

LIFE CARE CENTERS OF AMERICA, INC.

SUMMARY PLAN DESCRIPTION

FOR THE

LIFE CARE CENTERS OF AMERICA, INC. CAFETERIA PLAN

January 1, 2025

Overview

Life Care Centers of America, Inc. Cafeteria Plan

The Life Care Centers of America, Inc. Cafeteria Plan (“the Plan”) allows eligible associates to choose coverage for themselves and/or their eligible dependents under medical, dental, and other benefit plans sponsored by Life Care Centers of America, Inc. (the “Company”). The Plan gives eligible associates three advantages:

- the opportunity to choose whether or not to have benefit coverage; and
- the ability to pay for the coverage on a pre-tax basis.

The types of benefit coverage available under the Plan are:

- Medical coverage;
- Dental coverage;
- Vision coverage;
- Basic Life and AD&D coverage (up to \$50,000);
- Contributions to a Health Savings Account;
- Coverage under a Health Flexible Spending Account, allowing eligible associates to reimburse themselves for eligible medical, dental and vision expenses not paid under the medical, dental, or vision coverage plans; and
- Coverage under a Dependent Care Flexible Spending Account, allowing eligible associates to reimburse themselves for eligible child care and dependent care expenses.

Health Savings Accounts

The Plan allows you to contribute to a Health Savings Account. Contributing to a Health Savings Account (“HSA”) is a way to save for future medical expenses and reduce an individual’s income taxes. An HSA is a custodial account with a bank or other financial institution that holds contributions and earnings on those contributions for future use, similar to the way an Individual Retirement Account (“IRA”) holds contributions and earnings for use in retirement. As with an IRA, the contributions are deductible from the associate’s gross income and any account earnings are tax-free. The HSA offers one additional advantage that an IRA does not. When funds are distributed from the HSA to pay for qualified medical expenses for the

account holder, his or her spouse, or a dependent, the distribution is not included in the associate's taxable income.

Contributions can be made to an HSA by an "eligible individual," by the employer of the eligible individual, or both. Not every person is an eligible individual. The rules for being an eligible individual are explained below. In addition, the total amount of the contributions that can be made during a year is limited by law.

Health Flexible Spending Account

The Health Flexible Spending Account (sometimes called "the Health FSA") will reimburse you for qualified medical, dental and vision care expenses you incur for yourself and your family up to a dollar limit you specify, which can be as low as zero or can range up to and including \$3,300 (for 2025). The amount you select is divided over the number of pay periods within a calendar year and deducted from your pay in equal amounts on a pre-tax basis during the year.

The Health FSA is designed to allow pre-tax contributions for medical, dental and vision care services that are not covered under the medical, dental and vision Plan options while you are a participant in the Company's high-deductible health plan.

Dependent Care Flexible Spending Account

The Dependent Care Flexible Spending Account Plan (sometimes called "the Dependent Care FSA") will reimburse you for certain charges made by third parties such as daycare providers for taking care of your qualified dependents under the age of 13 or who are physically or mentally unable to take care of themselves, so that you or your spouse can be at work.

IMPORTANT TO READ!

The Dependent Care FSA does not cover medical or dental care for you or any dependent. The Dependent Care FSA covers only the charges made by a third party (such as a daycare center) who takes physical responsibility for your qualified dependents and watches over them so that you or your spouse can be gainfully employed.

The Purpose of This Summary Plan Description

The Company wants you to be able to take advantage of every available benefit under the Plan to the extent appropriate for your situation. This summary describes the terms and benefits of the Plan as of January 1, 2025. The Company has reserved the right to amend or terminate the Plan.

To make the best use of the Plan, you must understand the options available to you. This summary plan description is intended to present an overview of the Plan. You should read it

carefully so that you understand how the Plan works. Any questions should be directed to the Plan Administrator.

IMPORTANT TO READ!

There is a Plan document on file for the Plan which you may review if you desire. All matters of Plan administration are, in all respects, governed by the Plan document. In the event there is a conflict between this summary plan description and the Plan document, the Plan document will control. The Company reserves the right to change or discontinue the Plan at any time.

1. Becoming a Participant in the Plan

What does being a “participant” in the Plan mean?

A “participant” is an individual who has made an “election” through the Plan regarding coverage under one or more of the benefits offered under the Plan.

What is an “election” under the Plan?

An election under the Plan is a choice about whether to enroll for coverage under one or more of the benefits offered under the Plan; which benefit(s) to enroll in; and what level of coverage to select. The choices an eligible associate makes determine the amount deducted from his or her paycheck to pay the associate share of the cost of coverage elected.

To take effect, an election must be made during the time period designated by the Plan Administrator using one of the methods chosen by the Plan Administrator. Section 2 provides more details about how elections are made.

Is everyone eligible to make an election under the Plan?

No, only “eligible associates” of The Company are allowed to participate in the Plan. An “eligible associate” is an associate who meets the Plan’s eligibility rules.

What are the eligibility rules for an individual to be an “eligible associate” who can participate in the Plan?

The Plan has a general eligibility rule, and some exceptions to the general eligibility rule.

The Plan’s general eligibility rule

Under the general rule, after 60 days (6 months of employment prior to the Open Enrollment period for benefits that begin January 1 in the case of the Health FSA) all Company associates working at least 30 hours per week are “eligible associates” under the Plan for purposes of the Health FSA and the Dependent Care FSA. Company associates in Hawaii are “eligible associates” under the Plan for purposes of the Health FSA and Dependent Care FSA after the first day of the month on or after the date of hire. Otherwise, a Company associate is an “eligible associate” if he or she meets the separate eligibility requirements of one or more of the benefit coverages under the Plan. The eligibility terms for each of benefit coverage is contained in separate plan documents governing such benefits maintained by the Company.

The exceptions to the general eligibility rule

An individual is not an “eligible associate,” and cannot participate in the Plan, if he or she is designated or otherwise classified by his or her employer as:

- A non-resident alien who has no United States-sourced income;
- An associate whose terms and conditions of employment are subject to collective bargaining, unless a collective bargaining agreement is in effect that expressly provides for the associate to be eligible to participate in the Plan;
- A leased associate;
- An individual classified (whether correctly or incorrectly) by the Company as a contract worker, independent contractor, temporary associate, or in any category other than an associate;
- An individual who is not paid through, or identified as an associate in the Company payroll system, whether or not a governmental agency determines that the individual was an associate of the Company;
- An individual who is an undocumented worker; or
- An individual who has waived participation in the Plan through any means, including any individual whose employment is governed by a written agreement with the Company or a participating employer (including an offer letter setting forth the terms and conditions of employment) that provides that the individual is not eligible to participate in the Plan. A general statement in such an agreement, offer letter or other communication stating that the individual is not eligible for benefits shall be construed to mean that the individual is not eligible to participate in the Plan.

2. Making Elections under the Plan

When is an eligible associate given an opportunity to elect benefit coverage under the Plan?

An eligible associate is given an opportunity to elect benefit coverage under the Plan during each Enrollment Period that applies to the eligible associate.

There are three types of Enrollment Periods: (1) the eligible associate's Initial Enrollment Period; (2) the Annual Open Enrollment Period; and (3) Special Enrollment Periods.

What is an Initial Enrollment Period?

An eligible associate's Initial Enrollment Period is the period of 45 days that starts when the eligible associate first meets the eligibility rules for any of the following Plan:

The medical benefit

The dental benefit

The vision benefit

HSA

The Dependent Care FSA

Except for HSA elections, at the end of the Initial Enrollment Period, the benefit elections made by the eligible associate become "irrevocable" for the remainder of the calendar year. This means that the benefit elections will apply for the rest of the calendar year, even if the eligible associate would prefer that a different choice apply. However, the HSA election may be changed or stopped or restarted at any time prior to the pay period for which the change is effective. The rules on when elections become irrevocable and for how long they are irrevocable are explained in more detail in Section 4.

IMPORTANT TO KNOW!

If you fail to make an election or miss the deadline to make an election during your Initial Enrollment Period, you will be treated as electing not to participate any of the benefit coverages listed in the Plan and receiving your full cash compensation.

What is an Annual Open Enrollment Period?

An Annual Open Enrollment Period is a period announced in advance by the Plan Administrator when each eligible associate may make elections under the Plan that will apply during the next calendar year.

At the end of the Annual Open Enrollment Period, the benefit elections made by the eligible associate become “irrevocable” except with respect to HSA benefit elections, which may be changed at any time. This means that the benefit elections will apply for the entire calendar year that starts after the Annual Open Enrollment Period, even if the eligible associate would prefer that a different choice apply. The rules on when elections become irrevocable and for how long they are irrevocable are explained in more detail in Section 4.

What is a Special Enrollment Period?

A Special Enrollment Period is a period of up to 45 days (or 60 days in the case of the third Special Enrollment Event below) during which an eligible associate is allowed to change a benefit election under the Plan for the remainder of the calendar year because of the occurrence of a Special Enrollment Event. It is an exception to the general rule that an election is irrevocable for the full calendar year to which the election applies. However, the Special Enrollment events do not apply to the Health FSA. Changes to the Health FSA may only be made during the Annual Open Enrollment Period.

There are only three Special Enrollment Events:

- The first Special Enrollment Event is that you, your spouse, or your dependent loses coverage under a group health plan sponsored by a different employer. However, the loss of that coverage (“the other coverage”) is a Special Enrollment Event only if certain conditions are met.
 1. The other coverage must be coverage that you, your spouse, or your dependent had at the time coverage under the Company medical plan was offered to you.
 2. You declined coverage under the Company medical plan when it was offered to you.
 3. At the time you declined coverage under the Company medical plan, you stated in writing to the Plan Administrator that the other coverage was the reason you declined coverage under the Company medical plan.
- The second Special Enrollment Event is that an individual becomes your dependent as the result of a marriage, the birth of a child, an adoption, or a placement for adoption.
- The third Special Enrollment is that you, your spouse, or your dependent loses coverage under Medicaid or a state Children’s Health Insurance Program (or “CHIP”) because they

are no longer eligible, or your dependents become eligible for a state's premium assistance program from Medicaid or CHIP.

Some eligible associates may never experience one of these events. Other eligible associates may have one or more Special Enrollment Events during their lives.

If there is a Special Enrollment Event, the Special Enrollment Period must end on the 45th day (60th day in the case of the third Special Enrollment Event) after the day the Special Enrollment Event happened. However, the Special Enrollment Period cannot begin until the eligible associate provides satisfactory proof that the eligible associate has experienced a Special Enrollment Event and satisfactory proof of the date when the Special Enrollment Event occurred. Such proof must be provided prior to the end of the applicable Special Enrollment Period.

For this reason, it is extremely important to contact the Benefits Team at **MyLCCAbenefits.com** or **(866) 353-0441** as soon as possible when a Special Enrollment Event occurs. Any delay can cause you to lose your Special Enrollment Period, or to have a shorter Special Enrollment Period.

EXAMPLE No. 1

Marcus is an eligible associate who declined coverage under the medical plan for 2025. On April 1, 2025, Marcus and his wife adopted a daughter, Nicole. Marcus provided the LCCA Benefits Team with a certified copy of the adoption papers on April 20, 2025.

Marcus's Special Enrollment Period begins on April 20, 2025, and ends on May 15, 2025. If Marcus wants to elect medical coverage for himself, his wife, and Nicole, he only has 26 days to make that election.

EXAMPLE No. 2

Cathy is an eligible associate. During Open Enrollment in October, 2025, she elected associate-only coverage under the Company high-deductible medical plan for 2026.

On June 14, 2026, Cathy gave birth to her first child, Garrett. Cathy thinks the best thing to do in terms of health coverage for herself and Garrett going forward would be to switch to associate-plus-child coverage under the Company high-deductible medical plan for the rest of 2026.

On July 30, 2026, Cathy realizes that she forgot to contact the SiteOne Benefits Team and send them a copy of Garrett's birth certificate.

Garrett's birth was a Special Enrollment Event, but Cathy will not have a Special Enrollment Period. Cathy could have started a Special Enrollment Period by providing the GSOC Benefits Team with proof of Garrett's date of birth, but that Special Enrollment Period would have ended on July 28, 2026, the 45th day after the day Garrett was born. Because Cathy did not take the steps necessary to start a Special Enrollment Period until after July 28, 2026, there is no Special Enrollment Period.

Is a new election made during a Special Enrollment Period subject to any rules about being irrevocable?

Yes. At the end of the Special Enrollment Period, the benefit elections made by the eligible associate become "irrevocable" for the remainder of the calendar year except for HSA elections which may be changed at any time. This means that the benefit elections will apply for the rest of the calendar year, even if the eligible associate would prefer that a different choice apply. The rules on when elections become irrevocable and for how long they are irrevocable are explained in more detail in Section 4.

What are the enrollment procedures the Plan Administrator has selected?

Associates may contact a Benefit Specialist by emailing MyLCCAbenefits.com or by calling a benefits specialist at **(866) 353-0441**.

3. Payroll Reductions, Contributions, and Account Credits

If I elect coverage under one or more of the benefit plans available to me, how will that affect my pay?

When an eligible associate elects coverage under a benefit plan, the eligible associate is agreeing to pay some or all of the cost of that coverage out of future wages. Payroll deductions to pay for the cost of coverage are made on a pre-tax basis if coverage under the particular benefit plan chosen can be paid for on a pre-tax basis.

What happens when my pay is reduced to pay my share of the coverage I have elected?

The answer depends on the type of coverage selected.

If the coverage you elect is provided under an insurance policy, the amount of your payroll deductions for that coverage are used to pay the premium the insurance company charges for the coverage. For some insured plans, the associate is not expected to pay the full premium. In those cases, the employer pays part of the premium and the associate's payroll deductions are used to pay the remaining part of the premium.

If the coverage you elect is coverage under the Company's self-insured medical plan, the amount of the payroll deductions from all the eligible associates who have elected coverage are used to pay the claims of all the individuals covered by the medical plan for medical diagnosis, treatment, and care during the coverage period that was covered under the medical plan. Because the Company expects and intends to pay for a portion of these covered claims itself, the associate contributions are set at a lower level than would be necessary to pay for 100% of the claims during any given period of time.

If you elect to contribute to your Company-designated HSA, the amount of your payroll deduction is sent to the bank that is the custodian of your HSA for deposit.

If the coverage you elect is coverage under the Health FSA, two steps take place:

- The Plan Administrator, through a third-party Claims Administrator, sets up an accounting record showing the total amount of coverage you chose so that the full amount of that coverage is available from the beginning of the coverage period (even if your payroll deductions have not yet caught up with the total amount of covered medical expenses reimbursed to you). As claims for reimbursement are made and approved as "qualifying medical expenses" for you, your spouse, or

your dependent, the Claims Administrator pays the reimbursed amount. When the reimbursement payment is made to you, the opening balance of the accounting record for your FSA is reduced by the amount of the payment to you. The new balance in the accounting record shows the maximum amount of reimbursement the FSA can make for any later claims by you or your covered family members during the period when you are covered by the the Health FSA.

- Your payroll deductions are retained by the employer so that, by the end of the calendar year, the employer has retained the maximum amount it may need to bring the expense of its reimbursement payments back to zero.

If you elect coverage under the Dependent Care FSA, two steps take place:

- The Plan Administrator, through a third-party Claims Administrator, sets up an accounting record with an opening balance of zero and each payroll period the Company adds the amount elected by the associate and subsequently deducted from your pay to the opening balance in your account. The balance shown in the account at any given time is the total amount available at that time to reimburse you for qualified dependent care expenses.
- Your payroll deductions are retained by the employer so that the employer can reimburse you as claims for reimbursement are made and approved for qualified dependent care expenses.

**TWO IMPORTANT FACTS
ABOUT FLEXIBLE SPENDING ACCOUNT PLANS**

1. Under Internal Revenue Service rules, money you put into your reimbursement accounts that are not used to cover qualified expenses incurred during the plan year (which ends December 31) cannot be returned to you. The deadline for *incurring* qualified expenses is December 31, and *submission* of reimbursement requests for expenses incurred during a plan year is 90 days (typically March 31) following the end of the plan year. Under the Health FSA, you are able to rollover up to the IRS maximum carryover amount (\$660 for 2025) of your contributions to be available for reimbursement of expenses incurred the following Plan year. However, federal law requires that the balance of your contributions be forfeited after the deadline. *Because this is possible, you must carefully evaluate the amount you elect to contribute to the Plan.*

2. The accounting record that is set up when a participant elects coverage under a flexible spending account plan is merely a way of keeping track of the maximum amount that can be paid to you under that plan at any given time. Any amount shown on these records does not earn interest or represent any specific cash or property set aside for the participant who elected the coverage.

Is there a minimum or a maximum amount I can elect to contribute under the Plan?

If you decline a type of coverage offered under the Plan, then there is no contribution for you to make for the coverage you declined.

If you elect a type of coverage offered under the Plan, there is a maximum amount you can contribute for the type of coverage you elect under the Plan. For some types of coverage offered under the Plan, there is also a minimum amount you can contribute.

Chart 1
 Minimum and Maximum Contributions for
 Coverages Available Under the Plan – 2025 Limits
 (Except Dependent Care FSA)

Benefit Selected	Minimum	Maximum
Medical Plan	The minimum amount is the cost of the lowest option under the plan. The maximum amount is the cost of the highest option under the plan.	
Dental Plan	The minimum amount is the cost of the lowest option under the plan. The maximum amount is the cost of the highest option under the plan.	
Health FSA	\$360	\$3,300/year
Contribution to HSA		\$4,300/year (EE only) \$8,550/year (family)
Dependent Care FSA	\$360/year	\$5,000/year

There is a minimum contribution of \$360 for coverage under the Dependent Care FSA. However, there is a maximum amount. The maximum depends on your earned income, your marital status, your spouse’s earned income, and whether you file a joint federal tax return with your spouse.

For a typical single person the maximum annual contribution is \$5,000.

For a typical married person filing separate tax returns, the maximum annual contribution is \$2,500.

For a typical married person filing joint tax returns with a spouse who is employed outside the home for pay, the maximum annual contribution combined is \$5,000.

Are there additional limitations that can apply to Participants who are highly compensated?

Yes. The Plan Administrator may be required to limit contributions and/or benefits under the Plan for highly compensated participants, key employees, or their families in order to comply with requirements under the Internal Revenue Code.

For purposes of these limitations, “highly compensated participants” and “key employees” generally are participants who are officers, or highly paid. You will be notified by the Plan Administrator before or during each plan year if you are a highly compensated participant or a key employee and your contributions and/or benefits under the Plan must be limited.

4. Changing Your Elections

What are the general rules about changing elections under the Plan?

The general rules are:

Whatever elections an eligible associate has made as of the end of an Initial Enrollment Period or the end of a Special Enrollment Period will be applied for the entire remaining portion of the calendar year; and

Whatever elections an eligible associate has made as of the end of an Annual Open Enrollment Period will be applied for the entire calendar year to which the Annual Open Enrollment Period relates.

Notwithstanding the above general rules, you may change your election to contribute to your Health Savings Account at any time by **contacting a Benefits Specialist in writing at MyLCCAbenefits.com**. Your new election will become effective beginning with the first

pay period after submitting your election change form. However, your HSA contribution amount is subject to the minimum contribution level described in Section 3 above.

EXAMPLE No. 1

During the Annual Open Enrollment Period for 2026, which was held in October 2025, Alicia enrolled for coverage for herself and her spouse, Jason, under the Traditional medical plan option. By the end of July 2026, neither Alicia nor Jason has needed any medical care or even any prescription medication. Jason asks Alicia whether they could save some money during the rest of the year by dropping medical coverage, or at least switching to the Consumer Directed Health high-deductible plan with an HSA.

The answer is no. Alicia cannot change her election by dropping medical coverage for the rest of 2026. She also cannot change her election by switching to another level of coverage for the rest of 2026.

During the Annual Open Enrollment Period in the fall of 2026, Alicia can decide whether she wants medical coverage for herself and/or Jason during 2027, and if so what level of coverage she wants.

Are there any exceptions to the general rule for the Dependent Care Health FSA?

Yes. These exceptions are explained in Section 9 of this Summary Plan Description.

Are there any exceptions to the general rule for coverage under the Medical Plan, the Dental Plan or the Health FSA?

Yes. There are two main exceptions that come up relatively often, and there are a handful of other exceptions that occur less frequently.

1. An eligible associate is allowed to revoke an existing election and make a new election with respect to a group health plan during a Special Enrollment Period if the rules related to Special Enrollment Events have been followed.
2. An eligible associate is allowed to revoke an existing election and make a new election during a change period that ends 45 days (60 days for loss of Medicaid/CHIP coverage or gaining a Medicaid/CHIP premium subsidy) after the day when a Qualified Change in Status Event took place, if the rules related to Qualified Change in Status Events have been followed and if the Qualified Change in Status Event permits the type of change the eligible associate wishes to make.

What are the rules relating to revoking a previous election and making a new election during a Special Enrollment Period?

During a Special Enrollment Period, the eligible associate can revoke an existing election relating to any group health plan and make a new group health plan election that will be effective for the rest of the calendar year, but the eligible associate cannot change the amount of coverage under a Health FSA.

Remember that a Special Enrollment Period cannot start until you provide satisfactory proof of the date when your Special Enrollment Event occurred, but the Special Enrollment Period must end on the 45th day (60th day in the case of certain events) after the day the Special Enrollment Event took place.

There is a list of events that are Special Enrollment Events on page 6 above.

What is a Qualified Change in Status Event?

A Qualified Change in Status Event is an event that satisfies two requirements.

1. The event must be:
 - A change in associate's legal marital status (divorce, annulment, marriage, death of spouse)
 - A change in the associate's number of dependents
 - A change in the employment status of the associate, the spouse, or a dependent
 - A dependent begins to satisfy dependent eligibility requirements
 - A dependent ceases to satisfy dependent eligibility requirements
 - A change in residence of the associate, the spouse, or a dependent
 - The commencement or termination of adoption proceedings
 - Loss of eligibility for Medicaid or State Children's Health Insurance Program (CHIP) coverage
 - Becoming eligible for a state premium assistance subsidy from Medicaid or CHIP
2. The event must cause you as the participant, your spouse, or your dependent to gain or lose eligibility for coverage under a group health plan maintained by the Company or by the employer of your spouse or your dependent.

EXAMPLE No. 1

Jonathon is a single father with one child, Matthew. Jonathon elected associate-plus-child coverage under the medical benefit option. On July 22, 2016, Matthew reaches age 26. Matthew's 26th birthday is a Qualified Change in Status Event because Matthew lost eligibility for coverage as a dependent on that date as the end of the payroll period in which Matthew turned age 26.

EXAMPLE No. 2

Jia elected associate-only coverage under the high deductible health plan option. On August 5, 2016, Jia moves from her old apartment to a new apartment three miles away. The move does not change Jia's ability to see any of her regular doctors. The move to the new apartment is not a Qualified Change in Status Event.

EXAMPLE No. 3

Calvin elected associate-plus-spouse coverage under the medical benefit option. On March 12, 2016, Calvin's spouse is promoted into a full time position with her employer, which makes her eligible for her employer's health plan as of April 1, 2016. Calvin has a Qualified Change in Status Event on April 1, 2016.

Can a Participant always revoke a previous group health plan election and make a new group health plan election based on a Qualified Change in Status Event?

No. A Participant may revoke an existing election relating to any group health plan and make a new group health plan election only if the revocation and new election are consistent with the type of change in status event experienced by the eligible associate, and only if the eligible associate documents the occurrence of the "change in status event" and completes the election change within 45th days (60 days for certain events) of the date the change in status event occurred.

In addition, a Participant may never change the amount of coverage he or she elected under the Health FSA.

When is revoking a previous group health plan election and making a new group health plan election considered to be "consistent" with the Qualified Change in Status Event?

If your Qualified Change in Status involves divorce, annulment, or legal separation from your Spouse, or the death of your Spouse, then switching from associate-plus-spouse to associate-only coverage is consistent with a Qualified Change in Status. Switching from associate-plus-family to associate-plus-children also is consistent with this Qualified Change in Status Event.

If your Qualified Change in Status involves loss of coverage under a plan sponsored by your Spouse's employer because of divorce, annulment, or legal separation from your Spouse, or the death of your Spouse, then switching from no coverage to associate-only coverage is consistent with the Qualified Change in Status. In addition, increasing your Health FSA coverage also is consistent with this Qualified Change in Status.

If your Qualified Change in Status involves your Dependent's ceasing to satisfy the eligibility requirements for coverage, you may only elect to cancel coverage under a group health plan for the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances does not satisfy the consistency requirement.

If your Qualified Change in Status involves someone gaining eligibility for coverage under a group health plan sponsored by the employer of your Spouse or Dependent, you may elect to cease or decrease coverage for yourself and/or your Spouse or Dependent, but only if coverage under the other employer's plan actually becomes effective.

EXAMPLE

Calvin elected associate-plus-spouse coverage under the medical benefit option. On March 12, 2016, Calvin's spouse is promoted into a full time position with her employer, which makes her eligible for her employer's health plan as of April 1, 2016. Calvin has a Qualified Change in Status Event on April 1, 2016.

However, Calvin and his wife do not actually enroll in the plan sponsored by the other employer. For that reason, Calvin may not drop coverage under the medical benefit option for himself or his wife.

Is there also an exception to the rule about irrevocability if the cost of a plan changes during the Plan Year?

Yes.

If the cost of a group health plan you elected increases or decreases by an insignificant amount during the Plan Year, your payroll deduction will be changed automatically to reflect the increase or decrease.

If the cost of a group health plan you elected increases by more than an insignificant amount during the Plan Year, you will have a 31 day period during which you can revoke your election of that group health plan and, if you wish, you may elect coverage for the remainder of the Plan Year under a lower cost group health plan.

If the cost of a group health plan you declined decreases by more than an insignificant amount during the Plan Year, you will have a 31 day period during which you can elect coverage for the remainder of the Plan Year under that group health plan. Since you cannot be enrolled in more than one option under the medical plan, you also may revoke your existing election to enable yourself to elect coverage under the plan that experienced the decrease in cost.

Is there an exception to the rules if the coverage terms of a plan change during the Plan Year?

Yes, but the exception applies only if the change in the coverage terms significantly reduces coverage under a group health plan you elected or significantly increases coverage under a group health plan you declined.

If coverage under the group health plan you elected is significantly reduced during the Plan Year, you will have a 31 day period during which you can revoke your election of that group health plan and, if you wish, you may elect coverage for the remainder of the Plan Year under a different group health plan.

If the cost of a group health plan you declined is significantly expanded during the Plan Year, you will have a 31 day period during which you can elect coverage for the remainder of the Plan Year under that group health plan. Since you cannot be enrolled in more than one option under the medical plan, you also may revoke your existing election to enable yourself to elect coverage under the plan that experienced the significant coverage expansion.

If there is a court order about group health coverage for my child, can I change my election during the Plan Year to reflect the court order?

Yes. If you receive a judgment, decree or order resulting from a divorce, legal separation, or change in legal custody, including a Qualified Medical Child Support Order (“QMCSO”), that requires accident or health coverage for your dependent(s), you may:

- Change your election to provide coverage (A) for your dependent (provided that the judgment, decree or order requires you to provide coverage; and (B) for yourself if you are not already covered and the particular accident or health plan in question does not provide dependent-only coverage; or
- Change your election to revoke coverage for the dependent if the order, judgment or decree requires that another individual (including your Spouse or former Spouse) provide coverage under that individual’s plan and such coverage is actually provided.

If I enroll for Medicare Part A or Part B or for Medicaid, or if my spouse or dependent enrolls for Medicare Part A or Part B or for Medicaid, may I change my election to reduce coverage under the Company Medical Plan for the person who enrolled?

Yes.

Are there special rules that affect participants who take a leave of absence under Family and Medical Leave Act (FMLA)?

Yes. The following is a summary of the rules regarding participation in the Plan during a leave of absence. You may contact the Plan Administrator for additional details or review the official plan document.

If you go on an approved paid leave, under the FMLA or non-FMLA, your coverage under the benefit options will continue as long as you timely make the required premium payments for such benefits. Your share of the premium payments will be automatically deducted from your pay on a pre-tax basis in accordance with your election in effect prior to the leave of absence and subject to applicable wage and hour laws.

In the event of unpaid FMLA or non-FMLA leave, your participation in all benefit options will cease, except that your participation in the group health benefit options, including the Health FSA, will continue if your leave qualifies under the FMLA unless you elect to stop participating in such benefit options. If you opt to continue your group health coverage, and Health FSA coverage while on unpaid FMLA leave, you must timely pay your share of the contribution amounts based on the same schedule as contributions would have been made if you were not on FMLA leave. Please note that your contribution amounts will be paid with after-tax dollars. For most Health FSA participants, losing the ability to use pre-tax contributions to pay for qualifying medical expenses will outweigh any benefit of continued participation in the Health FSA during an unpaid FMLA leave. You should consult your tax advisor to evaluate your particular circumstances.

If your group health plan benefit coverage ceases while on FMLA leave (e.g., for non-payment of required contributions), you will be permitted to re-enter the group health plan benefit option(s) upon return from such leave on the same basis as you were participating in the plans prior to the leave, or as otherwise required by the FMLA. If you were participating in the Health FSA benefit option, you may elect to be reinstated in your Limited-Purpose Health FSA at the coverage level that is reduced pro-rata for the period of FMLA leave you did not make any contributions.

5. When Participation Ends

When will my participation in the Plan end?

The Company may amend the Plan, discontinue any or all benefits, or terminate the Plan at any time for any reason. Generally, your participation in the Plan will end on the earlier of:

- When you leave your employment with the Company.
- When you are no longer eligible to participate in the Health FSA, the Dependent Care FSA, the Medical Plan, the Dental Plan, and the Vision Plan.
- When the Plan is amended to exclude you or is terminated.

In the event your participation ends, your coverage under the various benefits maintained by the Company will be governed by the provisions of specific plans in which you are a participant. The documents given to you explaining those benefits describe their termination provisions. You may be allowed to continue your coverage in certain group health plans under federal law (COBRA). You may also have the option of continuing your coverage under the Health FSA, provided you keep contributing to it. However, your contributions would be made with after-tax dollars. See “COBRA Continuation Coverage” below.

What happens if my employment ends during a plan year?

Subject to applicable COBRA continuation requirements, if you terminate employment, you will be ineligible to participate for the remainder of the plan year. Your elections will terminate on the date on which you cease to be a Participant. If you terminate employment with the Company or a participating employer and then resume employment with the Company or a participating employer not more than 13 weeks from the date of termination, then your elections in effect on the date of termination shall be reinstated upon reemployment without any further election or revocation of election by you. If you terminate employment and are subsequently rehired more than 13 weeks from the date of termination, you may rejoin the Plan when you again satisfy the eligibility requirements.

You may submit claims for qualified expenses incurred during the year of termination and prior to your termination date to the extent of the balance of amounts withheld prior to your date of termination, less the amount of any benefits previously paid from your reimbursement account(s) during the plan year. Any amounts remaining in your account(s) after this date will be forfeited.

6. Special Rules for the Health FSA

The Health FSA is designed to help you pay for qualified expenses that are not covered under any other plan. Please note that expenses reimbursed through the Plan *cannot also be claimed as a deduction for income tax purposes.*

EXAMPLE No. 1

Anoush elected associate-only coverage under the traditional health plan option. She also elected to contribute \$700 under the Health FSA for 2025. On March 3, 2025, Anoush was seen by her regular doctor in his office. Her bill for the office visit was \$200 and it was applied towards her annual deductible. Anoush used the Health FSA debit card and paid the \$200, leaving a balance of \$500 available for additional qualifying expenses. In September, Anoush has root canal surgery on one of her teeth. Her portion of the bill for the root canal surgery is \$700. Anoush paid the \$500 using the Health FSA debit card. The additional \$200 must be paid by Anoush out of pocket.

A number of special rules apply to the Health FSA.

1. You are not eligible to participate in the Health FSA while you also have a HSA.
2. The rules allowing changes in your elections during a Special Enrollment Period or because of a Change in Status Event do not apply to Health FSA.
3. You may be reimbursed from a Health Care Reimbursement Plan only for certain types of health-related expenses for the diagnosis, treatment or care of a health condition that was received during the period when you, your spouse, and/or your dependents are covered by your Health FSA Plan account.
4. If you or a member of your family loses coverage under your Health FSA due to termination of employment, divorce, or certain other events, you and/or your family members may be eligible to continue that coverage for up to a certain period of time after the event.

Each of these special rules is explained in greater detail in this Section, Section 7 and Section 8.

SOME BASIC RULES FOR THE HEALTH FSA

If I elect coverage under a Health FSA account, how long does that coverage apply?

The FSAs operate on a calendar year basis. Coverage you elect under FSAs apply only during the Coverage Period for which you elected the coverage. The Coverage Period corresponds with the plan year (i.e. the 12-month period that ends on December 31).

Thus, if you enroll for coverage during an Open Enrollment Period, the Coverage Period starts on January 1 following open enrollment and ends on December 31. If you enroll for coverage during an Initial Enrollment Period, the Coverage Period starts on the effective date of your enrollment and ends on December 31 of that year.

What if I don't spend the entire amount in my Health FSA account during the Coverage Period?

Under Internal Revenue Service rules, any unspent portion of payroll deductions for your Health FSA account at the end of the Coverage Period of up to the annual maximum IRS limit (\$660 for 2025) will be rolled over to the next Coverage Period and available to reimburse expenses incurred. The deadline for submission of reimbursement requests for expenses incurred during a plan year is 90 days after the end of the plan year (typically March 31). Federal law requires that the balance of your contributions above the carryover limit be forfeited after the deadline. *Because this is possible, you must carefully evaluate the amount you elect to contribute to the Plan.*

QUALIFIED MEDICAL EXPENSES

What expenses are “qualified medical expenses” for purposes of the Health FSA?

To be a “qualified medical expense” for purposes of the Health FSA, an expense must meet all four of the following conditions:

- It must be an expense for medical, dental or vision services, medication, medical device, implement, or supply provided for the prevention, diagnosis, cure, treatment, and/or care of an illness or injury (“a medical expense”) for yourself, your spouse, your dependent, or your child who is not yet 26 years old or older, excluding any domestic partners or children of a domestic partner except to the extent such an individual is your tax-qualified dependent.
- The services, medication, medical device, implement, or supply must be provided during the period you are covered by the reimbursement plan (“the period of coverage”) related to your election. The start and end dates for each period of coverage is explained in more detail below.

- The expense cannot be for services, medications, medical devices, implements, or supplies that would not be deductible on your federal income tax return because it is for a medical, dental or vision condition or procedure that federal law does not allow deductions for.
- The expense cannot be for any of the following:
 - Expenses for care unrelated to qualifying medical, dental or vision services;
 - Expenses for qualified long term care services;
 - Expenses incurred for the payment of premiums under a health insurance plan;
 - Any expense for which you or another person incurring the expense will take as a deduction from income on your or the other person's federal income tax return in any tax year;
 - Any expense for which you or another person incurring the expense will be reimbursed through any other insurance or group health plan or any other source; or

How do I request reimbursement under the Health FSA?

When you want to be reimbursed, you simply submit a claim form and the required attachments to the Claims Administrator (as described on the Plan Summary List on p. 35). Claim forms are available from your Plan Administrator or the Claims Administrator. Reimbursement payments will be made as soon as administratively feasible.

For additional convenience, you will be issued a debit card. Use the card to pay for eligible medical expenses just as you would use your bank debit card. The money is automatically debited from your Health FSA. You should keep copies of all receipts for any expenses you pay for from your Health FSA in case further substantiation is required.

Prior to using the debit card you must certify that the card will only be used for qualifying medical expenses and, that any qualifying expenses paid with the card have not already been reimbursed by any health plan.

Note: You cannot use the card to prepay for qualified expenses, except that you may be able to use the card to prepay for qualifying orthodontia expenses. Contact the Claims Administrator prior to prepaying for orthodontia expenses.

The Card will be automatically cancelled upon your death or termination of employment, or if you have a change in status that results in your becoming ineligible for a Health FSA.

The dollar amount available on the card will be the Health FSA coverage amount you elected for the Plan Year, minus reimbursements paid for the plan year.

Your debit card will permit all transactions to be made in the pharmacy at the point of sale. This

includes prescription and eligible over-the-counter products. Internal Revenue Service (IRS) regulations require documentation to verify that claims are legitimate. Therefore, any transaction that does not match a copayment/coinsurance from the Company group plan or is not otherwise clearly a dental or vision expense based on the information obtained from the vendor's inventory system at the point of sale will be audited by the Claims Administrator.

If you are audited for a transaction, you are required to provide documentation to validate the expense. Return to the Claims Administrator a receipt or Explanation of Benefits (EOB) which includes the following:

- Provider
- Service(s) received or item(s) purchased
- Date of service
- Amount of expenses incurred
- Amount covered by insurance

If the Claims Administrator later determines that any purchase is not a qualified medical expense, the Claims Administrator may, in its sole discretion, use one of the following correction methods to make the Plan whole:

- Require you to repay the improper amount to the Plan;
- Offset future claims until the improper amount is repaid.

Until the amount is repaid, the Claims Administrator will take steps to ensure that further violations of the terms of the debit card do not occur, up to and including denial of access to the card.

Claims for benefits under the Health FSA must be submitted to the Claims Administrator in accordance with procedures established by the Claims Administrator. To submit a claim for medical, dental or vision care expenses, documentation that substantiates a claim must establish the person on whose behalf medical, dental or vision care expenses have been incurred, the nature and date of the expenses and the amount of the requested reimbursement. Such documentation must also include a statement that the expenses have not been reimbursed and are not reimbursable under any other plan of coverage and any other details about the expenses that the Claims Administrator requests. Claims for benefits will not be reimbursed until acceptable documentation substantiating the claims has been received by the Claims Administrator. Claims for expenses incurred during a Coverage Period under the Health FSA (including any required substantiation) must be submitted no later than 90 days following the end of the plan year (typically March 31).

Only expenses incurred while you are a participant and during the applicable Coverage Period may be reimbursed.

What if my request for reimbursement is denied?

If any claim under the Health FSA is denied, in whole or in part, the Claims Administrator must provide you with a written notice within a reasonable period of time, which generally shall not

exceed 30 days after the receipt of your claim. The Claims Administrator may extend this period by up to 15 days if it determines that an extension is necessary due to matters beyond the control of the Health FSA and notifies you prior to the expiration of the initial 30-day period of the circumstances requiring the extension of time and the additional time needed to make a decision. If the extension is necessary to request additional information, the extension notice will describe the required information and the amount of time the Participant has to submit the information, which will be at least 45 days. The Claims Administrator will make its determination within 15 days from receipt of a response from you, or if earlier, from the deadline for you to submit the information. If a claim is denied, the Claims Administrator shall provide you with a written notification that:

- Sets forth the reason or reasons for the denial;
- References the specific plan provisions on which the denial is based;
- Describes any internal rule, guideline, protocol or other similar criterion relied on in denying the claim (or includes a statement that you may obtain such information without charge upon request);
- Describes any additional material or information necessary for you to perfect the claim and explain why such information is necessary;
- Describes the claims review procedure to appeal a denial and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review;
- Includes a statement that the Claims Administrator will, at your request, provide free of charge, a copy of any internal rule, guideline, protocol, or other similar criteria relied on in denying the claim; and

How do I appeal my denied claim for reimbursement?

If any claim under the FSA is denied, in whole or in part, you may request a review upon written application to the Claims Administrator. Your appeal must be made in writing within 180 days after receipt of the notice of the claim denial. If you do not appeal on time, you lose your right to appeal the denial and your right to file suit in court. During this review process, you may submit written comments and other information related to your claim and you will have reasonable access to, and copies of, all documents and other information relevant to your claim free of charge. Any items you submit to the Claims Administrator will be considered without regard to whether the items were considered in the initial benefit determination.

Your appeal will be reviewed and decided in a reasonable time but not longer than 60 days after the Claims Administrator receives your request for review. In addition, the review of your denied claim must be conducted by a Plan fiduciary different from the fiduciary who originally denied your claim and who is not a subordinate to the fiduciary who originally denied your claim. If the original denial of your claim was based on a medical judgment, the reviewing fiduciary must

consult with an appropriate health care professional who was not consulted on the original claim and who is not subordinate to someone who was. The review must identify any medical or vocational experts consulted on the original claim. You may request, in writing, a list of those medical or vocational experts.

Within 60 days following your request for review of a denial of medical expenses, the Claims Administrator will, after providing you with a full and fair review, render its final decision in writing or electronically to you. The notice shall include:

- Set forth the reason or reasons for the denial;
- Reference the specific plan provisions on which the denial is based;
- Describe any internal rule, guideline, protocol or other similar criterion relied upon in denying the claim (or include a statement that you may obtain such information without charge upon request); and
- Describe your right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.

You must fully complete the claims review procedures described above before you (or any person claiming rights through you) may begin any lawsuit in connection with a claim for benefits under the Plan.

The Plan Administrator and any persons acting in a fiduciary capacity at the direction of the Plan Administrator shall have the maximum legal discretion to make decisions concerning the operation and administration of the Plan including, but not limited to, the provision or denial of benefits, and such decisions shall not be subject to further review unless determined to be an abuse of the Plan Administrator's discretion.

7. COBRA Continuation Coverage Under the Health FSA

COBRA CONTINUATION COVERAGE RULES FOR THE HEALTH FSA

What is “COBRA continuation coverage”?

COBRA refers to a federal law that ensures that associates and other “Qualified Beneficiaries” have the opportunity to continue health care coverage upon the occurrence of a “Qualifying Event” that would otherwise result in such person losing coverage under a group health plan. “COBRA continuation coverage” means your right, or your spouse’s and dependents’ rights, to continue to be covered under any group health plan offered under the Plan including the Health FSA.

Who are “Qualified Beneficiaries”?

A “Qualified Beneficiary” is any person who, at the time of a Qualifying Event, is a participant or a spouse or dependent of a participant covered under a group health plan offered under the Plan. The term Qualified Beneficiary also includes children born to or placed for adoption with a participant during the period of COBRA continuation coverage. *An individual who fails to elect COBRA continuation coverage within the election period described below shall not be considered a Qualified Beneficiary.*

What is a “Qualifying Event”?

Any of the following will be considered a “Qualifying Event” if it would otherwise cause the Qualified Beneficiary to lose coverage under a group health plan:

- Death of a covered associate
- Termination (other than by reason of gross misconduct) of the covered associate or reduction of his or her hours of employment
- Divorce or legal separation of a covered associate
- A covered associate becoming enrolled in Medicare benefits under Title XVIII of the Social Security Act (Part A, Part B, or both)
- A change of a dependent child to nondependent status under a group health plan
- (In the case of a retired associate) the employer filing for Chapter 11 bankruptcy

Do I have to pay anything for COBRA continuation coverage under the Health FSA?

You must pay premiums for any period of COBRA continuation coverage. In the case of the Health FSA, your premium would be the amount of the salary reduction you elected to be placed in your account. If you make the election after the Qualifying Event, any initial premiums due must be paid within 45 days of the date of the election. Subsequent premiums are due on the first of each month and must be paid within 30 days of their due date.

How do I elect COBRA continuation coverage?

When a Qualifying Event occurs, any Qualified Beneficiary entitled to COBRA continuation coverage shall have a period to elect continuation coverage which begins on the date the coverage terminates, is of at least 60 days duration, and which ends not earlier than 60 days after the later of (i) the date coverage terminates, or (ii) the date a required notice is given of continuation coverage rights.

What notices are required for COBRA continuation coverage?

The following notices are required upon occurrence of a Qualifying Event:

In the case of termination or reduction of hours, death, entitlement to Medicare, or Chapter 11 bankruptcy, the Plan Administrator shall furnish each Qualified Beneficiary with written notification of the termination of regular coverage and his or her right to elect continuation coverage.

In the case of divorce or legal separation, or a dependent child ceasing to be a dependent child under the group health plan (as more specifically described above), a Qualified Beneficiary must notify the Benefit Specialist in writing within 60 days of the Qualifying Event.

Each Qualified Beneficiary who is determined, under Title II or XVI of the Social Security Act, to have been disabled at the time of a covered associate's termination or reduction in hours or during the first 60 days of COBRA continuation coverage, is responsible for notifying the Plan Administrator of such determination within 60 days after the date of the determination and for notifying the Plan Administrator within 30 days of the date of any final determination under such title or titles that the Qualified Beneficiary is no longer disabled.

IMPORTANT:

If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

If you experience a COBRA Qualifying Event, you must notify the Plan Administrator within 31 days. You must provide written notice (oral notification will not be accepted) via e-mail, U.S. Mail or fax to:

**Life Care Centers of America, Inc.
3001 Keith Street
Cleveland, TN 37320-3480
423-472-9585**

Once the Plan Administrator or its designee 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. Covered associates may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their minor children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

How long can a Qualified Beneficiary continue COBRA coverage?

Qualifying Events for Continuation Coverage under COBRA

The following table outlines situations in which you may elect to continue coverage under COBRA for yourself and your Dependents, and the maximum length of time you can receive continued coverage. These situations are considered qualifying events.

If Coverage Ends Because of the Following Qualifying Events:	You May Elect COBRA		
	For Yourself:	For Your Spouse	For Your Child(ren)
Your work hours are reduced	18 months	18 months	18 months
Your employment terminates for any reason (other than gross misconduct)	18 months	18 months	18 months
You or your family member become eligible for Social Security disability benefits at any time within the first 60 days of losing your coverage	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce (or legally separate)	N/A	36 months	36 months
Your child is no longer an eligible family member (e.g., reaches the maximum age limit)	N/A	N/A	36 months
You become entitled to Medicare	N/A	See table below	See table below
SiteOne Landscape Supply files for bankruptcy under Title 11, United State Code.	36 months	36 months	36 months

Automatic Termination of Continuation Coverage. COBRA continuation coverage shall automatically cease if (1) the Company no longer offers any group health plan to any of its associates, (2) the required premium for continuation coverage is not paid within 30 days of the date due (except 45-days in case of the initial premium), (3) after COBRA continuation coverage is elected, a Qualified Beneficiary becomes covered under another group health plan that does

not exclude or limit coverage for a preexisting condition of such individual, or (4) after COBRA continuation coverage is elected, a Qualified Beneficiary becomes enrolled in Medicare.

For More Information

If you have any questions concerning your rights to COBRA continuation coverage of your health care reimbursement benefits, you should contact the Plan Administrator,

Life Care Centers of America, Inc.
3001 Keith Street, NW
Cleveland, TN 37312
(866) 353-0441

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), and other laws affecting group health Plan, contact the U.S. Department of Labor’s Associate Benefits Security Administration (“EBSA”) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA officers are available through the EBSA’s website.)

Keep Your Plan Administrator Informed of Address Changes

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

8. ERISA Rights Under the Health FSA

YOUR RIGHTS UNDER ERISA REGARDING THE HEALTH FSA

If you participate in either the Health FSA, this section applies to you.

As a participant in the Health FSA, you are entitled to certain rights and protections under the Associate Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all Plan documents, 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 Pension and Welfare Benefits Administration.

Obtain, upon written request to the Plan Administrator, copies of all documents governing the 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 the summary annual report.

Continue Group Health Plan Coverage

You have a right to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under a group health plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You have a right to a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months

after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 an associate benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants and beneficiaries. No one, including the Company 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 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 any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may request the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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 domestic relations order or 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 questions about your 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 Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits 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 Pension and Welfare Benefits Administration.

Qualified Medical Child Support Order

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

HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health (HITECH) Act, is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As a group health plan under ERISA, the Health FSA is subject to the HIPAA privacy and security rules. Pursuant to the HIPAA privacy and security rules, the Health FSA will not use or disclose your protected health information without your authorization, except for purposes of payment, health care operations, plan administration or as required or permitted by law. You may request a description of the uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy and security rules as set forth in the Notice of Privacy Practices related to the Health FSA, by contacting the HIPAA Privacy Officer at:

Life Care Centers of America, Inc.
3001 Keith Street, NW
Cleveland, TN 37312
(866) 353-0441

The Company Medical Plan and Other Group Insurance Plan Documents and Information

This Summary Plan Description does not describe the Medical Plan, the Dental Plan, the Vision Plan or any other group insurance plan. Consult the Medical Plan document, the Dental Plan document, and the separate summary plan descriptions for the Medical Plan and the Dental Plan. Neither does this Summary Plan Description describe any other group insurance benefit sponsored by the Company. Consult the applicable group insurance benefit plan document and separate summary plan description for that particular benefit.

9. Special Rules for the Dependent Care FSA

The Dependent Care FSA is designed to help you pay for qualified dependent care expenses that make it possible for you and your spouse to work. It also may be used to help pay for the care of a disabled spouse or dependent.

A number of special rules apply to the Dependent Care FSA.

Dependent care expenses reimbursed through the Plan *cannot also be claimed as a credit for income tax purposes.*

What is the basic purpose of coverage under the Dependent Care FSA?

The Dependent Care FSA has the effect of letting you pay on a pre-tax basis for someone to watch over your “Qualified Dependent” so that you and/or your spouse can work.

Who counts as a “qualifying dependent?”

There are two types of qualifying dependents.

- The first is your or your spouse’s dependent child who is under age 13 and who you or your spouse is entitled to claim as a dependent on your federal income tax return. Note: If you are divorced, you must be the custodial parent of your dependent child in order to incur eligible dependent care expenses on his or her behalf;
- The second is your spouse or other tax dependent who is physically or mentally incapable of caring for him or herself and who has the same principal place of abode as you for more than half the year.

What kind of expenses can be reimbursed under the Dependent Care FSA?

The only types of expenses that can be reimbursed under the Dependent Care FSA are Qualified Dependent Care Expenses. Medical, dental, vision, and prescription drug coverage do not count as Qualified Dependent Care Expenses.

What are “Qualified Dependent Care Expenses?”

Qualified Dependent Care Expenses are expenses that meet all of the following requirements:

- The expense was paid for custodial care provided during the Coverage Period;
- The care was provided to your Qualifying Dependent(s);

- The expense was incurred to enable you and your Spouse (if married) to be gainfully employed during a period in which you have a Qualifying Dependent;
- The expense was incurred for services at your household or, if the expenses are incurred for services outside your home, the expenses are incurred for the care of a dependent under the age of 13, or a dependent who regularly spends at least 8 hours per day in your household;
- If the expenses are incurred for care provided outside your home at a facility that provides care for more than six individuals who do not regularly reside at the facility (such as a day care center), the facility must comply with all applicable state and local laws and regulations, including licensing requirements, if any;
- The expenses are not paid or payable to your Spouse;
- The expenses are not paid or payable to your child who is under age 19 at the end of the year in which expenses are incurred; and
- The expenses are not paid to any individual that you or your spouse are entitled to claim as a dependent for purposes of a personal exemption on your federal income tax return.

What if I don't spend the entire amount in my reimbursement accounts?

Under Internal Revenue Service rules, any unspent portion of payroll deductions for your Dependent Care FSA account at the end of the Coverage Period cannot be returned to you. The Coverage Period is the plan year (i.e. the 12-month period that ends on December 31. The deadline for submission of reimbursement requests for expenses incurred during the Coverage Period is 90 days following the end of the plan year. Federal law requires that the balance of your contributions be forfeited after the deadline. *Because this is possible, you must carefully evaluate the amount you elect to contribute to the Plan.*

A portion of the amounts you elect for qualified dependent care expenses will be allocated to your account(s) each pay period and reimbursed to you upon request.

How do I request reimbursement of dependent care expenses?

When you want to be reimbursed, you simply submit a claim form and the required attachments to the Claims Administrator. Claim forms are available from your Plan Administrator and on the Claims Administrator website. Reimbursement payments will be made as soon as administratively feasible.

Claims for benefits under the Dependent Care FSA shall be presented to the Claims Administrator in accordance with procedure established by the Claims Administrator. To submit a claim for dependent care expenses, documentation that substantiates the claim must include a written statement from an independent third party stating that the dependent care expense has

been incurred and the amount thereof, and a written statement by you that the expense has not been reimbursed and is not reimbursable under any other plan or coverage. Claims for expenses incurred during a plan year under the Dependent Care FSA must be submitted no later than 90 days following the end of the plan year.

Only expenses incurred while you are a participant and during the applicable plan year may be reimbursed.

You must fully complete the claims review procedures described above before you (or any person claiming rights through you) may begin any lawsuit in connection with a claim for benefits under the Plan.

The Plan Administrator and any persons acting in a fiduciary capacity at the direction of the Plan Administrator shall have the maximum legal discretion to make decisions concerning the operation and administration of the Plan including, but not limited to, the provision or denial of benefits, and such decisions shall not be subject to further review unless determined to be an abuse of the Plan Administrator's discretion.

Plan Summary List

PLAN NAMES	Life Care Centers of America, Inc. Cafeteria Plan
EMPLOYER NAME AND ADDRESS	Life Care Centers of America, Inc. 3001 Keith Street, NW Cleveland, TN 37312 (866) 353-0441
EMPLOYER ID NUMBER	62-0963862
TYPE OF PLAN	Flexible compensation plan with options for health care spending accounts, and dependent care spending accounts as well as pretax payment of premium expenses.
PLAN FISCAL YEAR	January 1 - December 31
PLAN ADMINISTRATOR, AGENT FOR LEGAL SERVICE, AND NAMED FIDUCIARY	Life Care Centers of America, Inc. 3001 Keith Street, NW Cleveland, TN 37312 (866) 353-0441
PLAN ADMINISTRATION	The Plan is administered by the Benefits Committee for the Company with claims administration for the Health FSA, and the Dependent Care FSA delegated to HealthEquity as the Claims Administrator.
CLAIM ADMINISTRATION	Claims under the Plan are administered by the Claims Administrator appointed by the Plan Administrator. HealthEquity healthequity.com