Lee's Marketplace

Section 125 Plan
Plan Document

Amended and Restated as of April 1, 2026, unless otherwise noted

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Lee's Marketplace

Section 125 Plan

ARTICLE I

Introduction

1.1 Purpose of Plan. The purpose of this Plan is to provide eligible employees of Lee's Marketplace a choice between cash and benefits under one or more Qualified Benefit Plans.

1.2 Plan Status and Establishment. This Plan is intended to satisfy the requirements of Section 125 of the Internal Revenue Code of 1986, as amended from time to time (the "Code"). The Plan was established effective April 1, 2025, and amended and restated effective April 1, 2026.

ARTICLE II

Participation

2.1 Commencement of Participation. Each Employee will be eligible to participate in the Plan on the first day on which he or she meets the eligibility requirements of any Qualified Benefit Plan. An Employee will become a Participant upon making an election in accordance with the provisions of Section 3.3.

2.2 Cessation of Participation. A Participant will cease to be a Participant in this Plan as of the earlier of (i) the date on which this Plan terminates or (ii) the date on which he or she dies, terminates employment with the Plan Sponsor, or ceases to be an Employee eligible to participate under Section 2.1.

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

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

ARTICLE III

Optional Benefits

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

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

3.3 Election of Benefits. Once a Participant enrolls in any one or more of the Qualified Benefit Plans, he or she will be deemed to have elected to have his or her Compensation reduced to the extent necessary to satisfy the Participant's Employee Provided Premiums due under such Qualified Benefit Plans, unless by written notice (on forms provided by the Plan Sponsor) to the Administrator prior to the start of any coverage period, a Participant elects not to have any Compensation reductions contributed to the Employee Provided Premiums under one or more Qualified Benefit Plans.

3.4 Irrevocability of Election by the Participant.

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

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

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

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

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

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

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

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

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

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

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

(f) If the Participants' share of the cost of coverage under a Qualified Benefit Plan significantly increases or significantly decreases during the Plan Year, a Participant may make a corresponding change in election under the

Plan for the balance of the Plan Year, which will include (but not be limited to) the following:

(i) for a significant cost increase, Participants electing such coverage for the Plan Year may revoke their election and either elect a similar coverage under another Qualified Benefit Plan for the balance of the Plan Year, or drop such coverage if there is no similar coverage under a Qualified Benefit Plan; or

(ii) for a significant cost decrease, Participants may elect to commence participation under certain options under a Qualified Benefit Plan with the significant cost decrease and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

Despite any other contrary provision of the Plan, for any insignificant changes in the costs of any Qualified Benefit Plans, the Administrator shall automatically change Participants' elections to account for such changes in cost.

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

(i) for a significant curtailment that is not a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his or her election and elect a similar coverage under another Qualified Benefit Plan for the balance of the Plan Year; or

(ii) for a significant curtailment that is (or is deemed by the Administrator to be) a loss of coverage, the Participant electing such coverage for the Plan Year may revoke his or her election and either elect similar coverage under another Qualified Benefit Plan for the balance of the Plan Year, or drop such coverage if there is no similar coverage under a Qualified Benefit Plan.

(h) If during the Plan Year a new Qualified Benefit Plan, or option under a Qualified Benefit Plan, becomes available, or an existing Qualified Benefit Plan, or option under a Qualified Benefit Plan, is significantly improved, Participants may elect the new or significantly improved coverage, and may make corresponding election changes regarding similar coverage, for the balance of the Plan Year.

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

(i) the election change made by the Participant's spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code Section 125; or

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

(j) If a Participant or his or her spouse or Dependent loses group health coverage sponsored by a governmental or educational institution, the Participant may elect health coverage under one or more Qualified Benefit Plan(s) for the balance of the Plan Year for the Participant, his or her spouse or Dependent.

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

(i) the Participant's

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

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

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

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

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

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

3.5 Consistency Rules. A Participant's requested revocation and new election under Section 3.4(b) will be consistent with a change in status if the election change is on account of and corresponds with a change in status that affects the eligibility for coverage under a Qualified Benefit Plan or under a plan maintained by the employer of the Participant's spouse or Dependent. A change in status that affects the eligibility under an employer's plan shall include a change in status that results in an increase or decrease in the number of a Participant's family members or Dependents who may benefit from coverage under the plan.

3.6 Automatic Termination of Election. Elections made or deemed to be made under Section 3.3 will automatically terminate on the date on which the Participant (i) terminates employment with the Plan Sponsor or (ii) elects under Section 3.3 or 3.4 to receive cash in lieu of benefits under the Qualified Benefit Plans, although coverage or benefits under any group health plan that is a Qualified Benefit Plan may continue if and to the extent provided by such plan or as required by law. Despite any other contrary provision of the Plan, if a Participant's employment with the Plan Sponsor terminates and the Participant returns to employment with the Plan Sponsor within thirty (30) days of such termination and within the same Plan Year of the Participant's date of termination, then the Participant's pre-termination elections under the Plan will be automatically reinstated, and no election changes shall be permitted unless otherwise specified by Section 3.4.

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

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

3.9 Premium Payments by Employees of FMLA and Uniformed Services Leave of Absence; Similar State Leaves. Any Employee who elects to maintain coverage under Section 2.4 while on an FMLA Leave, a similar or equivalent, applicable state family and medical leave law, if any, and/or while absent from work for more than 31 days for duty in the Uniformed Services must continue to make any required contributions specified in Section 3.3. During such absence, an Employee may choose to make such contributions by (i) remitting payment to the Plan Sponsor on or before each pay period for which the contributions would have been deducted from the Employee's paycheck if leave

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

ARTICLE IV

Administration

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

(a) to make and enforce such rules and regulations as the Administrator deems necessary or appropriate for the efficient administration of the Plan;

(b) to interpret the Plan (such interpretation will be final, binding and conclusive with respect to all claims arising under this Plan);

(c) to decide all questions concerning the eligibility of any person to participate in and to receive benefits under the Plan, and to make all factual determinations;

(d) to provide Employees with a reasonable and timely notification of benefit options available under the Plan;

(e) to authorize the payment of benefits, which will be paid only if the Administrator decides in its sole discretion that the Participant or applicant is entitled to them; and

(f) to appoint such agents, counsel, accountants, consultants, and actuaries as may be required to assist in administering the Plan.

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

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

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

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

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

ARTICLE V

Amendment and Termination

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

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

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

ARTICLE VI

Claims Provisions

6.1 Claims Procedure. Claims for underlying benefits under the Qualified Benefit Plan shall be governed by the claims procedures in the applicable Qualified Benefit Plan, except that claims with respect to eligibility for salary reductions under this Plan (such as the ability to pay for Qualified Benefit Plan coverage on a pre-tax basis) shall be submitted to, and decided by, the Administrator.

ARTICLE VII

Miscellaneous

7.1 Communication to Employees. Promptly after the Plan is made effective, the Plan Sponsor will notify all Employees of its availability and terms. The Plan Sponsor will notify each new Employee of the availability and terms of the Plan as soon as practicable following the date the Employee commences his or her employment with the Plan Sponsor. Within a reasonable period of time prior to the commencement of each Plan Year, or, in the case of a newly eligible Employee, as soon as practicable following the date on which he or she commences his or her employment with the Plan Sponsor, the Plan Sponsor will provide to Employees booklets, brochures, or other explanatory items which describe the material provisions of the Plan (to the extent the same have not been previously furnished).

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

7.3 Protective Clauses.

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

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

pursue, settle or compromise such claim as the Participant, in the sole exercise of his or her discretion, sees fit.

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

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

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

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

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

7.6 Funding. Unless otherwise required by law, (i) contributions to the Plan will be deemed general assets of the Plan Sponsor until the amount thereof has been paid over to or under a Qualified Benefit Plan and (ii) nothing herein contained will be construed to require the Plan Sponsor or the Administrator to maintain any fund or segregate any amount, in trust or otherwise, for the benefit of any Participant, and no Participant or other person will have any claim against, right to, or security or other interest in, any asset of the Plan Sponsor from which any payment under the Plan may be made.

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

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

7.9 Governing Law. This Plan will be construed, administered and enforced according to the laws of Utah, to the extent not superseded by the provisions of the Code and any other applicable federal law.

7.10 Effect of Mistake. In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Administrator shall, to the extent that it deems administratively possible and otherwise permissible under Code Section 125 or the regulations issues thereunder, cause to be allocated or cause to 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 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.

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

ARTICLE VIII

Definitions

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

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

8.2 "Affiliated Employer" means the Plan Sponsor and any corporation, listed on Appendix B, which is: (i) a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Plan Sponsor; (ii) any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Plan Sponsor; or (iii) any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Plan Sponsor; and any other entity required to be aggregated with the Plan Sponsor pursuant to Treasury regulations under Code Section 414(o).

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

8.4 "Compensation" means the total cash remuneration received by a Participant from the Plan Sponsor during a Plan Year prior to any reductions under Section 3.3. Compensation includes overtime, commissions and bonuses.

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

8.6 "Dependent" means any person who falls within the definition of dependent under Code Section 152, as modified by Code Section 105(b), and any child of a Participant as defined in Code Section 152(f)(1) until the end of the year in which the child attains age 26. For purposes of the HSA Program, a Dependent means any person who falls within the definition of dependent under Code Section 152, without regard to subsections (b)(1), (b)(2), and (d)(1)(B) thereof. Notwithstanding anything in the Plan to the contrary, any pre-tax payments made pursuant to the Plan with respect to a domestic partner and/or the child of a domestic partner who does not qualify as the Employee's Dependent shall be treated as taxable compensation. This taxable compensation shall be treated as wages reportable on the Employee's Form W-2 and shall be subject to income tax and social security tax withholding.

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

8.8 "Employee Provided Premium" means the sum of (i) that portion of the total premium cost of a Qualified Benefit Plan that requires payment of premiums, which is required to be paid by the Employee, either by law or by agreement, and depending on what options exist under such plan (e.g., to the extent applicable, individual or family coverage, high or low deductibles, etc.), as adjusted from time to time to reflect changes, if any, in the percentage of such premiums paid by the Employee and/or changes in the total amount of such premiums, and (ii) a pro rata share of the costs of the administration of the Plan (allocated on a uniform basis) to the extent that the Plan Sponsor determines that such costs will be borne by Participants pursuant to Section 4.2.

8.9 "FMLA" means the Family and Medical Leave Act of 1993, as amended.

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

provisions of the FMLA.

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

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

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

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

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

8.16 "Plan" means the Lee's Marketplace Section 125 Plan as set forth herein, together with all amendments and restatements.

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

8.18 "Plan Year" means the twelve-month period ending each March 31st.

8.19 "Qualified Benefit Plan" refers to any employer-sponsored welfare benefit plan designated from time to time by the Plan Sponsor, and communicated in writing to Participants, for purposes of providing various benefits under this Plan.

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

Executed this ____ day of _____, 2026.

Lee's Marketplace

By: _____

Name: _____

Title: _____

APPENDIX A

THE HEALTH SAVINGS ACCOUNT PROGRAM

Article I

PLAN ESTABLISHMENT

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

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

Article II

DEFINITIONS

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

Article III

PARTICIPATION AND TERMS

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

3.2 **Annual Contribution Limits**
The maximum amount that an HSA-Eligible Employee may elect to contribute to an Eligible HSA during the Plan Year is the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution is made, determined pursuant to Code Section 223(b)(2) ($4,400 for single and $8,750 for family are the statutory maximum amounts for 2026).

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

The annual contribution limit shall be reduced by any HSA contributions made by the Plan Sponsor on behalf of the HSA-Eligible Employee. For Employees who elect to participate in the Plan Sponsor's High Deductible Health Plan, the Plan Sponsor will contribute an amount communicated in the initial and annual open enrollment materials furnished to Employees, which contributions shall be credited to the Employee's HSA on a pro rata basis at the beginning of each quarter of the Plan Year. If the enrollment materials provided by the Employer specify a time period within which the HSA must be opened by the Participant in order to receive the Employer's HSA contribution, the Employer's HSA contribution will be forfeited for any Participant who does not meet the applicable deadline. The annual contribution limit (and the catch-up limit, if applicable) will be prorated by the number of months during the Plan Year in which the Employee is an HSA-Eligible Employee unless the HSA-Eligible Employee is enrolled in a High Deductible Health Plan on December 1 of a given year in which case the Employee may elect the entire annual contribution limit (including the catch-up contribution, if otherwise eligible); however, in order for such Employee's contribution to retain its tax-favored status, the Employee must remain eligible for an HSA through the end of the following calendar year.

Article IV

MISCELLANEOUS

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

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

4.3 **Amount Payable** The tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.

Executed this ____ day of _____, 2026.

Lee's Marketplace

By: _____

Name: _____

Title: _____

APPENDIX B

PARTICIPATING EMPLOYERS

As of April 1, 2026

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

None