SUMMARY PLAN DESCRIPTION
FOR THE
LIFE CARE CENTERS OF AMERICA, INC.
WELFARE BENEFITS PLAN

Amended and Restated
January 1, 2022

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1. INTRODUCTION

Life Care Centers of America, Inc. is the sponsor of the Welfare Benefits Plan (the "Plan"). The Plan provides eligible employees with welfare benefits such as those described in Attachment A (the "Benefits"). Benefits are also provided to eligible employees of those companies affiliated with the Company who has adopted the Plan, as identified in Attachment B.

This document, along with the attached or previously distributed Benefit Booklets, Summary Plan Descriptions, Plans, Certificate Booklets, HMO Contracts and Certificates of Insurance (the "Booklets"), is the summary plan description for the Plan. All of the Booklets are incorporated into this summary plan description by reference.

This document is intended to describe the features of the Plan. However, this is only a summary of the important features of the Plan, and it cannot explain every situation that might arise. The Plan is governed by a separate legal document that is available for your review. If there is a conflict between this summary and the legal documents for the Plan, the legal documents will control, unless stated otherwise herein.

The Company has the right to amend or terminate the Plan, or any Benefit provided under the Plan (including the right to change the Insurer providing a Benefit) at any time, in its sole discretion. You will be notified of any changes which are made to the Plan that change the information provided in this summary.

The Company and/or any claims fiduciaries have the discretion and authority to determine eligibility and claims for benefits and interpret the terms of the Plan.

The Plan will not be deemed to constitute a contract between the Company and any Participant or Employee. Neither a Participant nor beneficiary in this Plan has any right to assign his rights or benefits or any cause of action arising at any time against the Company, Plan or Plan Sponsor to any third party. Any assignments of rights, benefits or causes of action under the Plan will be void and unenforceable.

This summary plan description contains only that information and those Booklets providing benefits to the particular facility at which the employee works for which they are eligible. Other employees may have received different Booklets describing Benefits available to them.

In this document, capitalized terms have a special meaning. You should refer to the end of the document for the definitions of any capitalized terms.

2. ELIGIBILITY

The Employees eligible to participate in a Benefit and the waiting periods and effective dates of coverage for a Benefit are generally described in the attached or previously distributed Booklets. Notwithstanding the information provided in the Booklets, Employees eligible to participate in this Plan and in any Covered Benefit are full-time Employees who regularly work 30 or more hours per week for the Company. Eligibility for health Benefits for new Employees classified by the Company as variable hour, seasonal or part-time Employees or for all ongoing Employees is governed by the Eligibility Policy attached hereto as Attachment D. Employees designated in writing by the Company as a Pay In Lieu of Benefits Employee or have a job title that is designated by the Company as a Pay In Lieu of Benefits position for the geographic location in which the Employee works is eligible to participate in this Plan and in any Covered Benefit if such Employee elects benefits coverage instead of cash in the form required by the Company and otherwise meets the eligibility requirements set forth herein.

Employees may elect dependent coverage in any Covered Benefit as specified in the summary plan descriptions, plans, contracts, policies, or other written instruments governing the Covered Benefits, except that a spouse of an Employee is only eligible for coverage in the Life Care Centers of America, Inc. Associate Benefit Plan if the spouse and Employee are legally married by obtaining and recording a marriage license with the appropriate agency under the laws of the applicable state in which the spouse and Employee reside at the time of marriage.

Notwithstanding the information provided in the Booklets, coverage begins under the Benefits of this Plan on the day coincident with or on the first day of the next calendar month following 60 days of the Employee's employment with the Company. This period is called a waiting period and coverage under the Benefits of this Plan do not begin until the waiting period is satisfied.

Employees who return to work from a leave of absence other than approved Family and Medical Leave Act (FMLA) leave or Military Leave, may have to satisfy a new waiting period before coverage for a Benefit again becomes effective, as described in the applicable Booklets. However, with respect to health Benefits, an Employee must satisfy a new waiting period only if the Employee returns to work after a period of at least thirteen consecutive weeks of having no hours of service for the Company, or if less than thirteen consecutive weeks, the period of absence with no hours of service for the Company is less than the employment period with the Company immediately before the absence began.

3. TERMINATION OF PARTICIPATION

Coverage under a Benefit ends at the times described in the attached or previously distributed Booklets. In some instances, you may be able to elect to convert your coverage to an individual policy of insurance. Please refer to the applicable Booklets for more information. Also, if your coverage under a Group Health Plan ends, you may be eligible to elect COBRA continuation coverage, as described later in this summary.

You are required to pay premiums for your elected benefits under this Plan. If your pay for any pay period is less than the required premiums for your coverage, you are required to remit

your premium payments directly to the Plan Administrator within three business days following the date such premiums would have been deducted from your pay if your pay was sufficient to cover the premiums. If you fail to timely make the required premium payment on a timely basis, the Company will terminate your coverage retroactive to the date for the coverage period for which the premium was unpaid.

4. LEAVES OF ABSENCE

A. Family and Medical Leaves. If the Company is subject to the federal Family and Medical Leave Act ("FMLA") and you are absent from work for a family or medical leave covered by the FMLA, you may revoke your election of coverage under a Group Health Plan and reinstate coverage when you return from the FMLA leave.

If you elect to maintain your Group Health Plan coverage during your absence and your leave is a paid leave, payroll deductions will continue in accordance with your election. If you wish to maintain your coverage under these programs and your leave is unpaid, you must pay the premiums for the coverage using one of the following methods:

i. Prepayment. Under the prepayment option, you may (at your option) increase your salary reduction in an amount sufficient to cover the premiums that will come due during the FMLA leave during the same Plan Year. Alternatively you can elect to prepay the premiums that will come due during the leave on an after-tax basis.

ii. Pay-as-you-go. With the pay-as-you-go option, you continue to pay premiums on a regular basis throughout the FMLA leave. If you choose this option, you will have to reimburse the Company at regular intervals from your after-tax funds for the premiums that come due during the leave. Your coverage will end if you fail to make the payments required under this option.

B. Military Leaves. If you are absent from work for active military duty that is covered by the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"), your right to continued participation in the Plan will be as follows:

i. If you are absent from work for less than 31 days, your coverage under a Group Health Plan will be continued at active employee rates.

ii. If you are absent for more than 30 days, you may elect to continue coverage under a Group Health Plan for up to 24 months or the period of your military service, whichever is shorter. You may be required to pay up to 102% of the normal premium for this continued coverage. If you elect not to continue coverage under a Group Health Plan, your coverage will be reinstated to the extent required under USERRA upon your return to employment.

C. Payment of Premiums During Unpaid Leave. If you are absent from work on unpaid leave for any reason and you remain covered under a Benefit, you must timely pay the required premium for coverage on the same date such premiums would have been deducted from your pay if you were actively at work. If you fail to timely make the required premium payment

on a timely basis, the Company will terminate your coverage retroactive to the date for the coverage period for which the premium was unpaid.

5. ENROLLMENT PROCEDURES

If you are eligible for and wish to become covered under a Benefit, you must complete any required enrollment forms through the plan's website at: lcca.hrintouch.com. The attached or previously distributed Booklets describe the deadlines for completing the enrollment forms. If you do not enroll for coverage on a timely basis, your coverage under a Benefit may be delayed or subject to evidence of insurability requirements.

The Booklets for the health plans describes special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA). In addition to the HIPAA special enrollment rights described in the Booklets, a special enrollment period is available in the health plans if coverage of an eligible Employee, spouse or dependent child under Medicaid or under the Children's Health Insurance Program (CHIP) terminates due to loss of eligibility; or an eligible Employee, spouse or dependent child becomes eligible for a CHIP premium assistance subsidy. The special enrollment period described in this paragraph is available for 60 days following the date of the event. The Employee, spouse or dependent child must request special enrollment by contacting the Plan Administrator within 60 days of the occurrence of one of these events or by making the change through the plan's website at: lcca.hrintouch.com.

6. BENEFITS AND COSTS OF COVERAGE

The benefits provided under a Benefit are described in detail in the attached or previously distributed Booklets. Under the health and dental plan, you may receive services at a lower cost by using a network provider, as described in the attached or previously distributed Booklets. A list of participating providers will be provided to you automatically, free of charge.

The Benefits available under the Plan are provided through contracts of insurance with insurance companies (the "Insurers") in return for premium payments paid to the Insurers. As described in Attachment C, the Company pays the cost of certain Benefits, while the cost of other Benefits are shared by the Company and eligible employees or are paid entirely by eligible employees. The Company forwards all contributions that it or eligible employees make for coverage under a Benefit directly to the Insurers as premium payments, when the Benefit is provided under a contract of insurance.

The cost of coverage under a Benefit may change from time to time. The current cost for coverage under a Benefit is described on Attachment C to this summary. The Company will inform eligible employees of any change in the cost of a Benefit.

Note: In accordance with the Women's Health and Cancer Rights Act of 1998, the health plans will cover certain breast reconstructive benefits in connection with a mastectomy. If you choose breast reconstruction in connection with a mastectomy, coverage is available in a manner determined in consultation with you and your Physician for:

i. **Reconstruction of the breast on which the mastectomy was performed**

ii. **Surgery and reconstruction of the other breast to produce a symmetrical appearance**

iii. **Prosthesis and treatment of physical complications for all stages of mastectomy, including lymphedemas**

Such coverage is subject to all the terms of the Plan, including relevant deductibles and coinsurance provisions.

7. CLAIMS PROCEDURES

To obtain a Benefit, you should follow the claims procedures described in the attached or previously distributed Booklets. However, the following claims procedures also apply to any claim for a Benefit, and take precedence over any conflicting procedures in the Booklets.

A Participant or his or her duly authorized representative ("Claimant") may file a claim for a Benefit, and may appeal the denial of a claim. All claims and appeals should be filed directly with the Insurer, if the Benefit is provided through a contract of insurance; if the Benefit is not provided through a contract of insurance, the claim should be filed with the Claims Processor and any appeals should be filed with the Plan Administrator. The Insurer, Claims Processor, and the Plan Administrator are referred to as the Claims Adjudicator for purposes of these claims procedures. The Claims Adjudicator will decide claims in a consistent manner with respect to similarly situated Claimants.

A. Claims Not Involving Health or Disability Benefits. If a claim for a Benefit is wholly or partially denied, the Claims Adjudicator will notify the Claimant of its decision in writing. The notice will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the denial, (ii) specific reference to pertinent Plan provisions, (iii) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary, and (iv) a description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review. The notice will be provided within 90 days after the claim is received by the Claims Adjudicator (or within 180 days, if special circumstances require an extension of time for processing the claim, and if written notice of the extension, the circumstances requiring the extension, and the date a decision is expected to be made, is provided within the initial 90 day period). If the notice is not provided within this period, the claim will be considered denied as of the last day of the period and the Claimant may request a review of the claim.

Within 60 days after the date of a written notice of denial (or, if applicable, within 60 days after the date on which the denial is considered to have occurred) the Claimant may (i) file a written request with the Claims Adjudicator for a review of the claim, and (ii) submit written comments, records and other information to the Claims Adjudicator. The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The Claims Adjudicator will provide for a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. Written notice regarding the decision on review will be provided to the Claimant. The notice will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the decision, (ii) specific references to pertinent Plan provisions, and (iii) an explanation that the Claimant can have access to or copies of relevant documents upon request and without charge. The decision on review will be made within 60 days after the request for review is received by the Claims Adjudicator (or within 120 days, if special circumstances require an extension of time for processing the request, such as an election by the Claims Adjudicator to hold a hearing, and if written notice of the extension, the circumstances requiring the extension, and the date a decision is expected, is given to the Claimant within the initial 60 day period). If the decision on review is not made within this period, the claim will be considered denied.

B. Claims Involving Disability Benefits. All disability claims will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions such as claims adjudicators and medical/vocational experts (i.e., not based on the likelihood that the individual will support the denial of benefits).

If a claim is for a disability benefit, the claim procedure described above applies, except that notice of the initial decision regarding the claim will be provided within 45 days of receipt of the claim. The 45-day period may be extended for an additional 30 days if the extension is necessary due to matters beyond the control of the Claims Adjudicator, and the Claimant receives notice of the extension prior to the expiration of the initial 45-day period, including an explanation of the circumstances requiring the extension and the date by which the Claims Adjudicator expects to make a decision. The 30-day extension period can be extended for a second period of 30 days due to matters beyond the control of the Claims Adjudicator, provided the Claimant again receives notice prior to the expiration of the first extension period in the same manner as for the first extension. Any notice of an extension will explain the standards upon which entitlement to a benefit is based, the unresolved issues that prevent a decision from being made, and any additional information that is needed to resolve those issues. If the Claimant is asked to provide additional information so that the claim can be adjudicated, the Claimant will have 45 days to provide the additional information.

In the case of an adverse determination with respect to a claim, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Claims Adjudicator will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request.

A Claimant has 180 days following the receipt of an adverse determination involving a disability benefit to request a review of the determination. If a review of the adverse decision is requested, (i) no deference will be given to the initial decision, and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial decision nor a subordinate of that individual, (ii) if the initial decision was based in whole or in part on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the

medical judgment, (iii) the Claims Adjudicator will provide to the Claimant the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied on in making the determination, and (iv) any health care professional engaged for purposes of reviewing the initial decision will be an individual who is neither an individual who was consulted in connection with the initial decision, nor a subordinate of that individual. You are guaranteed right to present evidence and testimony to support your claim during the appeal process. You will be given a fair opportunity to respond to new or additional evidence or rationales before they become a basis for denials and filing an appeal.

The Claims Adjudicator must notify the Claimant of its decision on review within 45 days after the request for review is received, or within 90 days if special circumstances require an extension of time, the Claimant is given written notice of the extension within the first 45-day period, and the notice describes the special circumstances and indicates the date a decision is expected to be made.

The notice of the decision on appeal will be written in a manner calculated to be understood by the Claimant and will contain, in a culturally and linguistically appropriate manner, (i) specific reasons for the decision, (ii) standards that govern the decision for denial, (iii) specific references to pertinent Plan provisions upon which the denial is based (iv) a description of any additional material or information needed and why such material or information is necessary, (v) a description of the review procedures and time limits (including a statement of the Claimant's right to bring a civil action under Section 502(a) of the Act and a description of any contractual limitation period that applies to bringing an action including the date the period expires, (vi) a discussion of the decision with an explanation for disagreeing with the (a) views of the Claimant's health care, professional treating, or vocational professionals evaluating the Claimant (b) the views of the medical or vocational experts or the determination of the medical or vocational professional whose advice was obtained (whether or not relied upon), and (c) any Social Security Administration disability determination; (viii) an explanation that the Claimant can have access to or copies of relevant documents upon request and without charge, (ix) a statement that the Claimant is entitled to receive, upon request, all documents relevant to the claim, and (x) a summary of any new or additional evidence considered, relied upon, or generated and/or any rationale applied by the Plan in making the decision. You will be given timely notice of your right to access your entire claim file and relevant documents, free of charge

In the case of an adverse determination on appeal, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Claims Adjudicator will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that either (i) a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request or (ii) that such rules, guidelines, protocols, standards, or other similar criteria do not exist. In addition, if an adverse decision is based on medical necessity or experimental treatment or a similar exclusion or limit, the Claims Adjudicator will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If a Claimant chooses a 502(a) remedy, the claim and appeal is deemed denied on review without exercise of discretion by an appropriate fiduciary.

The notice will also contain the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

C. Claims Involving Health Benefits. If a claim is for a health benefit, the claim procedure described above applies, except that:

i. In the case of a claim involving urgent care, the Claims Adjudicator will notify the Claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Claims Adjudicator will notify the Claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claims Adjudicator will notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (i) the Plan's receipt of the specified information, or (ii) the end of the period afforded the Claimant to provide the specified additional information. If the decision regarding the claim is adverse, the notice will include a description of the expedited review process applicable to the claim.

ii. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments (i) any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Claims Adjudicator will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of the adverse benefit determination before the benefit is reduced or terminated, and (ii) any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Claims Adjudicator will notify the Claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

iii. In the case of a claim not described in paragraphs (i) or (ii) above, the Claims Adjudicator will notify the Claimant of the Plan's benefit determination:

(a) In the case of a pre-service claim, within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Adjudicator both determines that such an extension is necessary due to matters beyond the

control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(b) In the case of a post-service claim, within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Claims Adjudicator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

If a Claimant fails to follow the Plan's procedures for filing a pre-service claim, the Claimant will be notified of the failure and of the proper procedures to be followed. The notice will be provided as soon as possible, but not later than 5 days (24 hours in the case of a failure involving an urgent care claim) following the failure.

In the case of an adverse determination with respect to a claim, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Claims Adjudicator will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request. In addition, if an adverse decision is based on medical necessity or experimental treatment or a similar exclusion or limit, the Claims Adjudicator will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

A Claimant has 180 days following the receipt of an adverse determination involving a health benefit to request a review of the determination. If a review of the adverse decision is requested, (i) no deference will be given to the initial decision, and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial decision nor a subordinate of that individual, (ii) if the initial decision was based in whole or in part on a medical judgment, including whether a treatment, drug or item is experimental or investigational or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted during the initial decision and is not a subordinate of such a person, (iii) the Claims Adjudicator will provide to the Claimant the identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse determination, without regard to whether the advice was relied on in making the determination, and (iv) any health care professional engaged for purposes of reviewing the initial decision will be an individual who is neither an individual who was consulted in connection with the initial decision, nor a subordinate of that individual. If the claim is an urgent

care claim, the Claimant will have available an expedited appeal process, can submit a request for review orally or in writing, and can submit information regarding the appeal by phone or other expeditious method.

The Claims Adjudicator must notify the Claimant of its decision on review within 72 hours of the date the request was received if the appeal involves an urgent care claim, within 30 days if the appeal involved a pre-service claim, and within 60 days if the appeal involves a post-service claim. The notice of the decision on appeal will be written in a manner calculated to be understood by the Claimant and will contain (i) specific reasons for the decision, (ii) specific references to pertinent Plan provisions, and (iii) an explanation that the Claimant can have access to or copies of relevant documents upon request and without charge. In the case of an adverse determination on appeal, if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the decision, the Claims Adjudicator will notify the Claimant that such a rule, guideline, protocol or other similar criterion was relied on, and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon written request. In addition, if an adverse decision is based on medical necessity or experimental treatment or a similar exclusion or limit, the Claims Adjudicator will provide either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also contain the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

D. Extended Claims and Appeals Deadlines. Notwithstanding the claims procedure deadlines described in the attached or previously distributed Booklets, and Section 7.A – 7.C above, the period from March 1, 2020 until 60 days after the end of the declared COVID-19 National Emergency ("Outbreak Period") will not count toward the following deadlines:

- The deadline to file a claim for benefits under the Plan.
- The deadline to file an appeal of a denied claim.
- The four-month deadline to request an external review of eligible denied medical claims.
- The deadline to supply the Plan with any additional information needed for an external review of eligible denied medical claims.
- The deadline to submit a claim for reimbursement under the health flexible spending account provisions of the Flex Plan.

8. RIGHTS TO CONTINUE COVERAGE UNDER FEDERAL LAW (COBRA)

A. General. If you are a Qualified Beneficiary, you have the right to continue your coverage under a Group Health Plan if you lose that coverage due to a Qualifying Event. If you are an employee, you are a Qualified Beneficiary if you are covered by the Group Health Plan on the day prior to a Qualifying Event that is your termination of employment (for reasons other than

gross misconduct) or a reduction in your hours of employment. If you are the spouse or dependent child of an employee, you are a Qualified Beneficiary if you are covered by the Group Health Plan on the day prior to a Qualifying Event. A child born to or placed for adoption with an employee during a period of COBRA coverage is also a Qualified Beneficiary. Employees who are nonresident aliens with no U.S.-source income, and the spouse or dependent children of such employees, are not Qualified Beneficiaries.

A Qualifying Event means each of the following events, if it causes a Qualified Beneficiary to lose coverage under a Group Health Plan:

i. The employee's hours of employment are reduced;

ii. The employee's employment ends for any reason other than gross misconduct (as defined below);

iii. The death of the employee;

iv. The employee's entitlement to Medicare benefits;

v. A divorce or legal separation between the employee and his or her spouse; or

vi. For a dependent child, the child's ceasing to satisfy the definition of a dependent under the terms of the applicable program.

Sometimes, filing a proceeding in bankruptcy under Title II of the United States Code can be a qualifying event. If a proceeding in a bankruptcy is filed with respect to the Company, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

If you are a Qualified Beneficiary and you lose coverage under a Group Health Plan due to the first four Qualifying Events listed above, or if you are a retired employee and lose coverage as a result of bankruptcy of the Company, you will automatically receive a Qualifying Event notice from the Plan Administrator of your right to elect COBRA continuation coverage. **However, if you are a Qualified Beneficiary and you lose coverage under a Group Health Plan due to a divorce or legal separation, or due to a child's loss of dependency status, <u>you must notify the Plan Administrator of the event within 60 days after the Qualifying Event occurs</u> or you will lose your right to elect COBRA continuation coverage.**

As indicated previously, an employee's termination of employment for gross misconduct is not considered a Qualifying Event. Gross misconduct means conduct that could have an adverse impact on the business of the Company, including but not limited to theft, embezzlement, and serious violations of Company policy that subject an employee to dismissal.

In response to the COVID-19 emergency, certain deadlines with respect to COBRA continuation coverage have been extended effective March 1, 2020 and will not expire until 60 days after the end of the COVID-19 emergency ("Outbreak Period").

B. Electing COBRA Coverage. If you are a Qualified Beneficiary and you experience a Qualifying Event, you will receive a Qualifying Event notice from the Plan Administrator describing your rights to elect COBRA continuation coverage, as well as an election form you can use to apply for that coverage. Remember, if the Qualifying Event is a divorce, legal separation, or a child's loss of dependency status, you must first notify the Plan Administrator of the event before this notice will be sent to you. If you do not receive a Qualifying Event notice and election form within 30 days of your Qualifying Event (or within 14 days of the date you notified the Plan Administrator of a Qualifying Event, if applicable), you should contact the Plan Administrator.

Although each Qualified Beneficiary has an independent right to elect COBRA coverage, the Qualifying Event notice and election form will usually only be sent to the employee and spouse, at the employee's address shown in the records of the Plan. However, if the records of the Plan show that the employee and spouse live at different locations, or that a dependent child lives at a different location, separate notices will be sent. For this reason, it is very important that you keep the Plan Administrator informed of your current address and the addresses of your spouse and covered dependents. Again, each Qualified Beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA coverage will be provided only if it is elected by a Qualified Beneficiary during the COBRA election period. The COBRA election period begins on the date of the Qualifying Event and ends 60 days after the date a Qualifying Event Notice is sent to the Qualified Beneficiary or, if later, the date the Qualified Beneficiary would otherwise lose coverage as a result of the Qualifying Event. However, beginning March 1, 2020, the COBRA election period for Qualifying Events is paused and will not start again until the end of the Outbreak Period. For elections sent by mail, the postmark date is used to determine whether an election was made prior to the end of the COBRA election period.

If elected, COBRA coverage begins on the date coverage would otherwise have been lost. The Plan does not permit you to waive COBRA coverage during the election period and then revoke the waiver before the end of the election period in order to elect coverage as of a date other than the date coverage was initially lost.

Prior to the time a Qualified Beneficiary elects COBRA coverage, his or her coverage under the Plan will be terminated. However, the coverage will be retroactively reinstated to the date coverage was lost following a timely election of COBRA coverage and the timely payment by the Qualified Beneficiary of the first premium payment. This means that, until you elect COBRA coverage, any provider who asks will be told that your coverage has been terminated, but may be retroactively reinstated if you timely elect and pay for COBRA coverage.

C. Paying for COBRA Coverage. Qualified Beneficiaries must pay for each one-month period of COBRA coverage on a monthly basis. A period of COBRA coverage runs from the first day of the month through the end of that month, except that the initial period of coverage runs from the date coverage was lost due to the Qualifying Event, through the end of the month in which the Qualifying Event occurred.

The cost for each one-month period of COBRA coverage depends on the type of coverage that is being continued. The cost will be communicated to you in the Qualifying Event notice sent to you by the Plan Administrator. The cost may change at the beginning of each Plan Year. Any changes will be communicated to you.

The first payment for COBRA coverage must be postmarked or received by the Plan no later than 45 days after the date you elect COBRA coverage. However, the 45-day period to make the initial COBRA payment is suspended effective March 1, 2020 and will not start again until the end of the Outbreak Period The first payment must include payment for all one-month periods of coverage that have begun between the date coverage was lost and the date the first premium payment is received. If the payment is not postmarked or received within 45 days of the date you elected COBRA coverage, you will lose your right to COBRA coverage.

Payments for subsequent one-month periods are due on the first day of those periods and should be sent to the Plan Administrator. You will have a 30-day grace period to send in these payments, but they must be postmarked or received no later than 30 days after the first day of the coverage period or your COBRA coverage will be terminated retroactively to the first day of that period and cannot be reinstated. However, the 30-day period to make the subsequent COBRA payment is suspended effective March 1, 2020 and will not start again until the end of the Outbreak Period Any payment that is less than the full premium payment due will not be accepted unless the balance is paid prior to the end of the normal grace period. In some cases, however, if your payment is not significantly less than the applicable premium, you will have 30 days following the date you are notified of the shortfall to make up the balance.

If payment for a period of COBRA coverage is made after the first day of that period, your coverage will be continued but will be subject to retroactive termination if payment for that period is not received during the grace period. However, any claims incurred prior to payment will not be processed until payment is made. This means that, until you pay for COBRA coverage, any health care provider who asks will be told that your coverage is in force, but may be retroactively terminated if you do not timely pay for COBRA coverage. In addition, you will be required to reimburse the Plan for any claims that are paid if you do not subsequently send in timely payment.

D. Application of Deductibles and Other Plan Limits. If COBRA coverage begins during the middle of a Plan Year, the Qualified Beneficiary's deductibles for the remainder of the Plan Year will be administered as follows:

i. Each Qualified Beneficiary who elects COBRA coverage will receive credit for any expenses previously applied during the Plan Year to his or her individual deductible.

ii. If the Qualified Beneficiary was previously part of a family unit, only those expenses incurred by family members electing COBRA coverage will be credited. If the Qualifying Event results in more than one family unit (for example, due to a divorce), the expenses incurred by the members assigned to a given family unit following the COBRA election will be credited as of the date coverage begins.

Other Plan limits will be applied consistent with the rules applicable for deductibles.

E. Duration of COBRA Coverage. COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA continuation coverage for Qualified Beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

When the Qualifying Event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

i. If you or anyone in your family covered under a Group Health Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must make sure that the Plan Administrator is notified of the SSA's determination before the end of the 18-month period of COBRA continuation coverage and not later than 60 days after the latest of (i) the date of the disability determination by the SSA, (ii) the date on which a Qualifying Event occurs, or (iii) the date on which you or another Qualified Beneficiary loses (or would lose) coverage under the program as a result of the Qualifying Event. However, the 60-day period to notify the Plan Administrator of the SSA's determination is suspended effective March 1, 2020 and will not start again until the end of the Outbreak Period. If a Qualified Beneficiary who was previously determined by the SSA to be disabled is subsequently determined by the SSA to be no longer disabled, you must notify the Plan Administrator of that determination within 30 days of the date you receive the determination from the SSA.

ii. In addition, if your family experiences another Qualifying Event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available only if the second event would have caused the spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, you must make sure that the Plan Administrator is notified of the second Qualifying Event within 60 days of the event. However, the 60-day period to notify the Plan Administrator of a second Qualifying Event is suspended effective March 1, 2020 and will not start again until the end of the

Outbreak Period. Only individuals who were Qualified Beneficiaries in connection with the first Qualifying Event and who are still Qualified Beneficiaries at the time of the second Qualifying Event are eligible for this extension.

COBRA coverage will end prior to the 18-, 29- or 36-month period described above under the following circumstances:

i. the first day of a coverage period for which timely payment is not made;

ii. the date the Company ceases to provide any group health plan to any employee;

iii. the date, after the date a COBRA election is made, upon which the Qualified Beneficiary first becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary;

iv. the date, after the date a COBRA election is made, upon which a Qualified Beneficiary first becomes entitled to Medicare benefits;

v. the first day of the coverage period that is more than 30 days after the date a Qualified Beneficiary entitled to a disability extension is finally determined to not be disabled; or

vi. the date coverage is terminated for cause.

If the COBRA coverage of a Qualified Beneficiary terminates early, the Plan Administrator will send a notice regarding the termination of COBRA Coverage to you as soon as practicable.

F. How to Notify the Plan Administrator. You must send written notice of a Qualifying Event that is a divorce, a legal separation, or a child's loss of dependent status, to the Plan Administrator within 60 days of the event. Also, if you elect COBRA coverage and you are eligible for an 11-month extension of that coverage due to the disability of a Qualified Beneficiary, or for an 18-month extension of that coverage due to the occurrence of a second Qualifying Event, you must provide written notice of the disability determination or the second Qualifying Event to the Plan Administrator. Notice must be sent by first class mail or other nationally-recognized courier service, or by hand-delivery. Oral notice will not be accepted. Your notice must include your name and the names of other affected family members, the type of Qualifying Event and written documentation of the event that identifies the date on which the event occurred. You may also make changes through the plan's website at lcca.hrintouch.com. You should keep a copy, for your records, of any notices you send to the Plan Administrator.

Any notices required to be provided to the Plan Administrator may be provided by the employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of either of them, and will be sufficient for all beneficiaries affected by the same Qualifying Event.

G. If You Have Questions. Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee 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 Offices are available through EBSA's website.)

9. QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Any Benefit which is a Group Health Plan will provide benefits to a child of an eligible employee in accordance with a Qualified Medical Child Support Order ("QMCSO"), as defined in ERISA § 609. You may obtain a copy of the Plan's Qualified Medical Child Support Order Procedures, free of charge, upon written request to the Plan Administrator.

10. STATEMENT OF ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants will be entitled to:

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

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

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

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

v. 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer 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.

If your claim for a welfare 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 a suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 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 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.

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

11. GENERAL PLAN INFORMATION

Plan Name: Life Care Centers of America, Inc.
Welfare Benefits Plan

Plan Number: 503

Identification Number: 62-0963862

Plan Year: January 1 – December 31

Type of Plan:	Welfare benefit plan, providing health, dental, vision, life and accidental death and dismemberment insurance, long-term disability, voluntary disability, short-term disability, and health flexible spending account benefits.
Name and Address of Employer:	Life Care Centers of America, Inc. 3001 Keith Street Cleveland, TN 37320-3480
Plan Administrator:	Life Care Centers of America, Inc. Attention: Benefits Department 3001 Keith Street Cleveland, TN 37320-3480 423-472-9585 lcca.hrintouch.com Please note that the Insurers are the claim fiduciaries for all Benefits under the Plan which are provided through contracts of insurance. The name, address and phone number of the Insurers are described in the attached or previously distributed Booklets.
Type of Administration:	Self-administered, with certain duties contracted to outside third parties
Agent for Service of Legal Process:	Legal Department Life Care Centers of America, Inc. 3001 Keith Street Cleveland, TN 37320-3480

12. DEFINITIONS

A. Booklets mean the summary plan descriptions, plans, booklets, HMO contracts or certificates that describe the Benefits and have been previously distributed or are attached hereto. The Booklets are an integral part of this summary.

B. Claims Processor means any third party engaged by the Company to process claims under the Plan where Benefits are not provided under a contract of insurance. The name, address and phone number of each Claims Processor processing claims for any Benefit is described in the attached or previously distributed Booklets

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

D. Company means Life Care Centers of America, Inc. and any affiliated company listed on Attachment B.

E. **Employee** will not mean: (i) any leased employee or any person classified as a leased employee by the Company regardless of whether such person is later determined, whether by the Company or otherwise, to be a common law employee of the Company; (ii) any person who is classified by the Company as an independent contractor or sub-contractor for purposes of withholding and payment of employment taxes, even if such person is later determined, whether by the Company or otherwise, to be a common law employee of the Company; or (iii) any person who is classified by the Company as a temporary, limited-term, borrowed or on-call employee on the Company's payroll records, regardless of the number of hours such person works for the Company or duration of employment with the Company.

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

G. **FMLA** means the Family and Medical Leave Act, as amended.

H. **Group Health Plan** means a plan that provides health care benefits to employees. The health dental, vision plans and health flexible spending account are considered Group Health Plans.

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

J. **Insurer** means an insurance company which has issued an insurance contract through which one or more Benefits are provided. The name, address and phone number of each Insurer providing a benefit is described in the attached or previously distributed Booklets. The Insurers are responsible for financing all insured Benefits in exchange for payment of insurance premiums, and are also responsible for processing and deciding all claims for insured Benefits.

K. **Plan** means the Life Care Centers of America, Inc. Welfare Benefits Plan.

L. **USERRA** means the Uniformed Services Employment and Reemployment Act, as amended.

ATTACHMENT A

Benefits Provided under the
Life Care Centers of America, Inc.
Welfare Benefits Plan

Life Care Centers of America, Inc. Associate Benefit Plan
Life Care Centers of America, Inc. Dental Plan
Life Care Centers of America, Inc. Vision Plan
Life Care Centers of America, Inc. Life and Accidental Death and Dismemberment Insurance Plan
Life Care Centers of America, Inc. Long-Term Disability Plan
Life Care Centers of America, Inc. Voluntary Long-Term Disability Plan
Life Care Centers of America, Inc. Short-Term Disability Plan
Harvard Pilgrim Health Plans
Health New England (HNE) Health Plans
Health Plan of Nevada Plans
Kaiser Health Plans
Health Flexible Spending Account under the Life Care Centers of America, Inc. Flexible Spending Account

ATTACHMENT B

LIST OF ADOPTING COMPANIES

Physician Onsite, Inc.
Christensen Financing, LLC
Life Care Physician Services, LLC
Mill Run
Executive Flight, Inc.
Life Care Legal and Risk Services, LLC

ATTACHMENT C

COST OF COVERAGE UNDER PLAN BENEFITS

As described in the rate sheets or materials provided to each Participant in the Life Care Centers of America, Inc. Welfare Benefits Plan during each open enrollment.

ATTACHMENT D

ELIGIBILITY POLICY FOR HEALTH PLAN COVERAGE

This Eligibility Policy for Health Plan Coverage Offered by Life Care Centers of America, Inc. ("Policy") shall be used to determine whether certain Employees of Life Care Centers of America, Inc. (the "Company") are eligible to participate in the Life Care Centers of America, Inc. Welfare Benefits Plan ("Plan") with regard to the health benefits provided therein. This Policy is intended to comply with the safe harbor described in Internal Revenue Service ("IRS") Final Regulations published on February 2, 2014 under Section 4980H of the Internal Revenue Code of 1986, as amended ("Code"), and this Policy shall be interpreted, construed, and limited in accordance with such intent.

For purposes of the Examples in this Policy, assume that Bert is a Variable Hour Employee and that he has a Date of Hire of February 12, 2015.

I. Definitions. The following definitions apply for purposes of this Policy.

a. **Employee** means a person who is classified as an employee by the Company under the common-law standard.

b. **Break in Service** means a period of time during which an Employee does not have an Hour of Service credited to the Employee.

c. **Date of Hire** means the day on which a New Employee first performs an Hour of Service for the Company.

d. **Eligible Employee** means an Employee who has been classified as eligible to participate in Health Coverage pursuant to this Policy.

e. **Full-Time Employee** means an Employee who is employed by the Company, with respect to a Measurement Period, for at least the Minimum Hours.

f. **Hour of Service** means: (i) each hour for which an Employee is paid by the Company, or entitled to payment, for performing duties for the Company; and (ii) each hour for which an Employee is paid by the Company, or entitled to payment, for vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence even though no duties are performed during those time periods.

g. **Initial Administrative Period** means the period from the first day immediately following the last day of the Initial Measurement Period to the last day of the first calendar month beginning on or after the one-year anniversary of a New Employee's Date of Hire.

h. **Initial Measurement Period** means the period beginning on the first day of the month following the New Employee's Date of Hire or, if the New Employee's Date of Hire is the first day of the month, the Date of Hire, and concluding on the last day of the twelfth month thereafter.

Example: *Bert, who started work on February 12, 2015, has an Initial Measurement Period from March 1, 2015 through February 29, 2016.*

i. **Initial Stability Period** means the twelve (12) month period from the first day of the second calendar month beginning on or after the one-year anniversary of a New Employee's Date of Hire to the last day of the first calendar month beginning on or after the two-year anniversary of a New Employee's Date of Hire.

Example: *Bert, who started work on February 12, 2015, will have an Initial Stability Period from April 1, 2016 through March 31, 2017.*

j. **Look-Back Measurement Method** means the method by which the Company determines an Employee's status as a full-time employee by averaging an Employee's Hours of Service over the course of an Initial or Standard Measurement Period.

k. **Minimum Hours** means the minimum number of hours required for an individual to average at least 30 Hours of Service per week during a Measurement Period. For example, the Minimum Hours for a fifty-two (52) week Standard Measurement Period would be 1560 Hours of Service. There are special rules for calculating an Employee's Minimum Hours if he or she takes a Special Unpaid Leave of Absence. These rules are explained in Section V(b) of this Policy. Notwithstanding anything to the contrary in this definition of Minimum Hours, and only for purposes of the 2021 Standard Measurement Period of October 4, 2020 through October 3, 2021 for an Ongoing Employee, the Minimum Hours required for an individual to be an Eligible Employee for the 2022 Standard Stability Period of January 1, 2022 through December 31, 2022 shall be 1,040 Hours of Service.

l. **Monthly Measurement Method** means the method by which the Company determines an Employee's status as a full-time employee by counting the Employee's Hours of Service for each calendar month.

m. **New Employee** means an Employee who has not yet worked for one complete Standard Measurement Period.

n. **Ongoing Employee** means an Employee who has worked for at least one complete Standard Measurement Period. Notwithstanding the foregoing, an Ongoing Employee does not include any Employee who serves in any of the following categories:

- Employees subject to the terms of a collective-bargaining agreement.

Example: *Bert, who started work on February 12, 2015, will become an Ongoing Employee on January 1, 2017 because he will have been an Employee for one complete Standard Measurement Period, running from October 4, 2015 through October 3, 2016.*

o. **Health Coverage** means health plan coverage offered by the Company to its Employees, including, but not limited to, the Plan.

p. **Part-Time Employee** means a new Employee who the Company reasonably expects to be employed less than the Minimum Hours during the Initial Measurement Period.

q. **Plan** means the Life Care Centers of America, Inc. Welfare Benefits Plan.

r. **Policy** means this Eligibility Policy for Health Plan Coverage Offered by Life Care Centers of America, Inc.

s. **Seasonal Employee** means an Employee who is hired into a position for which the customary annual employment is six months or less.

t. **Standard Administrative Period** means the period from October 4 to December 31 of each calendar year.

u. **Standard Measurement Period** means each twelve (12) month period from the first day of the payroll period that includes October 4 to the last day of the payroll period preceding the payroll period that includes the next following October 3.

Example: *The first Standard Measurement Period for Bert, who started work on February 12, 2015, will run from October 4, 2015 through October 3, 2016.*

v. **Standard Stability Period** means the twelve (12) month period immediately following the Standard Administrative Period that applies to Ongoing Employees. The Standard Stability period is from January 1 to the next following December 31**.**

Example: *The first Standard Stability Period for Bert, who started work on February 12, 2015, will run from January 1, 2017 through December 31, 2017.*

w. **Special Unpaid Leave of Absence** means an unpaid leave of absence taken by a New Employee or an Ongoing Employee on account of jury duty, or pursuant to regulations established by the Family and Medical Leave Act of 1993 or the Uniformed Services Employment and Reemployment Rights Act of 1994.

x. **Variable Hour Employee** means an Employee for whom, based on the facts and circumstances at the Employee's Date of Hire, the Company cannot determine whether the Employee is reasonably expected to work at least the Minimum Hours during the Initial Measurement Period because the Employee's Hours of Service are variable or otherwise uncertain. Employees will not be classified as Variable Hour Employees because their employment is expected to be short-term or temporary.

II. Determination of Plan Eligibility for Ongoing Employees

(a) Tracking. The Company will maintain a record of the Hours of Service of each Ongoing Employee during each Standard Measurement Period. At the conclusion of each Standard Measurement

Period, the Company will determine whether each Ongoing Employee worked at least the Minimum Hours over the duration of the Standard Measurement Period.

(b) Eligible. If an Ongoing Employee worked at least the Minimum Hours during the Standard Measurement Period (1,040 Hours of Service only for the 2021 Standard Measurement Period of October 4, 2020 through October 3, 2021), the Ongoing Employee will be classified as an Eligible Employee for the Standard Stability Period that starts at the end of the Standard Administrative Period. The Company will notify the Ongoing Employee of this determination and will offer enrollment in Health Coverage to the Ongoing Employee, effective on the first day of the Standard Stability Period.

(c) Stability. Except for in cases of Material Changes in Employment Status as provided in Section II(f) below, if the Company classifies an Ongoing Employee as an Eligible Employee at the end of a Standard Measurement Period, the Employee will remain an Eligible Employee for the duration of the following Standard Stability Period, regardless of the number of Hours of Service actually worked by the Employee during the Standard Stability Period, so long as the Ongoing Employee remains employed and otherwise eligible for Health Coverage.

***Example**: If Bert worked at least the Minimum Hours from October 4, 2015, through October 3, 2016 (the Standard Measurement Period), then, so long as he is employed and otherwise eligible, he will be permitted to enroll in Health Coverage, effective January 1, 2017 through December 31, 2017 (the Standard Stability Period), regardless of his Hours of Service during this Stability Period.*

(d) Not Eligible. Except as provided in Section II(f) below, if an Ongoing Employee did not work at least the Minimum Hours during the Standard Measurement Period, then the Ongoing Employee will not be classified as an Eligible Employee for the Standard Stability Period that starts immediately at the end of the Standard Administrative Period, regardless of the number of Hours of Service actually worked by the Employee during that Standard Stability Period.

***Example**: If Bert did not work at least the Minimum Hours from October 4, 2015, through October 3, 2016 (the Standard Measurement Period), he will not be eligible to enroll in Health Coverage for the January 1, 2017 through December 31, 2017 Standard Stability Period, regardless how much he works during 2017. His eligibility to enroll in Health Coverage on January 1, 2017 will depend on whether he works at least the Minimum Hours during the October 4, 2015, through October 3, 2016 Standard Measurement Period.*

(e) Special Eligibility Determination Rules for 2021 Only

(i) Notwithstanding anything to the contrary in this Attachment D – Eligibility Policy for Health Plan Coverage, an Ongoing Employee determined to be an Eligible Employee for Plan Year 2020 under this Attachment D - Eligibility Policy for Health Plan Coverage, will be automatically deemed an Eligible Employee for Plan Year 2021 (the "Standard Stability Period"), regardless of the Employee's Hours of Service during the Standard Measurement Period, and offered enrollment in Health Coverage for Plan Year 2021.

(ii) An Ongoing Employee determined not eligible for benefits for Plan Year 2020 under Attachment D - Eligibility Policy for Health Plan Coverage, shall have Hours of Service measured from October 4, 2019 – March 31, 2020 to determine benefit eligibility for Plan Year 2021. The period of April 1, 2020 – October 3, 2020 shall be disregarded for purposes of the Standard Measurement Period. If an Ongoing Employee averages a minimum of 30 hours per week during the period of October 4, 2019 – March 31, 2020, the Employee will be an Eligible Employee for Plan Year 2021 (the "Standard Stability Period") and offered enrolled in Health Coverage for Plan Year 2021.

(iii) If an Employee is furloughed between April 1, 2020 – September 30, 2020, his/her Minimum Hours for purposes of this Attachment D – Eligibility Policy for Health Plan Coverage will be equal to the product of 30 times the difference between the numbers of weeks in the Standard Measurement Period (52), less the number of weeks furloughed (not to exceed 12 weeks) for the period of October 4, 2019 – October 3, 2020 (the "Standard Measurement Period") to determine benefit eligibility for Plan Year 2021 (the "Standard Stability Period").

(iv) If any Employee is determined to be not eligible for benefits for Plan Year 2021, the Employee may appeal the determination. The Plan will consider any extenuating circumstances due to the COVID-19 pandemic, which may have prevented the Employee from achieving Minimum Hours for eligibility. Appeals must be direct to the Benefit Representative or the Executive Director and submitted to abt@lcca.com within thirty (30) days of the date of notification of the ineligible determination.

(f) Material Change in Employment Status.

(i) Change to Full-Time Status. If an Ongoing Employee has been classified as a Part-Time Employee, Variable Hour Employee or Seasonal Employee for a period of at least thirteen (13) weeks, and after the end of the eligibility waiting period and the end of the Employee's Initial Measurement Period, the Employee has a material change in his or her employment status, the Employee will be treated as an Eligible Employee, as of the date of the material change in their employment status. For purposes of this Subsection (f), a "material change in employment status" is a material change in the position of employment or other employment status that, had the Employee begun employment in that new position or status, the Employee would have reasonably been expected to work at least the Minimum Hours during the Standard Measurement Period.

(ii) Change to Part-Time Status. If an Ongoing Employee is classified as a Full-Time Employee, but subsequently, either before or after the end of the Initial Measurement Period, has a change in employment status such that if the Employee had begun employment in the new position or status, the Employee would have been reasonably expected to be employed less than the Minimum Hours, then the Company may apply the Monthly Measurement Method to that Employee beginning on the first day of the fourth full month following their change in status. The Company must maintain the Ongoing Employee's status as a full-time employee during

the first three full months after the change in status. This special rule only applies if the Employee was offered minimum value health coverage no later than the first day of the calendar month following the Employee's initial three full calendar months of employment through the month of the change in status, and only if the Employee actually averages less than 30 Hours of Service per week during the first three full calendar months after their change in status. The Company will continue to apply the Monthly Measurement Method through the end of the first full Measurement Period that would have applied had the Employee remained under the Look-Back Measurement Method.

III. Determination of Plan Eligibility for New Employees

(a) Classification of New Employees. New employees shall be classified as Full-Time, Part-Time, Variable or Seasonal. For a new Employee who is reasonably expected at the Employee's start date to be a Full-Time Employee (and not a Seasonal Employee), the Company shall determine the Employee's status based on the Employee's Hours of Service under the Monthly Measurement Method until the Employee becomes an Ongoing Employee. The status of new Employees who are classified as Part-Time, Variable or Seasonal Employees shall be determined under the Look-Back Measurement Method as set out below.

(b) Tracking. Under the Look-Back Measurement Method, the Company will maintain a record of the Hours of Service of each New Part-Time, Variable and Seasonal Employee during the individual's Initial Measurement Period. At the conclusion of the Initial Measurement Period, the Company will determine whether the Employee worked at least the Minimum Hours during the Initial Measurement Period.

(c) Eligible. If the New Part-Time, Variable or Seasonal Employee worked at least the Minimum Hours during the Initial Measurement Period, the New Employee will be classified as an Eligible Employee for his or her Initial Stability Period. The Company will notify the New Employee of its determination and will offer enrollment in Health Coverage to the New Employee, effective on the first day of the Initial Stability Period.

(d) Initial Stability Period. Except as provided in Section III(f) below, if the Company classifies a New Part-Time, Variable or Seasonal Employee as an Eligible Employee at the end of the Initial Measurement Period, the New Employee will remain an Eligible Employee during the Initial Stability Period, regardless of the number of Hours of Service actually worked by the New Employee during the Initial Stability Period, so long as the New Employee remains employed and otherwise eligible for coverage.

(e) Not Eligible. Except as provided in Section III(f) below, if a New Part-Time, Variable or Seasonal Employee did not work at least the Minimum Hours during the Initial Measurement Period, then the New Employee will not be classified as an Eligible Employee and will not be eligible to participate in Health Coverage during the Employee's Initial Stability Period, regardless of the number of Hours of Service actually worked by the New Employee during the Initial Stability Period.

(f) Material Change in Employment Status During Initial Measurement Period. If an Employee is categorized as a New Part-Time, Variable or Seasonal Employee for a period of at least thirteen (13) weeks, and subsequently, during the Employee's Initial Measurement Period, has a material change in their employment status, the New Employee will be treated as an Eligible Employee for purposes of Health Coverage, as of the date of the material change in their employment status. For purposes of this Subsection (f), a "material change in employment status" is a material change in the position of employment or other employment status that, had the Employee begun employment in that new position or status, the Employee would have reasonably been expected to work at least the Minimum Hours during the Initial Measurement Period.

IV. Transition from New Employee to Ongoing Employee

(a) Tracking. Once a New Full-Time, Part-Time, Variable or Seasonal Employee has been employed for an entire Standard Measurement Period, the New Employee must be tested for full-time status based on that Standard Measurement Period, at the same time and under the same conditions as other Ongoing Employees.

***Example**: Bert, who started work on February 12, 2015, has an Initial Measurement Period of March 1, 2015 through February 29, 2016. He will be tested for eligibility during his Initial Measurement Period and during the Standard Measurement Period that runs from October 4, 2015, through October 3, 2016.*

(b) Eligible. A New Part-Time, Variable or Seasonal Employee who works the Minimum Hours during either the Initial Measurement Period or during a Standard Measurement Period must be treated as an Eligible Employee during the entire associated Initial Stability Period and/or Standard Stability Period. A New Full-Time Employee who works the Minimum Hours during a Standard Measurement Period must be treated as an Eligible Employee during the entire associated Standard Stability Period.

(c) Not Eligible During Initial Stability Period. In contrast, if a New Part-Time, Variable or Seasonal Employee does not work the Minimum Hours during their Initial Measurement Period, but does work the Minimum Hours during the overlapping or immediately following Standard Measurement Period, the Employee must be treated as an Eligible Employee for the entire Standard Stability Period that relates to the Standard Measurement Period, even if the Standard Measurement Period begins before the end of the Initial Stability Period. Thereafter, the Employee's eligibility is determined under the Ongoing Employee rules.

***Example**: See the chart below for a summary of Bert's eligibility during his Initial and Standard Measurement Periods and his Initial and Standard Stability Periods.*

Bert's Initial Measurement Period	***Bert's Initial Stability Period***	***Bert's First Standard Measurement Period***	***Bert's First Standard Stability Period***
March 1, 2015 to February 29, 2016	*April 1, 2016 to March 31, 2017*	*October 4, 2015 to October 3, 2016*	*January 1, 2017 to December 31, 2017*
Works Minimum Hours	*Eligible*	*Works Minimum Hours*	*Eligible*

Does Not Work Minimum Hours	*Not Eligible*	*Works Minimum Hours*	*Eligible*
Works Minimum Hours	*Eligible*	*Does Not Work Minimum Hours*	*Not Eligible*

V. Rehires and Leaves of Absence

(a) Rehired Treated as Ongoing or New Employee. Solely for purposes of this Policy, an Employee who resumes providing service to the Company after a Break in Service will be treated as a New Employee subject to an Initial Measurement Period if the Employee was gone for either:

(i) thirteen or more consecutive weeks; or

(ii) at least four consecutive weeks and the Break in Service period was longer than the period of service immediately prior to the Break in Service.

If the Break in Service period is less than both (i) and (ii), then the Employee shall be treated as an Ongoing Employee when rehired.

(b) Rehire Treated as Ongoing Employee.

(i) If an Employee is treated as an Ongoing Employee pursuant to Section V(a), then the rehired Employee retains the status the Employee had with respect to the Stability Period in progress when the Employee is rehired. Specifically, if the Employee was an Eligible Employee for that Stability Period and had enrolled in Health Coverage, the Employee will be eligible to re-enroll as of the Employee's rehire date, or as soon as administratively practicable, for the rest of the Stability Period. If the Employee prior to the Break in Service had been offered Health Coverage and had declined, the Employee will not be offered another opportunity to enroll for that Stability Period. If the Employee was not an Eligible Employee for the Stability Period in progress upon the Employee's rehire, then the Employee will not be eligible to re-enroll until the beginning of the next Stability Period, assuming the Employee works the Minimum Hours of Service during the ongoing Measurement Period.

(ii) If an Employee is treated as an Ongoing Employee pursuant to Section V(a), and the Employee is returning from Special Unpaid Leave of Absence, then for any Measurement Period that is in progress during the unpaid leave, the Employee's Minimum Hours will be equal to the product of thirty (30) times the difference between the number of weeks in the Measurement Period, less the number of weeks the Employee was on a Special Unpaid Leave of Absence.

Example: *Bert is on an unpaid FMLA leave for four weeks during a Measurement Period, so his Minimum Hours for the Measurement Period will equal 30 times 48 weeks (which is 52 weeks less four weeks of leave).*

(c) Rehire Treated as New Employee. If an Employee is treated as a New Employee under Section V(a), then the Employee will start another Initial Measurement Period on rehire, and will follow the rules of Section III.