AMENDED & RESTATED CAFETERIA PLAN

ARTICLE I. INTRODUCTION

1.1 Establishment of Cafeteria Plan

Life Care Companies LLC ("Employer") hereby adopts this Amended & Restated Cafeteria Plan ("Cafeteria Plan") effective as of January 1, 2022 (the "Effective Date"). Capitalized terms used in this Cafeteria Plan that are not otherwise defined shall have the meanings set forth in Article II.

This Cafeteria Plan is designed to permit an Eligible Employee to elect to pay for his or her share of premiums for Premium Payment Benefits on a pre-tax salary reduction basis (except for coverage of Qualified Domestic Partners) and to contribute on a pre-tax Salary Reduction basis to an account for reimbursement of certain Medical Care Expenses ("Health FSA") and Dependent Care Expenses ("DCAP") and an Employee's Health Savings Account ("HSA").

1.2 Legal Status

This Cafeteria Plan is intended to qualify as a "cafeteria plan" under Code § 125, and regulations issued thereunder and shall be interpreted to accomplish that objective.

The Health FSA is intended to qualify as a "self-insured medical reimbursement plan" under Code § 105, and the Medical Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 105(b). The DCAP is intended to qualify as a "dependent care assistance plan" under Code § 129, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a). The HSA funding feature described in the HSA is not intended to establish an ERISA plan.

The Premium Payment Benefits, Health FSA and DCAP are governed by and part of the Life Care Companies LLC Employee Benefits Plan Document and corresponding summary plan description which provide the specific details on the benefits provided, eligibility, claims and appeals procedures. The purpose of this Plan is to govern the pre-tax elections to pay for such Benefits.

ARTICLE II. DEFINITIONS

"Account(s)" means the Health FSA Accounts and DCAP Accounts described in Section 7.5 and 8.5 respectively. In some contexts the term "Account(s)" may also include the record of HSA Contributions described in Section 9.4

"Administrator" means the Employer.

"Annual Enrollment Period" with respect to a Plan Year means the month of November in the year preceding the Plan Year or such other period as may be prescribed by the Administrator.

"Benefits" means the Premium Payment Benefits selected by the Employer to be offered for the Plan Year as outlined on Exhibit A, attached hereto, the Health FSA and DCAP Benefits, and the HSA Benefits.

"Benefit Package Option" means a qualified benefit under Code § 125(f) that is offered under a cafeteria plan, or an option for coverage under an underlying accident or health plan (such as an indemnity option, an HMO option or a PPO option under an accident or health plan).

"**Cafeteria Plan**" has the meaning described in Section 1.1

"Change in Status" has the meaning described in Section 12.3.

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

"Code" means the Internal Revenue Code of 1986.

"Compensation" means the wages or salary paid to an Employee by the Employer determined prior to (a) any Salary Reduction election under this Plan, (b) any Salary Reduction election under any other cafeteria plan, and (c) any Compensation reduction under any Code § 132(f)(4) plan; but determined after (d) any salary deferral elections under any Code § 401(k), 403(b), 408(k), or 457(b) plan or arrangement. Thus, "Compensation" generally means wages or salary paid to an Employee by the Employer as reported in Box 1 of Form W-2 but adding back any wages or salary forgone by virtue of any election described in (a), (b), or (c) of the prior sentence.

"Contributions" means the amount contributed to pay for the cost of Benefits as calculated under Section 6.2 for Premium Payment Benefits, Section 7.2 for Health FSA Benefits, Section 8.2 for DCAP Benefits, and Section 9.2 for HSA Benefits.

"DCAP" means the dependent care assistance program sponsored by the Employer.

"DCAP Account" means the account described in Section 8.5.

"DCAP Benefits" has the meaning described in Section 8.1.

"Dependent" means any individual who qualifies as a dependent under a Benefit Program for purposes of coverage under that Benefit Program only or under Code Section 152 (as modified by Code Section 105(b)). Any child of a Participant who is determined to be an alternate recipient under a qualified medical child support order under ERISA § 609 shall be considered a Dependent.

"Dependent Care Expenses" has the meaning described in Section 8.3.

"Earned Income" means all income derived from wages, salaries, tips, self-employment, and other Compensation (such as disability or wage continuation benefits), but only if such amounts are includible in gross income for the taxable year. Earned income does not include (a) any amounts received pursuant to any DCAP established under Code § 129; or (b) any other amounts excluded from earned income other Code § 32(c)(2), such as amounts received under a pension or annuity or pursuant to workers' Compensation.

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

"Election Form/Salary Reduction Agreement" means the form (whether in paper or electronic utilizing an online enrollment system) provided by the Administrator for purposes of allowing an Eligible Employee to participate in this Plan by electing Salary Reductions to pay for any of Benefits. It includes an agreement pursuant to which an Eligible Employee or Participant authorizes the Employer to make Salary Reductions.

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

"Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for certain benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer.

"Employer" has the meaning in Section 1.1 and also includes any Related Employer that adopts this Plan. Related Employers that have adopted this Plan, if any are listed in Appendix A to this Plan. However, for purposes of Article XIV and Section 15.2, "Employer" does not include any Related Employers.

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

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

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

"Health FSA" means health flexible spending arrangement sponsored by the Employer.

"Health FSA Account" means the account described in Section 7.5.

"Health FSA Benefit" has the meaning described in Section 7.1.

"Health Savings Account" or **"HSA"** means a health savings account established under Code § 223. Such arrangements are individual trusts or custodial accounts, each separately established and maintained by an Employee with a qualified trustee/custodian.

"High Deductible Health Plan" means the high deductible health plan offered by the Employer that is intended to qualify as a high deductible health plan under Code § 223(c)(2), as described in materials provided separately by the Employer. The High Deductible Health Plan may or may not be the sole Medical Insurance Plan eligible for pre-tax Salary Reduction funding hereunder.

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

"HSA Benefits" has the meaning described in Section 9.1

"HSA Eligible Individual" means an individual who is eligible to contribute to an HSA under Code § 223 and who has elected qualifying High Deductible Health Plan coverage offered by the Employer and who has not elected any disqualifying non-High Deductible Health Plan coverage offered by the Employer.

"Limited (Vision/Dental/Preventative Care) Health FSA Option" has the meaning described in Section 7.3(b).

"Medical Care Expenses" has the meaning defined in Section 7.3.

"Participant" means a person who is an Eligible Employee and who is participating in this Plan in accordance with the provisions of Article III. Participants include those who elect one or more of the Premium Payment Benefits, Health FSA Benefits, HSA Benefits, or DCAP Benefits, and Salary Reductions to pay for such Benefits.

"Period of Coverage" means the Plan Year, with the following exceptions: (a) for Employees who first become eligible to participate, it shall mean the portion of the Plan Year following the date participation commences, as described in Section 3.1; and (b) for Employees who terminate participation, it shall mean the portion of the Plan Year prior to the date participation terminates, as described in Section 3.2.

"Plan Year" means the twelve month period described in the Election Form/Salary Reduction Agreement except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.

"Premium Payment Benefits" means the Premium Payment Benefits as described in Section 6.1.

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

"Qualifying Dependent Care Services" has the meaning described in Section 8.3.

"Qualified Benefit" means any benefit excluded from the Employee's taxable income under Chapter 1 of the Code (other than benefits excluded under Code § § 106(b), 117, 127 or 132) and any other benefit permitted by regulations under the Code (i.e., any group-term life insurance coverage that is includible in gross income by reason of exceeding the dollar limitation on non-taxable coverage under Code § 79). Long-term care insurance shall not be a Qualified Benefit.

"Qualifying Individual" has the meaning described in Section 8.3.

"**Qualified Domestic Partner**" means an unmarried person of the same or opposite sex with whom the Employee shares a committed relationship and who meets the requirements adopted by the applicable State and the 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" means any employer affiliated with the Employer that, under Code § 414(b), (c), or (m) is treated as a single employer with Employer for purposes of Code § 125(g)(4) and who has adopted this Cafeteria Plan for its employees.

"Salary Reduction" means the amount by which the Participant's Compensation is reduced and applied by the Employer under this Plan to pay for one or more of the Benefits, as permitted for the applicable Benefit, before any applicable state and/or federal taxes have been deducted from the Participant's Compensation (i.e., on a pre-tax basis); provided, however, amounts paid for coverage of a Qualified Domestic Partner is deducted on an after-tax basis to the extent required by applicable tax laws.

"Spouse" means an individual who is legally married to a Participant as determined under applicable state law (and who is treated as a spouse under the Code). Notwithstanding the above, for purposes of the DCAP, the term "Spouse" shall not include (a) an individual legally separated from the Participant under divorce or a separate maintenance decree; or (b) an individual who, although married to the Participant, files a separate federal income tax return, maintains a principal residence, separate from the Participant during the last six months of the

taxable year, and does not furnish more than half of the cost of maintaining the principal place of abode of the Participant.

"Student" means the individual, who, during each of five or more calendar months during the Plan Year, is a full-time student at any educational organization that normally maintains a regular faculty and curriculum and normally has an enrolled student body in attendance at the location where its education activities are regularly carried on.

ARTICLE III. ELIGIBILITY AND PARTICIPATION

3.1 Eligibility to Participate

An individual is eligible to participate in this Plan if the individual is an Employee and meets the Employer's eligibility requirements for one or more of the Benefits offered on a pre-tax basis pursuant to this Plan. A former Employee may continue eligibility for certain benefits for the remainder of the Plan Year in which the Employee ceased to be employed by the Employer. To participate in the HSA the individual must be an HSA Eligible Individual and shall also be subject to the additional requirements, if any, specified in the High Deductible Health Plan.

3.2 Termination of Participation

A Participant will cease to be a Participant in this Plan upon the earlier of:

- The expiration of the Period of Coverage for which the Employee has elected to participate (unless during the Annual Enrollment Period for the next Plan Year the Employee elects to continue participating);
- The termination of this Plan;
- The date on which the Employee ceases (because of retirement, termination of employment, layoff reduction in hours, or any other reason) to be an Eligible Employee, provided that eligibility may continue beyond such date for purposes of pre-taxing COBRA coverage, as may be permitted by the Administrator on a uniform and consistent basis (but not beyond the end of the current Plan Year);
- The date the Participant revokes his or her election to participate under a circumstance when such change is permitted under the terms of this Plan.

Termination of participation in this Plan will automatically revoke the Participant's elections and terminate Benefits as of the date specified in the applicable insurance policy or benefit plan. Reimbursements from the Health FSA and DCAP accounts after termination of participation will be made in accordance with the Employer's plan document for the Health FSA and DCAP. Distributions from a Participant's HSA (whether before or after termination of employment) and all other matters relating to a Participant's HSA are outside of this Plan and are

to be handled by the Participant and his or her trustee/custodian in accordance with the agreement between them (See Article IX).

3.3 Participation Following Termination of Employment or Loss of Eligibility

If a Participant terminates his or her employment for any reason, including (but not limited to) disability, retirement, layoff, or voluntary resignation, and then is rehired within 30 days or less of the date of a termination of employment, the Employee will be reinstated with the same elections that such individual had before termination. If a former Participant is rehired more than 30 days following termination of employment and is otherwise eligible to participate in the Plan, then the individual may make new elections as a new hire as described in Section 3.1. Notwithstanding the above, an election to participate in the Premium Payment Benefits will be reinstated only to the extent that coverage under the applicable insurance policy or benefit plan is reinstated. Likewise an HSA Benefit election will only be reinstated if an individual is an HSA- Eligible Individual. If an Employee (whether or not a Participant) ceases to be an Eligible Employee for any reason (other than for termination of employment), including (but not limited to) a reduction in hours, and then becomes an Eligible Employee again, the Employee must complete the waiting period described in Section 3.1, if any, before again becoming eligible to participate in the Plan.

3.4 FMLA Leaves of Absence

(a) Health and Dental Benefits. Notwithstanding any provision to the contrary in this Plan, if a Participant goes on a qualifying leave under FMLA, then to the extent required by FMLA, the Employer will continue to maintain the Participant's health and dental insurance benefits, HSA Benefits, and Health FSA Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium.

A Participant may elect to continue his or her coverage under his or her health and dental insurance benefits, HSA Benefits, and Health FSA Benefits during the FMLA leave. If the Participant elects to continue coverage while on leave, then the Participant may pay his or her share of the premium in one of the following ways:

- With after-tax dollars, by sending monthly premium payments to the Employer by the due date established by the Employer;

- With pre-tax dollars, by pre-paying all or a portion of the premium for the expected duration of the leave on a pre-tax Salary Reduction basis out of pre-leave Compensation. To pre-pay the premium, the Participant must make a special election to that effect prior to the date that such Compensation would normally be made available (pre-tax dollars may not be used to fund coverage during the next Plan Year); or

- Under another arrangement agreed upon between the Participant and the Administrator (e.g., the Administrator may fund coverage during the leave and withhold catch-up amounts upon the Participant's return).

If a Participant's coverage cease while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis as the Participant was participating in the Plan prior to the leave, or as otherwise required by FMLA.

(b) Non-Health Benefits. If a Participant goes on a qualifying leave under the FMLA, entitlement to non-health benefits is to be determined by the Employer's policy for providing such Benefits when the Participant is on non-FMLA leave, as described in Section 3.5.

3.5 Non-FMLA Leaves of Absence

If a Participant goes on an unpaid leave of absence that does not affect eligibility, then the Participant will continue to participate and the premium due for the Participant will be paid by pre-payment before going on leave, by after-tax contributions while on leave, or with catch-up contribution after the leave ends, as may be determined by the Administrator.

If a Participant goes on an unpaid leave that affects eligibility, the election change rules in Section 12.4 will apply.

ARTICLE IV. METHOD AND TIMING OF ELECTIONS

4.1 Elections When First Eligible

An Employee who first becomes eligible to participate in the Plan mid-year may commence participation on the date the eligibility requirements have been satisfied, provided that an Election Form/Salary Reduction Agreement is submitted to the Administrator within 30 days of the date the Employee first becomes eligible. An Employee who does not elect to participate when first eligible may not enroll until the next Annual Enrollment Period, unless an event occurs that would justify a mid-year election change, as described under Section 12.4. Eligibility for Premium Payment Benefits shall be subject to the additional requirements, if any, specified in the applicable insurance policy or benefit plan. The provisions of this Plan are not intended to override any exclusions, eligibility requirements or waiting periods specified in the applicable insurance policy or benefit plan.

4.2 Elections During Annual Enrollment Period

During each Annual Enrollment Period with respect to a Plan Year, the Administrator shall provide an Election Form/Salary Reduction Agreement to each Employee who is eligible to participate in this Plan. The Election Form/Salary Reduction Agreement shall enable the Employee to elect to participate in the various Benefits of this Plan for the next Plan Year, and to authorize the necessary Salary Reductions to pay for the benefits elected. The Election

Form/Salary Reduction Agreement must be returned to the Administrator on or before the last day of the Annual Enrollment Period. If an Eligible Employee makes an election to participate during an Annual Enrollment Period, then the Employee will become a Participant on the first day of the next Plan Year. If an Eligible Employee fails to return the Election Form/Salary Reduction Agreement during the Annual Enrollment Period, then the Employee's then current elections for Premium Payment Benefits will carried over to the subsequent Plan Year and Employee may not change these elections or elect to participate in the Health FSA or DCAP until the next Annual Enrollment Period, unless an event occurs that would justify a mid- year election change, as described under Section 12.4.

4.3 Failure of Eligible Employee to File an Election Form/Salary Reduction Agreement

If an Eligible Employee fails to file an Election Form/Salary Reduction Agreement within the time period described in Sections 4.1 and 4.2, then the Employee may not elect to participate in the Plan: (a) until the next Annual Enrollment Period; or (b) until an event occurs that would justify a mid-year election change, as described under Section 12.4.

4.4 Irrevocability of Elections

Unless an exception applies (as described in Article XII), a Participant's election under the Plan is irrevocable for the duration of the Period of Coverage to which it relates.

4.5 Administrator Imposed Election Changes for Highly Compensated and Key Employees

It is the intent of the Administrator that this Cafeteria Plan at all times comply with applicable non-discrimination requirements under the Code, including those applicable to cafeteria plans, health flexible spending accounts, self-funded health plans, and dependent care assistance programs. These requirements generally prohibit these plans from discriminating in favor of highly compensated individuals and/or key employees in the receipt of, or eligibility for, tax free benefits. To ensure compliance with the Code and the non-discrimination rules applicable to the Cafeteria Plan and the Benefits, the Administrator may modify a Participant's election(s) downward during the Plan Year if (a) the Participant is a key employee or highly compensated individual as defined by the relevant Code provision or implementing regulation; and (b) such adjust is necessary to prevent the Cafeteria Plan or applicable benefit plan from becoming discriminatory within the meaning of the Code.

ARTICLE V. BENEFITS OFFERED AND METHOD OF FUNDING

5.1 Benefits Offered

When first eligible or during the Annual Enrollment Period as described under Article IV, Participants will be given the opportunity to elect those benefits selected by the Employer to be

offered for the Plan Year as outlined on Exhibit A, attached hereto. In no event shall Benefits under the Cafeteria Plan be provided in the form of deferred Compensation.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventative Care) Health FSA Option is selected. In addition, a Participant who has an election for the Health FSA Benefits (other than the Limited (Vision/Dental/Preventative Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits, unless the balance in the Participants Health FSA Account is $0 as of the last day of that Plan Year or the Participant elects to carry over any amounts remaining after the run out period and subject to a maximum of the maximum amount allowed by the IRS to a Limited (Vision/Dental/Preventative Care) Health FSA Option with any amounts above the maximum amount allowed by the IRS being forfeited.

5.2 Employer and Participant Contributions.

(a) Employer Contributions. The Employer may, but is not required to, contribute towards the cost of any Premium Payment Benefit or HSA Benefit. For any applicable Plan Year the Employer will make the premium and HSA Benefit contributions, if any, outlined on the Election Form/Salary Reduction Agreement.

(b) Participant Contributions. Participants who elect Benefits under this Cafeteria Plan may pay for the cost of that coverage on a pre-tax Salary Reduction basis except for coverage for Qualified Domestic Partners, the cost of which may be deducted on an after-tax basis in accordance with applicable tax laws.

5.3 Using Salary Reductions to Make Contributions

(a) Salary Reductions per Pay Period. The Salary Reduction for a pay period of a Participant is, for the Benefits elected, an amount equal to the annual premium for such Benefits divided by the number of pay periods in the Period of Coverage, or an amount otherwise agreed upon between the Employer and the Participant.

(b) Considered Employer Contributions for Certain Purposes. Salary Reductions are applied by the Employer to pay for the Participant's share of the premiums for the Benefits elected and for purposes of this Cafeteria Plan and the Code are considered to be Employer contributions.

(c) Salary Reduction Balance Upon Termination of Coverage. If, as of the date that any elected coverage under this Cafeteria Plan terminates, a Participant's year-to-date Salary Reductions for Premium Payment Benefits exceed or are less than the Participant's required contributions for the coverage, then the Employer will, as applicable, either return the excess to the Participant's additional taxable wages or recoup the due Salary Reduction amounts from any remaining Compensation.

5.4 Funding This Cafeteria Plan

All of the amounts payable under this Cafeteria Plan shall be paid from the general assets of the Employer, but Premium Payment Benefits are paid as provided in the applicable insurance policy or applicable benefit plan. Nothing herein will be construed to require the Employer or the Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account or asset of the Employer from which any payment under this Cafeteria Plan may be made. There is no trust or other fund from which Benefits are paid. While the Employer has complete responsibility for the payment of Benefits out of its general assets (except for Premium Payment Benefits paid as provided in the applicable insurance policy), it may hire an unrelated third party paying agent to make Benefit payments on its behalf. The maximum contributions that may be made under this Cafeteria Plan for a Participant is a total of the maximums that may be elected as Employer and Participant Contributions as described in the specific plan document and SPD for the Benefits.

ARTICLE VI. PREMIUM PAYMENT BENEFITS

6.1 Benefits

The benefits that can be elected under the Premium Payment Benefits are those described in Exhibit A. Benefits elected will be funded by Employer and Participant contributions as provided in Section 5.2. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

6.2 Benefit Premiums (aka Cost of Coverage)

The annual premium for a Participant's Premium Payment Benefits is equal to the amount as set by the Employer, which may or may not be the same amount charged by the insurance carrier, if any, and outlined in the Election Form/Salary Reduction Agreement.

6.3 Premium Payment Benefits Provided Under the Applicable Insurance Policy/Benefit Plan

All Premium Payment Benefits will be provided by the applicable insurance policy or benefit plan not this Cafeteria Plan. The types and amounts of such Premium Payment Benefits, the requirements for participating in the applicable Premium Payment Benefits, and the other terms and conditions of coverage are set forth in the applicable insurance policy or benefit plan. All claims to receive benefits shall be subject to and governed by the terms and conditions of the applicable insurance policy or benefit plan and the rules, regulations, policies and procedures from time to time adopted in accordance therewith, as may be amended from time to time.

ARTICLE VII. HEALTH FSA

7.1 Benefits

An Eligible Employee can elect to participate in the Health FSA by electing (a) to receive benefits in the form of reimbursements for Medical Care Expenses (Health FSA Benefits); and (b) to pay the premium for such Health FSA Benefits on a pre-tax Salary Reduction basis. Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

HSA Benefits cannot be elected with Health FSA Benefits unless the Limited (Vision/Dental/Preventative Care) Health FSA Option is selected.

When enrolling in the Health FSA, Participants will designate the dollar amount of Health FSA Benefits they are electing for the Plan Year which cannot exceed the lesser of (a) the maximum allowed by the Code; or (b) the maximum amount stated in the Election Form/Salary Reduction Agreement.

7.2 Benefit Premiums (aka Cost of Coverage)

The annual premium for a Participant's Health FSA Benefits is equal to the annual benefit amount elected by the Participant for the Plan Year (for example, if the annual benefit amount elected is $2,400 then the annual premium amount is also $2,400).

ARTICLE VIII DCAP

8.1 Benefits

An Eligible Employee can elect to participate in the DCAP by electing to receive benefits in the form of reimbursements for Dependent Care Expenses, and to pay the premium for such benefits on a pre-tax Salary Reduction basis (DCAP Benefits). Unless an exception applies (as described in Article XII), such election is irrevocable for the duration of the Period of Coverage to which it relates.

When enrolling in the DCAP, Participants will designate the dollar amount of DCAP Benefits they elect for the Plan Year which cannot exceed the lesser of (a) the maximum allowed by the Code; or (b) the maximum amount stated in the Election Form/Salary Reduction Agreement.

8.2 Benefit Premiums (aka Cost of Coverage)

The annual premium for a Participant's DCAP Benefits is equal to the annual benefit amount elected by the Participant (for example, if the annual benefit amount elected is $3,000, the annual premium amount is also $3,000).

ARTICLE IX HSA

9.1 HSA Benefits

An Eligible Employee can elect to participate in the HSA by electing to pay the Contributions on a pre-tax Salary Reduction basis to the Employee's HSA established and maintained outside the Cafeteria Plan by a trustee/custodian to which the Employer can forward contributions to be deposited (this funding feature constitutes the HSA Benefits offered under this Cafeteria Plan). As described in Article XII, such election can be increased, decreased or revoked prospectively at any time during the Plan Year, effective no later than the first day of the next calendar month following the date that the election change was filed.

HSA Benefits cannot be elected with the Health FSA Benefits unless the Limited (Vision/Dental/Preventative Care) Health FSA Option is selected. In addition, a Participant who has an election for Health FSA Benefits (other than the Limited (Vision/Dental/Preventative Care) Health FSA Option) that is in effect on the last day of a Plan Year cannot elect HSA Benefits unless the balance in the Participant's Health FSA Account is $0 or the Participant elects to carry over any amounts remaining after the run out period and subject to a maximum of the maximum amount allowed by the IRS to a Limited (Vision/Dental/Preventative Care) Health FSA Option with any amounts above the maximum amount allowed by the IRS being forfeited.

9.2 Contributions for Cost of Coverage for HSA; Maximum Limits

The annual Contribution for a Participant's HSA Benefits is equal to the annual benefit amount elected by the Participant. In no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Participant's High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the Contribution is made.

An additional catch-up Contribution may be made for Participants who are age 55 or older which is limited to the maximum catch-up contribution allowed for the calendar year by the Code. In addition, the maximum annual Contribution shall be:

(a) reduced by any matching (or other) Employer Contribution made on the Participant's behalf; and

(b) prorated for the number of months in which the Participant is an HSA Eligible Individual.

9.3 [Reserved]

9.4 Recording Contributions for HSA

The HSA is not an employer-sponsored employee benefit plan- it is an individual trust or custodial account, separately established and maintained by a trustee/custodian outside the Cafeteria Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant not the Employer. The Employer may, however, limit the number of HSA providers to whom it will forward contributions that the Employee makes via pre-tax Salary Reductions or Employer contributions, if any, such a list is not an endorsement of any particular HSA provider. The Administrator will maintain records to keep track of HSA Contributions an Employee makes via pre-tax Salary Reductions, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

9.5 Tax Treatment of HSA Contributions and Distributions

The tax treatment of the HSA (including contributions and distributions) is governed by Code § 223.

9.6 Trust/Custodial Agreement; HSA Not Intended to Be an ERISA Plan

HSA Benefits under this Cafeteria Plan consist solely of the ability to make Contributions to the HSA on a pre-tax Salary Reduction basis. Terms and conditions of the coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by and are set forth in the HSA, not this Cafeteria Plan. The terms and conditions of each Participant's HSA trust or custodial account are described in the HSA trust or custodial agreement provided by the applicable trustee/custodian to each electing Participant and are not a part of this Cafeteria Plan.

The HSA is not an employer-sponsored employee benefit plan. It is a savings account that is established and maintained by an HSA trustee/custodian outside this Cafeteria Plan to be used primarily for reimbursement of "qualified eligible medical expenses" as set forth in Code § 223(d)(2). The Employer has no authority or control over the funds, deposited in a HSA. Even though this Cafeteria Plan may allow pre-tax Salary Reduction contributions to an HSA, the HSA is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

ARTICLE X-XI. RESERVED

ARTICLE XII. IRREVOCABILITY OF ELECTIONS, EXCEPTIONS

12.1 Irrevocability of Elections

Except as described in this Article XII, a Participant's election under the Cafeteria Plan is irrevocable for the duration of the Period of Coverage to which it relates. In other words, unless an exception applies, the Participant may not change any elections for the duration of the Period of Coverage regarding:

- Participation in this Cafeteria Plan;
- Salary Reduction amounts;
- Election of particular Benefit Package Options; or
- Election of Cash-Out Amounts, if applicable.

However, as described in Section 12.5, an election to make a Contribution to an HSA can be changed at any time on a prospective basis.

It is the intent of the Employer and Administrator to treat Qualified Domestic Partners in the same manner as Spouses for purposes of the election change outlined herein for Premium Payment Benefits to the extent the Qualified Domestic Partner is covered or eligible to be covered by the applicable Premium Payment Benefit and subject to any requirements or limitations of the underlying benefit plan.

12.2 Procedure for Making New Election If Exception to Irrevocability Applies

(a) Timing for When New Election Must Be Made. A Participant (or an Eligible Employee who, when first eligible under Section 3.1 or during the Annual Enrollment Period under Section 3.2, declined to be a Participant) may make a new election within 30 days of the occurrence of an event described in Section 12.4, as applicable, but only if the election under the new Election Form/Salary Reduction Agreement is made on account of and is consistent with the event, and the election is made within any specified time period (e.g., for subsections 12.4(d) through (i) within 30 days of the events described in such subsections).

(b) Effective Date of New Election. Elections made pursuant to this Section 12.2 shall be effective for the balance of the Period of Coverage following the change of election unless a subsequent event allows for a further election change. Except as provided in Section 12.4(e) for HIPAA special enrollment rights in the event of birth, adoption, or placement for adoption, all election changes shall be effective on a prospective basis only (i.e., election changes will become effective on the first pay period following the date that the election change was filed utilizing the online enrollment system, but, as determined by the Administrator, election changes may become effective later to the extent the coverage in the applicable Benefit Package Option commences later).

(c) Effect of New Election Upon Amount of Benefits. For the effect of a changed election upon the maximum and minimum benefits under the Health FSA and DCAP, see the plan document and SPD for the Health FSA and DCAP.

12.3 Change in Status Defined

A Participant may make a new election upon the occurrence of certain events as described in Section 12.4, including a Change in Status, for the applicable Benefit. "Change in Status" means any of the events described below, as well as any other events included under subsequent changes to Code § 125 or regulations issued thereunder, which the Administrator, in its sole discretion and on a uniform and consistent basis, determines are permitted under IRS regulations and under this Cafeteria Plan:

(a) Marital Status. A change in a Participant's legal marital status, including marriage, death of a Spouse, divorce, legal separation or annulment;

(b) Number of Dependents. Events that change a Participant's number of Dependents, including birth, death, adopting and placement for adoption;

(c) Employment Status. Any of the following events that change the employment status of the Participant or his or her Spouse or Dependents: (1) a termination or commencement of employment; (2) a strike or lockout; (3) commencement of or return from an unpaid leave of absence; (4) a change in worksite; and (5) if the eligibility conditions of this Cafeteria Plan or other employee benefit plan of the Participant or his or her Spouse or Dependents depend on the employment status of that individual and there is a change in that individual's status with the consequence that the individual becomes (or ceases to be) eligible under this Cafeteria Plan or other employee benefit plan, such as if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid, union to non-union, or full-time to part-time (or vice versa) with the consequence that the employee cease to be eligible;

(d) Dependent Eligibility Requirements. An event that causes a Dependent to satisfy or cease to satisfy the Dependent eligibility requirements for a particular benefit, such as attaining a specified age, Student status, or any similar circumstance; and

(e) Change in Residence. A change in the place or residence of the Participant or his or her Spouse or Dependents.

12.4 Events Permitting Exception to Irrevocability Rule

A Participant may change an election as described below upon the occurrence of the state events for the applicable Benefit of this Cafeteria Plan:

(a) Annual Enrollment Period (Applies to Premium Payment, Health FSA, and DCAP Benefits). A Participant may change an election during the Annual Enrollment Period in accordance with Section 3.2.

(b) Termination of Employment (Applies to Premium Payment, Health FSA, and DCAP Benefits). A Participant's election will terminate under the Cafeteria Plan upon termination of employment in accordance with Sections 3.3 and 3.4, as applicable.

(c) FMLA (Applies to Premium Payment, Health FSA, and DCAP Benefits). A Participant may change an election under the Cafeteria Plan upon FMLA leave in accordance with Section 3.4.

(d) Change in Status (Applies to Premium Payment Benefits, Health FSA Benefits, and DCAP Benefits as Limited Below). A Participant may change his or her actual or deemed election under the Cafeteria Plan upon the occurrence of a Change in Status (as defined in Section 12.3), but only if such election change is made on account of and corresponds with a Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer (referred to as the general consistency requirement). A Change in Status that affects eligibility for coverage under a plan of the Employer or a plan of the Spouse's or Dependent's employer includes a Change in Status that results in an increase or decrease in the number of an Employee's family members (i.e., a Spouse and/or Dependents) who may benefit from the coverage.

Election changes may be made to reduce or increase Health FSA coverage during a Period of Coverage. The amounts available to the Participant for eligible Medical Care Expenses prior to the effective date of the election change will be what the Participant previously elected. On and after the effective date of the mid-year election change, the maximum amount available to the Participant will be determined as set forth in the plan document/SPD for the Health FSA. The Administrator, in its sole discretion and on a uniform and consistent basis, shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming that the general consistency requirement is satisfied a requested election change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on the specified Change in Status:

(1) Loss of Spouse or Dependent Eligibility; Special COBRA Rules. For a Change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for (a) the Spouse involved in the divorce, annulment or legal separation; (b) the deceased Spouse or Dependent; or (c) the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other

individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant or his or her Spouse or Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's plan (and the Participant remains a Participant under this Cafeteria Plan in accordance with Section 3.2), the participant may increase his or her election to pay for such coverage (this rule does not apply to a Participant's Spouse who becomes eligible for COBRA or similar coverage as a result of divorce, annulment or legal separation).

(2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant or his or her Spouse or Dependent gains eligibility for coverage under a cafeteria plan or qualified benefit plan of the employer of the Participant's Spouse or Dependent as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the Spouse's or Dependent's employer's plan. The Administrator may rely on a Participant's certification that the Participant has obtained or will obtain coverage under the Spouse's or Dependent's employer's plan, unless the Administrator has reason to believe that the Participant's certification is incorrect.

(3) Special Consistency Rule for DCAP Benefits. With respect to the DCAP Benefits, a Participant may change or terminate his or her election upon a Change in Status if (a) such change or termination is made on account of and corresponds with a Change in Status that affects eligibility for coverage under an employer's plan; or (b) the election change is on account of and corresponds with a Change in Status that affects eligibility of Dependent Care Expenses for the tax exclusion under Code § 129.

(e) HIPAA Special Enrollment Rights (Applies to Premium Payment Benefits, Health FSA but not DCAP Benefits). If a Participant or his or her Spouse or Dependent is entitled to special enrollment rights under a group health plan, as required by HIPAA under Code § 9801(f), then a Participant may revoke a prior election for group health plan coverage or Health FSA coverage and make a new election, provided that the election change corresponds with such HIPAA special enrollment right. As required by HIPAA, a special enrollment right will arise if:

(1) A Participant or his or her Spouse or Dependent declined to enroll in group health plan coverage because he or she had other coverage, and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or the other coverage was non-COBRA coverage and employer contributions for such coverage were terminated; or

(2) A new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption. An election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right. An election change on account of a HIPAA special enrollment attributable to birth, adoption or placement for adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively (up to 30 days)(note, the change to the Health FSA will not be retroactive).

(3) A Participant or his/her Dependent loses coverage under Medicaid or the Children's Health Insurance Program ("CHIP") as a result of loss of eligibility and the Participant notifies the Plan Sponsor of the loss of eligibility within 60 days; or the Participant or his/her Dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the Participant notifies the Plan Sponsor within 60 days of becoming eligible for the premium assistance subsidy.

(f) Certain Judgments, Decrees and Orders (Applies to Premium Payment and Health FSA Benefits, but Not to DCAP Benefits). If a judgment, decree or order (an "Order") resulting from a divorce, legal separation, annulment or change in legal custody (including a QMCSO) requires accident or health coverage (including an election for Health FSA Benefits) for a Participant's Dependent Child (including a foster child who is a Dependent of the Participant), a Participant may (1) change his or her election to provide coverage for the Dependent child (provided that the order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan and such coverage is actually provided.

(g) Medicare and Medicaid (Applies to Premium Payment Benefits, to Health FSA Benefits; but Not to DCAP Benefits). If a Participant or his or her Spouse or Dependent who is enrolled in a health or accident plan under this Cafeteria Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person becoming entitled to Medicare or Medicaid and/or the Participant's Health FSA coverage may be canceled or reduced. Further, if a Participant or his or her Spouse or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may prospectively elect to commence or increase the accident or health coverage of the individual who loses Medicare or Medicaid eligibility and/or the Participant's Health FSA coverage may commence or increase.

(h) Change in Cost (Applies to Premium Payment Benefits, to DCAP Benefits as Limited Below, but Not to Health FSA Benefits). For purposes of this Section 12.4(h), "similar coverage" means coverage for the same category of benefits for the same individuals (e.g. family to family or single to single). For example, two plans that provide major medical coverage are considered to be similar coverage. For purposes of this definition, (1) a health FSA is not similar coverage with respect to an accident or health plan that is not a health FSA, (2) the HMO and PPO are considered to be similar coverage, and (3) coverage by another employer, such as a Spouse's or Dependent's employer, is treated as similar coverage.

(1) Increase or Decrease for Insignificant Cost Changes. Participants are required to increase their elective contributions (by increasing Salary Reductions) to reflect insignificant increases in their required contribution for their Benefit Package Option(s), and to decrease their elective contributions to reflect insignificant decreases in their required contribution. The Administrator, in its sole discretion and on a uniform and consistent basis, will determine whether an increase or decrease is insignificant based upon all the surrounding facts and circumstances, including, but not limited to, the dollar amount or percentage of the cost change. The Administrator, on a reasonable and consistent basis, will automatically effectuate this increase or decrease in affected employees elective contributions on a prospective basis.

(2) Significant Cost Increases. If the Administrator determines that the cost charged to an Employee of a Participant's Benefit Package Option(s) (such as the PPO) significantly increases during a Period of Coverage, the Participant may (a) make a corresponding prospective increase in his or her elective contributions (by increasing Salary Reductions); (b) revoke his or her election for that coverage, and in lieu thereof, receive on a prospective basis coverage under another Benefit Package Option offered by the Employer that provides similar coverage (such as the HMO, but not the Health FSA); or (c) drop coverage prospectively if there is no other Benefit Package Option available that provides similar coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost increase is significant in accordance with prevailing IRS guidance.

(3) Significant Cost Decreases. If the Administrator determines that the cost of any Benefit Package Option significantly decreases during a Period of Coverage, the Administrator may permit the following election changes: (a) Participants who are enrolled in a Benefit Package Option (but not the Health FSA) other than the Benefit Package Option that has decreased in cost may change their election on a prospective basis to elect the Benefit Package Option that has decreased in cost; and (b) Employees who are otherwise eligible under Section 3.1 may elect the Benefit Package Option that has decreased in cost (such as the PPO) on a prospective basis, subject

to the terms and limitations of the Benefit Package Option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a cost decrease is significant in accordance with prevailing IRS guidance.

(4) Limitation on Change in Cost Provisions for DCAP Benefits. The above "Change in Cost" provisions (Sections 12.4(h)(1)-(3)) apply to DCAP Benefits only if the cost change is imposed by a dependent care provider who is not a "relative" of the Employee. For this purpose, a relative is an individual who is related as described in Code §§ 152(a)(1) through (8), incorporating the rules of Code §§ 152(b)(1) and (2).

(i) Change in Coverage (Applies to Premium Payment and DCAP Benefits but Not to Health FSA Benefits). The definition of "similar coverage" under Section 1 2.4(h) applies also to this Section 12.4(i).

(1) Significant Curtailment. If coverage is "significantly curtailed" (as defined in subsection (i) below), Participants may elect coverage under another Benefit Package Option that provides similar coverage. In addition, as set forth in subsection (ii) below, if the coverage curtailment results in a "Loss of Coverage" (as defined in subsection (iii) below), Participants may drop coverage if no similar coverage is offered by the Employer. The Administrator in its sole discretion, on a uniform and consistent basis, will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant," and whether a Loss of Coverage has occurred.

(i) Significant Curtailment Without Loss of Coverage. If the Administrator determines that a Participant's coverage under a Benefit Package Option under this Cafeteria Plan (or the Participant's Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed without a Loss of Coverage (for example, when there is a significant increase in the deductible, the co-pay, or the out-of-pocket cost-sharing limit under an accident or health plan, such as the PPO) during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and in lieu thereof, prospectively elect coverage under another Benefit Package Option that provides similar coverage (but not the Health FSA). Coverage under a plan is deemed to be "significantly curtailed" only if there is an overall reduction in coverage provided under the plan so as to constitute reduced coverage generally.

(ii) Significant Curtailment With a Loss of Coverage. If the Administrator determines that a Participants Benefit Package Option coverage under this Cafeteria Plan (or the Participant's

Spouse's or Dependent's coverage under his or her employer's plan) is significantly curtailed, and such curtailment results in a Loss of Coverage during a Period of Coverage, the Participant may revoke his or her election for the affected coverage, and may either prospectively elect coverage under another Benefit Package Option that provides similar coverage (but not the Health FSA), or drop coverage if no other Benefit Package Option providing similar coverage is offered by the Employer.

(iii) Definition of Loss of Coverage. For purposes of this Section 12.4(i)(1), a "Loss of Coverage" means a complete loss of coverage (including the elimination of a Benefit Package Option, the HMO ceasing to be available where the Participant or his or her Spouse or Dependent resides, or a Participant or his or her Spouse or Dependent losing all coverage under the Benefit Package Option by reason of an overall lifetime or annual limitation). In addition, the Administrator in its sole discretion, on a uniform and consistent basis, may treat the following as a Loss of Coverage:

- a substantial decrease in the medical care providers available under the Benefit Package Option (such as a major hospital ceasing to be a member of a preferred provider network or a substantial decrease in the number of physicians participating);

- a reduction in benefits for a specific type of medical condition or treatment with respect to which the Participant or his or her Spouse or Dependent is currently in a course of treatment; or

- any other similar fundamental loss of coverage.

(2) Additions or Significant Improvement of a Benefit Package Option. If during a Period of Coverage, the Cafeteria Plan adds a new Benefit Package Option or significantly improves an existing Benefit Package Option, the Administrator may permit the following election changes: (I) Participants who are enrolled in a Benefit Package Option other than the newly-added or significantly improved Benefit Package Option may change their election on a prospective basis to elect the newly-added or significantly improved Benefit Package Option; and (2) Employees who are otherwise eligible under Section 3.1 may elect the newly-added or significantly improved Benefit Package Option on a prospective basis, subject to the terms and limitations of the Benefit Package Option. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether there has been an addition of, or a significant improvement in, a Benefit Package Option in accordance with prevailing IRS guidance.

(3) Loss of Coverage Under Other Group Health Coverage. A Participant may prospectively change his or her election to add group health coverage for the Participant or his or her Spouse or Dependent, if such individual(s) loses coverage under any group health coverage sponsored by a governmental or educational institution, including (but not limited to) the following: a state children's health insurance program (CHIP) under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government (as defined in Code § 7701(a)(40)), the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan, subject to the terms and limitations of the applicable Benefit Package Option(s).

(4) Change in Coverage Under Another Employer Plan. A Participant may make a prospective election change that is on account of and corresponds with a change made under an employer plan (including a plan of the Employer or a plan of the Spouse's or Dependent's employer), so long as (a) the other cafeteria plan or qualified benefits plan permits its participants to make an election change that would be permitted under applicable IRS regulations; or (b) the Cafeteria Plan permits Participants to make an election for a Period of Coverage that is different from the plan year under the other cafeteria plan or qualified benefits plan. For example, if an election is made by the Participant's Spouse during his or her employer's annual enrollment to drop coverage, the Participant may add coverage to replace the dropped coverage. The Administrator, in its sole discretion and on a uniform and consistent basis, will decide whether a requested change is on account of and corresponds with a change made under the other employer plan, in accordance with prevailing IRS guidance.

(5) DCAP Coverage Changes. A Participant may make a prospective election change that is on account of and corresponds with a change by the Participant in the dependent care service provider. For example: (a) if the Participant terminates one dependent care service provider and hires a new dependent care service provider, the Participant may change coverage to reflect the cost of the new service provider; and (b) if the Participant terminates a dependent care service provider because a relative becomes available to take care of the child at no charge, the Participant may cancel coverage.

(j) Revocation Due to Reduction in Hours of Service (Major Medical Coverage Only). If a Participant has been in any employment status under which the Participant was reasonably expected to average at least 30 hours of service per week and there is a change in that Participant's status so that the Participant will reasonably be expected to average less than 30 hours of service per week after the change but that reduction does not cause a loss of eligibility under the major medical plan, the Participant may prospectively revoke his/her election for major

medical coverage provided the Participant certifies in writing on forms prescribed by the Administrator that the coverage of the Participant, and any dependents whose coverage will also cease due to the revocation, is being revoked by Participant because of enrollment in another plan that provides minimum essential coverage as defined by the Affordable Care Act and its implementing regulations with such coverage being effective no later than the first day of the second month following the month that includes the date the coverage offered under this Cafeteria Plan was revoked.

(k) Enrollment in Qualified Health Plan (Major Medical Coverage Only). A Participant may prospectively revoke his/her election for major medical coverage if he/she becomes 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 seeks to enroll in the Qualified Health Plan through a Health Insurance Marketplace during the Marketplace's annual enrollment period provided the Participant certifies in writing on forms prescribed by the Administrator that the revocation corresponds to the intended enrollment by Participant and any dependents whose coverage will also cease in a Qualified Health Plan through a Health Insurance Marketplace that will be effective no later than the day immediately following the last day of the major medical coverage under this Cafeteria Plan that is being revoked.

A Participant entitled to change an election as described in this Section 12.4 must do so in accordance with the procedures described in Section 12.2.

12.5 Election Modifications Required by Administrator

The Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Cafeteria Plan or other cafeteria plan; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Cafeteria Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Employer's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Administrator will reduce the Salary Reduction amounts for each affected Participant, beginning with the Participant in the class who had elected the highest Salary Reduction amount, continuing with the Participant in the class who had elected the next-highest Salary Reduction amount, and so forth, until the defect is corrected.

12.6 Election Modifications for HSA Benefits May Be Changed Prospectively at Any Time

As set forth in Section 9.1, an election to make a Contribution to an HSA can be increased, decreased or revoked at any time on a prospective basis. Such election changes shall

be effective no later than the first day of the next calendar month following the date that the election change was filed. No Benefit Package Option election changes can occur as a result of a change in HSA election except as otherwise described in this Article XII. For example, a Participant generally would not be able to terminate an election under the Health FSA in order to be eligible for the HSA, unless one of the exceptions described in Section 12.4 for Health FSAs otherwise applied (such as or change in status).

A Participant entitled to change an election as described in this Section 12.5 must do so in accordance with the procedures described in Section 12.2.

ARTICLE XIII. APPEALS PROCEDURE

13.1 Procedure If Benefits Are Denied

If a claim for reimbursement under one of the Benefits is wholly or partially denied, claims shall be administered in accordance with the claims procedure set forth in the summary plan description for the applicable Benefit and the applicable Program Materials for that Benefit, including any applicable insurance policies and plan documents.

ARTICLE XIV. RECORDKEEPING AND ADMINISTRATION

14.1 Administrator

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

14.2 Powers of the Administrator

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

(a) to construe and interpret this Cafeteria Plan, including all possible ambiguities, inconsistencies and omissions in the Cafeteria Plan and related documents, and to decide all questions of fact, questions relating to eligibility and participation, and questions of benefits under this Cafeteria Plan

(b) to prescribe procedures to be followed and the forms to be used by Employees and Participants to make elections pursuant to this Cafeteria Plan;

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

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

(e) to furnish each Employee and Participant with such reports with respect to the administration of this Cafeteria Plan as the Administrator determines to be reasonable and appropriate, including appropriate statements setting forth the amounts by which a Participant's Compensation has been reduced in order to provide benefits under this Cafeteria Plan;

(f) to receive, review and keep on file such reports and information concerning the benefits covered by this Cafeteria Plan as the Administrator determines from time to time to be necessary and proper;

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

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

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

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

14.3 Reliance on Participant, Tables, etc.

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

14.4 Provision for Third-Party Plan Service Providers

The Administrator, subject to approval of the Employer, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Cafeteria

Plan. Unless otherwise provided in the service agreement, obligations under this Cafeteria Plan shall remain the obligation of the Employer.

14.5 Fiduciary Liability

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

14.6 Compensation of Administrator

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

14.7 Insurance Contracts

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

14.8 Inability to Locate Payee

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

14.9 Effect of Mistake

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

ARTICLE XV. GENERAL PROVISIONS

15.1 No Contract of Employment

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

15.2 Amendment and Termination

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

15.3 Governing Law

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

15.4 Code and ERISA Compliance

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

15.5 No Guarantee of Tax Consequences

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

15.6 Indemnification of Employer

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

15.7 Non-Assignability of Rights

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

15.8 Headings

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

15.9 Benefit Plan Provisions Controlling

In the event that the terms or provisions of this Cafeteria Plan are in any construction interpreted as being in conflict with the provisions of the applicable plan document or SPD applicable to a specific Benefit, the terms of the specific plan document/SPD for the Benefit shall apply.

15.10 Severability

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

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing instrument comprising the Employers Amended and Restated Cafeteria Plan, the Employer has caused this Plan to be executed in its name and on its behalf, on this 26th day of July, 2022.

EMPLOYER

Signature: Diane C Bridgewater

Printed Name: Diane C. Bridgewater

Title: EVP + Secretary

EXHIBIT A

PREMIUM PAYMENT BENEFITS OFFERED UNDER THE PLAN

- Medical
- Dental
- Vision
- Group Term Life
- AD&D
- Long Term Disability
- Supplemental Long Term Disability
- Supplemental Life & Dependent Life
- Supplemental AD&D
- Accident
- Critical Illness
- Hospital Indemnity
- Group Legal

APPENDIX A

RELATED EMPLOYERS THAT HAVE ADOPTED THIS PLAN

Life Care Services LLC
400 Locust Street, Suite 820
Des Moines, IA 50309-2334

LCS Development LLC
400 Locust Street, Suite 820
Des Moines, IA 50309-2334

Care Purchasing Services LLC
400 Locust Street, Suite 820
Des Moines, IA 50309-2334