

BrightSpring Health Services Welfare Benefit Plan

Amended and Restated Effective January 1, 2026

Wrap Plan Document, Summary Plan Description, and Cafeteria Plan

BrightSpring Health Services Welfare Benefit Plan

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Article 1 - Introduction

Section 1.1 - Purpose & Plan Sponsor

This document contains details regarding benefits provided under the BrightSpring Health Services Welfare Benefit Plan (the “Plan”) for Covered Persons. BrightSpring sponsors the Plan for the benefit of BrightSpring’s and Participating Employers’ Employees and their Dependents. Capitalized terms are defined in Article 12. The Plan consists of individual Component Benefit Plans, each of which is governed by applicable Component Benefit Documents. This document, together with Component Benefit Documents, constitutes both the summary plan description and plan document, as described by ERISA. ResCare, Inc. d/b/a BrightSpring Health Services (“BrightSpring”) sponsors the Plan. BrightSpring intends to maintain the Plan for an indefinite period; however, BrightSpring may, in its sole discretion, amend or terminate the Plan or any provision of the Plan for any reason or no reason, in accordance with Article 8.

Included as **Addendum G** to the Plan is the BrightSpring Health Services Section 125 Cafeteria Plan (the “Cafeteria Plan”). The Cafeteria Plan constitutes a “cafeteria plan” under Code Section 125, such that eligible employees are permitted to make pre-tax salary reduction contributions toward coverage for specified Component Benefit Plans, as well as enroll in certain flexible spending accounts (as described in the applicable Component Benefit Documents), if offered by BrightSpring. The Cafeteria Plan and all Component Benefit Documents are part of the Plan, and you should read all documents together.

To the extent benefits provided hereunder are subject to ERISA; the Plan is assigned plan number 501.

Detailed contact information referenced throughout the Plan for BrightSpring is in **Addendum A** and for Claim Administrators and other Plan service providers is in **Addendum B**.

Section 1.2 - History

The Res-Care, Inc. Welfare Benefit Plan was originally adopted by Res-Care, Inc. on July 1, 1986 (EIN 61-0875371, plan number 501). Effective January 1, 2019, the Res-Care, Inc. Welfare Benefit Plan was renamed the BrightSpring Health Services Welfare Benefit Plan. Prior to January 1, 2020, Res-Care, Inc. separately sponsored the Res-Care, Inc. Flexible Benefits Plan (EIN 61-0875371, plan number 504), which was originally adopted on May 1, 1991, to provide cafeteria plan benefits under Code Section 125. The Res-Care, Inc. Flexible Benefits Plan was amended, restated, and renamed as the BrightSpring Health Services Section 125 Cafeteria Plan effective January 1, 2019. On January 1, 2020, the BrightSpring Health Services Section 125 Cafeteria Plan (plan number 504) was merged into the BrightSpring Health Services Welfare Benefit Plan (EIN 61-0875371, plan number 501) so that cafeteria plan benefits became a component of and incorporated by reference into the Plan for purposes of the Health Care FSA and Limited Use FSA. Therefore, as of January 1, 2020, cafeteria plan benefits were no longer offered through a separately sponsored plan. The Plan was amended and restated in 2021 to incorporate good-faith compliance with the Families First Coronavirus Response Act, as amended by the Coronavirus Aid, Relief, and Economic Security Act, and other applicable law and guidance. The Plan was last amended and restated effective as of January 1, 2026, to clarify various Plan provisions and align benefits with current Plan administration.

Article 2 - Eligibility, Enrollment, and Elections

Section 2.1 - Benefits and Employee Classification

You are eligible to participate in the benefits described in the Plan if you are an eligible Employee of BrightSpring or a Participating Employer and satisfy service and hours requirements described in the Component Benefit Documents. In general, if you are a full-time Employee, you are eligible for benefits under the Plan. If you are a part-time, variable-hour, or seasonal Employee, you are eligible to participate in certain benefits as noted in enrollment materials. You are not eligible to participate in the Plan if you are:

- A client, trainee, foster parent or expatriate;
- A leased employee;
- Employed by an independent company (such as an employment or staffing agency);
- An independent contractor;
- Not paid from the U.S. payroll of BrightSpring or a Participating Employer; or
- A member of a CBA (union member), unless the CBA provides for your participation in the Plan.

Section 2.2 - Eligibility Waiting Periods

If you are a full-time Employee, you will be eligible to enroll in all benefits (except as otherwise provided in **Addendum E**) on the first day of the month following 30 days of employment.

If you are a part-time Employee of SpringHealth Behavioral Health who works 20 hours or more per week, you will be eligible to enroll in medical, health care spending accounts, limited medical, dental, vision, EAP and other voluntary benefits (including group legal, accident, critical illness, hospital indemnity insurances, and employee assistance program) on the first of the month following the applicable eligibility waiting period following your date of hire.

If you are a part-time Employee who does not meet the qualifications above or a variable hour or seasonal Employee, you will be eligible to enroll in limited medical, dental, vision, EAP and other voluntary benefits (including group legal, accident, critical illness, hospital indemnity insurances, and employee assistance program) on the first day of the month following the applicable eligibility waiting period following your date of hire.

Section 2.3 - Eligibility Determinations

In general, you will be eligible for Medical benefits during a particular Plan Year if you work an average of 30 hours per week. You may also be eligible for Medical benefits during a Plan Year if you are a part-time Employee of SpringHealth Behavioral Health who works an average of at least 20 hours per week.

It is solely within the authority of BrightSpring and/or a Participating Employer to determine whether you are eligible for any benefits under the Plan. If BrightSpring and/or a Participating Employer determines you are not an Employee and you are later required to be reclassified as an Employee, you will only be eligible prospectively, provided all other eligibility requirements are met. If BrightSpring or a Participating Employer determines you are not a common law employee, you will not be eligible to participate in the Plan regardless of whether a court, tax or regulatory authority determines that you are an employee.

BrightSpring uses the lookback method for determining eligibility for certain welfare benefits, in accordance with the ACA. To accurately measure and determine eligibility, BrightSpring may consider breaks in services (including certain special unpaid leave such as FMLA and USERRA), hours of service, different measurement periods, the position type (new, returning, part-time, variable hour, seasonal, etc.) of each individual Employee, and other items required by the ACA. If you have questions regarding your eligibility for welfare benefits under the ACA, please contact the BrightSpring Benefits Department.

Section 2.4 - Break in Service Rules

If you experience a period of at least 13 consecutive weeks during which you are not credited with an hour of service—either because you terminate employment or are on an unpaid leave of absence (other than a special unpaid leave)—you will have a break in service and you will be treated as a new employee to the extent permitted by law (see the rules that apply to new employees below). If your break in service is longer than 30 days but less than 13 consecutive weeks, upon your return to work at BrightSpring, you will be treated as a continuing Employee.

BrightSpring will consider any unpaid leave of absence subject to FMLA, USERRA, or on account of jury duty.

Section 2.5 - Eligible Dependents

Dependents are eligible to participate in the benefits described in the Plan if such individual satisfies the definition of Dependent and to the extent applicable, any applicable Component Benefit Document eligibility criteria for Dependents. To the extent a Component Benefit Document provides detailed eligibility criteria for Dependents that conflict with the Plan; such Component Benefit Document shall govern.

Medical, EAP, Dental, and/or Vision Coverage

The following Dependents are eligible for Medical, EAP, Dental or Vision coverage offered under the Plan, but only if you (the Employee) are enrolled in such benefit:

- Your legally married Spouse or Domestic Partner;
 - If your Spouse or Domestic Partner is eligible for Medical coverage at his or her employer, a spousal surcharge of \$100 per month will be assessed; attestation of coverage will be required.
 - The surcharge does not apply if spousal coverage is through Medicare
- Your children and your Domestic Partner's children through the end of the month in which they turn age 26, regardless of their marital status, student status, and whether or not they live with you or you provide financial support;
- Children for whom the Plan is required to provide coverage under a QMCSO; and
- Your mentally or physically disabled adult dependent children or Domestic Partner's adult dependent children over age 26 who live with you and who are primarily dependent on you for support (you must provide appropriate documentation) provided that the child was disabled prior to age 26.

If you are married to or in a Domestic Partnership with another BrightSpring employee, you may enroll as an Employee or a Dependent under the Plan, but you cannot enroll as both. Eligible Dependents may be enrolled under only one Employee's coverage under the Plan.

You are required to provide proof of your Dependents' eligibility upon request. False or misrepresented eligibility information will cause both your coverage and your Dependents' coverage to be irrevocably terminated, meaning that you and any Dependents may be prohibited from participating in the Plan ever again, retroactively to the extent permitted by law, and could be grounds for employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation. If your coverage is terminated retroactively due to fraud or intentional misrepresentation, you forfeit any contributions, deductions, or any other similar payments.

Your eligible dependent children are:

- Biological children;
- Stepchildren;

- Legally adopted children;
- Children of a Domestic Partner;
- Children who are placed in your home for adoption; and
- Children for whom you are appointed as legal guardian who are chiefly dependent on you for support and maintenance.

Additional eligibility requirements are contained in each applicable Component Benefit Documents.

Dependent Life and Supplemental AD&D

The following Dependents are eligible for Dependent Life and Supplemental AD&D coverage offered under the Plan:

- Your legally married Spouse;
- Your Domestic Partner (as defined below); and
- Your, your Spouse's or your Domestic Partner's unmarried natural child or stepchild, or legally adopted child under age 26.

Please see the applicable Component Benefit Document(s) for additional eligibility requirements.

Dependents Not Eligible

The following individuals are not eligible for Medical, Dental or Vision coverage, regardless of whether they are your tax dependents:

- A Spouse, Domestic Partner, or a child living outside the United States;
- A Spouse or Domestic Partner who is an eligible employee under the Plan; or
- Your parent or your Domestic Partner's or Spouse's parent.

Important Information about Domestic Partner Benefits

BrightSpring covers both same-sex and opposite-sex spouses and Domestic Partners.

Under Medical coverage options, you will be able to enroll a Domestic Partner, including a civil union spouse, if you complete an affidavit provided by the BrightSpring Benefits Support Center (see **Addendum A**) and your partner qualifies as a Domestic Partner, as defined in Article 12.

Tax Consequences of Domestic Partner Benefits

Unless your Domestic Partner or his or her dependent children, if any, are considered your federal tax dependents under the Internal Revenue Code for health benefit purposes, the IRS currently treats the value of the coverage provided for your Domestic Partner and his or her dependent children, if any, less any contributions paid by you on an after-tax basis for this coverage as imputed income to you. BrightSpring cannot give tax advice. You should consult with your tax advisor to determine if your Domestic Partner and his or her dependent children are your federal tax dependents and to review the tax consequences of electing domestic partner benefit coverage.

Additional Eligibility Information

You should review Component Benefit Documents for additional information regarding how and when you and your eligible Dependents become eligible for benefits under the Plan.

Section 2.6 - Initial Enrollment for New Employees

If you are an eligible Employee, you will receive the information necessary to enroll in the Plan upon starting work at BrightSpring or a Participating Employer. If you timely enroll, your coverage will begin on the later of: the date you enroll or the date you satisfy the eligibility

requirements. While enrollment may be automatic, coverage may not be automatic. Your coverage under the Plan will begin as described in the Plan and applicable Component Benefit Documents. Your eligible Dependents' coverage under the Plan will begin on the same date, if you make the necessary elections within the required time period.

If you do not elect Supplemental Life, Supplemental AD&D, or Supplemental Short-Term Disability when you are first eligible, you may enroll mid-year if you have a change in status, but you will have to provide evidence of insurability.

If you do not enroll in Group Pre-Paid Legal, Accident Coverage, Critical Illness Coverage or Hospital Indemnity Coverage when you are first eligible, you may enroll mid-year if you have a change in status.

If you enroll yourself or a Dependent in the Medical, Dental, Vision, Health Care FSA, Limited Use FSA, and/or Dependent Care FSA, Group Pre-Paid Legal, Accident Coverage, Critical Illness Coverage or Hospital Indemnity Coverage benefits mid-year due to a change in status, coverage will be effective as soon as administratively practicable following the date the BrightSpring Benefits Department receives your timely request for enrollment due to a change in status. However, if you have made a change to your Medical coverage due to the birth or adoption (including placement for adoption) of a child, your election change will be effective as of the date of birth or adoption (or placement for adoption).

If you and your eligible Dependents do not enroll within the timeframe required for each benefit, you will have to wait until the next open enrollment period to enroll, unless you experience a qualifying change in status as described in Section 2.8.

Section 2.7 - Enrollment for Current Employees (Open Enrollment)

Open enrollment is held every fall. This is your opportunity to enroll in, change, or drop coverage. Changes are effective on January 1 following open enrollment. You'll receive information, including instructions on how to enroll, additional benefit details, and other relevant information before, and during open enrollment each year.

Section 2.8 - Mid-Year Changes

In general, the benefit plans and coverage levels you choose when you first enroll will be maintained for the remainder of the Plan Year. If you experience a mid-year change in status as described below, you must notify the BrightSpring Benefits Support Center (see **Addendum A**) within 31 days (60 days for loss or gain of eligibility for Medicaid or CHIP) in order to make a change in your election during the year and indicate the change in status event, the date of the event, and your requested change. This may be done by contacting the BrightSpring Benefits Support Center. If a change in status event results in disenrollment retroactively, BrightSpring is not required to refund any amounts already contributed toward coverage. In addition, certain limitations may apply to retroactive disenrollment.

In the event of a divorce or your child ceases to meet eligibility requirements for benefits coverage, you must notify the BrightSpring Benefits Support Center to preserve your Dependent's COBRA rights within 60 days of the event. The following sections describe events that permit you to make benefit changes outside of open enrollment.

Change in Status

If you experience one of the events described below and want to make a change to your coverage due to such an event, you must notify the BrightSpring Benefits Support Center within 31 days of the event, or 60 days for certain HIPAA special enrollment events. If you do not notify the BrightSpring Benefits Support Center within the 31-day (or 60 day) period, you will not be able to make any changes to your coverage until the next open enrollment period.

To change your benefit elections, you may be required to show proof to verify the change in status event has occurred (e.g., a copy of a marriage or birth certificate, divorce decree, etc.). The following is a list of changes in status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below):

- **Legal marital status:** Any event that changes your legal marital status, including marriage, divorce, death of a Spouse, and annulment;
- **Change in Domestic Partnership status:** Commencement or dissolution of a domestic partnership;
- **Number of eligible Dependents:** Any event that changes your number of eligible Dependents including birth, death, adoption, legal guardianship, placement for adoption, and commencement or dissolution of a domestic partnership;
- **Employment status:** Any event that changes your or your eligible Dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:
 - Beginning or ending employment;
 - A strike or lockout;
 - Starting or returning from an unpaid leave of absence;
 - Changing from a part-time to full-time employment or vice versa; and
 - A change in work location.
- **Dependent status:** Any event that causes your Dependents to become eligible or ineligible for coverage because of age or similar circumstances;
- **Residence:** A change in the place of residence for you or your eligible Dependents if the change results in your Dependents living outside your Medical, Dental or Vision plan's network service area;
- **HIPAA Special Enrollment Events:** Events such as the loss of other coverage that qualify as special enrollment events under HIPAA;
- **FMLA leave:** Beginning or returning from an FMLA leave;
- **Reduction in hours of service:** You and your Dependents may drop your Medical Benefits under the Plan, even if you remain eligible for such coverage, if:
 - You were reasonably expected to work 30 hours per week and you experience a change in employment status, after which you are reasonably expected to work fewer than 30 hours per week, and
 - You intend to enroll yourself and any Dependents dropping coverage in another health plan (satisfying the ACA's definition of minimum essential coverage) effective no later than the first day of the 2nd month after you drop BrightSpring coverage. You are not permitted to change your health FSA elections because of a reduction in hours of service; or
- **Enrollment in a health plan offered through the public Marketplace:** If you or your Dependents are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you or your Dependents may drop Medical Benefit coverage under the Plan, even if you or your Dependents remain eligible for coverage under the Plan. You and/or any Dependents whose coverage is dropped must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the last day your coverage under the Plan is dropped. You or your Dependents are

not permitted to change Dental, Vision, Health Care FSA, Limited Use FSA, or Dependent Care FSA Benefit elections because you intend to enroll in a plan offered through the public Marketplace.

HIPAA Special Enrollment

If you decline enrollment for Medical coverage for yourself or your eligible Dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible Dependents (including a Domestic Partner) in Medical coverage if you or your eligible Dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your Dependents' other coverage). However, you must request enrollment within 31 days after your or your eligible Dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself, your Spouse and your new eligible dependent children. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. A newly acquired Domestic Partner does not trigger a HIPAA special enrollment; however, you may still be able to add them as described in the Plan. If you request a change due to a special enrollment event within the 31-day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment.

The Plan must allow a HIPAA special enrollment for Employees and Dependents (including Domestic Partners) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. You have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

To request special enrollment or obtain more information, contact the BrightSpring Benefits Support Center.

Cost or Coverage Change Events

In some instances, you can make elections if the type of coverage or cost of coverage changes. These rules do not apply for purposes of a Health Care FSA or Limited Use FSA. Please note that if the change occurs to another employer's plan, you may be required to show proof verifying these events have occurred.

Cost Changes

If BrightSpring determines there is a significant increase in the cost of Medical, Dental and/or Vision coverage, you may be permitted to revoke your election and make a corresponding new election within 31 days. If you previously declined coverage, you may also make a corresponding new election within 31 days when there is a significant decrease in the cost of Medical, Dental, and/or Vision coverage.

Any change in the cost of your plan option that BrightSpring determines is not significant will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Coverage Changes

The following events permit you to change your current coverage:

- **Restriction or Loss of Coverage:** If your coverage is significantly restricted or ceases entirely, you may revoke your elections and elect coverage under another option that

provides similar coverage. Coverage is considered “significantly restricted” if there is an overall reduction in benefits coverage. If the restriction is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election.

- **Addition to or Improvement in Coverage:** If BrightSpring adds a coverage option or significantly improves a coverage option during the year, you may revoke your existing election and elect the newly added or newly improved option.
- **Changes in Coverage under Another Employer Plan:** If your Spouse or dependent child(ren) is employed and his or her employer’s plan allows for a change in your family member’s coverage (either during that employer’s open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during his or her employer’s open enrollment period, you may request to end your coverage under the Plan.
- **Loss of Other Group Health Plan Coverage:** If you or your eligible dependent child(ren) lose coverage under another group health plan sponsored by a governmental or educational institution, including a state children’s health insurance program (CHIP), medical care program of an Indian Tribal government, state health benefits risk pool, or a foreign government group health plan, you may enroll for coverage under the Plan.

Entitlement to Government Benefits

If you or your eligible Dependents become entitled to or lose entitlement to Medicare or Medicaid or lose entitlement to certain other governmental group medical programs, you may make a corresponding change to your Medical, Dental, Vision and Health Care FSA coverage elections within 31 days of the event (60 days for CHIP/Medicaid) by notifying the BrightSpring Benefits Support Center.

Qualified Medical Child Support Order

A QMCSO is any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a Covered Person or beneficiary is eligible under the Plan, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don’t reside with you. However, children who are not eligible for coverage under the Plan, due to their age for example, cannot be added under a QMCSO.

If a QMCSO requires the Plan to provide coverage to your child, then BrightSpring automatically may change your election under the Plan to provide coverage for that child. In addition, you may make corresponding election changes as a result of the QMCSO, if you desire. If the QMCSO requires another person (such as your Spouse or former Spouse) to provide coverage for the child, then you may cancel coverage for that child under the Plan if you provide proof to BrightSpring that such other person actually provides the coverage for the child. The Plan may be required to cover your child due to QMCSO even if you have not enrolled the child. You may obtain a copy of BrightSpring’s procedures governing QMCSO determinations, free of charge, by contacting the BrightSpring Benefits Department (see **Addendum A**).

Additional Benefit Specific Requirements and Information

Supplemental Life, Dependent Life, Supplemental Short-Term Disability and Voluntary Long-Term Disability Mid-Year Changes

If you have a change in status and make a mid-year election change, you will have to provide evidence of insurability for Supplemental Life, Dependent Life, Supplemental Short-Term Disability or Voluntary Long-Term Disability coverage.

Dependent Care FSA Cost or Coverage Changes

In addition to the changes described above, you may make mid-year election changes to your Dependent Care FSA Benefit if you have one of the following events:

- An increase or decrease in dependent care provider fees (except for increases by a provider who is related to you);
- You choose a different dependent care provider who charges a different amount; or
- You make a change to your or your Spouse's regular work schedule that increases or decreases your need for dependent care.

Consistency Requirements for Mid-Year Changes

Except for election changes due to a HIPAA special enrollment, changes as a result of a reduction in hours of service, and changes because of your enrollment in a health plan offered by the Marketplace, must be "on account of and correspond with" the event. To satisfy the "consistency rule," both the event and the corresponding change in coverage must meet the following requirements:

- **Affect eligibility:** The event must affect eligibility for coverage under the Plan or under a plan sponsored by your Dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your Dependent child(ren) who may benefit from coverage under the Plan.
- **Corresponding election change:** The election change must correspond with the event. For example, if your Dependent child(ren) loses eligibility for coverage under the terms of Medical Benefit, you may cancel Medical Benefits only for that dependent child(ren). You may not cancel coverage for yourself or other covered Dependents.

Article 3 - Coverage During a Leave of Absence

Section 3.1 - Federal Family and Medical Leave Act

FMLA allows eligible Employees to take a specific amount of unpaid leave for serious illness, including a mental health condition, the birth or adoption of a child, to care for a Spouse, child, or parent who has a serious health condition, including a mental health condition, to care for family members wounded while on active duty in the Armed Forces, or to deal with any qualifying exigency that arises from a family member's active duty in the Armed Forces. This leave is also available for family members of veterans for up to five years after a veteran leaves service if he or she develops a service-related injury or illness incurred or aggravated while on active duty. For additional information on FMLA leaves, please contact the BrightSpring Benefits Department (see **Addendum A**).

If you take an FMLA leave, you may continue your group health coverages (Medical, Dental, Vision, EAP, and Health Care FSA or Limited Use FSA coverage) for you and any covered Dependents as long as you continue to pay your portion of the cost for your benefits during the leave. If you take a paid leave of absence, the cost of group health coverage will continue to be

deducted from your pay on a pre-tax basis. If you take an unpaid leave of absence that qualifies under FMLA, you may continue your participation as long as you contribute the active employee share of the cost of group health coverage during the leave by paying for coverage during your leave on an after-tax basis. You also have the option to suspend your health coverage during the leave.

If your Health Care FSA coverage terminates during your leave, your coverage may be reinstated if you return to work in the same year that your leave began. You will have a choice to resume contributions to the spending accounts at the same level in effect before your leave, or you may elect to increase your contributions to “make up” for contributions you missed during your leave period. If you simply resume your prior contribution level, the amount available for reimbursement for the year will be reduced by the contributions missed during your leave. Regardless of whether you choose to resume your former contribution level or make up for missed contributions, expenses incurred while your account participation is suspended will not be reimbursed.

If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections (for example, if you have a baby and want to increase your Health Care FSA coverage amount).

Your Supplemental Life, Dependent Life, Supplemental AD&D, Supplemental Short-Term Disability, Group Pre-Paid Legal, Voluntary Long-Term Disability, Accident Coverage, Critical Illness Coverage, and Voluntary Hospital Indemnity Coverage will continue during FMLA leave if you continue to pay the required after-tax contributions during your leave. Your contributions to the Dependent Care FSA will continue during a paid leave but will be suspended if the leave is unpaid.

Any coverage that is terminated during your FMLA leave will be reinstated upon your return without any evidence of good health or newly imposed waiting period.

If you lose any group health coverage during an FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your group health coverage will start again on the first day after you return to work and make your required contributions.

If you do not return to work at the end of your FMLA leave you may be entitled to purchase COBRA continuation coverage as described in Article 4.

Section 3.2 - Military Leave

Pursuant to USERRA, if you take a military leave, whether for active duty or for training, you are entitled to extend your Medical, Dental, Vision, Employee Assistance Plan and Health Care FSA or Limited Use FSA coverage for up to 24 months as long as you give BrightSpring advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). Your total leave, when added to any prior periods of military leave from BrightSpring, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit—including situations where service members are involuntarily retained beyond their obligated service date; additional required training; federal service as a member of the National Guard; and service under orders during war or national emergencies declared by the President or Congress. Additionally, the five-year limit may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or

longer, you may be required to pay up to 102% of the full amount necessary to cover an Employee (including any amount for Dependent coverage) who is not on military leave for Medical coverage.

All other coverages will continue during your military leave, except that participation in the Dependent Care FSA will terminate.

If you are called to perform military service for more than 179 days, you will be able to take your unused Health Care FSA or Limited Use FSA balance as a taxable cash distribution by the last day of the FSA plan year.

If you take a military leave, but your coverage under the Plan is terminated—for instance, because you do not elect the extended coverage—when you return to work at BrightSpring, you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health plan coverage. USERRA permits a health plan to impose an exclusion or waiting period to an illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during performance of service in the uniformed services.

If you do not return to work at the end of your military leave, you may be entitled to purchase COBRA continuation coverage if you extended benefits for less than 18 months. However, your military leave benefits continuation period runs concurrently with your COBRA coverage period, subject to the limitation of COBRA. This means that COBRA coverage and USERRA coverage begin at the same time. If you do not return to work at the end of your military leave you may be entitled to continue COBRA continuation coverage for the remainder of the COBRA continuation period, if any. In other words, any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible. Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to continuation coverage elected. If COBRA and USERRA give you (or your covered Spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply.

Section 3.3 - Other Types of Leave

In addition to the leaves described above, BrightSpring may also offer coverage for certain benefits for up to 26 weeks for approved medical leave. For more information about any type of leave of absence, including how such leave may affect benefits under the Plan or how to obtain an approved medical leave, you can contact the BrightSpring Benefits Support Center (see **Addendum A**).

Section 3.4 - Payments While on Leave

BrightSpring may require benefits to be directly billed to you while on leave, even if you are on paid leave. Please contact the BrightSpring Benefits Support Center for additional details about how your required contributions for applicable benefits will be collected while you are leave.

Article 4 - When Coverage Ends & COBRA

Section 4.1 - Termination of Participation

Your coverage will terminate on the earliest occurrence of a following event:

- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the insurance contract or agreement, or by discontinuance of contributions by BrightSpring;
- The date that your coverage is terminated pursuant to a Component Benefit Document;

- The date you die;
- The date your employment is terminated or hours are reduced so that you are no longer classified as a Covered Employee; and
- The date you report for active military service unless coverage is continued through USERRA.

Coverage for your Dependents (including a Domestic Partner) terminates when your coverage terminates. In addition, your Dependent's coverage will also terminate:

- 2

Depending on the reason for termination of coverage, you and your Dependents might have the right to continue health coverage temporarily under COBRA or due to a conversion right available under a particular Component Benefit Plan.

Section 4.2 - COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances (called "qualifying events") when coverage would otherwise end. The right to COBRA coverage was created by federal law. After a qualifying event, COBRA continuation coverage is offered to each "qualified beneficiary." You, your Spouse, and/or your dependent children could become qualified beneficiaries if you, your Spouse, or your dependent child is enrolled in health benefits under the Plan on the day before a qualifying event occurs and that health benefit coverage is terminated because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period.

While not legally considered a "qualified beneficiary" under the COBRA law, the Plan offers COBRA-like coverage to your Domestic Partner and children of your Domestic Partner and will be included in the term "qualified beneficiary" for purposes of this section. However, COBRA rights and protections do not apply to this extension of Domestic Partner coverage.

The following paragraphs generally explain COBRA coverage, when it may become available to you, your Spouse, dependent children, Domestic Partner and/or Domestic Partner's children and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, EAP and Health Care FSA coverage. COBRA does not apply to any other benefits offered under the Plan or by BrightSpring (such as Life, Long-Term Disability, or AD&D). Subject to this Section 4.2, the Plan only provides COBRA rights required by law.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a Spouse's plan), even if that plan generally doesn't accept late enrollees. The pronoun "you" in the following subsections regarding COBRA may refer to each person covered under the Plan who is or may become a qualified beneficiary, if context requires.

COBRA Coverage Overview

COBRA coverage is temporary continuation of group health coverage under the Plan when coverage would otherwise end because of a "qualifying event". After a qualifying event occurs and any required notice of that event is properly provided to BrightSpring, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary." You, your Spouse, your dependent children, your Domestic Partner and your Domestic Partners' children could become qualified beneficiaries and would be entitled to elect

COBRA (or COBRA-like coverage) if group health coverage under the Plan is lost because of the qualifying event.

COBRA coverage is the same coverage that the Plan provides to other Covered Persons or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other Covered Persons or beneficiaries covered under the Plan's group health coverage elected by the qualified beneficiaries, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay the full cost for COBRA coverage plus a 2% administrative fee.

COBRA Eligibility

Employees

You are eligible for COBRA continuation coverage if you lose your group health coverage under the Plan because of either one of the following qualified events:

- Your hours of employment are reduced or
- Your employment ends for any reason (other than gross misconduct on your part).

Spouse/Domestic Partner of Employee

Your Spouse/Domestic Partner is eligible for COBRA continuation coverage if he/she loses group health coverage under the Plan because of any of the following qualifying events:

- Your hours of employment are reduced;
- Your employment ends for any reason (other than gross misconduct on your part);
- You die;
- You become divorced from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce and a divorce later occurs, then the divorce may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce; or
- Your Domestic Partnership ends.

Dependent Children

- Your Dependent children are eligible for COBRA continuation coverage if they lose group health coverage under the Plan because any of the following qualified events:
- Your hours of employment are reduced;
- Your employment ends for any reason (other than gross misconduct on your part);
- You die;
- You become divorced from your Spouse;
- Your Domestic Partnership ends; or
- Your child loses eligibility as a "dependent child" under the Plan.

COBRA and FMLA

If you take a leave of absence that qualifies under FMLA and do not return to work at the end of the leave, you (and your Spouse, Domestic Partner, dependent children and Domestic Partner's children, if any) will have the right to elect COBRA if:

- You were covered by group health coverage under the Plan on the day before the FMLA leave began (or became covered by group health coverage under the Plan during the FMLA leave); and
- You lose group health coverage under the Plan because you do not return to work at the end of the leave.

COBRA Commencement

COBRA coverage will begin on the earliest of the following to occur:

- When you definitively inform BrightSpring that you are not returning at the end of the leave; or
- The end of the leave, assuming you do not return to work.

Benefits will commence as follows:

Newly Eligible Child

If you, the former Employee of BrightSpring, elect COBRA coverage and then have a child (either by birth, adoption, or placement for adoption) during the period of COBRA coverage, the new child is also eligible to become a qualified beneficiary. In accordance with the terms of the Plan's eligibility and other requirements for group health coverage and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing the BrightSpring Benefits Support Center (see **Addendum A**) with notice of the new child's birth, adoption or placement for adoption. This notice must be provided within 31 days of birth, adoption or placement for adoption. The notice must be in writing and must include the name of the new qualified beneficiary, date of birth or adoption of the new qualified beneficiary, and birth certificate or adoption decree. The new child's COBRA continuation coverage begins when the child is enrolled in the plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA continuation coverage lasts for your other family members who are qualified beneficiaries.

If you fail to notify BrightSpring within the 31 days, you will *not* be offered the option to elect COBRA coverage for the newly acquired child. Newly acquired dependent child(ren) (other than children born to, adopted by, or placed for adoption with the Employee) will not be considered qualified beneficiaries, but may be added to the Employee's continuation coverage, if enrolled in a timely fashion, subject to the Plan's rules for adding a new dependent.

QMCSO

A child of the Covered Employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by BrightSpring during the Covered Employee's period of employment with BrightSpring is entitled to the same rights to elect COBRA as an eligible dependent child of the Covered Employee.

Notification of COBRA Qualifying Events

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to the qualified beneficiaries. You do not need to notify BrightSpring of any of these three qualifying events.

For a qualifying event which is a divorce of the Employee and Spouse, the end of a domestic partnership or a dependent child's losing eligibility for coverage, a COBRA election will be available to you only if you notify the BrightSpring Benefits Support Center in writing within 60 days of the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. You or a representative acting on your behalf (such as a family member) are responsible for providing the required notice.

The notice must include the following information:

- The name of the Employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost (or will lose) coverage under the Plan due to the qualifying event;
- The qualifying event giving rise to COBRA coverage;
- The date of the qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the qualifying event, if BrightSpring requests it. Acceptable documentation includes a copy of the divorce decree or dependent child(ren)'s birth certificate(s), driver's license or marriage license. If the above procedures are not followed or if the notice is not provided to BrightSpring within the 60-day notice period, you will lose your right to elect COBRA. In addition, if any claims are mistakenly paid for expenses incurred after the date coverage would normally be lost because of the qualifying event, you will be required to reimburse the Plan for any claims mistakenly paid.

Electing COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election and ensure BrightSpring receives proper receipt. An election notice will be provided to qualified beneficiaries at the time of the qualifying event. You may be required to complete COBRA elections electronically or by any means approved by BrightSpring or the COBRA Administrator.

You must elect COBRA coverage within 60 days from the date you would lose coverage due to a qualifying event, or, if later, 60 days after the date you are provided with the COBRA election notice from the Plan. Your election must be completed and transmitted electronically or postmarked within the 60-day election period. If you do not submit a completed election form within the 60-day election period, you will lose your right to COBRA.

If you complete and transmit your COBRA election, waive your rights to COBRA and change your mind within the 60-day election period, you may revoke your waiver and still elect the COBRA coverage as long as it is within the original 60-day election period. However, your COBRA coverage will be effective as of the date you revoked your waiver of coverage.

Separate COBRA Elections

Each qualified beneficiary has an independent election right for COBRA coverage. For example, even if the Employee does not elect COBRA coverage, other family members who are qualified beneficiaries may elect to be covered under COBRA. Also, if there is a choice among types of coverage, each qualified beneficiary who is eligible for COBRA continuation coverage is entitled to make a separate election among the types of coverage. Thus, a Spouse or dependent child may elect different coverage than the Employee elects.

A covered Employee or Spouse/Domestic Partner can also make the COBRA election on behalf of all qualified beneficiaries and a parent or legal guardian may make the election on behalf of a minor child. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period will lose his or her right to elect COBRA coverage.

COBRA Coverage Details

If you elect COBRA continuation coverage, your coverage will generally be identical to coverage provided to "similarly situated" Employees or family members at the time you lose coverage. However, if any changes are made to coverage for similarly situated Employees or family members, your coverage will be modified as well. "Similarly situated" refers to a current

Employee or dependent child(ren) who has not had a qualifying event. Qualified beneficiaries on COBRA have the same enrollment and election change rights as active Employees.

Medicare and Other Coverage

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage. When you complete the election form, you must notify BrightSpring if any qualified beneficiary has become entitled to Medicare (Part A, Part B or both) and if so, the date of Medicare entitlement.

Health Care FSA or Limited Use FSA COBRA Coverage

COBRA coverage under the Health Care FSA or Limited Use FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected under the Health Care FSA or Limited Use FSA by the Covered Employee, reduced by reimbursements of expenses incurred up to the time of the qualifying event, is equal to or more than the amount of premiums for Health Care FSA or Limited Use FSA COBRA coverage that will be charged for the remainder of the Plan Year. COBRA coverage for the Health Care FSA or Limited Use FSA, if elected, will consist of the Health Care FSA or Limited Use FSA coverage in force at the time of the qualifying event (the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event).

All qualified beneficiaries who were covered under the Health Care FSA or Limited Use FSA will be covered together for Health Care FSA or Limited Use FSA COBRA coverage. However, each qualified beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that qualified beneficiary only, with a separate Health Care FSA or Limited Use FSA annual coverage limit and a separate COBRA premium.

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to disability, 150%) of the cost to the group health plan (including both Employer and Employee contributions) for coverage of a similarly situated Covered Person who is not receiving COBRA coverage.

The amount of your COBRA premiums may change during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Your first premium is due within 45 days after you elect COBRA coverage. If you do not make your first payment for COBRA coverage within the 45 days after the date of your timely election, you will lose all COBRA rights under the Plan. Thereafter, payments are due by the first day of each month to which the payments apply (payments must be postmarked on or before the end of the 30-day grace period). If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the Plan. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated through the end of the month before the month in which you make your first payment. You are responsible for making

sure that the amount of your first payment is correct. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

All COBRA premiums must be paid by check or ACH debit as permitted by the COBRA Administrator.

COBRA coverage is not effective until you elect it *and* make the required payment. Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

Duration of COBRA

If you lose Plan coverage because of termination of employment or reduction in hours, the law requires that you be given the opportunity to maintain COBRA coverage for 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for 36 months.

When Plan coverage is lost because of termination of employment or reduction in hours, and the Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the Employee) who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the covered Employee becomes entitled to Medicare within 18 months BEFORE termination or reduction of hours.

The maximum COBRA coverage period for the Health Care FSA or Limited Use FSA ends on the last day of the Plan Year in which the qualifying event occurred. Notwithstanding the previous sentence, a qualified beneficiary shall carryover up to the maximum permitted by the IRS (e.g. \$660 from 2025 to 2026) or, if less, the unused balance in his or her Health Care FSA (or the Limited Use FSA) at the end of the Plan Year, to a subsequent Plan Year. The carryover shall only be available for the duration of the period of COBRA continuation coverage. No premium will be charged for the subsequent Plan Year.

COBRA coverage can end before any of the periods described above for several reasons. See the Early Termination of COBRA section below for more information.

29-Month Qualifying Event (Due to Disability)

If the qualifying event that resulted in your COBRA election was the Covered Employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled as determined by the Social Security Administration. If you notify the COBRA Administrator in a timely fashion, all the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total of 29 months. The disability must have started at some time before the 61st day after the Covered Employee's termination of employment or reduction of hours and must last until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

To continue coverage for the additional 11 months, you or a representative acting on your behalf must notify the COBRA Administrator in writing of the Social Security Administration's determination within 60 days after the latest of:

- The date of the Social Security Administration's disability determination;
- The date of the Covered Employee's termination of employment or reduction of hours; and

- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered Employee's termination or reduction of hours in order to be entitled to a disability extension. The notice must be provided in writing and must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The name and address of the disabled qualified beneficiary;
- The date that the qualified beneficiary became disabled;
- The date that the Social Security Administration made its determination of disability;
- A statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- The signature, name and contact information of the individual sending the notice.

Your notice must include a copy of the Social Security Administration's determination of disability. You must mail, hand deliver, or electronically transmit (in a form approved by BrightSpring or the Administrator) this notice to the COBRA Administrator at the address listed in **Addendum A**.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no disability extension of COBRA coverage.

If, during continued coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA Administrator of this determination within 30 days of the date it is made and COBRA coverage will end no earlier than the first of the month that begins more than 30 days after the date of the final determination by the Social Security Administration that the qualified beneficiary is no longer disabled. The notice must be provided in the same manner as described above, and include the same information required for, a notice of disability as described above.

Second Qualifying Event

An extension of coverage will be available to the Spouse/Domestic Partner and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in case of a disability extension, the 29 months) following the Covered Employee's termination of employment or reduction in hours. Second qualifying events include an Employee's death, divorce, end of a domestic partnership, or a child losing Dependent status (if such qualifying event would have resulted in a loss of coverage under the plan for an active Employee or Dependent). If you experience a second qualifying event, COBRA coverage for a Spouse/Domestic Partner or dependent child can be extended from 18-months (or 29 months in case of a disability extension) to 36 months, but in no event will coverage last beyond 36 months from the initial qualifying event or the date coverage would have been lost due to the initial qualifying event.

This extension is only available if you or a representative acting on your behalf notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event or (2) the date on which the qualified beneficiary would have lost coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan as an active Covered Person). The notice must include the following information:

- The name(s) and address(es) of all qualified beneficiaries who are receiving COBRA due to the initial qualifying event;
- The second qualifying event;
- The date of the second qualifying event; and
- The signature, name and contact information of the individual sending the notice.

In addition, you must provide documentation supporting the occurrence of the second qualifying event if the Plan requests it. Acceptable documentation includes a copy of the divorce decree, death certificate or dependent child(ren)'s birth certificates, driver's license, or marriage license.

You must mail this notice to the COBRA Administrator at the address listed in **Addendum A** or return in an electronic form and using an electronic method approved by BrightSpring or the COBRA Administrator.

If the above procedures are not followed or if the notice is not provided to the COBRA Administrator within the 60-day notice period, there will be no extension of COBRA coverage due to a second qualifying event.

Early Termination of COBRA

The law provides that your COBRA continuation coverage may be cut short prior to the expiration of the 18-, 29-, or 36-month period for any of the following five reasons:

- BrightSpring no longer provides the applicable group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time;
- The qualified beneficiary first becomes covered—after the date COBRA is elected—under another group health plan (whether or not as an employee);
- The qualified beneficiary first becomes entitled to Medicare (under Part A, Part B or both) after the date COBRA is elected; or
- Coverage has been extended for up to 29 months due to disability, and there has been a final determination made by the Social Security Administration that the individual is no longer disabled. Coverage will end the first of the month that is more than 30 days from the date Social Security determines that the individual is no longer disabled.

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a Covered Person not receiving COBRA coverage (such as fraud). In addition, BrightSpring reserves the right to terminate your coverage retroactively in the event it determines you are not eligible for COBRA, in accordance with applicable law.

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage. COBRA coverage will terminate (retroactively, if applicable) as of the date of Medicare entitlement or as of the beginning date of other group health coverage.

BrightSpring, the insurance carriers and/or HMOs may require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide the required notice.

In addition, you must notify the COBRA Administrator in writing if, during a disability extension of COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled. See 29-Month Qualifying Event (Due to Disability) section above.

Other (non-COBRA) Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of

these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Contact Information

If you have any questions about COBRA coverage, please contact the COBRA Administrator or Plan Administrator (see **Addendum A**). You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa. For more information about the Marketplace, visit www.HealthCare.gov.

Address Changes

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

Special COBRA Rights for California Employees

If you are enrolled in a medical HMO or insured medical coverage in California at the time of your initial qualifying event, you and your eligible dependents may be eligible to extend COBRA coverage from 18 or 29 months to a total of 36 months measured from the date of the original qualifying event. The HMO or insurance company may charge up to 110% of the cost (disabled individuals may be charged up to 150% of the cost). This special California continuation benefit is provided by the HMOs and insurance companies and is not BrightSpring's responsibility. Contact your HMO or insurance carrier to find out whether you are eligible for this continuation benefit and how to obtain it.

Section 4.3 - Converting Coverage

If you are eligible to convert your coverage to an individual policy, you will be sent a conversion notice within the last 180 days of COBRA coverage. Contact the applicable HMO or insurance company for information on converting to an individual policy. HMOs and insurance companies will sometimes permit you to continue membership or equivalent coverage under an individual policy. Conversion rights may also be available to your Spouse and/or dependent child(ren). However, the cost of conversion coverage is usually high, and conversion coverage often will not offer the same comprehensive coverage as the Plan. For more information about conversion rights, contact the applicable Claim Administrator.

Article 5 - Benefits

Section 5.1 - Plan Benefits

If eligible, you have the right to elect benefits under applicable Component Benefit Documents. The list of Component Benefit Plans available under the Plan and corresponding Claim Administrators are contained in **Addendum B**.

Section 5.2 - Health Savings Accounts (not subject to ERISA)

You may contribute on a pre-tax basis to the HSA if you meet all of the following IRS requirements:

- You maintain enrollment in HDHP Medical coverage.
- You are not enrolled in Medicare (Part A and/or Part B) or any other group health coverage (excluding Dental, Vision, and Limited Use FSA coverage), such as a non-HDHP medical plan maintained by your Spouse's employer.
- You cannot be claimed as a dependent on any other person's tax return.

It is your responsibility to ensure that you are eligible to contribute to and receive reimbursement tax-free from your HSA. The HSA is not sponsored by BrightSpring. For HSA information, you can contact the BrightSpring Benefits Support Center.

Health Savings Account Advantages

An HSA is a tax-advantaged account that you can use to pay for any qualified health expenses incurred by yourself or your eligible dependents, while covered under a high deductible medical plan. The HSA can help you to cover, on a tax-free basis, medical expenses that require you to pay out-of-pocket, such as deductibles, copays, coinsurance, or other qualified medical expenses as defined by the IRS. You can find additional details regarding qualified medical expenses in **Addendum F**. If amounts are distributed from the HSA to pay non-medical expenses, the amounts will be subject to income tax and may be subject to 20% penalty. HSA contributions accumulate over time with interest or investment earnings, are portable after employment, and can be used to pay for qualified health expenses tax-free or for non-health expenses on a taxable basis.

Additional Health Savings Account Details

An HSA is not subject to ERISA and additional details can be found in the Cafeteria Plan (see **Addendum G**).

Section 5.3 - Health Care Flexible Spending Account

The Health Care FSA may be of interest to you if you are paying for health care expenses that are not fully reimbursed or not covered by your health coverage. If you are enrolled in the HDHP, you are not eligible to enroll in the Health Care FSA, but you may enroll in the Limited Use FSA. If elected, you will receive a portion of what would otherwise be your regular pay in health care expense reimbursements for qualified medical expenses. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes. You can find additional details regarding Health Care FSAs in the Cafeteria Plan (see **Addendum G**) and information regarding qualified medical expenses in **Addendum F**.

Section 5.4 - Dependent Care Flexible Spending Account

The Dependent Care FSA may be of interest to you if you are paying for the care of a child or disabled member of your household in order for you or, if you are married, for you and your Spouse to work. The Dependent Care FSA allows you to pay for certain dependent care expenses with pre-tax dollars. By participating, you will receive in dependent care expense reimbursement a portion of what would otherwise be your regular pay. This also reduces the amount of taxable income you receive and, therefore, reduces your taxes. You can find additional details regarding Dependent Care FSAs in the Cafeteria Plan (see **Addendum G**).

Section 5.5 - Limited Use Flexible Spending Arrangements

The Limited Use FSA may be of interest to you if you are enrolled in an HDHP and have an HSA. If you are enrolled in an HDHP, you are not eligible to enroll in the Health Care FSA, but you may enroll in the Limited Use FSA. The Limited Use FSA covers only dental and/or vision expenses as allowed under Code Sections 213 and 223 except that the Limited Use FSA will cover preventive medical expenses and medical expenses incurred after you meet the IRS required minimum deductible for an HSA-eligible HDHP. Please contact the Claim Administrator for more information, review the Cafeteria Plan (see **Addendum G**), or see **Addendum F** for additional information on qualified medical expenses.

Section 5.6 - Coordination of Benefits

If multiple benefits may pay for a single item, the coordination of benefit provisions contained in **Addendum C** may apply.

Article 6 - Contributions, Funding, and Plan Assets

Section 6.1 - Contributions

Employer Contributions

BrightSpring shall pay, as contributions to the Plan, all or a portion, as determined by BrightSpring, of the cost of the benefits provided under the Plan. BrightSpring reserves the right to cease payments under the Plan at any time and shall be under no obligation to make any contributions to the Plan after the Plan is terminated.

Employee Contributions

If you are a full-time Employee, you pay your share of the cost of Medical, Dental and Vision coverage on a pre-tax basis, based on a contribution level determined by your Employer. If you are a part-time Employee, you pay your share of the cost of Limited Medical, Dental and Vision coverage on a pre-tax basis.

Contributions to FSAs are also made on a pre-tax basis. By enrolling in benefits under the Plan, you agree to have your salary reduced by your elected contribution amount. If you are enrolled in the HDHP you may make pre-tax contributions to an HSA.

If you are enrolled in Supplemental Life, Dependent Life, Supplemental AD&D, Supplemental Short-Term Disability, Group Pre-Paid Legal, Voluntary Long-Term Disability, Accident Coverage, Critical Illness Coverage or Hospital Indemnity Coverage, you pay the cost for coverage on a post-tax basis via paycheck deductions, based on your election.

You do not pay Social Security taxes on the pre-tax dollars you use to pay for coverage under the Plan. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan will normally be greater than any eventual reduction in Social Security benefits. BrightSpring cannot provide you with tax advice because individual employee tax situations may vary. ***You should consult your trusted tax advisor, lawyer, or accountant if you have any questions regarding how electing benefits under the Plan may affect your individual tax situation.***

Employees on leave and not receiving regular paychecks must make any required contribution directly to the BrightSpring Benefits Support Center (see **Addendum A**). Coverage will be cancelled if not paid by the due date or the end of the legally required grace period.

As a condition of receiving benefits under the Plan, you agree, whether on forms, materials furnished by BrightSpring, through a telephone or web-based enrollment process, or other similar enrollment process to make contributions under the Plan and make such contributions when and as required.

Section 6.2 - Priority of Contributions

Payment of all benefits shall be deemed to come first from amounts contributed by you and then from amounts contributed by BrightSpring. Notwithstanding the foregoing, your contributions shall not be used for any administrative fees or other similar fees.

Section 6.3 - Funding Policy & Mechanism

The Plan and all benefits subject to ERISA offered under the Plan shall be a single plan for ERISA purposes. Contributions from the Employer and/or eligible Employees may be held under or paid to one or more of the following entities: insurance policies, HMOs, or similar arrangements. In addition, benefits may be paid directly from the general assets of the Employer.

Section 6.4 - Plan Assets

Subject to the right of the Employer to terminate its obligation hereunder, the Employer shall pay benefit(s), to the extent not:

- Provided for by Employee contributions; or
- Payable from an insurance policy held under the Plan.

Where an insurance policy provides for payment of premiums directly from the Employer, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, rebates or experience refunds are not Plan assets, except as required by applicable law. These dividends, retroactive rate adjustments, rebates or experience refunds are BrightSpring's property, which BrightSpring may retain to the extent they do not exceed the BrightSpring's aggregate contributions to Plan cost made from its own funds, except as required by law. To the extent the law requires that a rebate is considered a Plan asset, which may relate to premiums or payments by Participants, such Plan asset may be used for Plan administrative functions related to the Plan as a whole or any benefit program under it, to enhance any benefit program, for new benefit programs, or in any other manner related to Plan administration or the provision of benefits.

Section 6.5 - Uncashed Checks

For a Plan benefit that is self-funded, benefit payments made by check must be cashed within one year of issue. If a benefit payment check is not presented for payment within one year of issue, then the Plan will have no liability for the benefit payment and the amount of the check will be deemed a forfeiture. If a benefit payment check must be re-issued, then the amount may be reduced to reflect the cost to issue a replacement check.

Section 6.6 - Establishment of Employee Premiums and/or Contributions

The Plan Administrator will notify employees at least annually as to what the Employee contribution rates will be. BrightSpring, in its sole and absolute discretion, shall determine the amount of any required contributions under the Plan and may increase or decrease the amount of the required contribution at any time.

Section 6.7 - Acts of Third Parties & Subrogation

When you or your covered Dependent are injured or become ill because of the actions or inactions of a third party, the Plan may cover your eligible health care (Medical, Dental and Vision) expenses. However, to receive coverage, you must notify the Plan that your illness or injury was caused by a third party, and you must follow special Plan rules. This section describes the Plan's procedures with respect to subrogation and right of recovery.

Subrogation means that if an injury or illness is someone else's fault, the Plan has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party related to the illness or injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury;
- May appoint you as constructive trustee for any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or injury; and
- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed later in this section—through a judgment, settlement or otherwise—when an illness or injury is a result of a third party, you agree to place the funds in a separate, identifiable account and that the Plan has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney fees and costs) you incur in obtaining the funds.

The Plan's sources of payment through subrogation or recovery include (but are not limited to) the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;
- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;
- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and
- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this summary.
- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness.
- Provide all information requested by the Plan, the Claim Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits if you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these “Acts of Third Party” provisions conflict with subrogation provisions in an insurance contract governing the benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these “Acts of Third Party” provisions conflict with right of recovery provisions in an insurance contract governing the benefits at issue, the right of recovery provisions in the insurance contract will govern.

Section 6.8 - Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

Section 6.9 - Right to Recover Payments (Overpayment and Erroneous)

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made. Whenever payments have been made exceeding the amount necessary to satisfy the provisions of the Plan, the Plan has the right to recover these expenses from any individual (including you, and the insurance company or any other organization receiving excess payments). The Plan may also withhold payment, if necessary, on future benefits, pursuant to Section 6.9, until the overpayment is recovered. In addition, whenever payments have been made based on fraudulent information provided by you, the Plan will exercise the right to withhold payment on future benefits until the overpayment is recovered, as well as remove you and your covered dependents from coverage and not allow you to re-enroll at any time in the future.

Article 7 - Claims and Appeals Process

Section 7.1 - Claim Types

The claims and appeals procedures are slightly different, depending on whether you have an “eligibility” claim or a “benefit” claim. An eligibility claim is a claim to participate in a plan or plan option or to change an election to participate during the year. A benefit claim is a claim for a particular benefit under a Component Benefit Plan. It typically will include your initial request for benefits. All claims must be filed within 90 days after the end of the plan year to which the claim relates.

Section 7.2 - Filing an Eligibility Claim and Appeal

An eligibility claim is a claim to participate in the benefits offered under the Plan or to change an election to participate during the year. Examples of eligibility claims include claims regarding whether you are enrolled in the correct benefit option, or claims related to whether you properly enrolled a dependent. Eligibility claims do not address whether a particular treatment or benefit is covered under the Plan.

For initial eligibility claims for all Plan benefits subject to ERISA, the Claims Administrator is BrightSpring Benefits Support. To file an eligibility claim, you must request a form from the Benefits Support Center to initiate the eligibility claim. You will submit the form online at www.brightspringbenefits.com.

You will be notified of the decision within the time periods below:

- For Medical (including prescription drug), Health Care FSA, Limited Use FSA, Dental, Vision, and EAP benefits, within 30 days of the receipt of your eligibility claim form (in rare cases, if you have an urgent care claim, it will be 72 hours),

- For Short-Term Disability and Long-Term Disability benefits, within 45 days of the receipt of your eligibility claim form, or
- For all other benefits, within 90 days of the receipt of your eligibility claim form. If additional information is needed to process your eligibility claim, you will be notified within that initial period. The Plan may request an extension, not longer than:
 - For Medical (including prescription drug), Health Care FSA, Limited Use FSA, Dental, Vision, and EAP benefits, an additional 15 days,
 - For Short-Term Disability and Long-Term Disability benefits, up to two additional 30-day periods, or
 - For all other benefits, 90 days.

The BrightSpring Benefits Support Center will notify you of the deadline to submit additional information, if applicable. If your claim is approved, the BrightSpring Benefits Support Center will notify you in writing.

If your claim is denied, in whole or in part, your written denial notice will contain:

- The specific reason(s) for the denial;
- The Plan provisions on which the denial was based;
- Any additional material or information you may need to submit to complete the claim and an explanation as to why it is necessary;
- A description of the Plan's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following your appeal;
- Any internal procedures or protocols on which the denial was based (or a statement that this information will be provided free of charge, upon request);
- Information sufficient to identify the claim involved; and
- Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

Before you can bring any legal action to recover Plan benefits, you must exhaust this process. Specifically, you must file an appeal as explained in this section and your appeal must be finally decided by the appeals administrator. For eligibility claims for all ERISA-governed component benefit programs, the appeals administrator is the Plan Administrator or its delegate(s). All decisions by the appeals administrator are final and binding on all parties.

If your claim is denied and you want to appeal it, you must file your appeal within 180 days (for Medical (including prescription drug), Health Care FSA, Limited Use FSA, Dental, Vision, and EAP) or otherwise 60 days from the date you receive written notice of your denied claim. You may request access, free of charge, to all documents relating to your appeal. To file your appeal, write to the appeals administrator for the Plan and include:

- A copy of your claim denial notice;
- The reason(s) for the appeal; and
- Relevant documentation.

You will be notified of the decision within 60 days for Medical (including prescription drug), Health Care FSA, Limited Use FSA, Dental, Vision, and EAP benefits (unless it is an urgent care claim, in which case you will be notified within 72 hours of the appeal administrator's receipt of your appeal), 45 days for disability (90 days when special circumstances apply), or 60 days (120 days when special circumstances apply) for all other ERISA-covered benefit programs.

Section 7.3 - Filing a Benefits Claim

Benefit claim filing procedures are set forth in applicable Component Benefit Documents. In general, any Covered Person under the Plan (or his or her authorized representative) may file a written claim for benefits using the proper form and procedure. A claimant can obtain the necessary claim forms from the Claim Administrators. When the Claim Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan. Contact information on where to obtain information regarding filing a claim and where to send claims can be found in **Addendum B**.

This section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. Note that state insurance laws may provide additional protection to claimants under insured arrangements, and if so, those rules will apply. To obtain benefits from the insurer, you must follow the claims procedures under the applicable insurance contract, which may require that a written claim be completed, signed and submitted on the insurer's form.

For Medical benefits, the Plan will comply with additional claims and appeals rules required under the ACA and additional claim and appeals rules under Department of Labor regulations applicable to Short-Term Disability and Long-Term Disability benefits. In addition, the claims and appeals procedures described below only apply to benefits subject to ERISA.

Section 7.4 - Claim-Related Definitions

Claim

Any request for plan benefits made in accordance with the plan's claims-filing procedures, including any request for a service that must be pre-approved.

The Plan recognizes four categories of health benefit claims:

Urgent Care Claims

"Urgent care claims" are claims (other than post-service claims) for which the application of non-urgent care time frames could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Plan must defer to an attending provider to determine if a claim for Medical benefits is urgent.

Pre-service Claims

"Pre-service claims" are claims for approval of a benefit if the approval is required to be obtained before a patient receives health care (for example, claims involving preauthorization or referral requirements).

Post-Service Claims

"Post-service claims" are claims involving the payment or reimbursement of costs for health care that has already been provided.

Concurrent Care Claims

"Concurrent care claims" are claims for which the Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and the Plan later reduces or terminates coverage for those treatments. A concurrent care claim may be treated as an "urgent care claim," "pre-service claim," or "post-service claim," depending on when during the course of your care you file the claim. However, the Plan must give you sufficient advance notice of the initial claims determination so that you may appeal the claim before a concurrent care claims determination takes effect.

Adverse Benefit Determination

If the Plan does not fully agree with your claim, you will receive an “adverse benefit determination”—a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An adverse benefit determination includes a decision to deny benefits based on:

- Utilization review;
- A service being characterized as experimental or investigational or not medically necessary or appropriate;
- A concurrent care decision; and
- Certain retroactive terminations of coverage, whether or not there is an adverse effect on any particular benefit at that time.

An adverse benefit determination for Medical claims includes a rescission of coverage (generally a retroactive cancellation of coverage) under the Plan, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time

Section 7.5 - Initial Benefit Claim Determinations (ERISA Benefits)

For each of the Plan benefits subject to ERISA, the Plan has a specific amount of time, by law, to evaluate and respond to claims for benefits covered by the Employee Retirement Income Security Act of 1974 (ERISA). The period of time the Plan has to evaluate and respond to a claim begins on the date the Plan receives the claim. If you have any questions regarding how to file or appeal a claim, contact the Claim Administrator for the benefit at issue. These timeframes apply to the various types of claims that you may make under the Plan, depending on the benefit at issue.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include:

- The specific reasons for the adverse determination;
- The specific plan provisions on which the determination is based;
- A request for any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the plan’s review procedures and the time limits applicable to such procedures;
- A statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review;
- If any internal rules, guidelines, protocols or similar criteria was used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request;
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request; and
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than 3 days after the oral notice.

For medical claims, the notice will include information sufficient to identify the claim involved. This includes the:

- Date of service;
- Health care provider;
- Claim amount (if applicable); and
- Denial code.

Medical claim notices will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review process;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review process; and
- Depending on where you live, you may be able to receive the denial notice in your native language.

If the Claim Administrator relies on new evidence to deny your claim, you will be notified in advance, free of charge, with the rationale so that you can respond in advance of the final internal adverse benefit determination. You have a right to review your claim file.

Time Frames for Initial Benefit Claim Decisions

Time frames generally start when the Plan receives a claim. Notices of benefit determinations generally may be provided through in-hand delivery, mail, or electronic delivery, before the period expires, though oral notices may be permitted in limited cases. A reference to “days” means calendar days. Health Care FSA and Limited Use FSA claims are considered non-urgent “post-service” claims.

	Medical, Dental, Vision, EAP & Health Care FSA and Limited Use FSA				Short-Term & Long-Term Disability	Life, AD&D, Legal, & Voluntary Benefits
	Urgent Care Claims	Non-Urgent “Pre-Service” Claims	Non-Urgent “Post-Service” Claims	“Concurrent Care” Decision to Reduce Benefits		
Time frame for Providing Notice	Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan as soon as possible considering medical exigencies, but no later than 72 hours. If you request in advance to extend concurrent care, the Plan shall provide notice as soon as possible taking into account medical exigencies, but no later than 24 hours after receipt of the claim, 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.	Notice of determination (<i>whether adverse or not</i>) must be provided by the Plan within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days.	Notice of adverse determination must be provided within a reasonable period of time, but no later than 30 days.	Notice of adverse determination must be provided by the Plan enough in advance to give you an opportunity to appeal and obtain decision before the benefit at issue is reduced or terminated.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 45 days.	Notice of adverse determination must be provided by the Plan within a reasonable period of time, but no later than 90 days.

Medical, Dental, Vision, EAP & Health Care FSA and Limited Use FSA					Short-Term & Long-Term Disability	Life, AD&D, Legal, & Voluntary Benefits
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Extensions	If your claim is missing information, the Plan has up to 48 hours (subject to decision being made as soon as possible) from the earlier of the Plan's receipt of the missing information, or the end of the period afforded to you to provide the missing information, to provide notice of determination.	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before initial 15-day period ends.*	The Plan has up to 15 days, if necessary due to matters beyond the Plan's control, and must provide extension notice before the initial 30-day period ends.*	N/A	The Plan has up to 30 days, if necessary due to matters beyond the Plan's control. A second 30-day extension may also be permitted. The Plan must provide the extension notice before the period(s) ends.*	The Plan has up to 90 days for special circumstances and must provide the extension notice before the period ends.
Period for Claimant to Complete Claim	You have a reasonable period of time to provide missing information (no less than 48 hours from when you are notified by the Plan that your claim is missing information). If you provide additional information, you will be notified within 48 hours.	You have at least 45 days to provide any missing information. If you provide additional information, you will be notified within the time period remaining for the initial claim.	You have at least 45 days to provide any missing information. If you provide additional information, you will be notified within the time period remaining for the initial claim.	N/A	You have at least 45 days to provide any missing information. If you provide additional information, you will be notified within 30 days after the Plan's receipt of additional information.	N/A

Medical, Dental, Vision, EAP & Health Care FSA and Limited Use FSA					Short-Term & Long-Term Disability	Life, AD&D, Legal, & Voluntary Benefits
	Urgent Care Claims	Non-Urgent "Pre-Service" Claims	Non-Urgent "Post-Service" Claims	"Concurrent Care" Decision to Reduce Benefits		
Other Related Notices	Notice that your claim is not properly filed or that information is missing must be provided by the Plan as soon as possible (no later than 24 hours after Plan receives the claim).	Notice that your claim is not properly filed must be provided by the Plan as soon as possible (no later than 5 days after Plan receives the claims).	N/A	N/A	N/A	N/A

*15- or 30-day extension period (whichever is applicable) is measured from the time that the claimant responds to the notice from the Plan that the claim is missing information.

Section 7.6 - Appealing Benefit Claims (ERISA Benefits)

The following section generally describes the Plan's internal claim appeals process. The appeals process of fully insured health plans may vary. You must review Component Benefit Documents for more information on fully insured health benefits and any appeals processes.

If you receive notice of an adverse benefit determination and disagree with the decision, you are entitled to apply for a full and fair review of the claim and the adverse benefit determination. You (or an appointed representative) can appeal and request a claim review in accordance with the time frames described in the chart below. The request must be made in writing, except for urgent care claims which you may file orally or in writing and should be filed with the appropriate Claim Administrator as listed below under "*Time Frames for Appeals Process.*" If you don't appeal on time, you lose your right to later object to the decision.

Medical coverage for you and your dependents will continue pending the outcome of an internal appeal. This means that the Plan will not terminate or reduce any ongoing course of treatment without providing advance notice and the opportunity for review.

The Claim Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claim Administrator (if serving as the reviewer for appeals) or other appropriate named fiduciary of the Plan. In either case, the reviewer will not be the same individual who made the initial adverse benefit determination that is the subject of the review, nor the subordinate of such individual (including any physicians involved in making the decision on appeal if medical judgment is involved). Where the adverse determination is based in whole or in part on a medical judgment, the reviewer will consult with an appropriate health care professional. No deference will be afforded to the initial adverse benefit determination.

You will be able to review your file and present evidence as part of the review. You will have the opportunity to submit written comments, documents, records, and other information relating to the claim; you 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 for benefits. Whether a document, record, or other information is relevant to the claim will be determined in accordance with the applicable regulations. You are also entitled to the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination. The review will take 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.

For Medical claims, the Claim Administrator will ensure that all claims and appeals are adjudicated in a manner designed to ensure there is no conflict of interest with regard to the individual making the decision. The Claim Administrator will ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support a denial of benefits. The Claim Administrator will ensure that health care professionals consulted are not chosen based on the expert's reputation for outcomes in contested cases, rather than based on the professional's qualifications.

Prior to making a benefit determination on review, the Claim Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical plan (or at the direction of such plan) in connection with the claim. This evidence will be provided at no cost to you and will be given to you before the determination in order to give you a reasonable opportunity to respond. Prior to issuing a final internal adverse benefit determination on review based on a new or additional rationale, the rationale will be provided at no cost to you. It will be given to you before the determination in order to give you a reasonable opportunity to respond.

If the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to your medical claim, you are deemed to have exhausted the internal claims and appeals process. In this case, you may seek an external review or pursue legal remedies (as discussed below) without waiting for further Plan action. However, this will not apply if the error was *de minimis*, if the error does not cause harm to the claimant, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. In that case, you may resubmit your claim for internal review and you may ask the Plan to explain why the error is minor and why it meets this exception.

Additionally, if your claim is an Urgent Care Claim or a claim requiring an ongoing course of treatment, you may begin an expedited external review before the Plan's internal appeals process has been completed.

The Claim Administrator will provide you with written notification of the Plan's determination on review, within the time frames described below under "*Time Frames for Appeals Process.*" For urgent care, all necessary information, including the benefit determination on review, will be transmitted between the Plan and the claimant by telephone, fax, or other available similarly expeditious method. In the case of an adverse benefit determination, such notice will indicate:

- The specific reason for the adverse determination on review;
- Reference to the specific provisions of the Plan on which the determination is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- A description of your right to bring a civil action under ERISA following an adverse determination on review;

- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination, either the specific rule, guideline, protocols or other similar criteria or a statement that a copy of such information will be made available free of charge upon request (for health and disability claims);
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request (for health and disability claims); and
- A description of the voluntary appeals procedure under the Plan, if any, and your right to obtain additional information upon request about such procedures.

For medical claim adverse benefit determinations, the notice will include information sufficient to identify the claim involved. This includes:

- The date of service;
- The health care provider;
- The claim amount (if applicable); and
- The denial code.

Medical claim adverse benefit determination notices will also include:

- A statement that diagnosis and treatment codes (and their meanings) will be provided upon request;
- A description of the Plan's standard used in denying the claim. For example, a description of the "medical necessity" standard will be included;
- In addition to the description of the Plan's internal appeal procedures, a description of the external review process;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist enrollees with the internal claims and appeals and external review process; and
- Depending on where you live, you may be able to receive the denial notice in your native language.

The time periods for providing notice of the benefit determination on review depends on the type of claim, as provided in the chart below.

All decisions are final and binding unless determined to be arbitrary and capricious by a court of competent jurisdiction.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Component Benefit Documents. Please consult the Component Benefit Documents for the specific benefit involved. Where not otherwise covered by the Component Benefit Document, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of an adverse benefit determination. The time frame for providing a notice of the appeal decision (a "notice of benefit determination on review") starts when the appeal is filed in accordance with the Plan's procedures. The notice of appeals decision may be provided through in-hand delivery, mail, or electronic delivery before the period expires. Urgent care decisions may have to be delivered by telephone, facsimile, or other available expeditious method. References to "days" mean calendar days. The Plan can require two levels of mandatory appeal review.

Medical, Dental, Vision, EAP, Health Care FSA and Limited Use FSA					Short-Term & Long-Term Disability	Life, AD&D, Legal & Voluntary Benefits
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*	“Concurrent Care” Decision to Reduce Benefits		
Period for Filing Appeal	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 180 days.	You have at least 60 days.
Time frame for Providing Notice of Benefit Determination on Review	As soon as possible taking into account medical exigencies, but not later than 72 hours after receipt of request for review.	Within a reasonable period of time appropriate to medical circumstances, but not later than 30 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 15 days of each appeal.	Within a reasonable period of time, but not later than 60 days after receipt of request for review. If two levels of mandatory appeal review are required, notice must be provided within 30 days of each appeal.	Before a reduction or termination of benefits occurs. If involves urgent care, 72 hours.	Within a reasonable period of time, but not later than 45 days after receipt of request for review.	Within a reasonable period, but not later than 60 days from receipt of request for review.
Extensions	None.	None.	None.		Additional 45 days if special circumstances require extension (with period “tolled” until you respond to any information request from the Plan).	Additional 60 days if special circumstances require extension.

* An appeal of a concurrent care decision to reduce or terminate previously-approved benefits may be an urgent care, pre-service, or post-service claim, depending on the facts.

Under the Affordable Care Act, medical benefit claims and rescissions under a non-grandfathered health plan are eligible for a voluntary external review by an independent review organization (IRO). To be eligible for the external review, the medical benefit claim must involve medical judgment, excluding claims that involve only contractual or legal interpretation without any use of medical judgment as determined by the external reviewer. You will be provided with information regarding this external review if you receive a final internal adverse benefit determination on review. You cannot request an external review unless you have exhausted the internal claims and appeals process and receive a final adverse benefit determination on review.

The decision notice from the IRO will contain the following information:

- General description of the reason for the request for external review, including information to identify the claim (i.e., date[s] of service, health care provider, claim amount [if applicable], diagnosis, and treatment codes and their meaning, and the reason for the previous denial);
- Date IRO received the assignment to conduct the external review and date of IRO decision;
- References to evidence or documentation, including specific coverage provisions and evidence-based standards considered;
- Discussion of the principal reason(s) for its decision, including rationale and any evidence-based standards relied upon;
- Statement that the determination is binding except to the extent other remedies may be available under state or federal law to either the Medical plan or to the claimant;
- Statement that judicial review may be available to the claimant; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman.

Medical Plans				
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*	“Concurrent Care” Decision to Reduce Benefits
Period for Filing Appeal	4 months after date of receipt of notice final adverse benefit determination.	4 months after date of receipt of notice final adverse benefit determination.	4 months after date of receipt of notice final adverse benefit determination. Expedited appeal can be requested: (1) if the time frame for completion of a standard external review would seriously jeopardize life or health or ability to regain maximum function; or (2) if it concerns an admission, availability of care, continued stay, or health care item or service for emergency services, but have not been discharged from a facility.	4 months after date of receipt of notice final adverse benefit determination. Expedited appeal can be requested: (1) if the time frame for completion of a standard external review would seriously jeopardize life or health or ability to regain maximum function; or (2) if it concerns an admission, availability of care, continued stay, or health care item or service for emergency services, but have not been discharged from a facility.
Claim Administrator’s preliminary review	5 business days.	5 business days.	5 business days If involves urgent care, immediately.	Immediately.
Issue written notice to claimant	1 business day.	1 business day.	1 business day If involves urgent care, immediately.	Immediately.
<ul style="list-style-type: none"> ▪ If request is incomplete, claimant must provide required information 	Within the 4 month appeal filing deadline or 48 hours (whichever is later).	Within the 4 month appeal filing deadline or 48 hours (whichever is later).		

Medical Plans				
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*	“Concurrent Care” Decision to Reduce Benefits
Claim Administrator provide IRO with all documentation	5 business days.	5 business days	5 business days.	Immediately.
IRO written notice of acceptance of external	Timely.	Timely.	Timely, unless it involves urgent care.	N/A.
Claim Administrator’s notice of reversal of adverse benefit determination (if applicable)	1 business day following decision.	1 business day following decision.	1 business day following decision.	N/A.
IRO external appeal decision	Within 45 days.	Within 45 days.	Within 45 days. If involves urgent care, oral notice within 72 hours. IRO must provide written confirmation of decision to the claimant and the Claim Administrator within 48 hours.	Oral notice within 72 hours. IRO must provide written confirmation of decision to the claimant and the Claim Administrator within 48 hours.

Article 8 - Plan Administration, Amendments, Termination, and Other Important Legal Information

Section 8.1 - Plan Administrator & Duties

BrightSpring is the “named fiduciary” of the Plan for purposes of ERISA. BrightSpring or the Plan Administrator may delegate certain fiduciary duties to Claim Administrators or other entities. Except as to those functions reserved within the Plan to the Board of Directors, BrightSpring, or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall:

- Manage and carry out the Plan’s operation and administration according to the Plan’s terms and for Covered Employees’ exclusive benefit;
- Maintain:
 - Any records and data that are necessary or desirable for the Plan’s proper operation and administration, and
 - The Plan’s governing documentation for inspection by anyone who participates or is eligible to participate in the Plan. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies;
- Notify Employees eligible to participate in the Plan of:
 - The Plan’s availability and terms,
 - The cost of each component benefit under the Plan, and
 - The procedures for enrolling, making and changing elections;
- Supply eligible Employees with any forms and agreements they must complete;
- Prepare and file all annual reports or returns, summary plan descriptions, financial statements, and other documents required by law or under the Plan’s terms; and

- Record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

Section 8.2 - Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Board of Directors, BrightSpring or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

- Require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;
- Make and enforce such rules and prescribe the use of such forms as BrightSpring determines reasonably necessary for the proper administration of the Plan;
- Interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions in the Plan and related documents by general rule or particular decision, and to determine the eligibility of any person to participate in the Plan and the entitlement of any person to any benefits thereunder;
- Determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;
- Determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;
- Delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;
- Engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;
- Make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Plan Administrator, including such amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and
- Pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.
- Take corrective actions related to any incorrect amount paid to a beneficiary, any potential remaining payments, eligibility determinations or any other provision of the Plan that involves a mistake in fact that can be corrected in accordance with applicable law.

Section 8.3 - Power and Authority of an Insurance Company

All insured benefits under the Plan may be provided under a group insurance contract entered into between BrightSpring and an insurance company. With respect to fully insured benefits, claims for benefits are sent to the insurance company. The insurance company is the fiduciary with respect to these claims and responsible for paying claims, not BrightSpring.

The insurance company is responsible for:

- Determining the amount of any benefits payable under the Plan;
- Prescribing claims procedures to be followed and the claim forms to be used by employees and beneficiaries pursuant to the Plan; and

- Requiring employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Section 8.4 - Delegation of Authority

BrightSpring's Benefits Department, including the VP, Total Rewards & HR Conformity or if that position retitled or renamed, a similar position, has been designated the authority to act on behalf of the Plan Administrator for purposes of the day-to-day responsibilities for administration of the Plan. Further, BrightSpring's Benefits Department, on behalf of the reserved authority and responsibilities of BrightSpring, shall arrange for preparation of such reports and information concerning the Plans and the administration thereof as may be required under the Internal Revenue Code, ERISA or any other applicable law, and the regulations promulgated thereunder.

Section 8.5 - Finality of Decisions

The Plan Administrator or its delegee shall have full power, authority, and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator or its delegee with respect to any matter hereunder including the determination of facts shall be conclusive and binding on Covered Persons and all other interested parties, except where expressly prohibited by applicable laws or regulations.

Section 8.6 - Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by BrightSpring, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by BrightSpring or the Employer. Unless otherwise determined by BrightSpring or required by law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

Section 8.7 - Liability Insurance

BrightSpring may obtain liability coverage at BrightSpring's expense to insure any Employee serving as Plan Administrator or its delegee against legal liability that may arise from serving as the Plan Administrator or performing the Plan Administrator's duties.

Section 8.8 - Reserved Powers

Among other powers, BrightSpring reserves the powers to:

- Adopt the Plan;
- Amend, terminate the Plan;
- Appoint and remove any Claim Administrator or Plan Administrator;
- Change, modify, cancel, or otherwise terminate any funding arrangements available under the Plan including, but not limited to, the right to change insurance carriers or Claim Administrators and the right to provide previously insured benefits on a partially insured or fully uninsured basis; and
- To the extent permitted by law, revise any Addendum to the Plan without a formal amendment to the Plan and without providing notice to any Covered Person.

Section 8.9 - Right to Amend the Plan

BrightSpring has delegated to the VP, Total Rewards & HR Conformity or if that position retitled or renamed, a similar position, the authority to adopt, amend or merge the Plan or adopt, amend, merge or terminate any component benefit on its behalf. The BrightSpring Board of Directors shall also retain at all times its own authority to exercise these rights. Any amendment to the Plan shall be in writing and shall be adopted by the duly authorized representative of

BrightSpring. Claim Administrators may amend Component Benefit Documents or other related materials necessary to facilitate the administration of benefits pursuant to the Plan, and such amendments shall be automatically incorporated into the Plan by reference herein, without the need for formal written amendment of the Plan.

Section 8.10 - Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the authorized party shall determine, except that no amendment, termination or merger shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

Section 8.11 - Governing Instrument

The Plan must be read in connection with all Component Benefit Documents, Component Benefit Plans and Addendums, which may be prepared by the insurance companies, HMOs, Claim Administrators, and other Plan service providers. BrightSpring or applicable Claim Administrators will provide you with Component Benefit Documents. If there is ever a conflict or a difference between what is written in the Plan and a Component Benefit Document with respect to the specific benefits provided, the Component Benefit Document shall govern, unless otherwise dictated by any federal and/or state law. If there is a conflict between the Component Benefit Document and the Plan with respect to the legal compliance requirements of ERISA and any other federal law, the Plan will govern, unless otherwise dictated by any federal and/or state law. The terms of the Plan supersede any prior oral or written versions of the Plan.

Section 8.12 - No Employment Rights

The Plan is a voluntary undertaking of BrightSpring and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, BrightSpring, or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

Section 8.13 - Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein. In no event shall any right to benefits under the Plan be or become vested.

Section 8.14 - No Property Rights

No person has any right, title, or interest in the property of BrightSpring or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

Section 8.15 - No Assignment of Benefits

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a

provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

For clarity, no benefit, right or interest, or right to bring legal action, of any Covered Person or beneficiary thereof under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment (including assignment to a medical provider), pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, assignment to network providers if specifically permitted under the terms of a Component Benefit Document.

Section 8.16 - Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case-by-case basis. An Employee may be asked to provide proof of eligibility for his or her Dependents. False or misrepresented eligibility information could cause both the Employee's and his or her Dependents' coverage to terminate irrevocably (retroactively to the extent permitted by law) and could be grounds for Employee discipline, up to and including termination of employment. Failure to provide timely notice of loss of eligibility is intentional misrepresentation.

Section 8.17 - Legal Action

Before pursuing legal action, you or a person claiming Plan benefits or seeking redress related to the Plan, must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise required by law, BrightSpring and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in the Plan, nor shall an action be brought at all unless within 12 months after the date a claim is finally denied under the Plan.

Section 8.18 - Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Kentucky.

Section 8.19 - Savings Clause

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

Section 8.20 - Captions and Headings

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

Section 8.21 - Notices

No notice or communication in connection with the Plan made by a claimant, an Employee, or a Covered Person shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

Section 8.22 - Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

Section 8.23 - Parties' Reliance

BrightSpring, the Employer, the Claim Administrator, the Plan Administrator and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of BrightSpring, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

Section 8.24 - Disclaimer of Warranties

BrightSpring makes no assertion or warranty about:

- Health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits; or
- Whether Plan benefits will be excludable from a Covered Person's gross income for federal or state income tax purposes.

Section 8.25 - Indemnification

BrightSpring, to the extent permitted by law, shall indemnify and hold harmless the Board of Directors and any employee, officer, or shareholder of BrightSpring or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by BrightSpring.

Section 8.26 - Non-Assignment of Benefits

Covered Persons cannot assign, pledge, borrow against, or otherwise promise any benefit payable under the Plan before receipt of that benefit. However, benefits will be provided to a Covered Person's child if required by a QMCSO. In addition, subject to the written direction of a Covered Person, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a Covered Person requests otherwise in writing, be paid directly to the person rendering such service. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan and BrightSpring to the extent of such payment. No benefit, right or interest, or right to bring legal action, of any Covered Person, Spouse, Dependent or beneficiary under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment (including assignment to a medical provider), pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law or, in the case of assignments, assignment to network providers if specifically permitted under the terms of a health plan benefit.

Section 8.27 - Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under the Plan, the true facts will be used to determine the coverage in force, as determined by BrightSpring or the Claim Administrator, as applicable.

Article 9 - Your ERISA Rights

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

Receive Information about Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, Component Benefit Documents, CBAs, copies of the latest annual report (Form 5500 Series) and an updated summary plan description. The 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 may continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan because 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 for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties on 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, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan 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 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 administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about 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 office of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or:

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.

Article 10 - HIPAA Privacy and Security

Section 10.1 - Scope

The provisions of this Article 10 that relate to protected health information ("PHI") shall apply to the group health plan benefits in **Addendum A** that are subject by law to the HIPAA privacy and security rule.

Section 10.2 - Privacy and Security of Protected Health Information

For purposes of this Article 10, terms which are capitalized herein but not defined in the Agreement or this Article 10 shall have the meanings assigned to such terms under HIPAA. References to the HIPAA Privacy Standards shall mean 45 C.F.R. Part 164 Subpart E and references to the HIPAA Security Standards shall mean 45 C.F.R. Part 164 Subpart C. The Plan may disclose to the Employer, as permitted by the HIPAA Privacy Standards, information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan. The Plan, through the Plan's HIPAA Privacy Officer, may disclose Protected Health Information (other than genetic information) to stop-loss carriers, excess loss carriers or managing general underwriters for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the HIPAA Privacy Standards.

HIPAA Privacy Standards

(i) In General.

(I) The Plan shall not use or disclose Protected Health Information except as permitted by this Article 10 or as otherwise permitted or required by law, including, but not limited to, the HIPAA Privacy Standards.

(II) This Article 10 shall serve as the amendment and certification required under the HIPAA Privacy Standards for the applicable Group Health Plans to provide for the

Employer's receipt of Protected Health Information. The Employer agrees to comply with the provisions of this Article 10.

(ii) Uses and Disclosures by the Employer. The Employer:

(I) May use or disclose Summary Health Information for certain settlor purposes, including obtaining premium bids for health insurance coverage under the Plan; making Plan design and funding decisions; and modifying, amending or terminating the Plan.

(II) May use or disclose Protected Health Information for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.

(III) May use or disclose Protected Health Information for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Standards), and including quality assurance, claims processing, auditing, and monitoring of the Plan.

(IV) May not use or further disclose Protected Health Information other than as permitted or required by the Plan documents or by law.

(V) Must ensure that any agents, including subcontractors, to whom the Employer provides Protected Health Information received from the Plan agree to the same restrictions and conditions that apply to the Employer with regard to the Protected Health Information.

(VI) May not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.

(VII) May not use or disclose substance use disorder treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, in civil, criminal, administrative, or legislative proceedings against an Employee unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the Employee or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

(VIII) Must notify Covered Persons of any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for of which the Employer, or any "business associate" (as described in HIPAA) of the Employer becomes aware, in accordance with the HIPAA health breach notification rule.

(IX) Must report to the Plan any use or disclosure of the Protected Health Information of which the Employer becomes aware that is inconsistent with the requirements of the HIPAA Privacy Standards or this Article 10. Provide or assist in the provision of any notice required under the HIPAA breach notification rule and HIPAA Privacy Standards in connection with the unauthorized use or disclosure of Protected Health Information.

(X) Must make Protected Health Information available for access in accordance with the standards regarding an individual's right to access his/her Protected Health Information.

(XI) Must make Protected Health Information available for amendment and incorporate any amendment made to Protected Health Information in accordance with

the standards on an individual's right to have his Protected Health Information amended.

(XII) Must make available information necessary to provide an accounting to an individual in accordance with the individual's right to receive an accounting of disclosures of his/her Protected Health Information.

(XIII) Must make internal practices, books, and records relating to the use and disclosure of Protected Health Information available to the Secretary of Health and Human Services for purposes of determining compliance with the HIPAA Privacy Standards.

(XIV) Must, if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer must limit further uses and disclosures to those purposes that make the return or destruction not feasible.

(XV) Must ensure adequate separation between the Plan and the Employer by restricting access to the Protected Health Information by adopting a written policy or procedure that describes the persons or classes of person to whom Protected Health Information may be disclosed for the proper administration of the Plan, restricts access of Protected Health Information to only those person of classes of persons described in the policy or procedure, and provides an effective mechanism for resolving any issues of noncompliance with this Article 10 of the Plan by the persons or class of persons described in the policy or procedure.

HIPAA Security Standards.

The Employer will:

(iii) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan;

(iv) Ensure that adequate separation described in Section 10.2(A) is supported by reasonable and appropriate security measures;

(v) Ensure that any agent, including a subcontractor, who receives Electronic Protected Health Information from the Employer agrees to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information; and

(vi) Report to the Plan any "security incident" (as described in HIPAA) of which the Employer becomes aware within a reasonable time.

Article 11 - Compliance with Other Laws

The Plan, the Plan Administrator, fiduciaries, and other individuals involved in the operation of the Plan are required to follow additional laws, including but not limited to those listed in this Article 11.

Section 11.1 - Special Rights for Mothers and Newborn Children

For the mother or newborn child, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery, or 96 hours following a cesarean section. However, the mother's or newborn's attending provider, after

consulting with the mother, may discharge the mother or her newborn earlier or later than 48 hours (or 96 hours, as applicable) after the delivery. In any case, no authorization is required from the Plan or an insurance company for a length of stay that does not exceed 48 hours (or 96 hours).

Section 11.2 - Women's Health and Cancer Rights Act

The Plan will provide certain coverage for benefits received in connection with a mastectomy, including reconstructive surgery following a mastectomy. This benefit applies to any Covered Employee or Dependent, including you, your spouse, and your dependent child(ren).

If the Covered Person receives benefits under the Plan in connection with a mastectomy and elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the Covered Person. Coverage may apply to:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits for breast reconstruction are subject to annual Plan deductibles and coinsurance provisions that apply to other medical and surgical benefits covered under the Plan.

Section 11.3 - Consumer Protections Under the Affordable Care Act

The Affordable Care Act requires that medical and prescription drug plans implement additional changes – sometimes referred to as “group market reforms” or “consumer protections”, which BrightSpring and the applicable Component Benefit Plans comply with, including but not limited to the following:

- Designation of primary care providers;
- Obstetrical or gynecological care;
- In-network preventive care requirements;
- Minimum Essential Coverage requirements;
- In-network annual out-of-pocket maximums;
- Provider nondiscrimination;
- Coverage for individuals participating in approved clinical trials;
- Prohibition on preexisting condition exclusions;
- Prohibition on discriminating against covered persons based on a health factor;
- Prohibition on waiting periods that exceed 90 days;
- Prohibition on lifetime or annual dollar limits for Essential Health Benefits;
- Prohibition on rescissions (retroactive terminations);
- Eligibility of children;
- Summary of Benefits and Coverage and Uniform Glossary; and
- Medical Loss Ratio requirements.

BrightSpring or its Claims Administrators may pay claims utilizing a variety of arrangements including provider network arrangements, single case agreements, reference-based pricing, or other similar types of agreements. In all circumstances, BrightSpring and its Claims Administrators will administer these provider arrangements in a manner consistent with all laws and binding regulatory guidance.

Section 11.4 - Transparency and Internet-Based Self-Service Tool

You have access to an internet-based price comparison tool to compare all items and services for Medical coverage. Upon request, this information may be provided in paper without a fee, subject to certain limits.

Section 11.5 - Provider Directory Information

A directory of providers is available online from your Medical coverage Claim Administrator. At your request, the Claim Administrator will send you a directory of network providers free of charge.

You generally should receive a response within 1 business day of a telephonic request. All of the Medical coverage Claim Administrators strive to keep this information as current as possible; however, a provider's network status may change. It is always a good idea to check with your Medical coverage Claim Administrator to verify a provider is in-network. If you receive a covered health service from a provider in reliance on information provided to you by the Medical coverage Claim Administrator, but that information is not accurate, any cost-sharing will be calculated as if the provider was in-network. In addition, any cost-sharing will count toward your in-network deductible and out-of-pocket maximum.

Section 11.6 - Continuity of Care

If you are currently receiving treatment for covered health services from a provider whose network status changes from in-network to out-of-network during such course of treatment due to expiration or nonrenewal of the provider's contract, you may be eligible to request continued care from your current provider at the in-network level for specified conditions (for example, undergoing a course of treatment for a serious and complex condition, in institutional or inpatient care, scheduled for non-elective surgery, pregnant, or terminally ill). This continued care may last up to the earlier of 90 days or until you are no longer a continuing care patient. (This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud.) If you would like help to find out if you are eligible for continuity of care benefits, please call the telephone number on your Medical benefit ID card.

Section 11.7 - No Surprises Act and Balance Billing

When you receive emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgery center, you are protected from balance billing by federal law – the No Surprises Act. This also applies if you receive emergency care at a facility that is not contracted to accept the negotiated rate or you receive non-emergency care from a provider that does not accept the preferred rate at an in-network facility.

For certain claims, your cost-sharing amount will be calculated as though you were treated by an in-network provider or facility, which will accrue toward your in-network deductible and out-of-pocket maximum.

Claims subject to the No Surprises Act include:

- Emergency services;
- Non-emergency services rendered by an out-of-network provider, unless you have consented in writing to be balance billed; and
- Covered air ambulance services rendered by an out-of-network provider.

Please call the number on your Medical benefit ID card for assistance if you are billed for amounts in excess of your applicable cost-sharing. For more information on these balance billing protections, please visit [cms.gov/nosurprises](https://www.cms.gov/nosurprises).

Section 11.8 - Wellness Program and Tobacco-User Surcharge

To the extent BrightSpring or a Participating Employer has a wellness program with a tobacco surcharge, it may include a monthly surcharge per tobacco user for Medical coverage if you and/or your Spouse/Domestic Partner uses or has used tobacco or tobacco-related products within the last 6 months or fail to complete a required attestation. Tobacco or tobacco-related products include but are not limited to cigarettes (including electronic cigarettes), cigars, pipes, smokeless (tobacco chew), hookahs, vapor devices (vape pens, JUULs, etc.), and clove cigarettes. Your prior-year attestation will carry over if you do not take any action during open enrollment. If it is unreasonably difficult due to a medical condition for you to avoid the surcharge under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, contact the BrightSpring Benefits Support Center and we will work with you (or your doctor if you prefer) to develop another way to avoid the surcharge.

If you are enrolled in Medical coverage, you must attest that you and your spouse/domestic partner are non-tobacco users. Otherwise, you will be charged a monthly tobacco-user surcharge, which will increase your annual Medical coverage contribution. To avoid the tobacco-user surcharge, either (i) you and your Spouse/Domestic Partner must not have used any tobacco or tobacco-related products for at least 6 consecutive months and completed the attestation; or (ii) you satisfy a reasonable alternative standard and provide proof to BrightSpring. The tobacco-user surcharge does not apply to employees of Gateway Pediatric Therapy or employees enrolled in the Limited Medical plan option.

At the time of enrollment in a BrightSpring Medical benefit, if you:

- Certify that you and/or your Spouse/Domestic Partner are not tobacco users; you will avoid the tobacco-user surcharge.
- Certify that you and/or your Spouse/Domestic Partner are tobacco users; the tobacco-user surcharge will apply unless you complete a reasonable alternative standard.
- Certify that you and/or your Spouse/Domestic Partner have completed a program that satisfies a reasonable alternative standard (such as a tobacco cessation program) within the past six months; you will avoid the tobacco user surcharge.
- Certify that you and/or your Spouse/Domestic Partner are tobacco users but intend to satisfy a reasonable alternative standard (such as a tobacco cessation program) no later than July 31 following the beginning of the Plan Year.
 - If you complete a tobacco cessation program or reasonable alternative standard no later than July 31 in accordance with your certification, you will avoid the tobacco-user surcharge for the entire year. Your premium will be reduced to the non-tobacco user rate, and a reimbursement will be paid for months prior to August 1 (the retroactive period).
 - If you complete a tobacco cessation program or reasonable alternative standard after July 31 but before the end of the applicable Plan year (on or before December 31), your premium will be reduced to the non-tobacco user rate for the remainder of the Plan year; however, you will not be reimbursed for months before the completion of the tobacco cessation program.

How a “Reasonable Alternative Standard” Works If You Have Difficulty Quitting Tobacco

BrightSpring is committed to helping you achieve your best health. If you and/or your spouse/Domestic Partner use tobacco, BrightSpring offers tobacco cessation programs at no cost to you. If you and/or your spouse/Domestic Partner uses tobacco and attests prior to the

beginning of the Plan year that you and/or your Spouse/Domestic Partner will satisfy a reasonable alternative standard and then completes a tobacco cessation program no later than July 31 (e.g., for the 2026 Plan Year, you must complete by July 31, 2026), you will avoid the tobacco-user surcharge for the **entire** year. If the tobacco user completes a tobacco cessation program after July 31, your premium will be prorated to the non-tobacco user rate based on the months remaining in the Plan Year.

In addition, if you do not certify that you intend to complete a tobacco cessation program before the beginning of the Plan Year and indicate later (for example on or after January 1) that you would like to complete a smoking cessation program, you may be eligible to avoid the surcharge on a pro-rated basis depending on when the program is completed.

While the ultimate goal is to help you and your dependents become non-tobacco users, you will avoid the surcharge if you and/or your Spouse/Domestic Partner complete a tobacco cessation program (even if you are unable to quit). However, if you are unable to quit, you are required to complete another tobacco cessation program to avoid the tobacco-user surcharge in a subsequent year.

If your and/or your spouse/domestic partner's personal physician determines that quitting tobacco or completing a tobacco cessation program is not medically appropriate for you and/or your Spouse/Domestic Partner, the Medical plan will provide a reasonable alternative standard that accommodates the recommendations of your personal physician with regard to medical appropriateness. Contact the Benefits Support Center with the physician's recommendations.

Also, you can contact the BrightSpring Benefits Support Center (see **Addendum A**) to obtain more information on the reasonable alternative standard, including tobacco cessation programs that are available to you at no cost.

Section 11.9 - Mental Health Parity and Addiction Equity Act

You have access to medically necessary treatment for mental health and substance use disorders (MH/SUDs). Coverage is provided through your Medical benefit.

The Plan complies with the guidance supporting the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as amended by applicable regulations and rules, and is operated in accordance with this law in good faith. While many complicated provisions apply, BrightSpring monitors its designs through:

- **Financial and quantitative testing.** BrightSpring conducts periodic financial and quantitative testing to ensure that each Medical plan option's cost-sharing and treatment limits for MH/SUD benefits are not more restrictive than medical/surgical benefits within an MHPAEA classification.
- **Non-quantitative treatment limitation (NQTL) analysis.** BrightSpring works with Medical Benefit Claim Administrators to ensure that they have conducted NQTL analysis to confirm that each Medical benefit is in parity.

For more information regarding MH/SUD coverage provided under the Plan, please contact your Medical Benefits Claim Administrator.

Section 11.10 - Compliance with Other Federal Group Health Plan Benefits and Coverage Mandates

Adoption

The Plan provides group health benefits to dependent children placed with Employees for adoption under the same terms and conditions as apply in the case of dependent children who

are natural children of Employees, irrespective of whether the adoption has become final, and the Plan does not restrict coverage of such a child solely based on a preexisting condition of such child at the time that such child would otherwise become eligible for coverage under the Plan, if the adoption or placement for adoption occurs while the Employee is eligible for coverage under the Plan, in accordance with Section 609(c) of ERISA.

Pediatric Vaccines

To the extent it applies, the Plan shall not reduce the continued coverage costs of a pediatric vaccine, under Section 609(d) of ERISA.

Genetic Information Nondiscrimination Act

The Plan complies with the provisions of GINA and accordingly does not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment or adjust premiums based on genetic information, or require or request genetic information or genetic testing, prior to, or in connection with, enrollment.

Coordination with State Medicaid Programs

The fact that a Covered Person is eligible for coverage by, or is covered by, a state Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person or a beneficiary of the Covered Person as required by any state Medicaid program, as provided in section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a state Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any laws that provides that the state has acquired the right with respect to the Covered Person to receive payment for such expense.

Article 12 - Definitions

The following words and phrases, when capitalized, shall have the following meanings for the purposes of the Plan. Defined terms contained herein may differ from the definitions in Component Benefit Documents. Whenever any words are used in the singular form, they shall be construed as though they were also used in the plural form in all cases where the plural would so apply. Except where otherwise indicated by the context, any masculine terminology herein shall include the feminine and neuter.

Accident Coverage means a voluntary Component Benefit Plan that provides limited coverage for Covered Persons who elect such benefit for specified accidents, as described in an applicable Component Benefit Document. Accident Coverage is not major medical coverage or intended to be an alternative to Medical coverage.

AD&D (Basic and Supplemental) means a Component Benefit Plan that provides accidental death and dismemberment benefits, as described in an applicable Component Benefit Document. Basic AD&D refers to a benefit offered to specified Covered Persons at no cost to such Covered Persons. Supplemental AD&D refers to a voluntary, enhanced benefit offered to specified Covered Persons, which may require a Covered Person premium or contribution payment.

Affordable Care Act or ACA means the Patient Protection and Affordable Care Act enacted on March 23, 2010 as amended by the Health Care and Education Reconciliation Act enacted on March 30, 2010.

Board of Directors means the persons, and their successors, appointed or elected to manage and direct the affairs of BrightSpring.

BrightSpring means ResCare, Inc. d/b/a BrightSpring Health Services, a corporation and any successor, by merger or otherwise. BrightSpring is the Plan Sponsor as defined by ERISA.

BrightSpring Benefits Support Center means the contact center maintained by BrightSpring to provide benefits related information to Covered Persons (see **Addendum A**).

Cafeteria Plan means the BrightSpring Health Services Section 125 Cafeteria Plan, established by BrightSpring through which choices of and pre-tax payment for benefits are made in accordance with Section 125 of the Code, as amended, which is attached as **Addendum G**.

CBA means a collective bargaining agreement.

Claim Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, and the regulations issued thereunder. COBRA applies only to health care coverage that meets the definition of a "group health plan" under Section 5000(b)(1) of the Code, including the Medical, Dental, Vision, and EAP coverage provided under the Plan.

COBRA Administrator means BrightSpring or a delegated entity that assists with the administration of COBRA benefits (see **Addendum A**).

Code means the Internal Revenue Code of 1986, as amended, and its regulations.

Company means BrightSpring.

Component Benefit Document means an insurance policy, insurance contract, administrative services agreement, trust, certificate of coverage, evidence of coverage, member handbook, summary plan description or other similar document, which shall be incorporated by reference in the Plan, together with any exhibits, supplements, addendums or amendments thereto, and the Cafeteria Plan for purposes of the Health Care FSA and Limited Use FSA.

Component Benefit Plan means the specific welfare benefit arrangement(s) described in **Addendum B**, pursuant to which the Plan provides welfare benefits.

Covered Employee means an Employee who is a Covered Person; a Covered Employee is further defined by the Cafeteria Plan.

Covered Person means an Employee or Dependent who has satisfied the eligibility and enrollment provisions of the Plan and applicable Component Benefit Document(s). A Covered Person may have Plan coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

Critical Illness means a voluntary Component Benefit Plan that provides limited benefits in the event a Covered Person, who has elected such coverage, experiences a specified event, as described in a Component Benefit Document. Critical Illness coverage is not major medical coverage or intended to be an alternative to Medical coverage.

Dental means a Component benefit Plan that provides coverage for dental benefits, as described in an applicable Component Benefit Document.

Dependent means a Spouse or Domestic Partner (except in Puerto Rico) or dependent child of an Employee who is a Covered Person as determined under the applicable Incorporated

Document. The Cafeteria Plan also contains a definition of Dependent for purposes of the Cafeteria Plan benefits. For health care spending account plans, Dependent must also be the Employee's dependent as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) or, the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year. A Dependent may be eligible for coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

Domestic Partner means, in conjunction with a Covered Employee's enrollment (except in Puerto Rico), a same-sex or opposite-sex Domestic Partner. Domestic Partners of Covered Employees and children of Domestic Partners are eligible for Medical, Dental, Vision, Dependent Life, Supplemental AD&D and EAP coverage, if permitted by applicable Component Plan Documents.

Domestic Partners must complete an affidavit as required by the Company, and must meet at least one of the following requirements:

- A same-sex or opposite-sex domestic partnership by government registration as defined by the laws of the applicable state, county or municipality.

And/or

- A same-sex or opposite-sex domestic partnership by "Company registry" that meets all of the following requirements:
 - You are each other's sole same-sex or opposite sex Domestic Partner and have lived together in the same principal residence for at least 6 months and intend to do so indefinitely;
 - Neither of you are legally married to, the civil union spouse of, or a Domestic Partner of any other person;
 - Both of you are at least 18 years of age and capable of consenting to the domestic partnership;
 - The two of you are not related by blood in a way that would prevent you from being married to each other in the applicable state;
 - Both of you are capable of consenting to the domestic partnership and neither of you are not consenting to the partnership under force, duress or fraud; and
 - Your relationship is not in violation of any laws applicable to the benefit.

In addition, to the extent that the Company is doing business with a non-federal governmental entity (such as a municipality or state) and coverage of a Domestic Partner is required to engage in business as a result of an Equal Benefits Ordinance, a Covered Employee may be able to cover a Domestic Partner as defined by that Equal Benefits Ordinance.

EAP means employee assistance plan, which is a Component Benefit Plan as described in an applicable Component Benefit document.

Effective Date means the date this amended and restated Plan becomes operative; the Effective Date is January 1, 2026.

Employee means any person who renders services to the Employer for remuneration that the Employer determines is subject to federal income tax withholding and Federal Insurance Contributions Act (FICA) taxes payable by the Employer and classified by the Employer as a common-law employee of the Employer. Employee also includes persons who are employed by the Employer in a position whose employment is covered by a collective bargaining agreement that provides for participation in the Plan.

The term Employee does not mean any of the following persons:

- a self-employed individual, as defined in Code section 401(c)(1)(A),
- a member of the Board of Directors who is not otherwise an Employee,
- a person whom the Plan Administrator determines has been engaged by the Employer as an independent contractor,
- a temporary individual whose services are contracted from or through an entity that is not a Participating Employer,
- a leased employee as defined in Code section 414(n) (Leased employees within Code section 414(n) of the Code shall not be considered Employees, notwithstanding their including as required by law, in applicable nondiscrimination testing under relevant Code sections), or
- a person the Plan Administrator determines has been engaged by the Employer as a consultant or advisor on a retainer or fee basis.

A person whom the Plan Administrator determines is not an “Employee” as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters, and as determined by the Board of Directors, Plan Administrator and/or the Company’s legal counsel.

Employer means the Company, a Participating Employer, and any subsidiary, affiliated organization, or parent organization, and any successor(s) which, with the approval of BrightSpring, as determined by the Plan Administrator or its designee, and subject to such conditions as the Plan Administrator or its designee may impose, adopts and is subject to the Plan.

ERISA means the Employee Retirement Income Security Act of 1974, as now in effect or as hereafter amended, including any regulations and rulings promulgated thereunder and any successor statute of similar import. Reference to any section or subsection of ERISA includes references to any comparable or succeeding provisions of any legislation that amends, supplements, or replaces such section or subsection.

FMLA means the Family and Medical Leave Act of 1993, as amended, and the regulations issued thereunder or pursuant thereto.

FSA (Health Care, Limited Use, and Dependent Care) means a Component Benefit Plan that provides flexible spending account benefits, as described in an applicable Component Benefit Document. The Plan may offer the following types of FSAs:

- Health Care Flexible Spending Account or Health Care FSA, which is a bookkeeping account established on behalf of a Covered Employee, as defined by the Cafeteria Plan, in accordance with the provisions of the Health Care FSA component of the Cafeteria Plan, for the reimbursement of Health Care FSA expenses described in Section 213(d) of the Code, as explained under Section 125 of the Code and related regulations and subject to any applicable Component Benefit Documents;
- Limited Use FSA, which is a bookkeeping account established on behalf of a Covered Employee, as defined by the Cafeteria Plan, in accordance with the provisions of the Limited Use FSA component of the Cafeteria Plan, for the reimbursement of dental and vision care expenses described in Section 213(d) of the Code and subject to any applicable Component Benefit Documents; and
- Dependent Care FSA, which is a is a bookkeeping account established on behalf of a Covered Employee, as defined by the Cafeteria Plan, in accordance with the provisions of the Dependent Care FSA component of the Cafeteria Plan, for the reimbursement of certain dependent care expenses described in Section 129 of the Code and subject to any applicable Component Benefit Documents.

Group Pre-Paid Legal means a voluntary Component Benefit Plan that provides benefits for specified legal services if elected by a Covered Person, as described in a Component Benefit Document.

HDHP means a high deductible health plan, which is insurance coverage by a health plan that satisfies the cost-sharing limits established by the IRS.

HMO means a health maintenance organization, which is a type of health insurance plan that contains preferential coverage to a network of specific providers.

IRS means the Internal Revenue Service.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued pursuant thereto.

Hospital Indemnity Coverage means a voluntary Component Benefit Plan that provides limited benefits in the event a Covered Person, who elected such coverage, experiences a specified event, as described in a Component Benefit Coverage. Hospital Indemnity Coverage is not major medical coverage or intended to be an alternative to Medical coverage.

Life (Basic, Supplemental, and Dependent) means a Component Benefit Plan that provides benefits if an applicable Covered Person dies, as described in an applicable Component Benefit Document. Basic Life refers to a benefit offered to specified Covered Persons at no cost to such Covered Persons. Supplemental and Dependent Life refer to voluntary, enhanced benefits offered to specified Covered Persons, which may require a Covered Person to make a premium or contribution payment for such coverage.

Limited Medical means a Component Benefit Plan that provides limited medical benefits. Limited Medical is not comprehensive medical coverage and does not minimum value, as defined by the ACA.

Long-Term Disability means a voluntary Component Benefit Plan that provides benefits in the event a Covered Person, who has elected such coverage, experiences a qualifying long-term disability, as described in an applicable Component Benefit Document.

Marketplace means an online health insurance marketplace maintained at healthcare.gov or by an applicable state or delegated entity.

Medical means a Component Benefit Plan that provides major medical and prescription drug coverage, as described in an applicable Component Benefit Document.

Participating Employer means any company listed in **Addendum E** or any other entity determined in by BrightSpring in its sole and absolute discretion, unless otherwise excluded from the Plan Administrator or its designee in its sole and absolute discretion.

Plan means the BrightSpring Health Services Welfare Benefit Plan.

Plan Administrator means BrightSpring or its designee.

Plan Year means the 12-month period beginning January 1 and ending December 31.

QMCSO means a qualified medical child support order as defined in ERISA and described by Department of Labor regulations.

Short-Term Disability (Basic and Supplemental) means a Component Benefit Plan that benefits in the event a Covered Person becomes disabled, as described in an applicable Component Benefit Document. Basic Short-Term Disability refers to a benefit offered to specified Covered Persons at no cost to such Covered Persons. Supplemental Short-Term Disability refers to a

voluntary, enhanced benefit offered to specified Covered Persons, which may require a Covered Person premium or contribution payment.

Spouse means, for purposes of the Plan only, the Covered Employee's legal spouse.

USERRA means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

Vision means a Component Benefit Plan providing coverage to specified Covered Persons for vision benefits, as described in an applicable Component Benefit Document.

* * * * *

IN WITNESS WHEREOF, BrightSpring has amended and restated the Plan effective as of January 1, 2026.

Res-Care, Inc. d/b/a BrightSpring Health Services

Signature:

Shannon Ernst
Sr. Director, Benefits

Addendum A – Plan & BrightSpring Contact Information

This Addendum A is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.

Plan Name	BrightSpring Health Services Welfare Benefit Plan
Plan Number	501
Plan Sponsor	Res-Care, Inc. d/b/a BrightSpring Health Services 805 N. Whittington Parkway Louisville, KY 40222 Phone: 800-866-0860
Employer Identification Number	61-0875371
Plan Administrator	Same as Plan Sponsor
Agent for Service of Legal Process	Same as Plan Sponsor
Plan Year	January 1 through December 31
Plan Type	Welfare benefit plan providing the types of benefits described in Addendum B
Source of Contributions	Some benefits are provided through one or more insurance contracts, purchased with contributions by the Employer and with specified Employee contributions, as applicable. Other benefits may be self-insured from time to time, meaning that the Employer pays claims out of general assets, and may require specified contributions from Employees. Some benefits under the Plan may be self-insured but administered by a Claim Administrator. The Plan Sponsor may maintain a stop-loss policy to protect against catastrophic losses; however, the stop-loss policy merely reimburses the Plan Sponsor for claims and is not to be construed as “insuring” benefits under Plan. Some benefits under the Plan may be insured by one or more insurance companies. Addendum B describes benefits, whether they are insured or self-insured, and the identity of the insurance companies and/or Claim Administrators.
BrightSpring Benefits Support Center & COBRA Administrator Contact	Billing Services Address: PO Box 2617 Omaha, NE 68103-2617 Website (benefit changes, log-in required): www.brightspringbenefits.com Phone: 1-844-896-0169
BrightSpring Benefits Department	BrightSpring Benefits Department 805 N. Whittington Parkway Louisville, KY 40222 Phone: 1-800-866-0860 Email: BrightSpringBenefits@BrightSpringhealth.com

Addendum B – Component Benefit Plan & Claim Administrator Information

This Addendum B is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.

Component Benefit Plans Offered Under the Plan

Component Benefit Plan	Funding Type	Claim Administrator(s) & Contact Information
Medical ^{1, 2}	Self-funded	<p>Medical – Imagine360 Quantum Health 866-885-1491 brightspring.quantum-health.com/auth/login-credentials P.O. Box 749075 Dallas, TX 75374-9075</p> <p>Coup Health member.coupehealth.com Offered through Anthem BCBS Coupe Health, LLC P.O. Box 64560 St. Paul, MN 55164-0560 1-800-936-0865</p> <p>Prescription Drug – MedImpact 1-800-788-2949 customerservice@medimpact.com 10181 Scripps Gateway Ct., San Diego, CA, 92131</p> <p>MedImpact Healthcare Systems, Inc. Attn: Appeals Coordinator 10181 Scripps Gateway Ct. San Diego, CA 92131 Attn: Prior Authorization</p>
Medical ²	Fully insured	<p>Kaiser Northern California www.kp.org Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 1-800-464-4000</p> <p>Kaiser Southern California www.kp.org Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 1-800-464-4000</p> <p>Kaiser Washington www.kp.org/wa Send claims to: Kaiser Permanente P.O. Box 34585 Seattle, WA 98124-1585 Send appeals to:</p>

		<p>Kaiser Permanente ATTN: Manager, Consumer Appeals P.O. Box 34593 Seattle, WA 98124-1585 1-888-901-4636</p> <p>Kaiser Colorado Send Claims to: P.O. Box 373150 Denver, CO 80237-9998 1-303-338-3800</p> <p>Kaiser Northwest Send Claims to: P.O. Box 370050 Denver, CO 80237-9998 1-800-813-2000</p> <p>BCBS of Michigan Member Reimbursement – Mail Code: 0010 600 E. Lafayette Blvd. Detroit, MI 48226 1-800-810-BLUE (2583)</p> <p>HMSA www.hmsa.com For commercial plans (e.g., PPO, HMO, CompMed) HMSA—Claims Administration 8/CA P.O. Box 860 Honolulu, HI 96808-0860 1-866-520-4472</p> <p>Allegiance www.askallegiance.com Allegiance Life & Health Insurance Company, Inc. P.O. Box 1762 Miles City, MT 59301-1762 1-800-877-1122</p>
ICHRA ³	Self Funded	<p>Gravie Administrative Services LLC 10 NE 2nd Street Suite 300 Minneapolis, MN 55413</p>
Dental	Fully insured	<p>Delta Dental of KY 800-955-2030 deltadentalky.com 10100 Linn Station Rd. Louisville, KY 40223</p> <p>Best Life Dental Plan P.O. Box 19721 Irvine, CA 92623-9721</p>
Vision	Fully insured	<p>DeltaVision in partnership with VSP VSP www.vsp.com PO Box 495933 Cincinnati, OH 45249 800-877-7195</p>

EAP	Employer contributions	ComPsych 833-743-8184 guidanceresources.com WebID: BrightSpring 455 N. Cityfront Plaza Drive Chicago, IL 60611
Short-Term Disability (Basic & Supplemental)	Fully insured	MetLife www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-638-6420
Long-Term Disability (Basic & Supplemental)	Fully insured	MetLife www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-638-6420
Life (Basic, Supplemental and Dependent)	Fully insured	MetLife www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-638-6420
AD&D (Basic & Supplemental)	Fully insured	MetLife www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-638-6420
Health Care FSA	Fully insured	Fidelity NetBenefits www.netbenefits.com FSA 1-833-299-5089
Dependent Care FSA ⁴	Fully insured	Fidelity NetBenefits www.netbenefits.com FSA 1-833-299-5089
Limited Use FSA	Fully insured	Fidelity NetBenefits www.netbenefits.com FSA 1-833-299-5089
Health Savings Account ⁴	Employee & Employer contributions	Fidelity NetBenefits www.netbenefits.com FSA 1-833-299-5089
Limited Medical	Fully insured	UnitedHealthcare FlexWork https://flexwork.uhc.com/home [insert address and phone as applicable]
Group Pre-Paid Legal	Fully insured	MetLife www.legalplans.com 1-800-821-6400
Accident Coverage	Employee contributions	Voya https://presents.voya.com/EBRC/Brightspringhealthservices Group Number: 695840 P.O. Box 320 Minneapolis, MN 55440 877-236-7564
Critical Illness Coverage	Employee contributions	Voya https://presents.voya.com/EBRC/Brightspringhealthservices Group Number: 695840 P.O. Box 320 Minneapolis, MN 55440 877-236-7564
Hospital Indemnity Coverage	Employee contributions	Voya https://presents.voya.com/EBRC/Brightspringhealthservices Group Number: 695840 P.O. Box 320 Minneapolis, MN 55440 877-236-7564

¹ BrightSpring requires all Covered Persons who utilize the self-funded Medical option to enroll with Rx Savings Solutions, which provides a service for the benefit of enrollees that helps enrollees save money on prescription drug costs. The Rx Savings Solutions services are provided at no cost to enrollees. Failure to timely enroll in the Rx Saving Solutions may result in the loss of your Medical coverage.

² Some Participating Employer's Employees do not have access to Medical coverage under the Plan (see **Addendum E**). Some Participating Employer's Employees have access to an ICHRA instead of the self-funded or fully insured Medical coverage options (see **Addendum E**).

³ Eligibility for the ICHRA is limited to Employees of the Participating Employers identified in Addendum E who work at least 30 hours per week. These Employees are not eligible for the other Medical options. Individual coverage reimbursed through the ICHRA is not subject to ERISA.

⁴ This Component Benefit Plan is not subject to ERISA.

Addendum C – Coordination of Benefits

*This **Addendum C** is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.*

I. Applicability

Except as provided herein, the following coordination of benefits (“COB”) provisions apply to the Plan, as outlined in this **Addendum C**, when a Covered Person has health care coverage under more than one Health Care Arrangement.

II. COB Definitions

The following definitions only apply to this **Addendum C**:

Health Care Arrangement means any of the following coverages which provides benefits or services to the Covered Person for, or because of, medical, surgical or hospital care treatment:

- Group, blanket or franchise coverage, whether insured or uninsured;
- Group prepayment coverage on a group basis, including HMOs;
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Coverage under government programs and any other coverage required or provided by law other than Medicare or a state plan under Medicaid;
- Group or individual automobile no-fault coverage; or
- Other arrangements of insured or self-insured group coverage.

The term Health Care Arrangement shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Health Care Arrangements into consideration in determining its benefits and that portion which does not.

Allowable Expense means a usual and customary item of expense for health care, when the item of expense is covered at least in part by one or more Health Care Arrangements covering the individual for whom the claim is made.

When a Health Care Arrangement provides benefits in the form of services instead of cash payments, the reasonable cash value of each rendered will be considered both an Allowable Expense and a benefit paid.

Claim Determination Period means a calendar year. However, it does not include any part of a year during which an individual has no coverage under the Plan.

III. Order of Benefit Determination Rules

Subject to applicable law, the Plan determines its order of benefits using the first of the following rules which applies:

1. COB/Non-COB Provision

The benefits of a Health Care Arrangement which does not contain a COB provision always shall be determined before the benefits of a Health Care Arrangement which does contain a COB provision.

2. No Fault Auto Insurance

The benefits of the Health Care Arrangement which covers the person as a beneficiary under a no-fault automobile insurance policy required by law shall be determined prior to the Plan, regardless of whether the no-fault policy has been selected as secondary.

3. Non-Dependent/Dependent

The benefits of the Health Care Arrangement which covers the person as an employee, member or subscriber (that is, other than as a dependent) shall be determined before those of the Health Care Arrangement which covers the person as a dependent.

4. Dependent Child/Parents not Separated or Divorced

Except as stated in paragraph (5) below, when the Plan and another Health Care Arrangement cover the same child as a dependent of different persons, called "parents":

- a. the benefits of the Health Care Arrangement of the parent whose birthday falls earlier in a year are determined before those of the Health Care Arrangement of the parent whose birthday falls later in that year; but
- b. if both parents have the same birthday, the benefits of the Health Care Arrangement which covered the parent longer are determined before those of the Health Care Arrangement which covered the other parent for a shorter period of time.

However, if the other Health Care Arrangement does not have the rule described in (b) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, the rule in the other Health Care Arrangement will determine the order of benefits.

5. Dependent Child/Separated or Divorced Parents

If two or more Health Care Arrangements cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- a. first, the Health Care Arrangement of the parent with custody of the child;
- b. then, the Health Care Arrangement of the spouse of the parent with custody of the child; and
- c. finally, the Health Care Arrangement of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Health Care Arrangements of that parent has actual knowledge of those terms, the benefits of that Health Care Arrangement are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

The Plan will not cover the expenses of any child who does not meet the Plan's definition of Dependent, except as may be required pursuant to a qualified medical child support order under section 609(a) of ERISA.

6. Active/Inactive Employee

The benefits under a Health Care Arrangement which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Health Care Arrangement which covers that person as a laid off or

retired employee (or as that employee's dependent). If the other Health Care Arrangement does not have this rule, and if, as a result, the Health Care Arrangements do not agree on the order of benefits, this rule is ignored.

7. Continuation Coverage

If an individual is covered under a continuation plan as a result of the purchase of coverage as provided under federal or state law, and also under another group plan, the following shall be the order of benefit determination:

- a. First, the benefits of a plan covering the person as an employee (or as that employee's dependent);
- b. Second, the benefits of coverage under the continuation plan.

If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

8. Longer-Shorter Length of Coverage

If none of the above rules determines the order of benefits, the benefits of the Health Care Arrangement which covered an employee, member or subscriber longer are determined before those of the Health Care Arrangement which covered that person for the shorter time.

9. Medicare Coordination

- a. Employees and/or Spouses Age 65 or Older

Unless an active Employee age 65 or older gives the Plan written notice waiving his or her right to Plan benefits, the Plan is Primary. With respect to the spouse who is age 65 or older of an active Employee, unless the Employee gives the Plan written notice waiving Plan benefits, the Plan is primary.

- b. Medicare Disabled Covered Persons

If required by law, the Plan is primary with respect to a Covered Person who is also entitled to Medicare because of disability. Otherwise, the Plan is secondary.

- c. Covered Persons with End-Stage Renal Disease

For the period required by law, if any, the Plan is primary with respect to a Covered Person entitled to Medicare because of end-stage renal disease. Otherwise, the Plan is secondary.

IV. **Effect on Benefits**

1. When this section Applies

This Effects on Benefits section applies when, in accordance with the "Order of Benefit Determination Rules", the Plan is a secondary payor of benefits to one or more other Health Care Arrangements. In that event, the benefits of the Plan may be reduced under this section. Such other Health Care Arrangement or Arrangements are referred to as "the other Arrangements" in "2" immediately below.

2. Reduction in the Plan's Benefits

The benefits that would be payable under the Plan in the absence of the COB provisions specified in this **Addendum C** will be reduced by the benefits payable under the other Arrangements for the expenses covered in whole or in part under the Plan. This applies whether or not claim is made under a Health Care Arrangement.

When a Health Care Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an expense incurred and a benefit payable.

V. Limitation of Benefits

In applying this Addendum's provisions, the Plan does not pay health care benefits in an amount greater than it would have if it were primary.

VI. Right to Receive and Release Necessary COB Information

The Company has the right to obtain any information necessary to apply the COB provisions of this **Addendum C**. The Company has the right to obtain COB information from or give that information to any other organization or person involved in the administration of the COB provisions of the Plan or any other Health Care Arrangement. The Company need not tell, or get the consent of, any person prior to obtaining that information. Each person claiming benefits under the Plan must give the Company any information it needs to process the claim. Notwithstanding the foregoing, any action taken pursuant to this **Addendum C** shall be done as permitted by HIPAA.

V. Right to Receive and Release Necessary COB Information

The Company has the right to obtain any information necessary to apply the COB provisions of this **Addendum C**. The Company has the right to obtain COB information from or give that information to any other organization or person involved in the administration of the COB provisions of the Plan or any other Health Care Arrangement

VI. Facility of Payment

A payment made under another Health Care Arrangement may include an amount which should have been paid under the Plan. If it does, the Company may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under the Plan. The Company will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

VII. Right of Recovery

If the amount of the payments made by the Company is more than it should have paid under the COB provisions specified in this **Addendum C**, it may recover the excess from one or more of:

1. the persons it has paid or for whom it has paid;
2. insurance companies; or
3. other Health Care Arrangements, including Workers' Compensation.
4. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

VIII. Governing Provisions

When the provisions describing coordination of benefits are set forth in an applicable Component Benefit Document, such Component Benefit Document shall govern except to the extent the provisions fail to establish order of responsibility, in which case the provisions of this **Addendum C** shall govern.

Addendum D – Employees Approved to Access PHI

*This **Addendum D** is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.*

1. VP, Total Rewards & HR Conformity
2. Senior Director, Benefits & HR Compliance
3. Manager, Benefits & HR Compliance
4. Sr. Director, Total Rewards
5. Director, Benefits
6. Benefits Manager
7. Benefits Analyst
8. Benefits Administrator
9. Benefits Specialist
10. Sr. Benefits Analyst
11. Sr. Total Rewards Analyst
12. Sr. Benefits Administrator
13. Personnel in the legal department
14. Personnel in the information technology department
15. Privacy officer
16. Security officer
17. Other employees of the human resources department who regularly work on employee benefit-related issues

Addendum E – List of Participating Employers

*This **Addendum E** is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.*

Participating Employers as of January 1, 2026, are as follows:

1. PharMerica Corporation of America
2. EDUCARE-TEXAS
3. RESCARE, INC.
4. ADORATION HOSPICE CARE TEXAS L
5. VOCA NORTH CAROLINA
6. RSCR CALIFORNIA, INC.
7. RES-CARE FLORIDA
8. SOUTHERN HOME CARE
9. RES-CARE OKLAHOMA, INC.
10. COMMUNITY ALTERNATIVES ILL. NO
11. VOCA OF INDIANA
12. VOCA OF NEW JERSEY
13. RES-CARE KANSAS, INC.
14. VOCA
15. NORMAL LIFE, INC.
16. NORMAL LIFE OF CALIFORNIA INC.
17. RES-CARE OHIO, INC.
18. ONCOMED SPECIALTY LLC
19. PHARMERICA LOGISTIC SERVICES L
20. ALTERNATIVE YOUTH SERVICE, INC
21. COMMUNITY ALTERNATIVES KY
22. RES-CARE WASHINGTON, INC.
23. PHARMERICA PROFESSIONAL SERVIC
24. COMMUNITY ALT NEBRASKA
25. HHC STAFFING OF TN INC
26. EDUCARE-GULF COAST
27. EDUCARE-NEVEDA
28. RES-CARE CALIFORNIA
29. CREATIVE NETWORKS
30. RESCARE RESIDENTIAL SVCS INC
31. VOCA OF D.C.
32. CNC/ACCESS INC
33. RES-CARE PREMIER, INC.
34. TX COMM ALT,LP
35. RES-CARE TRAINING TECHNOLOGIES
36. RAIMENT, INC.
37. ADORATION HEALTH MANAGEMENT LL
38. AMERITA INC
39. AGAPE HOMES
40. PATE REHABILITATION ENDEAVORS
41. PHARMACY ALTERNATIVES LLC
42. SACRED JOURNEY HOSPICE INC
43. REST ASSURED
44. ALL WAYS CARING SERVICES, INC.

45. REHAB WITHOUT WALLS
46. COMMUNITY ALTERNATIVES HOMECAR
47. BRALEY & THOMPSON INC
48. RESCARE RES SERV WEST LLC
49. HOME HEALTH CARE SVCS II INC
50. SENESENCE LLC
51. MAGNOLIA HOSPICE LLC
52. ABILISHEALTH MANAGMENT INC
53. SPRINGHEALTH BEHAVIORAL ILLINO
54. SPRINGHEALTH BEHAVORAL GEORGIA
55. JOB READY INC
56. RESCARE HOME CARE SERVICES INC
57. NURSES IN TOUCH INC
58. COMMUNITY ALTERNATIVES VIRGINIA
59. ABILISHEALTH NASHVILLE LLC
60. RSCR WEST VIRGINIA
61. TEXAS HOME MANAGEMENT, INC.
62. VOCA WEST VIRGINIA
63. RESCARE MINNESOTA INC
64. OP PHARMACY LLC
65. HOSPICE OF THE MIDWEST LLC
66. RESCARE MAINE INC
67. CONNECTMED360 LLC
68. SPRINGHEALTH BEHAVIORAL HEALTH AND INTEGRATED CARE KENTUCKY, LLC
69. HOSPICE OF NORTH ALABAMA
70. AMERITA SOUTH ATLANTIC LLC
71. JOIN II LLC
72. ABILISHEALTH MARTIN LLC
73. SPRINGHEALTH BEHAVIORAL CA
74. ABODE HOSPICE AND HOMECARE MN
75. HOSPICE HOME CARE INC
76. SINA DRUG LLC
77. RESCARE CONNECTICUT
78. COMMUNITY ADVANTAGE, INC.
79. SPRINGHEALTH BEH MISSOURI
80. PHARMACY CORPORATION OF AMERIC
81. PHARMACY ALTERNATIVES CA LLC
82. SPRINGHEALTH BEHAVIORAL WA LLC
83. SPRINGHEALTH BEHAVIORAL VA
84. LEVEL 11 PHYSICAL THERAPY
85. CHEM RX PHARMACY SERVICES LLC
86. HOME HEALTH CARE OF EAST TENNE
87. LEVEL ELEVEN SAGINAW, LLC
88. LEVEL ELEVEN HOWELL LLC
89. HOME HEALTH CARE SERVICES INC
90. HOME HEALTH CARE OF WEST TN
91. ADORATION HOME HEALTH CARE DC
92. SORKINS RX LTD
93. PHARMERICA HOSPITAL PHARMACY S
94. PHARMERICA SOLUTIONS SERVICES

95. ILS PHARMACY LLC
96. ABILISHEALTH BROWNSVILLE LLC
97. SPRING VALLEY HOSPICE LLC
98. ABILISHEALTH KNOXVILLE LLC
99. GRANE HOSPICE CARE INC
100. ABILIS MCMINNVILLE LLC
101. DIXIE LODGE
102. ABODE HEALTHCARE INC
103. ADV TECHNOLOGIES IN HOME CARE
104. PALLIATIVE CARE INDIANA
105. ABODE HEALTHCARE COLORADO INC
106. HOSPICE OF MIAMI VALLEY LLC
107. COMPASSIONCARE HOSPICE LV LLC
108. ONCOMED PHARMACEUTICAL SERVICE
109. ALLAY HOME AND HOSPICE INC
110. HOSPICE HOMECARE PINE BLUFF PL
111. APREVA CORPORATION
112. EVENTUS RX INC
113. EVENTUS INFUSION INC
114. PROGRESSIVE REHAB ASSOC LLC
115. JOIN I LLC
116. SIGNATURE ADVANTAGE, LLC
117. ADORATION HOME HEALTH CARE NEV
118. PREMIER HOSPICE AND PALLIATIVE CARE, LLC
119. ADORATION HOME HEALTH CARE PEN
120. GATEWAY PEDIATRIC THERAPY LLC
121. RWW OUTPATIENT REHAB SERVICES LLC
122. ABODE HOSPICE OF FLORIDA LLC
123. WESTERN RESERVE MEDICAL GROUP, LLC
124. SHC MEDICAL PARTNERS LLC
125. ABODE CARE PARTNERS, P.C.*
126. INDIANA HOME BASED PRIMARY CARE, P.C.†
127. VIRGINIA HOME BASED PRIMARY CARE, INC.*
128. ICAREPRO OF TEXAS, P.A.†
129. THERAPY & REHABILITATION SVCS*
130. DELTA BEHAVIORAL GROUP LLC
131. RWW PEDIATRIC REHAB SERVICES, LLC
132. RWW HOME & COMMUNITY REHAB SERVICES OREGON, LLC
133. TANGRAM REHABILITATION NETWORK, INC.
134. SPRINGHEALTH BEHAVIOAL HEALTH & INTEGRATED CARE NORTH CAROLINA LLC
135. BRIGHTSPRING POPULATION HEALTH SOLUTIONS LLC
135. ADORATION HOME HEALTH CARE RHODE ISLAND LLC
136. CAMDEN HOMECARE, LLC
137. SUNCREST HOME HEALTH OF GEORGI
138. SENESENCE LLC
139. ADORATION HOME HEALTH OF IL
140. HOUSECALLS HOME HEALTH AND HOS
141. TENDER LOVING CARE HEALTH CARE
142. AMEDISYS SP-KY, L.L.C.
143. AMEDISYS HOME HEALTH OF ALABAM

144. LHCG CCXXVII, LLC
145. AMEDISYS WEST VIRGINIA, L.L.C.
146. FLOYD HOMECARE, LLC
147. ALABAMA HOMECARE OF MONTGOMERY
148. HOUSECALL HOME HEALTH, L.L.C.
149. OHIO HOMECARE, LLC
150. LHCG CCXXVIII, LLC
151. LHCG LII, LLC
152. GEORGIA HOMECARE OF HARRIS, LL
153. AMEDISYS SP-IN, L.L.C.
154. FAMILY HOME HEALTH CARE, L.L.C
155. FLORENCE HOME CARE SERVICES, L
156. NORTHWEST GEORGIA HOME HEALTH,
157. SUNCREST HOME HEALTH OF AL, IN
158. AMEDISYS MARYLAND, L.L.C.
159. AMEDISYS MARYLAND SUB, LLC
160. OMNI HOME HEALTH DISTRICT 1
161. ACCUMED HEALTH SERVICES, L.L.C
162. AMEDISYS HOME HEALTH, A LAWREN
163. AMEDISYS MISSISSIPPI, L.L.C.
164. NINE PALMS 2 LLP
165. EMPORIA HOME CARE SERVICES, LL
166. AMEDISYS ARKANSAS, LLC
167. UAMS HEALTH COMPREHENSIVE CARE
168. LANCASTER HOME CARE SERVICES,
169. LHCG CLXI, LLC
170. FAYETTE MEDICAL CENTER HOMECAR
171. CENTRE HOME CARE, LLC
172. MARION REGIONAL HOMECARE, LLC
173. LHCG CCXXVI, LLC
174. EAST ALABAMA MEDICAL CENTER HO
175. LHCG LXV, LLC
176. PATIENT CARE NEW JERSEY, INC.
177. LHCG LI, LLC
178. GADSDEN HOME CARE SERVICES, LL
179. FRANKLIN HOME CARE SERVICES, L
180. HOME HEALTH AGENCY-PENNSYLVANI
181. PATIENT CARE OF HUDSON COUNTY,
182. WARE VISITING NURSES SERVICE,
183. WESTERN REGION HEALTH CORPORAT
184. CLAY COUNTY HOSPITAL HOME CARE
185. COOSA VALLEY HOMECARE, LLC
186. ADORATION HEALTH MANAGEMENT LLC

*Not offered Medical or Limited Medical benefits through the Plan.
†Eligible for ICHRA, but not other Medical options through the Plan.

Addendum F – Qualified Medical Expenses

*This **Addendum F** is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.*

As described in the Plan, Health Care FSAs, Limited Use FSAs, and HSAs permit you to be reimbursed on a pre-tax basis for “qualified medical expenses” as defined under Section 213(d) of the Code and by IRS regulations.

Qualified medical expenses eligible to be reimbursed on a pre-tax basis include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body, including over-the-counter medications. Qualified medical expenses must be to alleviate or prevent a physical or mental defect or illness. Expenses incurred solely for cosmetic reasons or expenses that are merely beneficial to a person’s general health (except smoking cessation and physician-directed weight reduction programs) are not eligible for reimbursement.

IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care FSA, Limited Use FSA, or HSA.

Eligible Expenses

Below is a partial list of qualified medical expenses eligible for pre-tax reimbursement:

- **Medical Expenses**
 - Deductibles
 - Copayments
 - Charges for routine check-ups, physical examinations, and tests connected with routine exams
 - Charges over the “reasonable and customary” limits
 - Expenses not covered by the Medical plan due to exclusion by the insurance company
 - Drugs requiring a doctor’s written prescription that are not covered by insurance
 - Over-the-counter drugs, if obtained with a prescription, and only as permitted under applicable law or regulation. Certain other over-the-counter items such as bandages, crutches, and other supplies will be reimbursable without a prescription, but only to the extent applicable regulations permit
 - Insulin (which may be reimbursed without a prescription)
 - Smoking cessation programs and related medicines
 - Weight loss programs which are at the direction of a physician to treat a medical condition such as hypertension (weight loss programs for general health improvement do not qualify)
 - Other selected expenses not covered by the Medical plan that qualify for a federal income tax deduction, such as special services and supplies for the disabled (such as seeing eye dogs for the blind, dentures and artificial limbs, wheelchairs and crutches)
- **Dental Expenses**
 - Deductibles
 - Copayments
 - Expenses that exceed the maximum annual amount allowed by your dental plan
 - Charges over the “reasonable and customary” limits
 - Orthodontia treatments that are not strictly cosmetic
- **Vision and Hearing Expenses**

- Vision examinations and treatment not covered by insurance plan
- Cost of eyeglasses, laser surgery, prescription sunglasses, contact lenses including lens solution and enzyme cleaner
- Cost of hearing exams, aids and batteries
- Transportation— Amounts paid for transportation primarily for, and essential to, medical care can be claimed. You can include in medical expenses amounts you pay for transportation to another city if the trip is primarily for, and essential to, receiving medical services. You may be able to include up to \$50 for each night for each person. You can include lodging for a person traveling with the person receiving the medical care.

Ineligible Expenses

Below is a partial list of expenses ***not*** eligible for reimbursement under the Health Care FSA:

- Premiums
 - Premiums paid by the employee, a spouse or other dependents for coverage under any health plan for which the employee is claiming a credit or deduction
 - Premiums paid for Medicare Part A if you are covered under social security
 - Premiums paid for long-term care insurance
 - Premiums paid for policies that provide coverage for loss of earnings, loss of limbs, loss of sight, etc.
- Cosmetic procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery
- Expenses Related to General Health—Expenses incurred must be primarily for the prevention or alleviation of a physical or mental illness or defect. Therefore, an expense which is merely beneficial to the general health of an individual (such as an expenditure for vacation or health club dues, even if prescribed by a doctor) is generally not an expense for medical care. Generally, only foods prescribed by your doctor as supplements to the normal diet may qualify as a medical expense.

The IRS does not allow you to deduct the same expenses on your income tax return for which you are reimbursed under the Health Care FSA.

Additional Qualified Medical Expense Information

For more details, see IRS Publications 969 and 502, which can be located at www.irs.gov.

Addendum G – BrightSpring Health Services Section 125 Cafeteria Plan

This Addendum G is accurate as of January 1, 2026, and is subject to modification without formal amendment of the Plan.

**BrightSpring Health Services
Section 125 Cafeteria Plan**

Amended and Restated Effective January 1, 2026

ARTICLE I
PLAN ESTABLISHMENT

1.1 Effective Date and History

The ResCare, Inc. Flexible Benefits Plan was originally adopted by ResCare, Inc. on May 1, 1991, identified by Employer Identification Number (EIN) 61-0875371 and plan number (PN) 504. ResCare, Inc. separately sponsors the ResCare, Inc. Welfare Benefit Plan (named and referred to as the BrightSpring Health Services Welfare Benefit Plan as of January 1, 2019), identified by Employer Identification Number (EIN) 61-0875371 and plan number (PN) 501. On January 1, 2019, the ResCare Inc. Flexible Benefits Plan was amended, restated and renamed as the BrightSpring Health Services Section 125 Cafeteria Plan (the "Cafeteria Plan"). Effective as of January 1, 2026, the Cafeteria Plan was amended and restated to clarify various plan provisions and align benefits with current plan administration and became incorporated into the Welfare Plan.

1.2 Purpose

The Cafeteria Plan is created exclusively for Employees. The Cafeteria Plan's purpose is to provide Covered Employees, the means to exchange all or part of their compensation, for other Cafeteria Plan benefits they select.

1.3 Qualification

The Cafeteria Plan is intended to qualify as a Section 125 Cafeteria Plan under section 125 of the Internal Revenue Code of 1986, as amended (the "Code"); the Section 125 Cafeteria Plan is not intended to be an employee benefit plan under section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the written plan document requirement of Department of Treasury Proposed Regulations section 1.125-1(c).

The Dependent Care Flexible Spending Account set forth in Appendix A, is part of this Cafeteria Plan and is intended to qualify as a dependent care assistance program under section 129 of the Code. Appendix A is intended to satisfy the written plan document requirement of Code section 129(d)(1).

The Health Care Flexible Spending Account set forth in Appendix B, is part of this Cafeteria Plan and is intended to be an employee welfare benefit plan under section 3(3) of ERISA. The applicable provisions of this Cafeteria Plan are intended to satisfy the written plan document requirement of ERISA section 402. The Health Care Flexible Spending Account is intended to qualify as a health plan under section 105(e) of the Code. The Cafeteria Plan, including Appendix B, is also intended to satisfy the written plan document requirement of 26 CFR section 1.105-11(b)(1)(i).

The Limited Purpose Health Care Flexible Spending Account set forth in Appendix C, is part of this Cafeteria Plan and is intended to be an employee welfare benefit plan under section 3(3) of ERISA. The applicable provisions of this Cafeteria Plan are intended to satisfy the written plan document requirement of ERISA section 402. The Limited Purpose Health Care Flexible Spending Account is intended to qualify as a health plan under section 105(e) of the Code. The Cafeteria Plan, including Appendix C, is also intended to satisfy the written plan document requirement of 26 CFR section 1.105-11(b)(1)(i).

1.4 Duration

The Cafeteria Plan is established with the intention of being maintained for an indefinite period of time; however, the Company in its sole discretion and in accordance with the provisions of

Article VIII may amend or terminate the Cafeteria Plan or any provision of the Cafeteria Plan at any time.

ARTICLE II DEFINITIONS

Capitalized terms shall have the meaning described to such terms in the Plan or as follows:

Cafeteria Plan means the BrightSpring Health Services Section 125 Cafeteria Plan, as described herein, including all Schedules hereto and all documents incorporated herein by reference, as each is amended from time to time. The Cafeteria Plan consists of a Dependent Care Spending Account, a Health Care Flexible Spending Account, a Limited Purpose Health Care Flexible Spending Account, the ability to pay before-tax to purchase qualified health and welfare benefits, and the ability to contribute to a Health Savings Account on a before-tax basis. It is operated in accordance with Code section 125 and related guidance.

Change in Status means:

- A. A "special enrollment" event under HIPAA,
- B. The Covered Employee's marriage, divorce, legal separation or annulment,
- C. Commencement or dissolution of domestic partnership (as permitted by state and local laws, as applicable)
- D. The birth, adoption, placement for adoption, or change in dependency or custody of a Covered Employee's Dependent child,
- E. The death of the Employee's Spouse or Dependent child,
- F. A change in employment status by the Covered Employee, Spouse or Dependent, including commencement or termination of employment, a change in work shift, a change in worksite, a reduction or increase in hours of employment including changing from part-time to full-time employment status, a strike or lockout that affects eligibility for coverage under the Cafeteria Plan,
- G. Commencement or return from an unpaid leave of absence by the Employee, Spouse or Dependent,
- H. A change in worksite or personal residence resulting in eligibility or loss of eligibility of coverage for the Covered Employee, Spouse or Dependent under any health maintenance organization offered through the Cafeteria Plan,
- I. A change in legal custody (including the issuance of a qualified medical child support order) that affects the child's eligibility for coverage under this Cafeteria Plan or the plan of the child's other parent,
- J. Entitlement or loss of entitlement to Medicare or Medicaid by an Employee, Spouse, or Dependent,
- K. Attainment by Dependent child of limiting age for a benefit provided under this Cafeteria Plan,
- L. Loss of "Qualifying Individual" status, as defined in Article II of the Dependent Care FSA,
- M. Experiencing a change in employment that does not affect eligibility for coverage under the Cafeteria Plan, after which the Covered Employee is reasonably expected to work less than 30 hours per week, if the Covered Employee intends

to enroll in another plan that provides minimum essential coverage effective no later than the first day of the second month after the date that Cafeteria Plan coverage is revoked. This rule permits the Covered Employee to revoke group health plan benefits only, for the Covered Employee and his or her Dependents, and does not apply to Health Care Spending Account elections,

- N. Eligibility for special enrollment in a qualified health plan (QHP) through the public Marketplace, or seeking to enroll in a QHP offered through the public Marketplace during the Marketplace's annual open enrollment. This rule permits the Covered Employee to revoke group health plan benefits only, for the Covered Employee and his or her Dependents, and must correspond with the intended enrollment of the Covered Employee and his or her Dependents in a QHP effective beginning no later than the day immediately following the last day of the Cafeteria Plan coverage that is revoked. This rule does not apply to Health Care Spending Account elections, or
- O. Any other event the Plan Administrator determines permits revocation of an election without violating the Code.

Covered Employee means an Employee who satisfies the eligibility, participation, and coverage requirements of Article III and who has made an election to participate in the benefits described under the Cafeteria Plan.

Dependent means a Covered Employee's dependent, as defined in Code Section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) and, for health benefits, the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

Dependent Care FSA means the Dependent Care Flexible Spending Account component benefit set forth in Appendix A.

Effective Date means the date the amended and restated Cafeteria Plan becomes operative; which is January 1, 2026.

Employee for purposes of this Cafeteria Plan only, the term Employee means any person who renders services to the Employer for remuneration that the Employer determines is subject to federal income tax withholding and Federal Insurance Contributions Act (FICA) taxes payable by the Employer and classified by the Employer as a common-law employee of the Employer. Employee also includes persons who are employed by the Employer in a position whose employment is covered by a collective bargaining agreement that provides for participation in the Cafeteria Plan.

The term Employee does not mean:

- A. a self-employed individual, as defined in Code section 401(c)(1)(A),
- B. a member of the Board of Directors who is not otherwise an Employee,
- C. a person whom the Plan Administrator determines has been engaged by the Employer as an independent contractor,
- D. a temporary individual whose services are contracted from or through an entity that is not a Participating Employer,
- E. a leased employee as defined in Code section 414(n) (Leased employees within section 414(n) of the Code shall not be considered Employees, notwithstanding their inclusion as required by law, in applicable nondiscrimination testing under relevant Code sections), and

- F. a person whom the Plan Administrator determines has been engaged by the Employer as a consultant or advisor on a retainer or fee basis.

A person whom the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Cafeteria Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters, and as determined by the Plan Administrator and/or the Company's legal counsel.

Employer means the Company, a Participating Employer, and any subsidiary, affiliated organization, or parent organization, and any successor(s) which, as determined by the Plan Administrator or its designee, and subject to such conditions as the Plan Administrator or its designee may impose, is subject to the Cafeteria Plan.

For purposes of satisfying the nondiscrimination requirements of Code section 125(b), section 105(h) and 129(d), the term "Employer" shall include any Participating Employer, other corporation or other business entity which must be aggregated with the Employer under section 414(b), (c), (m) or (o) of the Code, but only for such period of time when the Employer or such other corporation or other business entity must be aggregated as aforesaid.

Health Care FSA means the Health Care Flexible Spending Account component benefit as defined and set forth in Appendix B.

Health Savings Account means an individual savings account that qualifies under Code section 223 established to pay for medical expenses as defined in section 213(d) of the Code. The Health Savings Account is not a Company-sponsored employee benefit plan and is not subject to ERISA; it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside of the Cafeteria Plan. The HSA trustee/custodian will be selected by the Covered Employee, not the Company or an Employer. The Company may limit the number of HSA providers to whom it will forward contributions; however, such a list is not an endorsement of a particular HSA provider. The Plan Administrator will maintain records of HSA contributions a Covered Employee makes via Salary Reduction Contribution, but it will not create a separate fund or otherwise segregate assets for this purpose. The Company has no authority or control over the funds.

Limited Use FSA means Limited Use Flexible Spending Account component benefit as defined and set forth in Appendix C.

Participating Employer Participating Employer is defined in the Welfare Plan, unless otherwise specified for purposes of this Cafeteria Plan by the Plan Administrator.

Plan Administrator means the Company or its designee.

Salary Reduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on a before-tax basis for selected Cafeteria Plan benefits. Any such Salary Reduction election must be made on a prospective basis (except as permitted by law).

Salary Reduction Contribution means the contributions taken from the Covered Employee's salary on a before-tax basis, pursuant to a Salary Reduction Agreement.

Spouse means, for purposes of this Cafeteria Plan only, the Covered Employee's legal spouse.

Summary Plan Description means a summary plan description, as defined under ERISA section 102, of the Company (and all summaries of material modifications thereto, including designated enrollment materials) that designates the Welfare Plan and the Cafeteria Plan as the applicable plans and describes the provisions of the Cafeteria Plan as a way to pay for or contribute to component benefits.

Welfare Plan means the BrightSpring Health Services Welfare Benefit Plan.

ARTICLE III
ELIGIBILITY, PARTICIPATION AND COVERAGE

3.1 Eligibility

An individual shall become eligible to participate in the applicable component benefit as outlined in the Appendices to this Cafeteria Plan in accordance with the terms and as of the date(s) set forth in the Summary Plan Description. Notwithstanding any other provision of this Cafeteria Plan, an eligible Employee shall not be eligible for the Health Care FSA or the Limited Use FSA unless such individual also is eligible to participate in a medical option under the Welfare Plan.

3.2 Participation

Employees become Cafeteria Plan participants on the date they satisfy the eligibility requirements of Section 3.1 and the enrollment and election requirements of Section 5.1.

3.3 Coverage

A. Coverage During Leave of Absence

1. Paid Leave

During a paid leave of absence, a Covered Employee continues to participate in the premium payment benefits he or she elected.

2. Unpaid Leave

Any participant who is not at work because of an unpaid FMLA leave, USERRA leave, or due to any other approved unpaid leave of absence may, at the participant's option, continue certain benefits under the Cafeteria Plan that the participant elected during the period of absence, so long as the participant continues to make any required contributions. The following shall be determined in accordance with the written leave of absence policies of the Company, as applicable, the incorporated documents, including the Summary Plan Description and any applicable law, including the FMLA and USERRA:

- a. whether such benefits are available for continuation during an unpaid leave of absence;
- b. payment for such benefits continued during leave of absence; and
- c. the period of time for which such benefits may be continued.

3. Any participant returning from an FMLA, USERRA leave, or other approved, unpaid leave of absence shall be reinstated in the same or equivalent benefits to the benefits they received prior to the unpaid leave of absence, adjusted for any changes in benefits that affected the workforce as a whole. Such reinstatement shall be made in accordance with the written leave of absence policies of the Company, the incorporated documents, including the Summary Plan Description and any applicable law.

B. Date Coverage Ceases

Cafeteria Plan coverage ceases on the earliest of:

1. for the benefits described in Sections 4.3(D), (E), (F) and (G), the day in which the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,
2. for the benefits described in Sections 4.3(A), (B) and (C), the last day of the pay period, in which the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,
3. except where participation continues during an unpaid leave of absence, the last day of the last pay period for which a Covered Employee makes a Salary Reduction Contribution as required for Cafeteria Plan participation,
4. the effective date of a Cafeteria Plan amendment that terminates coverage for the Covered Employee's job category, or
5. the date the Cafeteria Plan terminates.

C. Effect of Terminated Coverage

Termination of coverage automatically cancels a Covered Employee's Salary Reduction Agreement on the date coverage terminates. The Cafeteria Plan's terms governing the Covered Employee's selected premium payment benefit control whether and to what extent coverage and benefits under that component benefit continue.

D. Reinstatement of Coverage

1. If Previously Suspended

A Covered Employee who returns to the Employer's service during the same Plan Year that he or she took an unpaid leave of absence that is fewer than 13 consecutive weeks will have reinstated automatically the benefit elections in effect when Cafeteria Plan coverage was suspended provided such benefits continue to be provided by the Company. If an unpaid leave of absence was taken in accordance with FMLA, such Covered Employee may reinstate his or her election and Salary Reduction Agreement for the remainder of the Plan Year if participation has not continued pursuant to Section 3.3(A). In all other cases, the Covered Employee may only make any new benefit elections for the remainder of the Plan Year, as described in Section 5.1(F)(3).

2. If Previously Terminated

A former Covered Employee who returns to the Employer's service after 13 consecutive weeks shall be eligible to participate in the Cafeteria Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1. Notwithstanding the foregoing, if a former Covered Employee returns to service during the same Plan Year and within 30 days of the date prior participation ended, he shall have his prior benefit elections reinstated and may not make any new benefit elections for the remainder of the Plan Year, except as described in Section 5.1(F)(3). The above rule shall not apply, and the rehired Employee shall be eligible to make new elections for the balance of the Plan Year, if it is determined to the satisfaction of the Plan Administrator that the prior termination of employment and reinstatement was bona fide and not an attempt to avoid the irrevocable rule described in Section 5.1(F)(1).

E. Coverage under the Family and Medical Leave Act (FMLA) and Section 609 of ERISA

1. FMLA

If not otherwise provided for herein, the Cafeteria Plan shall provide coverage for a Covered Employee solely to the extent necessary to comply with FMLA, and the Cafeteria Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

2. Section 609 of ERISA

If not otherwise provided for herein, the Cafeteria Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order defined under section 609(a) of ERISA or to an adoptive child solely to the extent required by section 609(c) of ERISA. Further, the Cafeteria Plan shall be interpreted and administered as necessary to comply with section 609 of ERISA and the rulings and regulations issued thereunder.

3. Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section 3.3(E) shall be conditioned upon payment of applicable contributions by the Employee.

F. Uniformed Services Employment and Reemployment Rights Act (USERRA)

Solely to the extent required by USERRA, an Employee who is a Covered Employee and who enters military service shall have the right to continue coverage under the Cafeteria Plan for the period prescribed under USERRA. Continuation of coverage shall be conditioned upon payment of the required premiums.

This Section shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

ARTICLE IV

BENEFITS

4.1 Benefit Options

A. As a condition of Cafeteria Plan participation, Covered Employees must elect one of the following:

1. to receive the full unreduced compensation benefit described in Section 4.2, or
2. to forego all or part of the unreduced compensation benefit described in Section 4.2 and make Salary Reduction Contributions in exchange for one or a combination of premium payment benefits described in Section 4.3.

Employee contributions for benefits described in Section 4.3 must be made on an entirely before-tax basis through a Salary Reduction Agreement.

4.2 Unreduced Compensation Benefit

In lieu of all or some of the premium payment benefits described in Section 4.3 that a Covered Employee otherwise could elect, he or she may elect to receive unreduced compensation in an

amount equal to the value of the premium payment benefits not elected. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit is not additional compensation; it is the amount by which a Covered Employee's compensation is not reduced each pay period by not electing a premium payment benefit. The unreduced compensation benefit shall cease whenever the Covered Employee commences an unpaid leave of absence, terminates employment, or the Covered Employee's Employer determines, in its sole discretion, that compensation is not payable to such Employee.

4.3 Benefits

By electing one or more premium payment benefits, an Employee agrees to convert a portion of his or her compensation for the Plan Year into contributions to the Welfare Plan. The Welfare Plan's terms, as amended from time to time, govern a Covered Employee's rights and obligations under it. Covered Employees may elect one or more of these benefits:

A. Medical Premium Payment

A Covered Employee may elect any available coverage level and/or option as the medical premium payment benefit.

B. Dental Premium Payment

A Covered Employee may elect any available coverage level and/or option as the dental premium payment benefit.

C. Vision Premium Payment

A Covered Employee may elect any available coverage level and/or option as the vision premium payment benefit.

D. Dependent Care FSA Premium Payment

A Covered Employee, who is not located in Puerto Rico or the U.S. Virgin Islands, may elect any whole dollar annual contribution amount not less than an amount determined by the Plan Administrator or its designee (to be communicated in open enrollment materials) and not more than, for 2026, \$7,500 (per household) or \$3,750 (if married filing separately), or the maximum amount permitted by the Internal Revenue Service ("IRS"), as determined by the Plan Administrator or its designee, as the Dependent Care FSA benefit.

E. Health Care FSA Premium Payment

A Covered Employee, who is not located in Puerto Rico or the U.S. Virgin Islands, may elect any whole dollar annual contribution amount not less than an amount determined by the Plan Administrator or its designee (to be communicated in open enrollment materials), and not more than, for 2026, \$3,400, or the maximum amount allowed under Section 125 of the Code, as the Health Care FSA benefit.

F. Limited Use FSA Premium Payment

A Covered Employee, who elects to participate in the Employer-sponsored high deductible health plan, and who is not located in Puerto Rico or the U.S. Virgin Islands, may elect any whole dollar annual contribution amount not less than an amount determined by the Plan Administrator or its designee (to be communicated in open enrollment materials) and not more than, for 2026, \$3,400

per person, or the maximum amount allowed under Section 125 of the Code, as the Limited Use FSA benefit.

G. Health Savings Account Premium Payment

An Employee who participates in an Employer-sponsored high deductible health plan that meets the requirements of Code section 223 may elect any whole dollar annual contribution amount of not more than, for 2026, \$4,400 for self-only coverage and \$8,750 for family coverage, or the maximum allowed under Section 223 of the Code, as the Health Savings Account benefit.

The Employer will contribute the amounts corresponding to the value of the benefits that Covered Employees select to the plans governing the Covered Employees' selected benefits. Covered Employees forfeit unused Salary Reduction Contributions, if any, as required by law; this provision will not apply to the HSA. Covered Employees may not receive a cash out of Salary Reduction Contributions that are forfeited, nor may Covered Employees apply such forfeitures toward any other Cafeteria Plan benefit.

Notwithstanding the foregoing, a Covered Employee shall not forfeit unused Salary Reduction Contributions applicable to the Health Care FSA or Limited Use FSA that do not exceed the lesser of: (i) an amount determined by the Plan Administrator or its designee, which shall be within the carryover limits permitted by the IRS (the "FSA Carryover Limit"); or (ii) the unused balance of such Covered Employee's Health Care FSA or Limited Use FSA at the end of the Plan Year (after the claim runout period). Instead, a Covered Employee may elect to carryover up to the FSA Carryover Limit or, if less, the unused balance in his or her Health Care FSA or Limited Use FSA at the end of the Plan Year to a subsequent Plan Year. Such unused balance cannot be cashed out. Any amounts in excess of the FSA Carryover Limit shall be forfeited in the same manner as forfeitures for other Salary Reduction Contributions. A Covered Employee may opt out of the Health Care FSA or Limited Use FSA carry over at annual enrollment. Or, if a Covered Employee who had a Health Care FSA elects medical coverage under a high deductible health plan offered by the Company in the following Plan Year, unused Salary Reduction Contributions that are permitted to be carried over shall automatically be allocated to a Limited Use FSA for such Covered Employee.

4.4 Limits for Certain Employees

Benefits payable under the Cafeteria Plan to each highly compensated participant, as defined in Code section 125(e)(1) or highly compensated individual, as defined in Code section 125(e)(2), shall be limited to the extent necessary to avoid violating Code section 125(b)(1).

Benefits payable under the Cafeteria Plan to each key Employee, as defined in Code section 416(i)(1), are limited to the extent necessary to avoid violating Code section 125(b)(2). Benefits payable under the Cafeteria Plan to each highly compensated individual, as defined in Code section 105(h)(5) shall be limited to the extent necessary to avoid violating Code section 105(h)(1) as applicable.

Benefits payable under the Cafeteria Plan to a highly compensated Employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8). The Employer may determine prior to or during a Plan Year that the Salary Reduction Contributions of a highly compensated Employee must be reduced to avoid violating Code section 129(d)(8). Any amounts that are in excess of the Code section 129(d)(8) limit shall be returned to a highly compensated Employee in the form of taxable compensation.

4.5 Notification of Premium Payment Benefit Amounts

The Company shall provide written notification to eligible Employees of the amount of the premium payment benefits prior to the initial and annual enrollment/election period. The amount of the premium payment benefits shall be the contributions required of the Employee to participate in the group health or welfare benefits for which a premium payment benefit is available under the Cafeteria Plan. Any such written notification is hereby incorporated by reference and made part of the Cafeteria Plan.

4.6 Application of Other Plans

Notwithstanding any other provision of the Cafeteria Plan, Covered Employees electing one or more premium payment benefits under the Cafeteria Plan shall be subject to the provisions, conditions, limitations, and exclusions of the Welfare Plan.

ARTICLE V PROCEDURES

5.1 Enrollment/Election Procedures

A. Forms and Agreements

Employees may enroll, make elections, and direct their Employer to make Salary Reduction Contributions only by filing the appropriate, completed forms or agreements with the Plan Administrator before the deadline described in Section 5.1(C).

B. Annual Enrollment

A reasonable period of time before the beginning of each Plan Year, the Plan Administrator shall conduct an enrollment period during which Employees may make new elections or change existing ones for the next Plan Year.

C. Deadlines

1. Initial Enrollment/Election

For Employees who become eligible as of the Effective Date, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the first day of the Plan Year to which the enrollment/elections and Salary Reduction Agreement apply.

For Employees who become eligible after the Effective Date but before the annual enrollment described in Section 5.1(B), the deadline for enrolling and making initial elections is the 45-day period after the Employee's date of hire for all Employees located outside of Hawaii, and the 30-day period after the Employee's date of hire for all Employees located in Hawaii, unless otherwise determined by the Administrator and communicated in employee communication materials or as part of the onboarding process. Salary Reduction Agreements shall be effective as of the date of hire, provided the Employee enrolls within the time frames set forth herein.

2. Annual Enrollment/Election

For Covered Employees and Employees who become eligible as of the first day of a Plan Year, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the day preceding the first day of the Plan Year to which the enrollment/elections and Salary Reduction Agreements apply.

D. Missed Deadline Yields Default Election

1. Initial Enrollment

An Employee (other than a Covered Employee) who fails to submit a valid enrollment/election and Salary Reduction Agreement as required in Section 5.1(A), is deemed to elect the maximum unreduced compensation benefit, described in Section 4.2, unless the Plan Administrator approves a supplemental election, as described in Section 5.1(F)(2).

2. Annual Enrollment

A Covered Employee's enrollment/election and Salary Reduction Agreement as required in Section 5.1(A) will carry over from one Plan Year to a subsequent Plan Year, unless otherwise specified in annual enrollment materials that a new enrollment/election and Salary Reduction Agreement are required to participate in the premium payment benefits in 4.3(A) – (C). Notwithstanding the foregoing, a new election to participate in the Dependent Care FSA, Health Care FSA or Limited Use FSA must be made for each Plan Year. If a Covered Employee fails to submit a valid enrollment/election and Salary Reduction Agreement as required in Section 5.1(A) for the Dependent Care FSA, Health Care FSA or Limited Use FSA, then enrollment in the Dependent Care FSA, Health Care FSA and Limited Use FSA will be deemed to be waived for the next Plan Year.

E. Validity of Enrollment/Elections and Salary Reduction Agreement

1. Plan Administrator Approval

Enrollment/elections and Salary Reduction Agreements take effect only if valid, as determined by the Plan Administrator. Except for supplemental elections described in Section 5.1(F)(2), the Plan Administrator shall substitute the unreduced compensation benefit, described in Section 4.2, for any invalid premium payment benefit election.

2. Remedial Modification or Rejection

The Plan Administrator may modify or reject any enrollment/election and/or Salary Reduction Agreement or take other action the Plan Administrator deems appropriate under rules uniformly applicable to similarly situated persons to satisfy the nondiscrimination requirements of Code section 125(b). Any remedial modification, rejection, or other action the Plan Administrator takes must be on a reasonable basis that does not discriminate in favor of highly compensated individuals or participants, as defined in Code section 125(e)(1) and (2), respectively, or key employees, as defined in Code section 416(i)(1).

F. Changing Elections

1. General Rule

All elections (including default elections described in Section 5.1(D)) and Salary Reduction Agreements stay in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.1(F). During annual enrollment, however, Covered Employees may

make new benefit elections or change existing ones for the forthcoming Plan Year. This rule does not apply to the Health Savings Account.

2. Supplemental Elections

Section 5.1(F)(1) notwithstanding, the Plan Administrator may approve a supplemental election to correct an enrollment/election or Salary Reduction Agreement that is invalid for any reason if approval would not violate Code section 125.

3. Revocation of Elections

Except as provided in Section 3.3(C), Covered Employees may revoke elections (including default elections) and Salary Reduction Agreements during a Plan Year only in accordance with the provisions described in this Section 5.1(F)(3). Except for changes made in accordance with Section 5.1(F)(3)(g) and changes made pursuant to a HIPAA special enrollment due to initial entitlement to state premium assistance under Medicaid or a state children's health insurance program (CHIP) or loss of entitlement to Medicaid or CHIP, a Covered Employee must make the change within 31 days of the event giving rise to the election change. In the event of a HIPAA special enrollment due to the loss of Medicaid or CHIP or initial entitlement to state premium assistance by an Employee, Spouse or Dependent, a Covered Employee will have 60 days from the date of the event to make an election change. Notwithstanding the provisions of this Section 5.1(F), an Employee's or Covered Employee's ability to elect or revoke certain premium payment benefits mid-year may be restricted by the terms of the plan governing that premium payment benefit. Additionally, if a Change in Status is a loss of a Spouse's or Dependent's eligibility for coverage, the Employer has no obligation to provide a refund (nor earnings related to a refund) to the Employee for contributions made pursuant to a Salary Reduction Agreement after loss of such coverage and prior to the effectuation of such revocation of election. Further, the Employer may limit revocation of election requests pursuant to Appendix B, Section 3.3.

a. Separation from Service

Covered Employees may revoke elections and Salary Reduction Agreements on separating from the Employer's service.

b. Change in Status

A Covered Employee may revoke any election (including a default election) and make a new one if such revocation and new election are both on account of and necessary or appropriate because of a Change in Status.

Election and salary reduction changes must be consistent with the Change in Status, except for elections:

- (1) made pursuant to the special enrollment provisions of HIPAA,
- (2) made pursuant to a Change in Status event expressly identified in Article II as not requiring that Cafeteria Plan

eligibility be affected, and only to the extent permitted under applicable law or guidance, or

- (3) made to increase Salary Reduction Contributions in the event the Employee, Spouse or Dependent elects COBRA coverage.

For purposes of this subparagraph (b), the term “consistent” means that the Change in Status event must cause the Employee or Employee’s Spouse or Dependent children to gain or lose eligibility under an Employer-sponsored benefit offered through this Cafeteria Plan or the plan of the Spouse or Dependent. The election shall take effect as soon as administratively practicable, following receipt by the Plan Administrator of the election change, but not earlier than the date of the Change in Status. With respect to an election change made pursuant to a birth, adoption or placement for adoption of a child, the election change shall take effect as of the birth, adoption or placement for adoption.

The Plan Administrator may require such evidence as it deems necessary to satisfy the consistency requirement imposed by section 125 of the Code.

c. Cost Changes

If the cost of a premium payment benefit increases or decreases during a Plan Year, the Cafeteria Plan may, on a reasonable and consistent basis, automatically make a prospective change to Covered Employees’ contributions to reflect the cost of this change.

If the Plan Administrator determines that the increase in cost of such premium payment benefit is significant, Covered Employees who have elected that premium payment benefit may either change their Salary Reduction Agreement correspondingly or revoke their premium payment benefit election and — in lieu thereof — elect, prospectively, a premium payment benefit with similar coverage, or may revoke the existing premium payment benefit if no other option providing similar coverage is available. Employees who previously waived participation may elect benefits if the cost of the coverage significantly decreases during the Plan Year.

This opportunity for making new elections does not apply to the Health Care FSA or Limited Use FSA and applies to the Dependent Care FSA only if a cost increase is imposed by a dependent care provider who is not a relative of the Covered Employee. For purposes of this subparagraph (c), a “relative” is an individual who is related as described in Code section 152(d)(2)(A) through (G), incorporating the rules of Code sections 152(f)(1)(B) and 152(f)(4).

d. Coverage Changes

- (1) Significant curtailment *without a loss* of coverage

If coverage offered under the Cafeteria Plan is significantly curtailed without a loss of coverage during a Plan Year, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage. For purposes of this subparagraph (d), a significant curtailment occurs if there is an overall reduction in coverage generally.

(2) Significant curtailment *with loss* of coverage

If coverage offered under the Cafeteria Plan is significantly curtailed to the extent that the Covered Employee experiences a loss of coverage, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage or may revoke existing coverage if no other option providing similar coverage is available. For purposes of this subparagraph (d), a loss of coverage means a complete loss of coverage under the premium payment benefit and shall include the elimination of a benefit option, an HMO ceasing to be available where the individual resides, or other fundamental loss of coverage as determined by the Plan Administrator.

(3) Significantly Improved or New Benefit Option

If the coverage offered under the Cafeteria Plan is significantly improved or if a new benefit option is made available under the Cafeteria Plan, then: (A) Covered Employees who are enrolled in a benefit option other than the new benefit option or significantly improved benefit option may change their election on a prospective basis to elect the new or significantly improved benefit option, or (B) an Eligible Employee who had previously elected to waive coverage under a benefit option may elect to enroll on a prospective basis in the new or significantly improved benefit option. The Plan Administrator, in its sole discretion, will determine whether there has been an addition of, or a significant improvement in, a benefit option in accordance with Internal Revenue Service guidance.

e. Change in Coverage of Employee, Spouse or Dependent under Another Employer's Plan

If the Employee or the Employee's Spouse or Dependent is covered under another plan of the Employer or a plan of the employer of the Employee's Spouse or Dependent, the Employee may make an election change under this Cafeteria Plan in the following situations, provided such election change is on account of and corresponds with a change under the other plan:

- (1) if the plan year of such other employer plan is different than the Plan Year of this Cafeteria Plan, or

- (2) if the other employer plan permits the Employee, Spouse or Dependent to make changes for any of the situations described in this Section 5.1(F)(3).

f. Loss of Coverage under Another Health Plan

If an Employee, Spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, the Employee may make a new election on a prospective basis for health coverage provided under this Cafeteria Plan, provided such Employee, Spouse or Dependent is otherwise eligible for coverage under this Cafeteria Plan. For purposes of this subparagraph (f), a governmental or educational institution shall include the following:

- (1) a state children's health program (CHIP) under Title XXI of the Social Security Act,
- (2) a medical program of an Indian Tribal government (as defined in section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization,
- (3) a state health benefits risk pool, or
- (4) a foreign government group health plan.

g. Automatic Adjustment of Election

The election and Salary Reduction Agreement of a Covered Employee who loses a Spouse or Dependent due to death for purposes of a premium payment benefit described in Section 4.3, but fails to make a timely election in accordance with Section 5.1 shall be automatically adjusted.

5.2 Claims and Appeals Procedures

The claims and appeals procedures applicable to the premium payment benefits in Section 4.3(A) – (C) and 4.3(E) – (F) are set forth in the Employer's Summary Plan Description. The Health Care FSA and Limited Use FSA are subject to ERISA's claims and appeals procedures as outlined in Section 503 of ERISA. However, because the Health Care FSA and Limited Use FSA are limited excepted benefits under Section 732 of ERISA, they are not subject to the group market (insurance) reform requirements under the Affordable Care Act, including claims and appeals changes applicable to non-grandfathered health plans. Therefore, the Health Care FSA and Limited Use FSA will comply with Section 503 of ERISA, disregarding any changes made by the Affordable Care Act.

ARTICLE VI

CONTRIBUTIONS AND FUNDING

6.1 Contributions

A. Employer Contributions

The Employer shall pay premium payment benefits listed in Section 4.3 to the Employer-sponsored health and welfare plans to which such benefits are payable provided that the Covered Employee shall authorize Salary Reduction Contributions in a corresponding amount pursuant to Section 6.1(B)(2).

Notwithstanding any contrary Cafeteria Plan provision, the Employer is not obligated to contribute to the Cafeteria Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

The Employer may make a discretionary contribution to a Health Savings Account for Employees who elect such premium payment benefit under Section 4.3(G), as permitted by law and as limited by any IRS maximums.

B. Salary Reduction Contributions

As a condition of Cafeteria Plan participation, Employees must agree to direct the Employer to:

1. not reduce their compensation and not provide premium payment benefits pursuant to Section 4.3, or
2. reduce their compensation and make Salary Reduction Contributions to the component benefits under the Cafeteria Plan or Welfare Plan governing their selected premium payment benefits.

Any election of premium payment benefits shall be null and void unless the Employee authorizes a Salary Reduction Agreement as provided for herein. An Employer must take Salary Reduction Contributions and apply them as directed, except that the Employer may not apply a Salary Reduction Contribution for a selected premium payment benefit to any other premium payment benefit nor may a Salary Reduction Contribution be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage except as permitted by law on a uniform and consistent basis with respect to all Covered Employees.

C. Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Covered Employees and then from amounts contributed by the Employer.

D. COBRA Contributions

To the extent a former Covered Employee, Dependent or Spouse has exercised his or her continuation rights under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) with respect to benefits described in Section 4.3(A), (B), (C), (E) and (F), the Cafeteria Plan shall accept contributions from such individuals as COBRA premiums.

6.2 Funding

The Employer shall establish and carry out, and may revise from time to time, the funding policy for the Cafeteria Plan. The Employer shall make payments provided for in Section 6.1(A) from its general assets. The Employer shall make payments provided for in Section 6.1(B) and (D) by collecting Employee contributions and COBRA contributions and transmitting such amounts to the applicable Employer-sponsored health and welfare benefit plan.

For self-funded benefits, "contributions" means the Employer will pay benefits from its general assets, and the Employer has no obligation to segregate or fund any plan benefits.

**ARTICLE VII
ADMINISTRATION**

7.1 Plan Administrator

The Company is the Plan Administrator for purposes of ERISA. The Plan Administrator shall be the “named fiduciary” for purposes of ERISA.

7.2 Plan Administrator’s Duties

Except as to those functions reserved within the Plan to the Board of Directors, the Company, or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall:

- A. Manage and carry out the Cafeteria Plan’s operation and administration according to the Cafeteria Plan’s terms and for Covered Employees’ exclusive benefit;
- B. Maintain:
 - 1. Any records and data that are necessary or desirable for the Cafeteria Plan’s proper operation and administration, and
 - 2. The Cafeteria Plan’s governing documentation for inspection by anyone who participates or is eligible to participate in the Cafeteria Plan. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies;

Notify Employees eligible to participate in the Cafeteria Plan of:

- 3. the Cafeteria Plan’s availability and terms,
- 4. the premium payment benefits available for election,
- 5. the maximum annual Salary Reduction Contribution amounts for each available premium payment benefit, and
- 6. the procedures for enrolling, making and changing elections;
- C. Supply eligible Employees with any forms and agreements they must complete;
- D. Prepare and file all annual reports or returns, summary plan descriptions, financial statements, and other documents required by law or under the Cafeteria Plan’s terms; and
- E. Record its and the Employer’s acts and determinations regarding the Cafeteria Plan and preserve these records in its custody.

7.3 Plan Administrator’s Powers

Except as expressly limited or reserved in the Cafeteria Plan, the Board of Directors, the Company, or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Cafeteria Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

- A. Require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Cafeteria Plan and as a condition to the individual’s receiving benefits under the Cafeteria Plan;

- B. Make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Cafeteria Plan;
- C. Interpret the Cafeteria Plan and decide all matters arising under the Cafeteria Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions in the Cafeteria Plan and related documents by general rule or particular decision, and to determine the eligibility of any person to participate in the Cafeteria Plan and the entitlement of any person to any benefits thereunder;
- D. Determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Cafeteria Plan pursuant to the provisions of the Cafeteria Plan;
- E. Determine whether objective criteria set forth in the Cafeteria Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;
- F. Delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Cafeteria Plan;
- G. Engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Cafeteria Plan;
- H. Make such administrative or technical amendments to the Cafeteria Plan as may be reasonably necessary or appropriate to carry out the intent of the Employer, including such amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Cafeteria Plan with other governmental regulations or policies; and
- I. Pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Cafeteria Plan including, but not limited to, premiums or other considerations payable under the Cafeteria Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

7.4 Delegation of Authority

The Plan Administrator may delegate authority to act on behalf of the Plan Administrator. The Company's Benefits Department, including the Sr. Director, Total Rewards & HR Conformity, has been designated the authority to act on behalf of the Plan Administrator for purposes of the day-to-day responsibilities for administration of the Cafeteria Plan. Further, the Company's Benefits Department, on behalf of the reserved authority and responsibilities of the Company, shall arrange for preparation of such reports and information concerning the Plans and the administration thereof as may be required under the Internal Revenue Code, ERISA or any other applicable law, and the regulations promulgated thereunder.

7.5 Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Cafeteria Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Employees and all other interested parties.

7.6 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid as specified in Section 9.17. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

7.7 Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

7.8 Reserved Powers

The Company reserves the powers, among others to:

- A. Adopt the Cafeteria Plan;
- B. Amend, terminate, or merge the Cafeteria Plan according to Article VIII; and
- C. Appoint and remove any Plan Administrator.

ARTICLE VIII

AMENDMENT, TERMINATION OR MERGER OF PLAN

8.1 Right to Amend the Cafeteria Plan

The Cafeteria Plan was established with the bona fide intention and expectation that it will be continued indefinitely. Except as provided in Section 8.2, the Company, as Plan Sponsor, reserves the right to adopt, amend, terminate or merge the Cafeteria Plan or any component benefit at any time and from time to time and to any extent and in any manner that it deems advisable, by written resolution of the Board of Directors; the Board of Directors has delegated this authority to the Benefits Committee. The Benefits Committee has further delegated to the Sr. Director, Total Rewards & HR Conformity of the Company Benefits Department, the authority to adopt, amend or merge the Cafeteria Plan or adopt, amend, merge or terminate any component benefit on its behalf, but the Benefits Committee retains these rights and the Board of Directors shall also retain at all times its own authority to exercise these rights. Any amendment to the Cafeteria Plan shall be in writing and shall be adopted by the duly authorized representative of the Company acting in accordance with its regular duties for the Company.

8.2 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Cafeteria Plan shall be effective at such date as the authorized party identified in Section 8.1 shall determine except that no amendment, termination or merger may be retroactive unless remedial to comply with a law or regulatory requirement the Company or the Cafeteria Plan is subject to.

ARTICLE IX

MISCELLANEOUS

9.1 No Employment Rights

The Cafeteria Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Cafeteria Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Cafeteria Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any

Employee or any other person, any legal or equitable rights against his or her Employer, the Company or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

9.2 Exclusive Rights

No individual shall have a right to benefits under the Cafeteria Plan except as specified herein; and in no event shall any right to benefits under the Cafeteria Plan be or become vested. This Cafeteria Plan is not a guarantee of continuation of any benefits or coverage offered through the Cafeteria Plan.

9.3 No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Cafeteria Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

9.4 No Assignment of Benefits

Benefits payable under the Cafeteria Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void.

9.5 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Cafeteria Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Cafeteria Plan to recover an erroneous or excess payment in any other manner.

9.6 Right to Recover Payments

Whenever a payment has been made by the Cafeteria Plan, including erroneous payments, in a total amount in excess of the amount payable under the Cafeteria Plan, irrespective of to whom paid, the Cafeteria Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made. Further, the Summary Plan Description, including applicable incorporated documents, shall outline the Company's or its delegate's right to impose subrogation provisions.

9.7 Misrepresentation or Fraud

A Covered Employee who receives benefits under the Cafeteria Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation can be removed from the Cafeteria Plan (including any covered Dependents) and may be required to repay all amounts paid by the Cafeteria Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

9.8 Legal Action

Before pursuing legal action, a person claiming Cafeteria Plan benefits or seeking redress related to the Cafeteria Plan must first exhaust the Cafeteria Plan's claims and appeals procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Cafeteria Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Cafeteria Plan prior to the exhaustion of the claims and appeals procedures set forth in

Article V, nor shall an action be brought at all unless within 12 months after the date a final appeal decision is issued.

9.9 Governing Law

The provisions of the Cafeteria Plan shall be administered, and all questions pertaining to the validity or construction of the Cafeteria Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable and, to the extent not preempted, the laws of the State of Kentucky.

9.10 Governing Instrument

This document, together with any documentation incorporated by reference herein, is the legal instrument governing the Cafeteria Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern, unless there is a conflict with the Welfare Plan or an Incorporated Document (as defined in the Welfare Plan), in which case the Welfare Plan or Incorporated Document shall govern, as described in the Welfare Plan.

9.11 Savings Clause

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

9.12 Captions and Headings

The captions and headings of an Article, Section or provision of the Cafeteria Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Cafeteria Plan.

9.13 Notices

No notice or communication in connection with the Cafeteria Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

9.14 Waiver

No term, condition, or provision of the Cafeteria Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

9.15 Parties' Reliance

The Company, the Employer, the Plan Administrator and anyone to whom the Cafeteria Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Cafeteria Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Board of Directors, the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Cafeteria Plan.

9.16 Disclaimer

The Employer makes no assertion or warranty about:

- A. whether Cafeteria Plan benefits are or will be excludable from a Covered Employee's gross income for federal or state income tax purposes, or
- B. whether any other tax treatment is or will be applicable.

9.17 Expenses

All expenses of the Cafeteria Plan shall be paid from forfeitures, Employee contributions, or by the Cafeteria Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Cafeteria Plan, subject to reimbursement, without obligating itself to pay such expenses.

9.18 Indemnification

The Company, to the extent permitted by law, shall indemnify and hold harmless the any Employee or officer of the Company from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Cafeteria Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

9.19 Employees' Tax Obligations

A. Excludability Determination

Covered Employees themselves must determine whether Cafeteria Plan benefits are excludable for tax purposes and must notify the Plan Administrator if they have reason to believe a payment is not excludable.

B. Liability and Payment

If the Plan Administrator determines at any time after a Plan Year's end that Employees' Salary Reduction Contributions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Cafeteria Plan does not qualify as a Section 125 Cafeteria Plan under Code section 125 for the Plan Year, then Covered Employees must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess Salary Reduction Contributions or other Employer contributions, and
2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess Salary Reduction Contributions or other Employer contributions been treated as taxable income.

* * * * *

IN WITNESS WHEREOF, BrightSpring has amended and restated the Cafeteria Plan effective as of January 1, 2026.

Res-Care, Inc. d/b/a BrightSpring Health Services

Signature: _____

Shannon Ernst
Sr. Director, Benefits

IN WITNESS WHEREOF, Western Reserve Medical Group, LLC has adopted this Cafeteria Plan effective as of January 1, 2026.

Western Reserve Medical Group, LLC

Signature: _____
Shannon Ernst
Sr. Director, Benefits
On behalf of Western Reserve Medical
Group, LLC

IN WITNESS WHEREOF, SHC MEDICAL PARTNERS LLC has adopted this Cafeteria Plan effective as of January 1, 2026.

SHC MEDICAL PARTNERS LLC

Signature: _____
Shannon Ernst
Sr. Director, Benefits
On behalf of SHC MEDICAL PARTNERS
LLC

IN WITNESS WHEREOF, Abode Care Partners, P.C. has adopted this Cafeteria Plan effective as of January 1, 2026.

Abode Care Partners, P.C.

Signature:

Shannon Ernst
Sr. Director, Benefits
On behalf of Adobe Care Partners, P.C.

IN WITNESS WHEREOF, Indiana Home Based Primary Care, P.C. has adopted this Cafeteria Plan effective as of January 1, 2026.

Indiana Home Based Primary Care, P.C.

Signature:

Shannon Ernst
Sr. Director, Benefits
On behalf of Indiana Home Based Primary
Care, P.C.

IN WITNESS WHEREOF, Virginia Home Based Primary Care, Inc. has adopted this Cafeteria Plan effective as of January 1, 2026.

Virginia Home Based Primary Care, Inc.

Signature:

Shannon Ernst
Sr. Director, Benefits
On behalf of Virginia Home Based Primary
Care, Inc.

IN WITNESS WHEREOF, ICAREPRO OF TEXAS, P.A. has adopted this Cafeteria Plan effective as of January 1, 2026.

ICAREPRO OF TEXAS, P.A.

Signature: _____

Shannon Ernst
Sr. Director, Benefits
On behalf of ICAREPRO OF TEXAS, P.A.

IN WITNESS WHEREOF, THERAPY & REHABILITATION SVCS has adopted this Cafeteria Plan effective as of January 1, 2026.

THERAPY & REHABILITATION SVCS

Signature: _____

Shannon Ernst
Sr. Director, Benefits
On behalf of THERAPY &
REHABILITATION SVCS

APPENDIX A BRIGHTSPRING HEALTH SERVICES

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The BrightSpring Health Services Dependent Care Flexible Spending Account (the “Dependent Care FSA”) is amended and restated as of the Effective Date.

1.2 Purpose

The Dependent Care FSA is created exclusively for Employees, as defined in Article II of the Cafeteria Plan. The Dependent Care FSA’s purpose is to reimburse Covered Employees, as defined in Article II of this Appendix, for Dependent Care Expenses.

1.3 Qualification

The Dependent Care FSA is intended to qualify as a dependent care assistance program under section 129 of the Internal Revenue Code of 1986, as amended (the “Code”). The Dependent Care FSA’s reimbursements of Dependent Care Expenses are intended to be eligible for exclusion from Covered Employees’ gross income under Code section 129(a). This document is intended to satisfy the written plan document requirement of Code section 129(d)(1) and Prop. Treasury regulation section 1.125-1(c).

1.4 Incorporation by Reference

The Dependent Care FSA outlined in this Appendix A is a component of the Cafeteria Plan.

1.5 Duration

The Dependent Care FSA is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined in Article II of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Dependent Care FSA or any provision of the Cafeteria Plan.

ARTICLE II

DEFINITIONS

When capitalized in this Appendix A, these words and phrases have the following meanings to the extent not already defined elsewhere in the Cafeteria Plan:

Dependent Care Expenses means expenditures for dependent care as described in Section 4.4 of this Appendix A.

Dependent Care Flexible Spending Account or Dependent Care FSA means the notional account established on behalf of each Covered Employee who elects the Dependent Care FSA premium payment benefit under Section 4.3 of the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Dependent Care Expenses.

Exclusions means the exclusions in Article V of this Appendix A.

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Dependent Care FSA, according to the election requirements of Section 6.1 of this Appendix A, for Dependent Care Expense reimbursement, which amount must be not more than \$7,500 for 2026, except as otherwise limited under Section 4.5(B) of this Appendix A.

Qualifying Individual means an individual who is either:

- A. the Covered Employee's child under age 13 and claimable as a personal exemption deduction under Code section 152(a)(1) on the Covered Employee's federal income tax return; or
- B. the Spouse of a Covered Employee who is physically or mentally incapable of caring for him or herself, and who resides with the Employee for more than half of the year; or
- C. any other relative or household member who is physically or mentally incapable of caring for him or herself and is a qualifying relative under Section 152 of the Code (without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) and who resides with the Employee for more than half of the year.

Physically or mentally incapable of caring for him or herself means:

- 1. incapable of caring for one's own hygienic or nutritional needs, or
- 2. requiring another person's full-time attention for one's own safety or the safety of others.

Whether a person is physically or mentally incapable of caring for him or herself is determined on a daily basis.

ARTICLE III PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Dependent Care FSA during those periods in which the Employee:

- A. participates in the Cafeteria Plan, and
- B. has allocated an amount to his or her Dependent Care FSA.

Except for Dependent Care Expenses incurred before Dependent Care FSA coverage ceases and subject to satisfying the procedural requirements of Article VI of this Appendix A, no Dependent Care FSA benefits are payable after coverage terminates.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Dependent Care FSA when he or she is no longer a participant in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Dependent Care FSA, or when the Covered Employee terminates employment, retires or dies.

ARTICLE IV DEPENDENT CARE FSA PREMIUM PAYMENT BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the exclusions, Covered Employees are entitled to reimbursement for Dependent Care Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Dependent Care FSA for each Employee who elects the Dependent Care FSA. The Dependent Care FSA that the Employee elected under the Cafeteria Plan shall be credited to the Employee's Dependent Care FSA on a pro-rata basis over the period for which the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VI of this Appendix A, payable Dependent Care Expenses may not exceed the Dependent Care FSA the Covered Employee authorized and which was credited in accordance with Section 4.2 of this Appendix A to his or her Dependent Care FSA under the Cafeteria Plan, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

If any balance remains in the Covered Employee's Dependent Care FSA at the end of the Plan Year after all reimbursements have been made, such balance shall not be carried over to reimburse the Covered Employee for Dependent Care Expenses incurred during a subsequent Plan Year nor returned to the Covered Employee, and the Covered Employee shall forfeit all rights with respect to such balance. Any amounts forfeited under this Section 4.3 shall not be segregated or invested in an interest-bearing account, but shall remain the property of the Employer to be used to pay administrative expenses, to cover expense losses, or used in any other manner as the Employer in its discretion, exercised in a uniform and nondiscriminatory manner, directs.

4.4 Dependent Care Expenses

Dependent Care Expenses means employment-related expenses that a Covered Employee incurs — while employed — for:

- A. household services, and
- B. care of a Qualifying Individual.

Employment-related, as defined in Code section 21(b), means incurred to enable a Covered Employee to be gainfully employed. In the case of a married Covered Employee, to be employment-related, the expense must also enable the Covered Employee's Spouse to: be gainfully employed, actively seek gainful employment, or be a full-time student, unless the Spouse is described in Section 2.9(B) of this Appendix A.

Incurs refers to the date services resulting in employment-related expenses are provided not the date charged, billed, or paid.

Household services means services ordinarily necessary to maintain a Covered Employee's home and rendered as part of a Qualifying Individual's care.

Care means services primarily to assure the well-being and protection of at least one Qualifying Individual.

Full-time student means a person enrolled at and attending an educational institution during at least part of each of five calendar months of the Covered Employee's tax year for the number of course hours that the institution considers to be a full-time course of study.

4.5 Limits

- A. On What the Dependent Care FSA Pays
 - 1. For Care Furnished Outside Covered Employee's Household

Dependent Care Expenses for care provided outside a Covered Employee's home or in a Qualified Dependent Care Center is reimbursed only if such care is furnished for a Qualifying Individual:

- a. described in Section 2.9(A) of this Appendix A, or
- b. described in Section 2.9(B) or (C) of this Appendix A, who regularly spends at least 8 hours each day in the Covered Employee's home.

Qualified Dependent Care Center means a facility:

- c. in compliance with all applicable state and local laws and regulations, and
- d. providing care for more than 6 persons (other than facility residents) on a regular, compensation-for-service basis.

2. To Certain "Highly Compensated" Employees

Benefits payable under the Dependent Care FSA to each highly compensated employee, as defined in Code section 414(q), are limited to the extent necessary to avoid violating Code section 129(d)(8).

B. On Exclusion from Gross Income

1. Individual Exclusion Limit

Dependent Care FSA reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only to the extent the Dependent Care Expense does not exceed:

- a. the sum of the Covered Employee's actual Salary Reduction Contributions for the Plan Year,
or, if less,
- b. the Maximum Annual Benefit.

2. Gross Income Exclusion Limit

The amount of Dependent Care Expenses reimbursed during a Covered Employee's taxable year by all plans, including the Dependent Care FSA, that qualify as dependent care plans under Code section 129 may not exceed:

- a. \$7,500 (or \$3,750 for a married Covered Employee filing a separate federal income tax return),
or, if less,
- b. the Covered Employee's earned income (or if less, the Covered Employee's Spouse's earned income, if the Covered Employee was married at the end of his or her tax year).

Earned income means wages, salaries, tips, and other compensation, to the extent such amounts are includible in taxable income for the year, like strike benefits, disability pay reported as wages, and net earnings from self-employment.

Earned income does not include pensions, annuities, social security payments, workers' compensation, unemployment compensation, or a nonresident alien's income not connected with United States business.

Earned income is computed without considering community property laws.

Earned income of a Spouse who is a full-time student, as defined in Section 4.4 of this Appendix A, or who is physically or mentally incapable of caring for him or herself, as defined in Section 2.9 of this Appendix A, is deemed to be not less than \$250 per month for Covered Employees with one Qualifying Individual or \$500 per month for Covered Employees with two or more Qualifying Individuals.

3. Reporting Identifying Information Limit

Dependent Care FSA reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only if the Covered Employee reports on the federal income tax return to which the exclusion relates, the name, address, and taxpayer identification number (or other information acceptable to comply with federal reporting requirements) of each dependent care service provider furnishing dependent care services to the Covered Employee during the year.

**ARTICLE V
EXCLUSIONS**

5.1 General Rules

- A. The Dependent Care FSA pays only those Dependent Care Expenses incurred by an Employee:
 - 1. during the current Plan Year,
 - 2. while the Employee is a Covered Employee, and
 - 3. to allow the Covered Employee (and Spouse, if married) to continue gainful employment (or, if married and the Spouse is unemployed, to allow the Covered Employee's Spouse to actively seek gainful employment or be a full-time student, as defined in Section 4.4 of this Appendix A, unless the Spouse is described in Section 2.9(B), of the Dependent Care FSA described in this Appendix A).
- B. Except as provided in Section 5.1(A)(3) of this Appendix A, the Dependent Care FSA does not reimburse amounts paid for Dependent Care Expenses incurred while a Covered Employee (or Spouse, if married) is off work for any reason, including illness or vacation. However, if Dependent Care Expenses are paid to the dependent care service provider on a weekly or longer basis, Dependent Care Expenses incurred during a temporary absence from work for illness or vacation will not be subject to this exclusion.

5.2 Specific Exclusions

The Dependent Care FSA does not reimburse amounts paid in connection with:

- A. a Qualifying Individual's overnight camp;
- B. services rendered by:
 - 1. a Covered Employee's (and if married, the Covered Employee's Spouse's) child (within the meaning of Code section 152(c)(3)) under age 19 at the Plan Year's end,
 - 2. a Covered Employee's Spouse or parent of the Covered Employee's child, or
 - 3. a person for whom the Covered Employee (or if married, the Covered Employee's Spouse) is entitled to a federal income tax deduction under Code section 151(c) for the Covered Employee's tax year.

5.3 Conditional Exclusions

Unless incidental, minimal, and inseparable from the cost of caring for a Qualifying Individual, the Dependent Care FSA shall not pay any charges in connection with a Qualifying Individual's:

- A. food,
- B. clothing,
- C. entertainment,
- D. education (kindergarten and above), or
- E. transportation between the Covered Employee's home and the place where dependent care is provided unless such transportation is furnished by the dependent care provider.

ARTICLE VI PROCEDURES

6.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

6.2 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by 90 days following the Plan Year to which the claim relates.

6.3 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

6.4 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

6.5 Proof of Claim

As a condition of receiving Dependent Care FSA benefits, claimants must:

- A. submit to the Claim Administrator:
 - 1. a properly completed and timely filed claim form,
 - 2. a written declaration stating the Dependent Care Expense has not been reimbursed and is not reimbursable under any other dependent care plan, and
 - 3. a written declaration from an independent third party stating the Covered Employee has incurred the Dependent Care Expense and the amount of such expense; and
- B. prove any claimed status.

APPENDIX B
BRIGHTSPRING HEALTH SERVICES
HEALTH CARE SPENDING FLEXIBLE SPENDING ACCOUNT

ARTICLE I
PLAN ESTABLISHMENT

1.1 Effective Date

The BrightSpring Health Services Health Care Spending Flexible Spending Account (“Health Care FSA”) is amended and restated as of the Effective Date.

1.2 Purpose

The Health Care FSA is created exclusively for Employees, as defined in Article II of the Cafeteria Plan. The Health Care FSA’s purpose is to reimburse Covered Employees, as defined in Article II of this Appendix B, for Qualifying Medical Expenses, as defined in Article II of this Appendix B.

1.3 Qualification

A. ERISA

The Health Care FSA is an employee welfare benefit plan, as defined in ERISA. This document is intended to satisfy the written plan document requirement of ERISA section 402.

B. Internal Revenue Code

The Health Care FSA is intended to qualify as a health plan under section 105(e) of the Code. The Health Care FSA’s Qualifying Medical Expense reimbursements are intended to be eligible for exclusion from Covered Employees’ gross income under Code section 105(b). This document is intended to satisfy the written plan document requirement of Treasury regulations section 1.105-11(b)(1)(i) and Prop. Treasury regulations section 1.125-1(c).

1.4 Incorporation by Reference

The Health Care FSA outlined in this Appendix B is a component of the Cafeteria Plan.

1.5 Duration

The Health Care FSA is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined in Article II of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Health Care FSA or any provision of the Cafeteria Plan.

ARTICLE II
DEFINITIONS

When capitalized in this Appendix B, these words and phrases have the following meanings to the extent not already defined elsewhere in the Cafeteria Plan:

Dependent means a Covered Employee’s:

- A. spouse, and
- B. dependent(s) as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)), and

- C. the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

Exclusions means the exclusions in Article V of this Appendix B.

Health Care Flexible Spending Account (the "Health Care FSA") means the notional account established on behalf of each Covered Employee who elects the Health Care FSA premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses.

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care FSA, according to the election procedures of Section 7.1, for Qualifying Medical Expense reimbursement, which amount must be not less than an amount determined by the Plan Administrator or its designee (to be communicated via open enrollment materials) and not more than the maximum amount allowed under Section 125 of the Code in addition to any amount the Covered Employee may elect to carry over from the previous Plan Year, up to the FSA Carryover Limit or the amount of the account balance at the end of the previous Plan Year, whichever is less.

Qualifying Medical Expenses means a Covered Employee's and a Dependent's expenses incurred during the Plan Year for medical care, as defined in Code section 213(d)(1)(A) and (B). To be a Qualifying Medical Expense, the medical care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. Incurred refers to the date the medical care is provided — not to the date charged, billed, or paid.

ARTICLE III PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Health Care FSA during those periods in which the Employee:

- A. participates in the Cafeteria Plan, and
- B. has allocated an amount to his or her Health Care FSA.

Except for Qualifying Medical Expenses incurred before Health Care FSA coverage ceases and subject to satisfying the procedural requirements of Article VII of this Appendix B, no Health Care FSA benefits are payable after coverage terminates.

The Health Care FSA is intended to be an excepted benefit under 29 CFR section 2590.732(c)(3)(v) and 26 CFR section 54.9831-1(c)(3)(v) and therefore, all Covered Employees will be offered medical benefits that meet minimum essential coverage under the Welfare Plan.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Health Care FSA when he or she is no longer eligible to participate in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

Notwithstanding Section 3.1, a Covered Employee ordered or called to active military duty (by reason of being a member of a reserve component as defined in 37 USC section 101) for a period in excess of 179 days, or for an indefinite period of time, may elect take his or her unused Health Care FSA balance as a cash distribution by the last day of the Plan Year. Such distribution shall be subject to income tax and the Covered Employee shall cease to participate

in the Plan for the remainder of the Plan Year. Such distribution shall be calculated as the amount actually contributed for the Plan Year to date minus any reimbursements.

3.3 Limitation on Salary Reduction Agreement Changes

Except for Change in Status requests required to be granted by law, the Employer, Plan Administrator or its designee may reject or modify a request for a modification to a Salary Reduction Agreement made pursuant to a Change in Status event, to the extent the Covered Employee, at the time of such request, has received expense reimbursements from the Health Care FSA in excess of the amount that such Employee's salary has been reduced for such Plan Year.

ARTICLE IV

HEALTH CARE FSA PREMIUM PAYMENT BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Qualifying Medical Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Health Care FSA for each Employee who elects the Health Care FSA premium payment benefit. The Health Care FSA premium payment benefit elected by the Employee shall be credited to his or her Health Care FSA as of the first day that the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VII of this Appendix B, payable Qualifying Medical Expenses may not exceed the Health Care FSA premium payment benefit the Covered Employee elected to be credited to his or her Health Care FSA for the Plan Year, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit, plus any amounts carried over from prior Plan Years pursuant to Section 4.3 of the Cafeteria Plan.

4.4 Qualifying Medical Expenses

Qualifying Medical Expenses, as defined in Article II of this Appendix are expenses, that are not covered by any other health plan and include, for example, items described in **Addendum G** of the Welfare Plan.

4.5 Limits

The Health Care FSA reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses include deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

4.6 Ordering of Payments

Reimbursements made from the Health Care FSA shall always be paid first from any amounts carried over from a prior Plan Year and then from any remaining balances.

ARTICLE V

EXCLUSIONS

5.1 General Rules

- A. The Health Care FSA pays only those Qualifying Medical Expenses incurred by an Employee or the Employee's Dependent:
 - 1. during the current Plan Year, except as permitted under Section 4.3 of the Cafeteria Plan for amounts carried over into a subsequent Plan Year, and
 - 2. while the Employee is a Covered Employee.
- B. The Plan does not reimburse amounts paid for services or supplies that merely improve health or morale generally.

5.2 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

- A. cosmetic surgery or similar procedure unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- B. custodial or domiciliary care
- C. diaper service
- D. funeral and burial expenses
- E. health club membership fees and dues
- F. household and domestic help
- G. illegal services and supplies
- H. insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance
- I. meals and lodging at a non-medical facility
- J. maternity clothes or uniform
- K. nursing services for a normal, healthy newborn baby, except for breast pumps and supplies that assist lactation
- L. over-the-counter or nonprescription drugs or items unless specifically permitted under applicable law or regulation (for example, insulin does not require a prescription)
- M. personal use items like cosmetics, toiletries, and items for personal hygiene or beautification
- N. schooling or tuition for scholastic improvement or discipline
- O. social activities like dancing or swimming lessons
- P. special foods or dietary supplements like vitamins, minerals, bottled water, and diet foods
- Q. transportation for non-medical reasons
- R. trips or vacations
- S. long term care expenses

ARTICLE VI
COBRA CONTINUATION COVERAGE

6.1 Eligibility for Continuation Coverage

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Health Care FSA in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provided such individuals were covered persons under the Health Care FSA on the date immediately preceding the date of a Qualifying Event or become covered persons during the continuation period because a Dependent is born to or placed for adoption with the Employee.

6.2 Definitions

For purposes of this Article VI, the following terms have the following meanings:

- A. "Employee" means a person who is (or was) covered under the Health Care FSA by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.
- B. "Dependent" means, with respect to an Employee as defined in this Section 6.2 of Appendix B, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Health Care FSA as (1) the Dependent Spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period. To the extent that a Dependent is a domestic partner or a civil union spouse because such individual meets the definition of Dependent under the Cafeteria Plan, such individual is not entitled to COBRA under the law but will be provided with COBRA-like coverage as described in the Summary Plan Description.
- C. "Qualified Beneficiary" means an Employee or Dependent as defined in Section 6.2 of this Appendix B but shall not mean Dependents defined in Section 6.7(B) of this Appendix B, except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.
- D. "Qualifying Event" means any of the following, the occurrence of which would result in loss of coverage under the Health Care FSA were it not for the right to purchase COBRA continuation coverage:
 - 1. for Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;
 - 2. for Dependents:
 - a. death of the Employee;
 - b. divorce of the Employee and Spouse;
 - c. legal separation of the Employee and Spouse;
 - d. reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct; or

- e. ceasing to qualify as a Dependent child under the Health Care FSA.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event — not on the date coverage ends because of the Qualifying Event.

6.3 Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless:

- A. The Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:
 - 1. The date the Qualified Beneficiary's coverage under the Health Care FSA would otherwise terminate by reason of an event described in Section 6.2(D) of this Appendix B; or
 - 2. The date notice of eligibility is sent to the individual in accordance with Section 6.5(C) of this Appendix B; and
- B. The Qualified Beneficiary pays the initial required premium, as set forth in Section 6.8 of this Appendix B, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

6.4 Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

- A. the last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due;
- B. the date the Qualified Beneficiary first becomes, after the date of election, entitled to Medicare;
- C. the date the Qualified Beneficiary first becomes, after the date of election, covered under another group health plan, as defined in Code section 5000(b)(1);
- D. the last day of the Plan Year in which the Qualifying Event occurs; or
- E. the date the Company terminates all group health plans.

6.5 Notice Requirements

Notice requirements shall be as follows:

- A. The Employer shall notify the Plan Administrator of the occurrence of an event described in Section 6.2(D)(1), 6.2(D)(2)(a) and 6.2(D)(2)(d) of Appendix B within 30 days of the date of the described event;
- B. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 6.2(D)(2)(b), 6.2(D)(2)(c), or 6.2(D)(2)(e) of Appendix B within 60 days of the date of the described event.

- C. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Sections 6.5(A) and (B) of Appendix B.
- D. At the commencement of coverage under the Health Care FSA, the Plan Administrator shall provide each Employee or Dependent spouse who is a Covered Person with notice of their rights under COBRA.
- E. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.
- F. The Plan Administrator shall provide notice to each Employee, Spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, Spouse or Dependent is not entitled to COBRA continuation coverage.

6.6 Coverage Available for Continuation

A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health Care FSA immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

6.7 Election Rules

A. Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under Article VI of this Appendix B; provided, however, that in the event an Employee or his or her Spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to the Health Care FSA.

B. After Acquired Dependents

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents as defined in Section 6.2(B) of Appendix B acquired after the date of eligibility described under Section 6.1 of Appendix B to the same extent as Covered Employees, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in the Welfare Plan and Summary Plan Description, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in Section 6.2(C) of Appendix B, shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the

prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

6.8 Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Health Care FSA and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium may be 102 percent of the cost of coverage. The cost may be 150 percent of the cost of coverage during months 19 through 29 for a disabled qualified beneficiary and his or her family members whose COBRA is extended due to disability. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

6.9 Forfeiture of Unused Reimbursement Amount

If at the termination of COBRA continuation coverage, the expenses submitted for reimbursement are less than the level of reimbursement in effect under this Article VI of Appendix B, the amount of such excess shall be forfeited, and the Qualified Beneficiary shall have no further entitlement under the Plan and no entitlement to any such forfeited amount.

ARTICLE VII PROCEDURES

7.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

7.2 Claims and Appeals Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by the claim deadline. The claim procedures will be conducted in accordance with ERISA as described in Section 5.2 of the Cafeteria Plan and are outlined in the applicable Summary Plan Description.

7.3 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

7.4 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Cafeteria Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Cafeteria Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

7.5 Claimants

A Covered Employee (or his or her duly authorized representative) may file a claim for benefits to which such claimant believes he or she is entitled.

7.6 Claim Forms

The Claim Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Cafeteria Plan.

7.7 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Claim Administrator by 90 days following the Plan Year to which the claim relates. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

7.8 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust the claims and appeals process required under the Cafeteria Plan; only the Health Care FSA are subject to ERISA's claims and appeals procedures.

7.9 Payment Procedures

A. Payment of Claim

Subject to Section 9.4 of the Cafeteria Plan, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Health Care FSA, voluntarily or involuntarily, the Claim Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Claim Administrator deems appropriate.

B. Facility of Payment

If a claimant dies before all amounts payable under the Health Care FSA have been paid, or if the Claim Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Health Care FSA with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Claim Administrator to be entitled equitably thereto and without prejudice therefore. Any payment made in accordance with this provision shall discharge the obligation of the Health Care FSA, including the Cafeteria Plan hereunder to the extent of such payment.

C. Forfeiture

The Claim Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to effect delivery of benefits payable under the Health Care FSA. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Claim Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Health Care FSA, as well as the Cafeteria Plan, shall have no liability for payment of the benefit otherwise payable.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.1 Definitions

For purposes of this Article VIII, the following terms have the following meanings:

- A. “Business Associate” means a person or entity that performs a function or activity regulated by HIPAA on behalf of the group health plans provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure. A person or entity that transmits PHI to a covered entity (or its business associate) and routinely requires access to that PHI may also be a business associate. Examples of such entities include health information exchange organizations, regional health information organizations and e-prescribing gateways. Vendors that contract with covered entities offering certain personal health records to individuals may also be considered business associates. Vendors that contract with Business Associates (“subcontractors”) and require or have access to PHI or ePHI on a routine basis may also be Business Associates with respect to the Plan.
- B. “Covered Entity” means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).
- C. “Protected Health Information or PHI” means individually identifiable health information created or received by a Covered Entity. Information is “individually identifiable” if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. “Health Information” means information, including genetic information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

8.2 Uses and Disclosures of PHI

The Plan and the Employer may disclose a Covered Employee’s PHI or ePHI to the Employer (or to the agent of the Employer) for the plan administration functions under 45 CFR §164.504(a), to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Employer except upon receipt of a certification by the Employer that the Plan incorporates the agreements of Sections 8.3 and 8.4, except as otherwise permitted or required by law.

8.3 Privacy Agreements of the Employer

As a condition for obtaining PHI from the Plan and its Business Associates the Employer agrees it will:

- A. Not use or further disclose such PHI other than as permitted by Section 8.2, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;
- B. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Employer with respect to such information;
- C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- D. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware, including reporting any breach of unsecured PHI;
- E. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;
- F. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Employer pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;
- G. Make the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- H. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- I. Ensure that there is adequate separation between the Plan and the Employer by implementing the terms of subparagraphs (1) through (3), below:
 - 1. Employees with Access to PHI: The employees, classes of former employees or other individuals under the control of the Employer listed on Appendix B of the Welfare Plan are the only individuals that may access PHI or ePHI received from the Plan.
 - 2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to plan administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Employer for the Plan.
 - 3. Mechanism for Resolving Noncompliance: If the Employer or the persons listed on Appendix B of the Welfare Plan who are responsible for monitoring compliance determine that any person described in (1), above, has violated any of the restrictions of this Article VIII, then such individual shall be disciplined in accordance with the policies of the Employer established for purposes of privacy and security compliance, up to and including dismissal from employment. The Employer shall arrange to maintain records of such violations along with the persons involved, as

well as disciplinary and corrective measures taken with respect to each incident.

- J. Notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:
1. the names of the individuals whose PHI was involved in the Breach;
 2. the circumstances surrounding the Breach;
 3. the date of the Breach and the date of its discovery;
 4. the information Breached;
 5. any steps the impacted individuals should take to protect themselves;
 6. the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and
 7. a contact person who can provide additional information about the Breach.
- K. Not use or disclose substance use disorder treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, in civil, criminal, administrative, or legislative proceedings against an employee unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the employee or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

The Company will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

Notwithstanding the foregoing, the terms of this Article VIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

8.4 Security Agreements of the Employer

As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the Employer agrees it will:

- A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- B. Ensure that the adequate separation between the Plan and the Employer as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- C. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- D. Report to the Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access,

use, disclosure, modification or destruction of, or interference with, the e-PHI;
and

- E. Upon request from the Plan, the Employer agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Employer.

APPENDIX C
BRIGHTSPRING HEALTH SERVICES
LIMITED USE HEALTH CARE FLEXIBLE SPENDING ACCOUNT

ARTICLE I
PLAN ESTABLISHMENT

1.1 Effective Date

The BrightSpring Health Services Limited Use Health Care Flexible Spending Account (“Limited Use FSA”) is amended and restated as of the Effective Date.

1.2 Purpose

The Limited Use FSA is created exclusively for Employees, as defined in Article II of the Cafeteria Plan. The Limited Use FSA’s purpose is to reimburse Covered Employees, as defined in Article II of this Appendix, for Qualifying Medical Expenses, as defined in Article II of this Appendix.

1.3 Qualification

A. ERISA

The Limited Use FSA is an employee welfare benefit plan, as defined in the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). This document is intended to satisfy the written plan document requirement of ERISA section 402.

B. Internal Revenue Code

The Limited Use FSA is intended to qualify as a health plan under section 105(e) of the Internal Revenue Code of 1986, as amended (the “Code”). The Limited Use FSA’s Qualifying Medical Expense reimbursements are intended to be eligible for exclusion from Covered Employees’ gross income under Code section 105(b). This document is intended to satisfy the written plan document requirement of Treasury regulations section 1.105-11(b)(1)(i) and Prop. Treasury regulations section 1.125-1(c).

1.4 Incorporation by Reference

The Limited Use FSA outlined in this Appendix C is a component of the Cafeteria Plan.

1.5 Duration

The Limited Use FSA is established with the intention of being maintained for an indefinite period of time; however, Company, as defined in Article II of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Limited Use FSA or any provision of the Cafeteria Plan.

ARTICLE II
DEFINITIONS

When capitalized in this Appendix C, these words and phrases have the following meanings to the extent not already defined elsewhere in the Cafeteria Plan:

Dependent means a Covered Employee’s:

A. spouse, and

- B. dependent(s) as defined in Code section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)), and
- C. the Covered Employee's child as defined in Code section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

Exclusions means the exclusions in Article V of this Appendix C.

Limited Use FSA means the notional account established on behalf of each Covered Employee who elects the Limited Use Health Care Flexible Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses.

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care FSA, according to the election procedures of Section 7.1 of Appendix C, for Qualifying Medical Expense reimbursement, which amount must be not less than an amount determined by the Plan Administrator or its designee and not more than the maximum amount allowed under Section 125 of the Code in addition to any amount the Covered Employee may elect to carry over from the previous Plan Year, up to FSA Carryover Limit or the amount of the account balance at the end of the previous Plan Year, whichever is less.

Qualifying Medical Expenses means a Covered Employee's and a Dependent's expenses incurred during the Plan Year for dental or vision care, as defined in Code section 213(d)(1)(A) and (B). To be a Qualifying Medical Expense, the dental or vision care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. Incurred refers to the date the medical care is provided — not to the date charged, billed, or paid.

ARTICLE III PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Limited Use FSA during those periods in which the Employee:

- A. participates in the Cafeteria Plan, and
- B. has allocated an amount to his or her Limited Use FSA.

Except for Qualifying Medical Expenses incurred before Limited Use FSA coverage ceases and subject to satisfying the procedural requirements of Article VII of this Appendix C, no Plan benefits are payable after coverage terminates.

The Limited Use FSA is intended to be an excepted benefit under ERISA regulation section 2590.732(c)(3)(v) and Treasury regulation section 54.9831-1(c)(3)(v) and therefore, all Covered Employees will be offered medical benefits that meet minimum essential coverage under the Welfare Plan.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Limited Use FSA when he or she is no longer eligible to participate in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

Notwithstanding Section 3.1 of Appendix C, a Covered Employee ordered or called to active military duty (by reason of being a member of a reserve component as defined in 37 USC section 101) for a period in excess of 179 days, or for an indefinite period of time, may elect take his or her unused Limited Use FSA balance as a cash distribution by the last day of the Plan Year. Such distribution shall be subject to income tax and the Covered Employee shall cease to participate in the Plan for the remainder of the Plan Year. Such distribution shall be calculated as the amount actually contributed for the Plan Year to date minus any reimbursements.

3.3 Limitation on Salary Reduction Agreement Changes

Except for Change in Status requests required to be granted by law, the Employer, Plan Administrator or its designee may reject or modify a request for a modification to a Salary Reduction Agreement made pursuant to a Change in Status event, to the extent the Covered Employee, at the time of such request, has received expense reimbursements from the Limited Use FSA in excess of the amount that such Employee's salary has been reduced for such Plan Year.

ARTICLE IV

LIMITED USE FSA REIMBURSEMENT BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Qualifying Medical Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Limited Use FSA for each Employee who elects the Limited Use FSA premium payment benefit. The Limited User FSA premium payment benefit elected by the Employee shall be credited to his or her Limited Use FSA as of the first day that the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VII of this Appendix C, payable Qualifying Medical Expenses may not exceed the Limited Use FSA premium payment benefit the Covered Employee elected to be credited to his or her Limited Use FSA for the Plan Year, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit, plus any amounts carried over from prior Plan Years pursuant to Section 4.3 of the Cafeteria Plan.

4.4 Qualifying Medical Expenses

The following are examples of Qualifying Medical Expenses to the extent they are not covered by any other health plan and meet the limitations described below:

- A. dental treatment
- B. eye examinations, eyeglasses, and contact lenses

4.5 Limits

The Limited Use FSA reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses include deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor. Medical expenses that are not dental or vision expenses are not considered Qualifying Medical Expenses under this Limited Use FSA.

4.6 Ordering of Payments

Reimbursements made from the Limited Use FSA shall always be paid first from any amounts carried over from a prior Plan Year and then from any remaining balances.

ARTICLE V EXCLUSIONS

5.1 General Rules

- A. The Limited Use FSA pays only those Qualifying Medical Expenses that relate to dental or vision care incurred by an Employee or the Employee's Dependent:
 - 1. during the current Plan Year, except as permitted under Section 4.3 of the Cafeteria Plan for amounts carried over into a subsequent Plan Year, and
 - 2. while the Employee is a Covered Employee.
- B. The Limited Use FSA does not reimburse amounts paid for services or supplies that merely improve health or morale generally.

5.2 Specific Exclusions

The Limited Use FSA does not reimburse amounts paid in connection with:

- A. any otherwise eligible medical expenses, that are not dental or vision expenses
- B. cosmetic surgery or similar procedure unless the dental or vision surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease
- C. insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance
- D. over-the-counter or nonprescription drugs or items unless specifically permitted under applicable law or regulation for dental or vision services
- E. personal use items like cosmetics, toiletries, and items for personal hygiene or beautification
- F. schooling or tuition for scholastic improvement or discipline
- G. social activities like dancing or swimming lessons
- H. special foods or dietary supplements like vitamins, minerals, bottled water, and diet foods
- I. transportation for non-medical reasons
- J. trips or vacations
- K. long term care expenses

ARTICLE VI COBRA CONTINUATION COVERAGE

6.1 Eligibility for Continuation Coverage

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Limited Use FSA in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), provided such individuals were covered persons under the Limited Use FSA on the date immediately preceding the date of a Qualifying Event or become covered persons during the continuation period because a Dependent is born to or placed for adoption with the Employee.

6.2 Definitions

For purposes of Article VI of this Appendix C, the following terms have the following meanings:

Employee means a person who is (or was) covered under the Limited Use FSA by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

Dependent means, with respect to an Employee as defined in this Section 6.2 of this Appendix C, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Dependent Spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period. To the extent that a Dependent is a domestic partner or a civil union spouse because such individual meets the definition of Dependent under the Cafeteria Plan, such individual is not entitled to COBRA under the law but will be provided with COBRA-like coverage as described in the Summary Plan Description.

Qualified Beneficiary means an Employee or Dependent as defined in this Section 6.2 of Appendix C but shall not mean Dependents defined in Section 6.7(B) of Appendix C, except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

Qualifying Event means any of the following, the occurrence of which would result in loss of coverage under the Limited Use FSA were it not for the right to purchase COBRA continuation coverage:

1. for Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee;
2. for Dependents:
 - a. death of the Employee;
 - b. divorce of the Employee and Spouse;
 - c. legal separation of the Employee and Spouse;
 - d. reduction in hours worked by the Employee or termination of employment by the Employee for any reason other than gross misconduct; or
 - e. ceasing to qualify as a Dependent child under the Limited Use FSA.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event — not on the date coverage ends because of the Qualifying Event.

6.3 Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless:

- A. The Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:
 - 1. the date the Qualified Beneficiary's coverage under the Limited Use FSA would otherwise terminate by reason of an event described in Section 6.2(D) of Appendix C; or
 - 2. the date notice of eligibility is sent to the individual in accordance with Section 6.5(C) of Appendix C; and
- B. The Qualified Beneficiary pays the initial required premium, as set forth in Section 6.8 of Appendix C, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

6.4 Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

- A. The last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due;
- B. The date the Qualified Beneficiary first becomes, after the date of election, entitled to Medicare;
- C. The date the Qualified Beneficiary first becomes, after the date of election, covered under another group health plan, as defined in Code section 5000(b)(1);
- D. The last day of the Plan Year in which the Qualifying Event occurs; or
- E. The date the Company terminates all group health plans.

6.5 Notice Requirements

Notice requirements shall be as follows:

- A. The Employer shall notify the Plan Administrator of the occurrence of an event described in Section 6.2(D)(1), 6.2(D)(2)(a) and 6.2(D)(2)(d) of Appendix C within 30 days of the date of the described event;
- B. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Sections 6.2(D)(2)(b), 6.2(D)(2)(c), or 6.2(D)(2)(e) of Appendix C within 60 days of the date of the described event.
- C. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in Sections 6.5(A) and (B) of Appendix C.
- D. At the commencement of coverage under the Limited Use FSA, the Plan Administrator shall provide each Employee or Dependent spouse who is a Covered Person with notice of their rights under COBRA.
- E. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the

end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.

- F. The Plan Administrator shall provide notice to each Employee, Spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, Spouse or Dependent is not entitled to COBRA continuation coverage.

6.6 Coverage Available for Continuation

A Qualified Beneficiary may elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Limited Use FSA immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

6.7 Election Rules

- A. Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Article VI of Appendix C; provided, however, that in the event an Employee or his or her Spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person.

- B. After Acquired Dependents

A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents as defined in Section 6.2(B) of Appendix C acquired after the date of eligibility described under Section 6.1 of Appendix C to the same extent as Covered Employees, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in the Welfare Plan and Summary Plan Description and any other applicable document incorporated by reference under the Limited Use FSA, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in Section 6.2(C) of Appendix C, shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

6.8 Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Limited Use FSA and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium may be 102 percent of the cost of coverage. The cost may be 150 percent of the cost of coverage during months 19 through 29 for a disabled qualified beneficiary and his or her family members

whose COBRA is extended due to disability. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

6.9 Forfeiture of Unused Reimbursement Amount

If at the termination of COBRA continuation coverage, the expenses submitted for reimbursement are less than the level of reimbursement in effect under this Article, the amount of such excess shall be forfeited, and the Qualified Beneficiary shall have no further entitlement under the Limited Use FSA and no entitlement to any such forfeited amount.

ARTICLE VII PROCEDURES

7.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

7.2 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator by the claim deadline. The claim procedures will be conducted in accordance with ERISA as described in Section 5.2 of the Cafeteria Plan and are outlined in the applicable Summary Plan Description.

7.3 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

7.4 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Limited Use FSA, to determine what amount, if any, is due and payable under the terms and conditions of the Limited Use FSA, and to make appropriate disbursements of benefit payments to persons entitled thereto.

7.5 Claimants

A Covered Employee (or his or her duly authorized representative) may file a claim for benefits to which such claimant believes he or she is entitled.

7.6 Claim Forms

The Claim Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Limited Use FSA.

7.7 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services or supplies received, is received by the Claim Administrator by 90 days following the Plan Year to which the claim relates. Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a

claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

7.8 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust all claims and appeals procedures required under the Limited Use FSA.

7.9 Payment Procedures

A. Payment of Claim

Subject to Section 9.4 of the Cafeteria Plan, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Limited Use FSA, voluntarily or involuntarily, the Claim Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Claim Administrator deems appropriate.

B. Facility of Payment

If a claimant dies before all amounts payable under the Limited Use FSA have been paid, or if the Claim Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Limited Use FSA with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Claim Administrator to be entitled equitably thereto and without prejudice therefore. Any payment made in accordance with this provision shall discharge the obligation of the Limited Use FSA, including the Cafeteria Plan, hereunder to the extent of such payment.

C. Forfeiture

The Claim Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to effect delivery of benefits payable under the Limited Use FSA. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Claim Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Limited Use FSA, as well as the Cafeteria Plan, shall have no liability for payment of the benefit otherwise payable.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.1 Definitions

For purposes of this Article VIII of Appendix C, the following terms have the following meanings:

- A. "Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the group health plans provided under the Cafeteria Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting,

consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure. A person or entity that transmits PHI to a covered entity (or its business associate) and routinely requires access to that PHI may also be a business associate. Examples of such entities include health information exchange organizations, regional health information organizations and e-prescribing gateways. Vendors that contract with covered entities offering certain personal health records to individuals may also be considered business associates. Vendors that contract with Business Associates (“subcontractors”) and require or have access to PHI or ePHI on a routine basis may also be Business Associates with respect to the Cafeteria Plan.

- B. “Covered Entity” means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).
- C. “Protected Health Information or PHI” means individually identifiable health information created or received by a Covered Entity. Information is “individually identifiable” if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. “Health Information” means information, including genetic information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

8.2 Uses and Disclosures of PHI

The Cafeteria Plan and the Employer may disclose a Covered Employee’s PHI or ePHI to the Employer (or to the agent of the Employer) for the plan administration functions under 45 CFR §164.504(a), to the extent not inconsistent with the HIPAA regulations. The Cafeteria Plan will not disclose PHI or ePHI to the Employer except upon receipt of a certification by the Employer that the Cafeteria Plan incorporates the agreements of Sections 8.3 and 8.4, except as otherwise permitted or required by law.

8.3 Privacy Agreements of the Employer

As a condition for obtaining PHI from the Cafeteria Plan and its Business Associates the Employer agrees it will:

- A. Not use or further disclose such PHI other than as permitted by Section 8.2, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;
- B. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Employer with respect to such information;

- C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;
- D. Report to the Cafeteria Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Employer becomes aware, including reporting any breach of unsecured PHI;
- E. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;
- F. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Employer pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;
- G. Make the Employer's internal practices, books, and records relating to the use and disclosure of PHI received from the Cafeteria Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Cafeteria Plan with HIPAA;
- H. If feasible, return or destroy all PHI received from the Cafeteria Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- I. Ensure that there is adequate separation between the Cafeteria Plan and the Employer by implementing the terms of subparagraphs (1) through (3), below:
 - 1. Employees With Access to PHI: The employees, classes of former employees or other individuals under the control of the Employer listed on Appendix B of the Welfare Plan are the only individuals that may access PHI or ePHI received from the Cafeteria Plan.
 - 2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to plan administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Employer for the Cafeteria Plan.
 - 3. Mechanism for Resolving Noncompliance: If the Employer or the persons listed on Appendix B of the Welfare Plan who are responsible for monitoring compliance determine that any person described in (1), above, has violated any of the restrictions of this Article VIII, then such individual shall be disciplined in accordance with the policies of the Employer established for purposes of privacy and security compliance, up to and including dismissal from employment. The Employer shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.
- J. Notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:
 - 1. the names of the individuals whose PHI was involved in the Breach;

2. the circumstances surrounding the Breach;
3. the date of the Breach and the date of its discovery;
4. the information Breached;
5. any steps the impacted individuals should take to protect themselves;
6. the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and
7. a contact person who can provide additional information about the Breach.

The Company will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

- K. Not use or disclose substance use disorder treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, in civil, criminal, administrative, or legislative proceedings against an employee unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the employee or the holder of the record. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.

Notwithstanding the foregoing, the terms of this Article VIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

8.4 Security Agreements of the Employer

As a condition of obtaining e-PHI from the Cafeteria Plan, its Business Associates, Insurers and HMOs, the Employer agrees it will:

- A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Cafeteria Plan;
- B. Ensure that the adequate separation between the Cafeteria Plan and the Employer as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- C. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- D. Report to the Cafeteria Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and
- E. Upon request from the Cafeteria Plan, the Employer agrees to provide information to the Cafeteria Plan on unsuccessful unauthorized access, use,

disclosure, modification or destruction of the e-PHI to the extent such information is available to the Employer.