to decide all matters thereunder, and all determinations of the Administrator with respect to any matter hereunder shall be conclusive and binding on all persons. Without limiting the generality of the foregoing, the Administrator shall have the following discretionary authority:

(a) to construe and interpret this Plan, including all possible ambiguities, inconsistencies, and omissions in the Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of Benefits under this Plan (provided that, notwithstanding the first paragraph in this Section 14.2, the Committee shall exercise such exclusive power with respect to an appeal of a claim under Section 13.1);

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to enroll in and submit claims pursuant to this Plan;

(c) to prepare and distribute information explaining this Plan and the Benefits under this Plan in such manner as the Administrator determines to be appropriate;

(d) to request and receive from all Employees and Participants such information as the Administrator shall from time to time determine to be necessary for the proper administration of this Plan;

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Plan as the Administrator determines to be reasonable and appropriate;

(f) to receive, review, and keep on file such reports and information concerning the Benefits covered by

this Plan as the Administrator determines from time to time to be necessary and proper;

(g) to appoint and employ such individuals or entities to assist in the administration of this Plan as it determines to be necessary or advisable, including legal counsel and benefit consultants;

(h) to sign documents for the purposes of administering this Plan, or to designate an individual or individuals to sign documents for the purposes of administering this Plan;

(i) to secure independent medical or other advice and require such evidence as it deems necessary to decide any claim or appeal; and

(j) to maintain the books of accounts, records, and other data in the manner necessary for proper administration of this Plan and to meet any applicable disclosure and reporting requirements.

14.3 Reliance on Participant, Tables, etc.

The Administrator may rely upon the information submitted by a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Administrator.

14.4 Provision for Third-Party Plan Service Providers

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

To the extent permitted by law, the Administrator shall not incur any liability for any acts or for failure to act except for the Administrator's own willful misconduct or willful breach of this Plan.

14.6 Compensation of Plan Administrator

Unless otherwise determined by the Employer and permitted by law, any Administrator who is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Administrator's duties shall be paid by the Employer.

14.7 Bonding

The Administrator shall be bonded to whatever extent may be required by law.

14.8 Insurance Contracts

The Employer shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of, and be retained by, the Employer, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

14.9 Inability to Locate Payee

If the Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date that any such payment first became due.

14.10 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the EBHRA 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 §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be

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 EBHRA 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.

ARTICLE XV. General Provisions

15.1 Expenses

All reasonable expenses incurred in administering the Plan are currently paid by the Employer.

15.2 No Contract of Employment

Nothing herein contained is intended to be or shall be construed as constituting a contract or other arrangement between any Employee and the Employer to the effect that such Employee will be employed for any specific period of time. All Employees are considered to be employed at the will of the Employer.

15.3 Amendment and Termination

This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason by resolution of the Employer's Board of Directors or by any person or persons authorized by the Board of Directors to take such action, and any such amendment or termination will automatically apply to the Related Employers that are participating in this Plan.

15.4 Governing Law

This Plan shall be construed, administered and enforced according to the laws of the State of California, to the extent not superseded by the Code, ERISA, or any other federal law.

15.5 Code and ERISA Compliance

It is intended that this Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated, and administered accordingly, and in the event of any conflict between any part, clause, or provision of this Plan and the Code or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict.

15.6 No Guarantee of Tax Consequences

Neither the Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Administrator if the Participant has any reason to believe that such payment is not so excludable.

15.7 Indemnification of Employer

If any Participant receives one or more payments or reimbursements under this Plan on a tax-free basis, and such payments do not qualify for such treatment under the Code, such Participant shall indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from such payments or reimbursements.

15.8 Non-Assignability of Rights

The right of any Participant to receive any reimbursement under this Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

15.9 Headings

The headings of the various Articles and Sections (but not subsections) are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

15.10 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan, or of any other instrument, are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

15.11 Severability

Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

***

This document is executed this ____ day of _____, _____.

Grace Franchise Operating Company, Inc.

By:_____

Title:_____