VOLUNTARY OPT-OUT FORM

FRESH MARK MEDICAL COVERAGE

EFFECTIVE FOR THE 2024 BENEFIT YEAR

Fresh Mark provides employees eligible for medical coverage with the ability to opt-out of (or waive) medical coverage for the 2024 Plan Year (January 1, 2024 – December 31, 2024) as long as they have coverage under another employer sponsored medical plan.*

If you have other medical coverage and would like to opt-out of Fresh Mark's medical coverage, you are eligible to receive a payment of $700 (the "Opt-Out Payment"), which will be allocated, according to your election on the following page. You can put the full amount into the Flexible Spending Account (FSA), to be used to reimburse you for medical expenses, or to the Dependent Care Account (DCA), to be used to reimburse you for qualified daycare expenses. You may also elect to take the Opt-Out Payment in cash. If you elect to receive your Opt-Out Payment in cash, it will be paid in monthly installments of $58.33 throughout the year and is taxable when paid. The Opt-Out Payment will be allocated as elected as soon as administratively possible.

If you elect to allocate your Opt-Out Payment to the FSA, you may still contribute to the FSA from pre-tax wages, up to the plans limit of $3,200. However, if you elect to allocate your Opt-Out Payment to the DCA, the amount allocated from your Opt-Out Payment must be included when determining the amount you can contribute from pre-tax wages.

All amounts contributed to your DCA, both from pre-tax wages and any employer contributions, including allocation of your Opt-Out Payment, must not exceed $5,000 ($2,500 if you are married and file your federal taxes as "married filing separately").

*Note that the other coverage must provide minimum essential coverage. In addition, coverage obtained in the individual market does not qualify as "other coverage" for this purpose.

If you are electing to opt-out of medical coverage for the 2024 Plan Year, you must complete this form and return it to Human Resources within 30 days.

I,____, am electing to opt-out
(Employee Name – Please print)

of coverage under the medical plan sponsored by Fresh Mark for the 2024 Plan Year.

By opting out of medical coverage, I agree and acknowledge that:

I am making this choice freely because I, and my eligible dependents if applicable, have, or will: (Please check one; attach additional copies for dependents who are covered by different coverage options)

- ☐ Covered by Spouse's Group Medical Plan
- ☐ Covered by Parent's Group Medical Plan
- ☐ Receive medical benefits from the U.S. Government through active or retired military medical coverage
- ☐ Covered by Medicare
- ☐ Covered by Medicaid
- ☐ Other group coverage (please specify) ____

- I understand that individual health insurance (including coverage purchased through the state or federal Marketplace) does not qualify as other group coverage;
- I cannot change my election during the 2024 Plan Year unless I have a qualifying event, such as losing my other health coverage. If I make a change to participate in the Fresh Mark Medical plan due to a qualifying event, I understand that I must reimburse the opt out monies paid through this Opt-Out Provision;
- My election does not impact my ability to participate in the Flexible Spending Account ("FSA") or vision benefits, which I may be eligible for as an active, full- time employee;
- I may elect to receive my Opt-Out Payment in cash via monthly installments, or allocate my full Opt-Out Payment to my FSA or DCA, as elected below;
- I relieve Fresh Mark, its agents and officers, from any and all claims for any uncovered hospital or medical expenses for me or any member of my family incurred as a result of this election;
- If any information noted above changes, I will immediately notify Fresh Mark; and
- I am making this choice for the 2024 Plan Year only and any opt-out for subsequent plan years must be separately authorized by me.

Signed____Clock #______________Date ______________

I elect to have the 2024 Opt-Out Payment for the 2024 Plan Year paid or contributed as follows:

_______________FSA   Amount _____________________

_______________DCA   Amount _____________________

_______________Cash**   Amount _____________________

**Opt-Out Payment received as cash are paid in monthly increments and are taxable.