

LCS COMMUNITY EMPLOYMENT LLC

EMPLOYEE BENEFITS PLAN

Summary Plan Description

For Full-Time Employees

Effective as of January 1, 2025

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LCS COMMUNITY EMPLOYMENT LLC EMPLOYEE BENEFITS PLAN

SPD for Full-Time Employees

(Effective as of January 1, 2025)

INTRODUCTION

LCS Community Employment LLC (the “Company”) sponsors the LCS Community Employment LLC Employee Benefits Plan (the “Plan”) to provide health and welfare benefits to certain Eligible Employees (and, where applicable, their enrolled Spouses, Qualified Domestic Partners and Dependents) of the Company and its Related Employers who participate in the Plan.

This summary was created for those Eligible Employees (and, where applicable, their enrolled Spouses, Qualified Domestic Partners and Dependents) of the Company and its Related Employers who adopted this Plan who are considered “full time employees”. Please refer to this summary and the attached Program Materials for the applicable Benefit Program for information regarding your welfare benefits which together make up the Plan’s “summary plan description” or “SPD”. Because eligibility for Benefit Programs under the Plan varies depending on part-time or full-time employment status, this SPD applies to full-time employees only. Part-time employees should refer to the “LCS Community Employment LLC Employee Benefits Plan Summary Plan Description for Part-Time Employees” for a summary of the Plan applicable to them and the Benefit Programs in which they are eligible to participate.

The various welfare benefits offered under the Plan which are individually referred to as a “Benefit Program” and collectively as the “Benefit Programs”. The Benefit Programs Eligible Employees classified as “full-time” are potentially eligible for under the Plan are listed on Exhibit A.

The Company also has a cafeteria plan that qualifies under Code Section 125. This allows you to pay your premium contributions for these health and welfare benefits, when applicable, on a pre-tax basis. It also requires that the Company adhere to Code Section 125 regulations concerning such terms as when you may make changes to your elections each year which are discussed in this SPD.

This summary, together with the Program Materials for the specific Benefit Programs included (See Appendices), make up the Plan’s SPD. Together these documents describe the terms and conditions of the Plan and answer the most frequently asked questions about the Plan. Please read this summary carefully.

The benefits and other principal provisions described in this summary apply only if you are an employee (and, where applicable, an enrolled Spouse, Qualified Domestic Partner or Dependent of such employee) of the Company and its Related Employers who have adopted the Plan, and you:

- are eligible to participate in a Benefit Program;
- elect coverage under that Benefit Program; and

- remain covered in accordance with the provisions of the Plan and the applicable Benefit Program.

Additional information regarding the Benefit Programs offered under the Plan is set forth in the Program Materials for the Benefit Programs (See Appendices) listed at the end of this summary. The Appendices may be updated from time to time to reflect changes to the Benefit Programs. The Company reserves the right to amend or terminate any part or the entire Plan and/or any Benefit Program at any time. The Company shall have the sole authority to terminate part or the entire Plan as to some or all classes of Covered Persons at any time and may terminate inclusion of a particular Benefit Program within the Plan at any time. Any policy providing insured benefits may be amended by the Company with the agreement of the insurance company at any time, except that no amendment shall reduce the amount of benefits payable for claims incurred prior to the date of amendment, determined in accordance with the terms of the Benefit Program as in effect prior to such date.

Conflict Between the Documents Governing the Plan

Keep in mind that this SPD is based on official legal documents that govern the operation of the Plan. Some features of the Plan, particularly those that apply infrequently, are not included in this summary. More detailed information is provided in the official Plan document.

While every effort has been made to make this SPD as accurate as possible, unless indicated otherwise, if there are any inconsistencies between the SPD, the provisions of the Plan, and the Program Materials for the Benefit Programs provided by the insurance carriers or third party administrators, the provisions of the Program Materials shall control first. If there is a conflict between the Plan document and this SPD, the Plan document will control. Notwithstanding the foregoing, all documents shall be construed and interpreted in a manner consistent with the requirements of all applicable laws.

DEFINITIONS

Terms that have special meaning and are defined in this SPD are capitalized.

Annual Enrollment

The period designated by the Company during which currently enrolled Eligible Employees and other Eligible Employees may make Benefit Program enrollment elections to be effective the following Plan Year. Enrolled COBRA qualified beneficiaries and Eligible Employees on an authorized leave of absence may also make coverage elections for the following Plan Year during Annual Enrollment.

Benefit Program

A welfare benefit made available by the Company and listed in Exhibit A.

Company

LCS Community Employment LLC

Covered Person

An enrolled Eligible Employee and each Spouse, Qualified Domestic Partner and Dependent of the Eligible Employee who is enrolled in one or more of the Benefit Programs under the Plan that provides coverage for Spouses, Qualified Domestic Partners and Dependents. A Covered Person includes each qualified beneficiary who is eligible and who has elected COBRA coverage under a Benefit Program.

DCAP

The Dependent Care Assistance Program (sometimes referred to as a dependent care flexible spending arrangement) which is one of the Benefit Programs offered under this Plan; provided, however, the DCAP is not subject to ERISA.

Dependent

An individual who satisfies the definition of “dependent” under the applicable Benefit Program for purposes of coverage under that Benefit Program or under Code Section 152 (as modified by Code Section 105(b)).

Eligible Employee

Any person who is employed by the Employer, treated as a common law employee for purposes of Federal income tax and wage withholding, and meets the Employer’s eligibility criteria and any applicable waiting period under the applicable Benefit Program.

The term “Eligible Employee” shall not include leased employees, contract employees, independent contractors or nonresident aliens who do not receive any United States source earned income. If a court, the Internal Revenue Service, or any other third party retroactively determines that an individual is a common-law employee of an Employer such individual is nevertheless expressly excluded from the definition of “Eligible Employee” and is ineligible for benefits under the Plan.

Employer

The Company and the Related Employers identified in “Other Important Information about the Plan” who have adopted the Plan with the Company’s consent.

Health FSA

The Health Flexible Spending Arrangement which is one of the Benefit Programs included in this Plan.

Health Reimbursement Arrangement or HRA

The Health Reimbursement Arrangement or “HRA” is one of the Benefit Programs included in this Plan.

Health Savings Account or HSA

A health savings account established under Internal Revenue Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian. HSAs are not Benefit Programs under this Plan; however, Eligible Employees may elect to make pre-tax contributions through the Company’s cafeteria plan to an HSA in accordance with the Company’s cafeteria plan document and the Employer may, but is not required, to contribute to an Eligible Employee’s HSA.

Participant

An Eligible Employee who has elected to participate in one or more Benefit Programs in accordance with the terms and conditions established for that Benefit Program.

Plan Year

January 1 through December 31.

Qualified Domestic Partner

A Qualified Domestic Partner means an unmarried person of the same or opposite sex with whom the Eligible Employee shares a committed relationship and who meets the requirements adopted by the applicable State and the Eligible Employee has completed the necessary paperwork required by the Employer to designate the individual as a Qualified Domestic Partner. Domestic partners residing in States not requiring coverage by the Employer of domestic partners are not considered Qualified Domestic Partners under this Plan.

Related Employer

Any corporation or unincorporated trade or business that is with respect to the Company: (i) a member of a controlled group of corporations (as defined in Code Section 414(b)); (ii) under common control (as defined in Code Section 414(c)); or (iii) a member of an affiliated service group (as defined in Code Section 414(m); and has adopted this Plan for the benefit of its eligible employees. Related Employers who have adopted this Plan for their eligible employees are listed later in this SPD.

Spouse

Spouse means a spouse as defined by the specific Benefit Program; provided however, “Spouse” shall include a same-sex spouse who is legally married under applicable law.

ELIGIBILITY AND PARTICIPATION

Eligibility

You are eligible to participate in the Plan if you are an Eligible Employee of the Employer. Participants may cover eligible Spouses, Qualified Domestic Partners and Dependents where Spouse, Qualified Domestic Partner and Dependent coverage is available and you have satisfied the eligibility and enrollment requirements of the Benefit Programs. Eligibility for the Benefit Programs depends on work location and the specific Benefit Programs offered to Eligible Employees varies based on the community at which they are located. For information regarding which Benefit Programs you are eligible for, please referenced the current Benefits Guide for the community at which you work.

When an Eligible Employee elects coverage for a Spouse, Qualified Domestic Partner and/or Dependent, it is the responsibility of the Eligible Employee to make sure the Spouse and/or Dependent meets the definition of a Spouse, Qualified Domestic Partner or Dependent under the Benefit Program and is eligible. In addition, the Eligible Employee is responsible for notifying the Plan Administrator when a spouse, qualified domestic partner and/or dependent no longer meet the eligibility criteria. The Company reserves the right to audit spouse, qualified domestic partner and dependent eligibility for proof of eligibility and to take appropriate actions if it is discovered that an ineligible spouse, qualified domestic partner and/or dependent has been added.

The following are **not** Eligible Employees:

- An individual who has not met the applicable waiting period for coverage under the applicable Benefit Program, if any;
- Leased employees;
- Independent contractors; or
- Nonresident aliens who do not receive any United States source earned income.

The Plan Administrator has the exclusive right to classify an individual as an Eligible Employee. Classification, reclassification, or retroactive classification of an individual's status with the Employer by any other entity (even a court or government agency) will not cause the individual to become an Eligible Employee for purposes of this Plan.

Participation Timing

You can participate in the Plan once you meet the eligibility requirements of at least one Benefit Program (including satisfying any applicable waiting period) and enroll in it. Coverage for Spouses, Qualified Domestic Partners and Dependents can begin on the same day as your coverage. Please refer to Exhibit A and the applicable Benefit Program summaries listed in the Appendices to determine if you are eligible for a Benefit Program.

Enrollment

When you first become eligible to participate in a Benefit Program, you will receive enrollment information from your community HR representative. To participate, elect the Benefit Programs in which you want to enroll within 30 days of becoming eligible. Follow the process

outlined in your new hire communication materials. If you require assistance with enrollment, you may reach out to your community HR representative or the Benefit Advocate Center at 844-348-0625.

Annual Enrollment

Generally, you may elect or change your benefit elections in subsequent Plan Years during the Annual Enrollment period (sometimes referred to as “Open Enrollment”) before the Plan Year begins, but **if you do nothing during an Annual Enrollment, your coverage remains the same for the new Plan Year with the exception of Health FSA and DCAP accounts.** The Plan Administrator will provide you with the necessary benefit information for Annual Enrollment.

Election Changes

Generally, your elections under the Plan are effective for the Plan Year and cannot be changed until the next year. Exceptions to this general rule are outlined below and in the Program Materials and may vary depending upon the Benefit Program

Change in Status

You may change or revoke your elections (including waiving coverage) if you have a “Change in Status.” A Change in Status includes:

- Changes in your legal marital status, such as by marriage, divorce, legal separation, death of your Spouse, or annulment;
- Changes in the number of your Dependents (as defined in Internal Revenue Code (“Code”) Section 152), such as by birth, adoption, placement for adoption, or death of a Dependent;
- Changes in your, your Spouse’s, or your Dependent’s employment status if it causes you, your Spouse, or your Dependent to become eligible or cease to be eligible under the Plan or another employee benefit plan;
- A change of your, your Spouse’s, or your Dependent’s residence or worksite if it causes you, your Spouse, or your Dependent to gain or lose eligibility for insurance;
- Your Spouse or Dependent ceasing to be classified as a covered “Spouse” or “Dependent” under the applicable Benefit Program

Please contact your community HR representative or the Benefit Advocate Center if you have any questions regarding whether you have experienced a Change in Status. It is the intent of the Employer for Qualified Domestic Partners to be treated the same as “Spouses” for purposes of a Change in Status event but subject to any requirements or limitations of the underlying Benefit Program. For example, an event outlined below applicable to a Spouse that allows a change to the Health FSA election would not apply to Qualified Domestic Partners since medical care expenses of Qualified Domestic Partners cannot be reimbursed by the Health FSA unless such individual qualifies as a Spouse or Dependent.

Consistency Requirement

If you experience a Change in Status, you may change or revoke your elections under the Plan for the remainder of the Plan Year. Your election change, however, must be consistent with your Change in Status. For example, you cannot decrease your medical coverage after the birth of your child, because that election change would not be consistent with your Change in Status. You could, however, add your child as a Dependent under your medical plan. The Plan Administrator, in its sole discretion and on a uniform and consistent basis, determines whether a requested change is on account of and corresponds with a Change in Status.

Special rules also apply to some of the Benefit Programs requiring you to satisfy the following specific requirements in order to alter your election based on that Change in Status:

- **Loss of Spouse or Dependent Eligibility/Special COBRA Rules:** For Benefit Programs qualifying as group health plans (such as medical insurance), a special rule governs which type of election changes are consistent with the Change in Status. For a Change in Status involving your divorce, annulment or legal separation from your Spouse, the death of your Spouse or your Dependent, or your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may elect only to cancel the health benefits for the affected Spouse or Dependent. A change in election for any individual other than your Spouse involved in the divorce, annulment or legal separation, your deceased Spouse or Dependent or your Dependent that ceased to satisfy the eligibility requirements would fail to correspond with that Change in Status. However, if you, your Spouse or Dependent elect COBRA continuation coverage under the Company's group health plan for any reason other than divorce, annulment or legal separation, or your child's ceasing to be a Dependent and you remain a Participant under the terms of this Plan, you may be able to increase your contribution to pay for such coverage.
- **Gain of Coverage Eligibility Under Another Employer's Plan.** For a Change in Status in which you, your Spouse, or your Dependent gains eligibility for coverage under another employer's cafeteria plan (or qualified benefit plan) as a result of a change in your marital status or a change in your, your Spouse's, or your Dependent's employment status, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- **DCAP Benefits.** With respect to DCAP Benefits, you may change or terminate your election with respect to a Change in Status event only if (1) such change or termination is made on account of and conforms with a Change in Status that affects eligibility for coverage under an

employer's Plan; or (2) your election change is on account of and conforms with a Change in Status that affects the eligibility of Dependent Care Expenses for the available tax exclusion.

Special Circumstances.

You may also change your elections in the middle of a Plan Year for some of the Benefit Programs if:

- You provide the Plan Administrator with a certified copy of a QMCSO (See "Certain Judgments and Orders" under "Other Important Information About the Plan") (not applicable to DCAP);
- You, your Spouse or your Dependent becomes entitled to or loses coverage under Medicare or Medicaid (applicable to medical and Health FSA coverage) (not applicable to DCAP).
- There is a significant change in the cost of your coverage under a Benefit Program, but only if, in the event of a cost increase, you elect another similar coverage instead (if similar coverage is available) or drop coverage (not applicable to Health FSA);
- There is a significant reduction or curtailment in the level of coverage offered under a Benefit Program that constitutes a loss of coverage but only if you elect another similar coverage instead (if similar coverage is available) or drop coverage (not applicable to Health FSA);
- There is a significant reduction or curtailment in the level of coverage offered under a Benefit Program that does not constitute a loss of coverage, but only if you elect another similar coverage instead (not applicable to Health FSA);
- There is a significant improvement in the cost or level of coverage offered under a Benefit Program, or if a new benefit option is made available, but only to change your election to the improved or new coverage option (not applicable to Health FSA);
- In the event that your Spouse or Dependent makes an election change under a plan maintained by his or her employer, you revoke an election under this Plan (except for the Health FSA) 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 your Spouse or Dependent, if:
 - the election change made by your Spouse or Dependent under his or her employer's plan satisfies the regulations and rulings under Code Section 125; or
 - the annual enrollment period of coverage under the plan maintained by Spouse's or Dependent's employer does not correspond with the Annual Enrollment period of this Plan;
- You, your Spouse or Depend loses coverage under any group health plan sponsored by a governmental or educational institution (not applicable to Health FSA).

In addition, you may prospectively revoke an election for medical coverage under this Plan in either the following scenarios:

- You were in any employment status under which you were reasonably expected to average at least 30 hours per week and there is a change in your status such that you are reasonably expected to average less than 30 hours per week after the change but that reduction does not cause a loss in eligibility under the medical coverage. You may revoke the medical coverage in this instance if you certify that you and any covered Spouse and/or Dependents are revoking coverage because you are enrolling in another plan that provides minimum essential coverage as defined by the Affordable Care Act with such coverage being effective no later than the first day of the second month following the month that includes the date coverage under this Plan is revoked; or
- You become eligible for a special enrollment period to enroll in a qualified health plan through a Health Insurance Marketplace pursuant to guidance issued by the U.S. Department of Health and Human Services or you seek to enroll in the qualified health plan through a Health Insurance Marketplace during the Marketplace's annual open enrollment period provided you certify in writing that the revocation corresponds to the intended enrollment of you and any covered Spouse/Dependents in a qualified health plan that will be effective no later than the day immediately following the last day of the medical coverage under this Plan that is being revoked.

HIPAA Special Enrollment Rights

In addition, you can change or revoke your elections during a Plan Year if the Benefit Program permits and you have special enrollment rights under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). If you did not elect to participate in a Benefit Program that qualifies as a group health plan when you first became an employee, you may be entitled to enroll before the next Annual Enrollment, if either:

- you previously waived coverage under the group health plan because you and/or your Spouse and Dependents had other coverage, and that coverage is later lost, or
- you acquire a new Spouse or Dependent.

In the event that you and/or your Spouse and Dependents lose other coverage, the special enrollment period applies if:

- you and/or your Spouse and Dependents are eligible for the group health plan; and
- the other coverage was lost due to (a) exhaustion of COBRA continuation coverage; (b) loss of eligibility, for example as the result of legal separation, divorce, death, termination of employment, or reduction in hours; or (c) termination of the employer contributions for the other coverage.

If you acquire a new Dependent by marriage or through the birth, adoption or placement for adoption of a child, the special enrollment period will apply. If you were not previously enrolled and you are an Eligible Employee, you and your Spouse may also enroll during this special enrollment period for newly acquired Dependents.

You have 30 days from the triggering event (loss of coverage, marriage, birth, adoption, or placement for adoption) to enroll. Coverage will be effective as of the first payroll period following the date you enter your life event into the HCM Cloud system to enroll or, if applicable, as of the date of the birth, adoption or placement for adoption.

You and your Spouse and Dependents also have a HIPAA special enrollment right if you lose Medicaid or CHIP coverage because you (or your Spouse/Dependent) are no longer eligible, or you become eligible for a state's premium assistance program. You have 60 days from the date of the triggering event to request enrollment under the Plan. Coverage will be effective as of the date the coverage is lost.

For more information about HIPAA special enrollment rights, contact your community HR representative or the Benefit Advocate Center at 844-348-0625.

Making an Election Change

Please note that you can change or modify your elections due to an event described above only if you make the request through the HCM Cloud system and request the change within 31 days of the triggering event (e.g., Change in Status). Contact your community HR representative or the Benefit Advocate Center at 844-348-0625.

Your election change will be effective for the first payroll period following the later of (a) the date you enter your life event in the HCM Cloud system to request the change, or (b) the effective date of the change, itself.

Special Rule for Health FSA Elections

In the event you experience a qualifying event which allows you to increase or decrease your Health FSA election, the amount available to you prior to the effective date of your election change will be the initial amount you elected for the Plan Year. The new amount available to you after the election change will be the total contributions paid up to the effective date of the election change plus the total contributions which will be paid for the remainder of the Plan Year minus the amount of any expenses already reimbursed. For example, if you elected \$100 per month (or \$1,200 per year) at the beginning of the Plan Year and change this election after three months to \$200 per month (or \$2,400 per year) without having submitted any expenses for reimbursement, the amount available to you after the election change and for the remainder of the Plan Year is \$2,100 (\$300 of contributions paid in the first three months, plus \$1,800 contributions to be paid for the remainder of the Plan Year). Likewise, if you elected \$200 per month (or \$2,400 per year) at the beginning of the Plan Year and change this election after three months to \$100 per month (or \$1,200 per year) without having submitted any expenses for reimbursement, the amount available to you for the remainder of the Plan Year will be \$1,500 (\$600 of contributions already paid plus \$900 in contributions for the remainder of the Plan Year). If, however, in either instance you had eligible expenses reimbursed prior to the election change, the amount available to you after the election change would be reduced by the amount of expenses already reimbursed for the Plan Year.

Costs Changes During the Plan Year

Your election may automatically be adjusted if the cost of a Benefit Program increases or decreases during a Plan Year or if your contribution amount increases or decreases due to a change in your employment status. For example, if you elect medical coverage or dental coverage, and the amount you must pay for that coverage increases, the amount withheld from your paycheck for that coverage will automatically increase to match the new amount you are required to pay for that coverage.

HOW THE PLAN WORKS IN GENERAL

Benefit Programs

The Plan consists of several different Benefit Programs outlined on Exhibit A. Some of the Benefit Programs are fully-insured benefits provided through insurance companies selected by the Company. As fully-insured benefits, the applicable insurance company is solely responsible for financing and administering the benefits for the Benefit Program. Some of the Benefit Programs are self-funded meaning benefits are paid by the Employer (including through Participant contributions as determined by Employer), up to the attachment point for any stop loss coverage purchased by the Company. Exhibit A lists whether the Benefit Program is fully-insured or self-funded and lists the insurance companies through which the fully-insured Benefit Programs are offered. The specific details of each Benefit Program can be found in the applicable Program Materials in the Appendices.

To the extent the Company elects to purchase insurance with respect to any Benefit Program, any benefits to be provided under such Benefit Program shall be the sole responsibility of the insurer and the Company and Related Employers shall have no responsibility for the payment of such benefits (except for refunding any Participant contributions that were not remitted to the insurer).

The cost of the benefits provided through the Benefit Programs may be paid for in part by Employer contributions and in part by Participant contributions. The Employer will determine and periodically communicate the Participant's share of the cost of the benefits provided through each Benefit Program, and it may change that determination at any time. Nothing herein shall require the Employer to make any contributions toward the cost of the benefits provided through the Benefit Programs. Whether the Employer pays any portion of the benefits and the specific amount is determined by the Employer in its sole discretion.

The Employer will make its contributions in an amount that in its sole discretion is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Participant contributions. Participant contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Participation in the Plan and payment of benefits attributable to Employer contributions is conditioned on a Participant contributing his/her required contribution.

The Benefit Programs that you elect will determine how much you must contribute. For those Benefit Programs which require Eligible Employee contributions, a pro-rata portion of the cost for your Benefit Program coverage will be withheld from each of your paychecks on a pre-tax or after-tax basis.

“Pro rata” means that the cost for the coverage you selected for the Plan Year is divided by the number of pay periods in the Plan Year. Pre-tax means that your contribution is withheld before your taxes are determined, so that you are taxed on less income (which reduces your income taxes). After-tax means that your pay is first taxed and then your contribution is withheld from your pay. For example, if you elect medical coverage, your share of the premiums for that coverage will be withheld from your paycheck before your taxes are determined.

HOW THE BENEFIT PROGRAMS WORK

Please read the Program Materials for the Benefit Programs and attached in the Appendices which contain the specific details about the benefits provided by the Benefit Programs.

Additional details regarding the Health Reimbursement Arrangement, Health FSA and DCAP are outlined below.

Health Reimbursement Arrangement

The Health Reimbursement Arrangement (“HRA”) is one of the self-funded Benefit Programs under this Plan. Not all Eligible Employees are eligible for the HRA. In addition to meeting the other eligibility criteria for benefits provided by this Plan, the Eligible Employee must (a) work at a community that has elected to have the HRA offered to Eligible Employees working at the community, and (b) be covered by one of the medical insurance options offered through this Plan that is paired with an HRA. Eligible Employees should refer to the Program Materials and Benefits Guide for the community at which they are employed for more information regarding whether they are eligible for an HRA and the amount of HRA benefits, if any. If you are eligible for the HRA, the HRA is intended to subsidize your medical insurance and to reimburse you for Medical Care Expenses which would have been covered by the insurance but for your cost-sharing requirements up to the HRA’s annual limit as listed in the Program Materials and the Benefits Guide for the community at which they are employed. The Program Materials provide more information on how claims are submitted and administered.

Health FSA Benefits

If you elect Health FSA benefits, you provide a source of pre-tax funds to reimburse yourself for your eligible Medical Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Under that Agreement, you agree to a salary reduction to fund Medical Care Expense instead of receiving a corresponding amount of your regular pay. This means that the premiums you pay will be paid with pre-tax funds. In return, you may be reimbursed from the Plan for certain eligible Medical Care Expenses. This

arrangement helps you because the coverage you elect is nontaxable, which saves you Social Security and income taxes on the amount of your salary reduction.

Health FSA Benefits are intended to pay benefits solely for Medical Care Expenses not previously reimbursed or reimbursable elsewhere. Accordingly, the Health FSA shall not be considered to be a group health plan for coordination of benefits purposes, and the Health FSA shall not be taken into account when determining benefits payable under any other plan.

If you elect Health FSA Benefits, an account called a Health FSA Account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the premiums that you have paid for such benefits during the Plan year. Your Health FSA 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.

A Health FSA election may be for:

- General-Purpose Health FSA Coverage; or
- Limited (Vision/Dental/Preventative Care) Health FSA Coverage

Note, if you elect Health FSA Benefits, you cannot also elect HSA Benefits or otherwise make contributions to an HSA unless you elect the Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option. If you are married and elect the General-Purpose Health FSA Coverage Option, your spouse will also be ineligible to make HSA contributions.

You may choose any amount of Medical Care Expenses reimbursement that you desire under the Health FSA, subject to the maximum reimbursement amount allowable under the Code or as stated in the Election Form/Salary Reduction Agreement or other documentation provided to you, whichever amount is the least, per Plan Year. The current minimum contribution and maximum contribution amounts are listed in Exhibit A. You will be required to pay the annual Health FSA “premium” equal to the coverage level you have chosen.

When you complete the Election Form/Salary Reduction Agreement, you specify that your share of the costs will be paid through pre-tax salary reductions. From then on, you must pay a premium for such coverage by having that portion deducted from each paycheck (unless otherwise agreed with, or as deemed appropriate by the Administrator). The Company may, but is not required, to make contributions to your Health FSA.

So long as you remain a Participant, the full amount of the coverage that you have elected (reduced by prior reimbursement made during the same Plan Year) will be available to reimburse you for eligible Medical Care Expenses incurred during the Plan Year regardless of the amount of contributions that have been credited to your account.

Your Health FSA election may be for the General Purpose Health FSA Coverage or Limited (Vision/Dental/Preventative Care) Health FSA Coverage. Each of these Health FSA coverage options is described in detail below. Note: You cannot elect HSA Benefits and Health FSA Benefits together unless you elect the Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option.

The eligible “Medical Care Expenses” vary according to the type of Health FSA coverage option that is elected as described below.

- General Purpose Health FSA Coverage Option. For purposes of the General-Purpose Health FSA Coverage Option, “Medical Care Expense” means expenses incurred by you, your Spouse or your Dependents for “medical care” as defined in Code § 213(d). Under the tax laws, “Medical Care Expenses” include expenses for prescription drugs, insulin, and over the counter drugs.
- Limited (Vision/Dental/Preventative Care) Health FSA Coverage Option. According to rules set forth in Code § 223 (applicable to HSAs), you will not be able to make/receive tax-favored contributions to your HSA if you participate in a Health FSA that reimburses medical expenses as defined for a General Purpose Health FSA in subsection (a) above. You may, however, be eligible to make/receive tax favored contributions to an HSA and participate in a Health FSA if the Health FSA reimbursement is limited to the following unreimbursed Code § 213(d) expenses:
 - Services or treatments for dental care (excluding premiums);
 - Services or treatments for vision care (excluding premiums); or
 - Services or treatments for “preventative care” as defined by Code § 223(c)(2)(C).

For Medical Care Expense to be reimbursed to you, they must have been incurred during the Plan Year. A Medical Care Expense is incurred when the service that gives rise to the expense is provided, not when the Expense was paid, provided, however, advance payments for orthodontia expenses are reimbursable when paid. Note that if you have paid for the expense but if the services have not yet been rendered, then the expense has not been incurred for this purpose. For example, if you pay for medical care on the first day of the month for care given on the 15th of that month, the expense has not been incurred until the 15th of that month. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form/Salary Reduction Agreement became effective, for any expenses incurred after the close of the Plan Year, or after a separation from service (except for Continuation Coverage).

You must either submit a claim to the Plan Administrator for Medical Care Expenses or use the debit card provided by the Plan Administrator. You must include written statements and/or bills from independent third parties stating that the Medical Care Expenses have been incurred, and the amount of such Medical Care Expenses along with the Flexible Spending Account Form. Generally, this requires including an Explanation of Benefits (EOB) Form from the medical insurance carrier (or a bill from a doctor’s office) indicating the amounts that you are obligated to pay.

You will have until March 31 after the end of the Plan Year in which to submit a claim for reimbursement for Medical Care Expenses incurred during the previous Plan Year. You will be notified if any claims for benefits is denied.

Please note that it is *not* necessary for you to have actually paid the bill in an amount due for a Medical Care Expense--only for you to have *incurred* the expense and that it is not being paid for or reimbursed from any other source.

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Medical Care Expenses you have incurred and the annual coverage level you have elected and paid for. The difference is forfeited by you in accordance with the requirements for Health FSAs under the Internal Revenue Code.

You will forfeit any amount allocated to your Health FSA Account above the maximum allowed by the IRS if that amount has not been applied to Health FSA Benefits for any Plan Year during the run-out period for expenses incurred during the Plan Year. Amounts so forfeited shall be applied to offset Health FSA administrative expenses and future costs and as otherwise allowed by applicable law.

There is a limited exception for a Participant who is a member of a reserve component of the United States Armed Forces and is ordered or called to active duty for a period of 180 days or more or for an indefinite period of time. He/she may receive a refund of amounts contained in his or her Health FSA provided the request is made during the period beginning with the date of the order or call to active duty and ending on the last day of the then current Plan Year. For more information see the Plan Document or contact the Plan Administrator.

Generally, you will not be taxed on your Health FSA Benefits. However, the Company cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims you submit. For example, to qualify for tax-free treatment, your Medical Care Expenses must meet the definition of “medical care” as defined in the Internal Revenue Code. If you are reimbursed for a claim that is later determined to not be for Medical Care Expenses, you will be required to repay the amount. Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. You may wish to consult a tax advisor.

DCAP Benefits

If you elect DCAP Benefits, you provide a source of pre-tax funds to reimburse yourself for your eligible Dependent Care Expenses by entering into an Election Form/Salary Reduction Agreement with your Employer. Under that Agreement, you agree to a salary reduction to pay for Dependent Care Expenses instead of receiving a corresponding amount of your regular pay. This means that the premiums you pay will be with pre-tax funds. In return, you may be reimbursed from the Plan for certain eligible Dependent Care Expenses. This arrangement helps you because the coverage that you elect is nontaxable, which saves you Social Security and income taxes on the amount of your salary reduction.

If you elect DCAP Benefits, an account called a DCAP Account will be set up in your name to keep a record of the reimbursements that you are entitled to, as well as the premiums that you have paid for such benefits during the Plan Year. Your DCAP Account is merely a

recordkeeping account; it is not funded (all reimbursements are paid from the general assets of the Employer).

You may choose any amount of Dependent Care Expenses reimbursement that you desire under the DCAP, subject to the maximum reimbursement amounts described below. The current minimum contribution amount, if any, will be stated on the Election Form/Salary Reduction Agreement or other documentation provided to you. You will be required to pay the annual DCAP “premium” equal to the coverage level you have chosen.

The amount of Dependent Care Expenses reimbursement that you choose cannot exceed the maximum amount specified in Code § 129. The maximum amount is the full amount of the maximum amount allowed by the Code or as stated on the Election Form/Salary Reduction Agreement or other documentation provided to you, whichever is less, for a calendar year if you:

- are married and file a joint return;
- are married, but you furnish more than one-half the cost of maintaining those Dependents for whom you are eligible to receive tax-free reimbursements under the DCAP, your Spouse maintains a separate residence for the last six months of the calendar year, and you file a separate tax return; or
- are single or are the head of the household for tax purposes.

If you are married and reside with your Spouse, but you file a separate federal income tax return, then the maximum DCAP Benefits that you may elect is half of the maximum amount allowed by the Code or stated on the Election Form/Salary Reduction Agreement or other documentation provided to you, whichever is less, for a calendar year.

The above maximum as applicable, applies to the amount that you may elect under this Plan and any plan of your Spouse. However, the above maximum is just the greatest amount that is possible; the election amount that applies to you may be less than the above maximum because of other limitations (for example, note that reimbursement cannot exceed the amount of you or your Spouse’s earned income for the Plan Year).

When you complete the Election Form/Salary Reduction Agreement, you specify that your share of the costs will be paid through pre-tax salary reductions. From then on, you must pay a premium for such coverage by having that portion deducted from each paycheck (unless otherwise agreed with, or deemed appropriate by the Administrator). Employer makes no contribution to your DCAP Account.

The amount of coverage that is available for reimbursement of Dependent Care Expenses at any particular time during the Plan Year will be equal to the amount credited to your DCAP Account at the time your claim is paid, reduced by the amount of any prior reimbursements paid to you during the Plan Year.

“*Dependent Care Expenses*” means employment-related expenses incurred on behalf of any Dependent who meets the requirements to be a *Qualifying Individual*, as defined in paragraph (a) below. All of the following conditions must be met for such expenses to qualify as

Dependent Care Expenses that are eligible for reimbursement:

- Each Dependent for whom you incur the expenses must be a Qualifying Individual--that is, he or she must be:
 - a person under age 13 for whom you are entitled to claim a dependency exemption on your federal income tax return (if you are a divorced parent, a child is your Dependent if you have custody of the child, even if you are not entitled to claim the dependency exemption); or
 - your Spouse or a person who is your Dependent under federal tax law (even if you cannot claim the dependency exemption on your federal income tax return), but only if he or she is physically or mentally incapable of self-care.
- No reimbursement will be made to the extent that such reimbursement would exceed the balance in your DCAP Account. In addition, no reimbursement will be made to the extent that such reimbursement, when combined with the total amount of reimbursements made for the Plan Year, would exceed the applicable statutory limit. Your applicable statutory limit is the smallest of the following amounts:
 - your earned income for the calendar year (after your Salary Reductions under the Plan;
 - the earned income of your Spouse for the calendar year (your Spouse will be deemed to have earned income of \$200 (\$400 if you have two or more Qualifying Individuals), for each month in which your Spouse is (1) physically or mentally incapable of self-care; or (2) a full-time student; or
 - either the full maximum amount allowed or one-half of the maximum amount allowed for the calendar year, depending on your marital and tax filing status.
- The expenses are incurred for services rendered after the date of your election to receive DCAP Benefits and during the Plan Year to which the election applies.
- The expenses are incurred to enable you (and your Spouse, if you are married) to be gainfully employed, which generally means working or looking for work. There is an exception: if your Spouse is not working or looking for work when the expenses are incurred, he or she must be a full-time student or physically or mentally incapable of self-care.
- You (or you and your Spouse together) are providing at least 50% of the cost of maintaining your household, and the expenses are incurred when at least one member of your household is a Qualifying Individual.
- The expenses are incurred for the care of a Qualifying Individual, or for household services attributable in part to the care of a Qualifying Individual.
- If the expenses are incurred for services outside your household, they are incurred for the care of (1) a person under age 13 who is your Dependent under federal tax law, or

(2) your Spouse or a person who is your Dependent under federal tax law, is physically or mentally incapable of self-care, and regularly spends at least eight hours per day in your household

- If the expenses are incurred for services provided by a dependent care center (that is, a facility that provides care for more than six individuals not residing at the facility), the center complies with all applicable state and local laws and regulations.
- The person who provided care was not your Spouse or a person for whom you are entitled to a personal exemption under Code § 151(c). If your child provided the care, he or she must be age 19 or older at the end of the year in which the expenses are incurred.
- The expenses are not paid for services outside your household at a camp where the dependent stays overnight.

Dependent Care Expenses must have been incurred during the Plan Year. A Dependent Care Expense is *incurred* when the service that gives rise to the expense is provided; when the expense is paid is irrelevant. Note that if you have paid for the expense but the services have not yet been rendered, then the expense has not been incurred for this purpose. For example, if you pay for your child's daycare on the first day of the month for care given during the entire month, the expense has not been incurred until the end of that month. You may not be reimbursed for any expenses arising before the Plan became effective, before your Election Form/Salary Reduction Agreement became effective, or for any expenses incurred after the close of the Plan Year.

When you incur an expense that is eligible for payment, you must submit a claim to the Administrator on a form that will be supplied to you. You must include written statements and/or bills from independent third parties stating that the Dependent Care Expenses have been incurred, and the amount of such Dependent Care Expenses along with the Flexible Spending Account Form.

If there are enough credits to your DCAP Account, then you will be reimbursed for your eligible DCAP Expenses within 30 days after the date you submitted the Flexible Spending Account Form (subject to a 15-day extension for matters beyond the Administrator's control). If a claim is for an amount that is more than your current DCAP Account balance, then the excess part of the claim will be carried over into the following months, to be paid out as your balance becomes adequate. Remember, though, that you can't be reimbursed for any total expenses above your available annual credits to your DCAP Account.

You will have until March 31 after the end of the Plan Year in which to submit a claim for reimbursement for Dependent Care Expenses incurred during the previous Plan year, including expenses incurred following termination of your participation in this Plan. You will be notified in writing if any claim for benefits is denied.

Note that it is not necessary for you to have actually paid the bill in an amount due for Dependent Care Expenses-- only for you to have *incurred* the expense, and that it is not being paid for or reimbursed from any other source.

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Dependent Care Expenses that you have incurred and the annual coverage that you have elected and paid for.

You will forfeit any amount allocated to your DCAP Account if that amount has not applied to DCAP Benefits for any Plan Year by March 31 following the end of the Plan Year for which the election was effective. Amounts so forfeited shall be applied as described in the Plan (for example, used to offset reasonable administrative expenses and future costs). Also, any DCAP Account benefit payments that are unclaimed (for example, uncashed benefit checks) by the end of the close of the Plan year following the Plan Year in which the Dependent Care Expense was incurred will be forfeited and applied as described in the Plan.

If you terminate your employment mid-year and have a positive DCAP Account balance you may be reimbursed for qualifying expenses that were incurred after the termination of your employment up to the remainder of the balance in your DCAP Account provided they are submitted in accordance with the Plan's policies as discussed in more detail above.

Generally, you will not be taxed on your DCAP Benefits, up to the annual limit. However, the Employer cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims that you submit. For example, to qualify for tax-free treatment, you will be required to file IRS Form 2441 (Child and Dependent Care Expenses) with your annual tax return (Form 1040) or a similar form. You must list on Form 2441 the names and taxpayer identification numbers of any persons who provided you with dependent care services during the calendar year for which you have claimed a tax-free reimbursement. If you are reimbursed for a claim that is later determined to not be for Dependent Care Expenses, you will be required to repay the amount. Ultimately, it is your responsibility to determine whether each payment to you under this Plan is excludable for tax purposes. You may wish to consult a tax advisor.

You may not claim any other tax benefit for the tax-free amounts received by you under this Plan, although the *balance* of your Dependent Care Expenses may be eligible for the household and dependent care services tax credit under Code § 21 (*Dependent Care Credit*) (e.g., if you elect \$3,000 of coverage under the DCAP and are reimbursed \$3,000, but you had Dependent Care Expenses totaling \$5,000, you could count the excess \$2,000 when calculating the Dependent Care Credit if you have two or more dependents). Note: the amount of any Dependent Care Credit you may have available will be offset by any DCAP Benefits received under the Plan. You should consult your tax advisor regarding the dependent care credit and the tax consequences of participating in the DCAP.

SUBMITTING CLAIMS FOR BENEFITS

Making a Claim for Benefits

To obtain benefits under a Benefit Program, you must follow the claims procedures of the applicable insurer or claims administrator outlined in the Program Materials for the specific Benefit Program. For purposes of determining the amount of, and entitlement to benefits under the fully-insured Benefit Programs, the respective insurer is the named fiduciary with full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Benefit Program. For self-funded Benefit Programs, the Program Materials provide the name of the claims administrator responsible for making claims decisions.

The insurance company or claims administrator will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company or claims administrator has the right to secure independent advice, including medical advice, and to require such other evidence as it deems necessary in order to decide the claim. If the insurance company or claims administrator denies a claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial. You may appeal a denial in accordance with the appeal procedures outlined in the Program Materials for the applicable Benefit Program. If you do not appeal on time, you lose your right to file suit in a state or federal court, because he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). The Program Materials provide more information about how to file a claim and details regarding the applicable claims procedures for each Benefit Program.

Legal Actions

You will not be entitled to challenge a claim decision made by an insurer, claims administrator or an appeals decision-maker in Federal or state court or in any other administrative proceeding unless and until the claims procedures described in the applicable Program Materials been complied with and exhausted and appeals brought within the required timeframes. The Program Materials may contain additional limitations, such as timeframes by which legal action must be brought once you have exhausted your appeal rights.

LEAVES OF ABSENCE

Military Leave of Absence

If you take a leave of absence that qualifies as service in the “uniformed services” (as that term is defined by USERRA), you will be entitled to continue to participate in group health coverage under the Plan. Please note that the military leave provisions of the Plan apply only to the extent required under USERRA and are intended and shall be construed to satisfy only the minimum requirements, and do not create any rights in excess of those minimum requirements. The Plan Administrator may adopt such rules for the administration of the military leave provisions of the Plan as it deems necessary and appropriate. It is the intent of the Employer for Qualified Domestic Partners to be treated similarly as Spouses for purposes of leaves of absences subject to any requirements or limitations of the applicable Benefit Program.

Payment for USERRA Coverage

Participants on a USERRA covered leave of absence for more than 30 days who elects USERRA coverage may be required to pay up to 102 percent of the cost of the group health plan coverage provided under the Plan during the period of USERRA coverage. The Plan Administrator will determine and notify you of the cost of coverage. Participants on a USERRA covered leave of absence of less than 31 days will continue to be eligible for the group health plan coverage as if the Participant was actively employed and not on a leave of absence.

Period of USERRA Coverage

The period of USERRA coverage shall begin on the effective date of your leave of absence to perform uniformed services and shall end on the earliest of the following dates:

- The last day of the 24-month period beginning on the effective date of your leave of absence;
- The date you do not make a required premium payment; and
- The date your rights to reemployment with the Employer conferred by USERRA (“Reemployment Rights”) end.

USERRA Return to Work Rights

If you are receiving USERRA coverage and are reemployed by the Employer before your Reemployment Rights expire, and you are eligible for coverage under a group health plan your coverage (and that of your Spouse and Dependents) shall be immediately reinstated when you are reemployed.

Not Returning to Work Before Reemployment Rights Expire

If you have maintained USERRA coverage but do not return to work before your Reemployment Rights expire, you and/or your Spouse and Dependents may be entitled to elect COBRA continuation coverage. If you are reemployed after your Reemployment Rights expire, you will be treated as a new Eligible Employee for purposes of eligibility under the group health plans.

Leave of Absence for Family or Medical Reasons

If you take a leave of absence that qualifies under the FMLA, you may continue coverage under some of the Benefit Programs in accordance with the Employer’s FMLA policies. Contact the Plan Administrator for more information about your FMLA leave rights.

FMLA Benefit-Related Rights

Federal law requires the covered employers to maintain group health plan coverage during your FMLA leave on the same conditions as coverage would be provided if you were continuously employed during the entire leave period. During your FMLA leave, any change to the Benefit Programs which qualify as group health plans will apply to you on the same basis as if you were not on leave, and you will be given notice of any opportunity to change your coverage.

If you do not continue your group health plan coverage during an FMLA leave, you are entitled to be reinstated upon your return from leave without any requirements to requalify, such as any waiting period. You have no greater right to reinstatement or to other benefits under the Plan than if you had been continuously employed during your FMLA leave.

Group Health Plan Coverage While on FMLA Leave

The Employer's obligation to provide benefit coverage ends on the earlier of the date on which:

- You inform your Employer that you do not intend to return from FMLA leave;
- You do not return from your FMLA leave and terminate employment; or
- You exhaust your FMLA leave entitlement.

Payment for Group Health Plan Coverage While on FMLA Leave

During FMLA leave, you must continue to pay the same share of the cost of benefit coverage that you paid before such leave. If, while on FMLA leave, premiums are raised or lowered for other Eligible Employees, you also must pay the new premium rates.

If you are on unpaid FMLA leave and do not return to work after your FMLA leave, the Employer may recover its share of the cost of group health plan coverage paid on your behalf. The Employer may also recover from you any premiums paid on your behalf while on unpaid FMLA leave to maintain other benefits if you do not return from FMLA leave. The Employer may recover its share of premiums through deductions from any sums due to you. Alternatively, the Employer may initiate legal action against you.

Non USERRA or FMLA Leave

Other leaves of absence shall be administered in accordance with your Employer's policy on leaves of absence. Please contact the Plan Administrator for more information on continuing coverage under a Benefit Program during a leave of absence.

If you take a paid leave of absence (whether under the USERRA, the FMLA, or otherwise), you continue to participate in the Plan on the same basis as an active Eligible Employee. The full amounts you elected for Plan benefits will continue to be deducted from your paychecks during the paid leave of absence.

Continuing Participation During an Unpaid Leave of Absence

When you take an unpaid leave of absence – whether a USERRA leave, FMLA leave, or other unpaid leave – the Plan Administrator will bill you monthly for the amounts due for your benefit elections during the leave or until the end of the Plan Year, whichever is earlier. If your leave extends beyond the end of the Plan Year, you shall be given notice of any opportunity to change your benefit elections, such as Annual Enrollment. If you elect to continue your benefit elections for the next Plan Year, the Plan Administrator will continue to bill you monthly for the amounts due for your benefit elections during the leave or until the end of the Plan Year, whichever is earlier. You also may pre-pay any contributions for the period of your leave or the remainder of

the Plan Year, whichever is earlier, out of pre-leave compensation by increasing your salary reduction election. For more information, contact the Plan Administrator.

If you take an unpaid leave of absence, you also are entitled to revoke your benefit elections. In that case, your participation in the Plan ends, and you do not make any contributions during your leave

COBRA CONTINUATION COVERAGE

This section applies to you if you are covered under one of the Benefit Programs that are considered “group health plans”. This section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. Below generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a “qualifying event.” Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your Spouse and Dependents could become qualified beneficiaries if coverage under the group health plan is lost because of a qualifying event. Under the group health plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Although the Health FSA is a “group health plan” continuation coverage is available under the Health FSA only for individuals who have underspent their accounts and only for the duration of the then current Plan Year. Except for the Health FSA, it is the intent of the Employer that Qualified Domestic Partners be treated similarly as Spouses for purposes of COBRA continuation coverage described below subject to any requirements or restrictions of the underlying Benefit Program.

COBRA Qualifying Event

A qualifying event is one of the following events that causes either you, your Spouse or Dependent to lose coverage under a group health plan.

You will become a qualified beneficiary if you lose your coverage under the group health plan because either one of the following qualifying events happens:

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

The following are qualifying events for your Spouse:

- You die;
- Your termination of covered employment (for reasons other than gross misconduct) or reduction in your hours of employment with the Employer;
- Your divorce or legal separation; or
- Your eligibility for Medicare.

The following are qualifying events for your Dependents:

- You die;
- The termination of your covered employment (for reasons other than gross misconduct) or reduction in your hours of employment with the Company;
- Parents' divorce or legal separation;
- Your eligibility for Medicare; or
- Ceasing to be a "Dependent," as defined under the group health plan.

Informing the COBRA Administrator

The group health plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or your becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company must notify the COBRA Administrator of the qualifying event.

For the other qualifying events (divorce or legal separation of you and your Spouse or a Dependent's losing eligibility for coverage as a Dependent), you must notify the COBRA Administrator within 60 days after the qualifying event occurs. For more information call OptumFinancial at 855-687-2021.

Providing COBRA Coverage

Once the COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. You may elect COBRA continuation coverage on behalf of your Spouse, and parents may elect COBRA continuation coverage on behalf of their eligible Dependents.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of your employment or reduction of your hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. When you lose coverage due to the qualifying event of death, your entitlement to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of your employment or reduction of your hours of employment, and you became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than you lasts until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before the date on which your employment terminates COBRA continuation coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the group health plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your eligible family members may be entitled to receive up to an

additional 11 months of COBRA continuation coverage, for a total maximum period of 29 months if you meet the following requirements:

- The disability must have begun at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage; and
- The qualified beneficiary must notify the COBRA Administrator within the first 60 days after disability determination by the SSA.

If the qualified beneficiary is determined by the SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days of SSA's determination.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and Dependents can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the COBRA Administrator. If notice is not provided to the COBRA Administrator within 60 days of the second qualifying event, there will be no extension of COBRA coverage due to a second qualifying event. This extension may be available to your Spouse and any Dependents receiving continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated, or if the Dependent stops being eligible under the group health plan as a Dependent, but only if the event would have caused your Spouse or Dependent to lose coverage under the Plan had the first qualifying event not occurred.

COBRA Coverage Payments.

If you or your eligible covered Dependent(s) elect continuation coverage after the qualifying event, then you or your eligible covered Dependent(s) will have 45 days from the date of that election to make the required initial premium contribution. That initial contribution must cover the entire period, from the date of the qualifying event to the date of your payment. Each other contribution payment is due within 30 days after the first day of each month of continuation coverage.

COBRA Continuation Coverage Ends

In addition to the maximum coverage durations previously discussed, COBRA continuation coverage will end on the earliest to occur of the following:

- The date you first become entitled to benefits under Medicare;
- The date on which the group health plan ceases;
- If you fail to make a required contribution; or
- The date you first become covered under any other group health plan.

COORDINATION OF BENEFITS

Coordination of Benefits ("COB") applies when you have coverage through more than one group plan. The purpose of COB is intended to avoid duplication of covered benefits when a person

is covered by two or more plans. When the Plan coordinates its benefits, it means the Plan and the other plan work together in providing their combined benefits so that the total benefit payments do not exceed the actual benefit charges.

One of the plans involved will pay benefits first – that is the primary. The other plan will pay benefits next – that plan is the secondary. If the Plan is primary, it will pay benefits as if it were the only plan involved. Benefits under this Plan will not be reduced because benefits are payable under the other plans. If the Plan is secondary, the benefits it pays may be reduced so that the total benefits paid or provided by all plans are not more than the actual benefit charges.

The insurer's coordination of benefits policies will apply to any Benefit Program that is fully-insured. For any self-funded Benefit Program the coordination of benefits policies of the applicable third party administrator will control. If the total payments made by the Plan are more than should have been paid under the insurer's or third party administrator's coordination of benefits policies, the Plan will have the right to recover the excess as the Plan Administrator will determine, from any of the persons it has paid or for whom it has paid, or from insurance companies or other organizations.

OTHER IMPORTANT INFORMATION ABOUT THE PLAN

Plan Name

LCS Community Employment LLC Employee Benefits Plan

Type of Plan

Welfare plan providing a variety of welfare benefits to eligible employees through fully-insured and self-funded programs.

Plan Year

The Plan year is January through December. Plan documents are kept on a plan year basis.

Plan Number

502

Effective Date

The original effective date of this wrap plan is January 1, 2016

Funding Medium and Type of Plan Administration

Some of the benefits offered under this Plan are fully-insured and others are self-funded as noted in Exhibit A. Premiums may be funded in part by employer and employee contributions. While the Plan is administered by the Plan Administrator, for fully-insured benefits the insurance carrier for the applicable Benefit Program is responsible for

financing and administering the Benefit Program and is solely responsible for payment of claims.

Plan Sponsor

LCS Community Employment LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309
(515) 875-4500

Plan Sponsor's Employer Identification Number

45-4590615

Plan Administrator

LCS Community Employment LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309
(515) 875-4500

Named Fiduciary

LCS Community Employment LLC

Agent for Service of Legal Process

Director of Benefits
LCS Community Employment LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309

Related Employers Who Have Adopted the Plan

LCS Dallas Operations LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309
(515) 875-4500
EIN: 46-5742858

Questions Regarding the Plan

If individuals have questions regarding the Plan, they should contact the Senior Benefits Analyst at (515) 875-4582.

Plan Administration

The Plan Administrator has the discretionary authority to determine all issues arising under the Plan, including issues of eligibility, Plan interpretation and coverage. An insurance company or other party that has contracted with the Company to provide administrative services to a Benefit Program may be responsible for determining whether a particular claim is covered by a Benefit Program or if a particular benefit is provided under a Benefit Program. The Plan Administrator may delegate some of their administrative duties to agents.

Representations Contrary To The Plan

No employee, officer, or director of the Company or a Related Employer has the authority to alter, vary or modify the terms of the Plan or any Benefit Program except by means of an authorized written amendment to the Plan. No verbal or written representations contrary to the terms of the Plan or a Benefit Program, or its written amendments, shall be binding upon the Plan, the Plan Administrator or any Employer.

Plan Amendment and Termination

The Company reserves the right to amend or terminate the Plan at any time, and the right to decrease or eliminate its contributions for Benefit Program premiums, with or without advance notice to Eligible Employees. No consent of any Covered Person or other person shall be necessary for the Company to amend or terminate the Plan. Any such amendment or termination may be made by proper action of the board of directors of the Company or its delegate.

In the event of the Plan's termination, the rights of all persons covered by the Plan at the time shall be limited to claims incurred as of the date of the termination. Benefits provided under the Plan are not vested benefits.

Limitation of Rights

No Covered Person, beneficiary, or other person shall acquire, by reason of the Plan, this SPD, or any other Benefit Program or Plan document, any right in or title to any assets, funds or property of the Company or an Employer. No employee, officer, director or agent of the Company guarantees in any manner the payment of Plan benefits.

Assignment of Benefits

To the extent permitted by law, no benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, assignment, pledge, attachment, garnishment, execution, levy, lien or encumbrance of any kind, and any attempt to accomplish the same shall be void. Notwithstanding the foregoing, the Plan Administrator will provide benefits to the extent required

by a QMCSO. The Plan Administrator also shall have the right, in its sole discretion, to accept a valid assignment for payment of Plan benefits made by a Covered Person to a company, doctor, dentist or other provider.

Certain Judgments and Orders

To the extent required by a QMCSO, and subject to procedures established by the Plan Administrator, your election may be changed by the Plan Administrator to provide coverage to a Dependent in accordance with the terms of a QMCSO. If a QMCSO requires your Spouse, your former Spouse, or another individual to provide coverage for your Dependent, and that coverage is, in fact, provided, you may cancel coverage under this Plan for that child within 30 days following the effective date of the other coverage.

The Plan Administrator or its designee, in its sole discretion, shall determine whether an order or notice qualifies as a QMCSO in accordance with the procedures established for such purpose.

Keep Plan Informed of Address Changes.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Information You Must Provide

You must provide the Plan Administrator with such documents, data or other information as the Plan Administrator considers necessary or desirable for administering the Plan. You may also be required to fully complete forms, releases or documents as necessary. The benefits payable under the Plan to you or on your behalf are conditioned on furnishing full, true and complete documents, data or other information reasonably related to the administration of the Plan requested by the Plan Administrator.

No Vesting

No person shall have any guaranteed or vested right to receive or continue to receive any benefits provided under the Plan.

No Employment Rights

The Plan does not confer employment rights on any person. No person shall be entitled, by virtue of the Plan, to become or to remain in the employ of the Company, or an Employer and nothing in the Plan shall restrict the right of the Company or an Employer to terminate the employment of any Eligible Employee or other person at any time.

Subrogation/ Reimbursement

If you have a claim to recover money from a third party due to an injury and you have received or will receive benefits from the Plan in connection with that injury, the applicable Benefit

Program will be subrogated to your rights with respect to that third party. If you receive any payment from any potentially responsible third parties as a result of an injury or illness, the applicable Benefit Program has the right to recover from, and be reimbursed by you for all amounts this Plan has paid and will pay as a result of that injury or illness, up to and including the full amount you received from all potentially responsible parties. In addition, as a condition of paying benefits, a Benefit Program may be entitled to reimbursement out of any money recovered by you from a third party for benefits paid to you by such Benefit Program. The Plan's rights to recover these amounts take priority over your right to be made whole. Any settlement proceeds or assets collected from judgments are subject to the imposition of a constructive trust.

Whenever the Plan pays welfare benefits in excess of the maximum amount of payment required under an applicable Benefit Program, the Plan Administrator or its delegate(s) will have the right to recover any such excess payments and associated earnings from any person who received the excess payments.

SPECIFIC RIGHTS AND NOTICES REGARDING THE PLAN

Women's Health and Cancer Rights Act Notice

The Women's Health and Cancer Rights Act requires group health plans that provide medical benefits for a mastectomy to also provide coverage for breast reconstruction for patients who choose to receive it.

Specifically, any patient whose mastectomy is covered under a group health plan must also be covered for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Reconstruction of the other breast to achieve symmetry; and
- Prostheses and physical complications of all stages of a mastectomy, including lymphedemas.

Decisions about these medical procedures will be determined in consultation with you and your attending physician. This coverage is subject to applicable deductibles, co-payments and co-insurance payments, and to the terms and provisions of the medical plan. Please refer to the applicable Benefit Program summary or contact your health plan for more information.

Newborns' and Mothers' Health Protection Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plans or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Mental Health Parity

To the extent any Benefit Program provides mental health and/or substance abuse disorder benefits, it will comply with the Mental Health Parity Act Mental Health Parity and Addiction and Equality Act which (a) prohibits the Plan from placing annual or lifetime maximums on those benefits which are lower than the annual and lifetime maximum dollar limits for medical/surgical benefits and (b) requires the Plan to ensure that financial requirements (such as co-pays deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Privacy Rights

The Department of Health and Human Services (“HHS”) has issued a series of regulations under HIPAA designed to protect the privacy of health information and to establish standards for its electronic transmission.

The Plan is considered a “hybrid entity” under HIPAA. The following Benefit Programs constitute the covered components of the hybrid entity and are subject to the requirements of the HIPAA privacy rule (“HIPAA Plans”):

- Medical Plan;
- Dental Plan;
- Vision Plan;
- Health Reimbursement Arrangement;
- Health FSA.

The HIPAA regulations govern how the HIPAA Plans and the business associates with whom they contract handle protected health information (“PHI”). PHI includes health information that could identify an individual. It is created or received by a health care provider, health plan, employer, or life insurer, and either relates to the physical or mental health of an individual, the provision of health care to an individual, or the payment for the provision of health care to an individual. PHI can be in an electronic, paper, or oral format.

In order for a number of entities, including a health plan, insurer, or provider (“Covered Entities”), to use an individual’s PHI for purposes other than treatment, payment or health care operations, that Covered Entity must obtain an authorization from the individual. The authorization must specify who will have access to the PHI, when that access expires, and the individual’s right to revoke the authorization.

As a Covered Person in the Plan you are entitled to receive a privacy notice from any HIPAA Plan insurers and from the Plan for self-insured HIPAA Plan benefits. This privacy notice describes your rights under HIPAA, including standards and procedures for the exercise of those rights. A copy of the Notice of Privacy Practices applicable to the Health Reimbursement Arrangement and Health FSA, is available a <http://bycell.mobi/wap/default/item.jsp?entryid=ECMzU3Nw==&itemid=114438>

You may also request the right to inspect or make copies of your PHI. The HIPAA Plan must act on your request to inspect your PHI within thirty (30) days, or sixty (60) days if the PHI is not on-site; however, the HIPAA Plan may receive a thirty (30) day extension as long as it notifies you. The HIPAA Plan may deny access under certain circumstances. You will have the right to request an amendment or correction of your PHI, and you will be able to request that the HIPAA Plan restrict the use and disclosure of your PHI. You will also have the right to request an accounting of the disclosure of your PHI by a Covered Entity to another Covered Entity or business associate for purposes other than treatment, payment or health care operations. Amendments, corrections, and accountings must be acted upon by the Covered Entity within sixty (60) days; however, the Covered Entity may receive a thirty (30) day extension with notice to the individual.

If you have questions regarding your privacy rights you may contact the Plan Administrator.

If you have complaints about the handling of your PHI, you may contact the Company's Privacy Officer or the insurance carrier.

Your Rights Under ERISA

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Covered Persons shall be entitled to:

Receive Information About Your Plan and Benefits

Examine without charge at the Plan Administrator's office and at other specified locations all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request, copies of documents governing operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or your Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this SPD, the Program Materials for Benefit Programs that are group health plans and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate this Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including the Company, your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan benefit is denied or ignored, 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 the 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 Plan documents or the latest annual report 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 Plan Administrator to provide the materials and pay you up to \$110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in 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 your claim is frivolous.

Assistance with Your Questions

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

EXHIBIT A
Benefit Program Information as of January 1, 2025

1. LCS Community Employment LLC Medical Insurance Plan

Fully-Insured By:

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

Kaiser Permanente
1 Kaiser Plaza
Oakland, CA 94612

2. LCS Community Employment LLC Health Reimbursement Arrangement

Self-Funded By:
LCS Community Employment LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309
(515) 875-4500

Administrative Assistance from: as the Claims Administrator	Cigna 900 Cottage Grove Rd Bloomfield, CT 06002
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3. LCS Community Employment LLC Dental Plan

Fully-Insured By:

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

4. LCS Community Employment LLC Vision Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

5. LCS Community Employment LLC Basic Group Term Life Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

6. LCS Community Employment LLC AD&D Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

7. LCS Community Employment LLC Short Term Disability Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

8. LCS Community Employment LLC Long Term Disability Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

9. LCS Community Employment LLC Supplemental Life & Dependent Life Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

10. LCS Community Employment LLC Supplemental AD&D/Dependent AD&D Plan

Fully-Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

11. LCS Community Employment LLC Accident Plan

Fully-Insured By:

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

12. LCS Community Employment LLC Critical Illness Plan

Fully-Insured By:

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

13. LCS Community Employment LLC Hospital Indemnity Plan

Fully-Insured By:

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

14. LCS Community Employment LLC Group Legal Plan

Fully Insured By:

MetLife
200 Park Avenue
New York, NY 10017
(800) 638-5433

15. LCS Community Employment LLC Health Flexible Spending Account Plan

Self-Funded By:

LCS Community Employment LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309
(515) 875-4500

Administrative Assistance from:
as the Claims Administrator

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

16. LCS Community Employment LLC Dependent Care Assistance Plan

Self-Funded By:
LCS Community Employment LLC
400 Locust Street, Suite 820
Des Moines, Iowa 50309
(515) 875-4500

Administrative Assistance from:
as the Claims Administrator

Cigna
900 Cottage Grove Rd
Bloomfield, CT 06002

APPENDICES

PROGRAM MATERIALS

Available Upon Request