BrightSpring Health Services

Welfare Benefit Plan

SUMMARY PLAN DESCRIPTION

Effective January 1, 2023

Contents

INTRODUCTION

This summary, together with the booklets, certificates and evidence of coverage documents listed in Appendix A (collectively, Benefit Booklets), is intended to serve as the Summary Plan Description (the "SPD"), as required by the Employee Retirement Income Security Act of 1974 (ERISA). The SPD describes the benefits provided by the BrightSpring Health Services Welfare Benefit Plan (the "Plan" or "Welfare Plan") for eligible employees and their eligible dependents. ResCare, Inc. d/b/a BrightSpring Health Services ("BrightSpring") sponsors the Welfare Plan and the BrightSpring Health Services Section 125 Cafeteria Plan f/k/a the "ResCare, Inc. Flexible Benefits Plan" (the "Cafeteria Plan"); BrightSpring and the employees of its affiliates participate in the Welfare Plan and Cafeteria Plan as explained in this SPD.

The Cafeteria Plan is intended to satisfy the requirements of Internal Revenue Code Sections 125, 129 and 105(e) to provide employees flexible spending accounts and the opportunity to make pre-tax contributions toward certain benefits. The Cafeteria Plan offers the following flexible spending accounts: the Health Care Flexible Spending Account ("Health Care FSA"), the Limited Purpose Health Care Flexible Spending Account ("Limited Use FSA"), and the Dependent Care Flexible Spending Account ("Dependent Care FSA"). The Cafeteria Plan is a separate plan, but it works in conjunction with the Welfare Plan document and this SPD.

BrightSpring also offers employees enrolled in a high deductible health plan (HDHP) medical option the ability to make pre-tax contributions to a Health Savings Account.

The Plan will provide benefits in accordance with applicable federal laws including the Consolidated Omnibus Budget Reconciliation Act (COBRA), the Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity and Addiction Equity Act (MHPAEA), the Newborns' and Mothers' Health Protection Act (NMHPA), the Women's Health and Cancer Rights Act (WHCRA), the Genetic Information Nondiscrimination Act (GINA), and the applicable provisions of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act (collectively referred to as the Affordable Care Act).

The Imagine 360 medical options and the spending accounts are self-insured and provided under other contracts with service providers. All other benefits are provided under insurance or HMO contracts. All benefits are summarized in this document and in the Benefit Booklets.

This summary should be read in connection with the Benefit Booklets (see Appendix A for a list of Benefit Booklets). The Benefit Booklets are prepared by the insurance companies, HMOs and service providers and will be provided to you by the Company. If there is ever a conflict or a difference between what is written in this summary and the Benefit Booklets with respect to **the specific benefits provided**, the Benefit Booklets shall govern unless otherwise dictated by any federal and/or state law. If there is a conflict between the Benefit Booklets and this summary with respect to **the legal compliance requirements of ERISA and any other federal law**, this summary will govern.

The applicable Benefit Booklets describe the benefits available, use of network providers, the composition of the network, and the circumstances, if any, under which coverage will be provided for out-of-network services. A directory of participating network providers may be accessed on the insurance companies' and HMOs' websites or you can call the insurance companies or HMOs at the phone numbers indicated in the Benefit Booklets. You will also be informed about any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Plan and any conditions or limits on the benefits available through the component benefits.

For additional information regarding the benefits provided under the Plan, please contact the Plan Administrator (See Administrative Information section below).

BrightSpring reserves the right to change, amend, suspend, or terminate any or all of the component benefits under this Plan, in whole or in part, at any time and for any reason at its sole discretion.

Note that by adopting and maintaining these benefits, BrightSpring has not entered into an employment contract with any employee. Nothing in the legal Plan documents or in this SPD gives any employee the right to be employed by BrightSpring or to interfere with BrightSpring's right to discharge any employee at any time.

ELIGIBILITY

ELIGIBILITY FOR BENEFITS

You are eligible to participate in the benefits described in this SPD if you are an eligible "common law" employee of BrightSpring and satisfy service requirements described in this section.

Generally, you are considered an "eligible employee" and are eligible to participate in most Plan benefits if you are classified as a Full-Time employee, or if you are a Part-time, Variable Hour, or Seasonal employee who averages 30 or more hours per week over a measurement period, as follows:

Type of Regular Employee	**Work Hours**	**Eligibility**	**Benefit**
Full-Time Employee	Scheduled to work 30 or more hours per week*	After the applicable eligibility waiting period, if any following the date: ▪ Of hire; ▪ An employee transfers into a regular Full-Time position; or ▪ You would become eligible in the first job (based on your Initial Measurement Period), if sooner. Note: After employment for 1 full Standard Measurement Period, eligibility for medical and health care spending accounts is subject to the Lookback Method.	Medical, dental, vision, health care spending accounts, EAP, dependent care spending account, basic, supplemental and dependent life, short term disability (core and voluntary), basic and supplemental AD&D, long-term disability for salaried employees and voluntary long-term disability for hourly employees, and "voluntary" benefits (group pre-paid legal, voluntary accident insurance, voluntary critical illness insurance, voluntary hospital indemnity). Note: You also can begin contributing to a health savings account (HSA) with the HDHP medical options.
		For Hawaii employees: First of the month following 30 days after date of hire or transfer.	Medical for employees in Hawaii.

Type of Regular Employee	**Work Hours**	**Eligibility**	**Benefit**
Part-Time/ Variable Hour/ Seasonal Employee	Employees who average 30 or more hours per week over a measurement period	First day of the month following 13 months after the anniversary of your start date (Initial Measurement Period). Continued eligibility for medical and health care spending accounts is determined based on the Standard Measurement Period.	Medical and health care spending accounts. Note: You may begin contributing to a health savings account (HSA) with the HDHP medical options.
	Employees who work 20 or more hours per week for 4 consecutive weeks	First of the month after meeting hours requirement, unless employee is exempt	Medical for employees in Hawaii
	All Part-Time/ Variable Hour/ Seasonal Employees	First of the month following the applicable eligibility waiting period from date of hire.	Dental, vision, voluntary benefits (group pre-paid legal, voluntary accident insurance, voluntary critical illness insurance, voluntary hospital indemnity).

Eligibility Waiting Periods

If you are a Full-Time employee, depending on your job classification, there may be a period of time that you will need to be employed by BrightSpring before becoming eligible to enroll in benefits. These waiting periods are described below.

All Employees First day of the month following 30 days of employment.

INDIVIDUALS NOT ELIGIBLE FOR PLAN BENEFITS

For all Plan benefits, you are not eligible to participate in the benefits shown above 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 another affiliate of BrightSpring;
- A member of a collective bargaining unit unless the collective bargaining agreement provides for your participation in the Plan.

ELIGIBILITY DETERMINATIONS ARE MADE BY BRIGHTSPRING

It is solely within the authority of the Plan Administrator to determine whether you are eligible for any benefits under this Plan. A person the Plan Administrator determines is not an employee and who is later required to be reclassified as an employee will only be eligible prospectively, provided all other eligibility requirements are met.

A person the Plan Administrator determines is not a common law employee will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the person is an employee.

ADDITIONAL ELIGIBILITY REQUIREMENTS FOR MEDICAL, HEALTH CARE FSA, OR LIMITED USE FSA BENEFITS BASED ON AFFORDABLE CARE ACT

Ongoing Employees

You are considered an ongoing employee once you have been employed for one (1) full Standard Measurement Period. All employees, regardless of their status as Full-Time or Part-Time, Variable Hour/Seasonal are measured to determine eligibility for certain benefits as described below.

You will be eligible for Medical, Health Care FSA, or Limited Use FSA coverage during a particular plan year if you work an average of 30 hours per week in a calendar month over the course of a measurement period that takes place before the plan year begins. This is called the "Lookback Method"—BrightSpring looks back at your prior service to determine whether you will be eligible for Medical, Health Care FSA, or the Limited Use FSA coverage during the next plan year.

> Refer to Appendix B for definitions of the capitalized terms in this section.

The Lookback Method works like this. To determine whether you are eligible for Medical, Health Care FSA, or Limited Use FSA coverage, BrightSpring will measure your Hours of Service from your payroll period that includes October 3 of year 1 through your payroll period ending immediately before October 2 of year 2. This October 3–October 2 timeframe is called the Standard Measurement Period. If you average at least 30 Hours of Service per week during the Standard Measurement Period, you will be eligible to participate in Medical, the Health Care FSA, or the Limited Use FSA for the Standard Stability Period, which is the plan year beginning January 1 through December 31 of the year that immediately follows the end of the Standard Measurement Period. You will be eligible for Medical, Health Care FSA, or Limited Use FSA benefits for the entire Standard Stability Period, even if your hours decrease during the Standard Stability Period, so long as you remain an employee and you continue to pay your required contributions toward your coverage by the due date.

Here is an example of how this will work:

> *Ann has 1,642 Hours of Service for the Standard Measurement Period of October 3, 2021 through October 2, 2022, which is more than 30 Hours of Service per week on average. She is therefore considered eligible for Medical, Health Care* FSA*, or Limited Use FSA benefits during the Plan's Standard Stability Period, which runs from January 1, 2023 through December 31, 2023. She will be eligible for these benefits for the entire Standard Stability Period even if her work hours are reduced during 2023.*

Each year, BrightSpring will calculate how many Hours of Service you have worked during the Standard Measurement Period and will inform you if you are eligible for benefits prior to the next Standard Stability Period.

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. This means that if you were eligible for and enrolled in benefits prior to your Break in Service, your prior elections will be restored as soon as administratively practicable for the remainder of the Standard Stability Period you were in prior to your Break in Service. If you were not eligible for benefits prior to your Break in Service, you will continue to not be eligible for benefits for the remainder of the Standard Stability Period. If you were eligible for Medical, Health Care FSA, or Limited Use FSA benefits prior to your Break in Service but declined the offer of coverage, you will not have the ability to elect these benefits upon your return.

The Plan Administrator may, in its discretion, determine that you have a Break in Service using an alternate "rule of parity." Refer to the definition of Break in Service in Appendix B for a description of the rule of parity.

New Employees

If you are a new hire or begin a new period of employment, you are considered a new employee for purposes of eligibility for Medical, Health Care FSA, or Limited Use FSA benefits. As a new employee, BrightSpring will classify you as either Full-Time, or a Part-Time, Variable Hour/Seasonal employee, which will determine your eligibility for Medical, Health Care FSA or Limited Use FSA benefits.

New Part-Time/Variable Hour/Seasonal Employee

If you are classified as a new Part-Time, Variable Hour/Seasonal employee, BrightSpring will determine your eligibility for Medical, Health Care FSA, or Limited Use FSA benefits based on your Hours of Service over an 11-month Initial Measurement Period. Your Initial Measurement Period will begin on the day of the first pay period following the date you are first credited with an Hour of Service and will end 11 months later.

If you average at least 30 Hours of Service during the Initial Measurement Period, you will be notified that you are eligible for coverage for a 12-month Initial Stability Period following the Initial Measurement Period, and you will be given an opportunity to elect Medical, Health Care FSA, or Limited Use FSA coverage. The Initial Stability Period will begin on the first day of the month that begins on or after 13 months after the anniversary of your start date. (Note: if your start date is the first day of a month, the 13-month period will include that month. If your Initial Stability Period spans two plan years, you will be given another opportunity to elect or change your Medical, Health Care FSA, or Limited Use FSA elections at annual enrollment along with all other eligible employees.

If you average fewer than 30 Hours of Service during the Initial Measurement Period, you will not be eligible for Medical, Health Care FSA, or Limited Use FSA coverage during the Initial Stability Period.

At the same time that you are in your Initial Measurement Period, you will also be placed into the Standard Measurement Period, as described above to determine your eligibility for Medical, Health Care FSA or Limited Use FSA in the following plan year. Once you have worked an entire Standard Measurement Period, your eligibility will be measured using the Standard Measurement Period as an ongoing employee, as described above.

What if you change job classifications during the Initial Measurement Period? If you are hired as a new Part-Time, Variable Hour/Seasonal employee, but during the Initial Measurement Period, you are moved to a Full-Time job classification that, had you been hired into that job classification originally, you would have been eligible for Medical, Health Care FSA or Limited Use FSA benefits beginning on the first of the month after meeting any applicable eligibility waiting period, you will be treated as if you were hired as a new Full-Time employee on the date of the job change. In this case, you will be eligible for Medical, Health Care FSA or Limited Use FSA benefits beginning on the first of the month after meeting any applicable eligibility waiting periods following the date of your job change, or the date you would become eligible in the first job (based on your Initial Measurement Period), if sooner.

If you are hired as a Full-Time employee, you enrolled in Medical, Health Care FSA or Limited Use FSA coverage after the applicable waiting period, and then you move to a Part-Time, Variable Hour/Seasonal employee classification before you have completed one full Standard Measurement Period, your coverage will be terminated and you will be offered COBRA continuation coverage. You will also be placed into an Initial Measurement Period that begins back to the day of the first pay period following the date you are first credited with an Hour of Service to determine your status as a Full-Time employee during the Initial Stability Period or the Standard Stability Period, whichever occurs first.

Special Unpaid Leave

If you are taking an unpaid leave of absence subject to the Family and Medical Leave Act (FMLA), the Uniformed Services Employment and Reemployment Rights Act (USERRA) or unpaid leave on account of jury duty, this period of absence is a Special Unpaid Leave and will be excluded from the applicable Measurement Period. This means that your average Hours of Service will be determined after excluding any Special Unpaid Leave under the FMLA, USERRA or unpaid jury duty and using that average as the average for the applicable Measurement Period. This ensures that any period of Special Unpaid Leave you take does not count against you in determining whether or not you are eligible for Medical, Health Care FSA or Limited Use FSA benefits. If you are already enrolled in these benefits during a Stability Period when you take a Special Unpaid Leave, your elections will continue through the end of the applicable Stability Period as long as you continue to make any required contributions.

See Appendix B for Additional Information

The Lookback Method for determining eligibility is based on IRS regulations. See Appendix B for definitions related to the Lookback Method.

ELIGIBLE DEPENDENTS

Medical, Including EAP and Prescription Drug, Dental, and Vision

The following dependents are eligible for Medical, including EAP and Prescription Drug, Dental or Vision coverage offered under the Plan:

- Your legally married spouse, who is not eligible for medical coverage at his or her employer;
- Your 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 any of their financial support;
- Children for whom the Plan is required to provide coverage under a Qualified Medical Child Support Order (QMCSO);
- Your mentally or physically disabled 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; and
- Your domestic partner (as defined below);
- Your domestic partner's children through the end of the month in which they turn age 26, regardless of their marital status, regardless of student status and whether or not they live with you or you provide any of their support; and
- Your mentally or physically disabled 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.

Your eligible dependents can be enrolled in the Medical, including EAP and prescription drug, Dental and Vision coverage under the Plan only if you (the employee) are enrolled.

If you participate in a Medical option, such as an HMO, that requires that you reside within a particular zip code area, but your eligible dependent child who has not yet attained age 26 moves outside the zip code area serviced by the Medical option, the Medical option will continue to provide coverage to your eligible dependent child in accordance with the Affordable Care Act.

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 a dependent and an employee. 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 the employee and any dependents can be prohibited from participating in the Plan ever again (retroactively to the extent permitted by law and in accordance with the Affordable Care Act's prohibition against rescissions), 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 will forfeit any contributions made.

Your eligible dependent children are:

- Biological children;
- Stepchildren;
- Legally adopted children;
- 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.

Please see the applicable Benefit Booklets in Appendix A for additional eligibility requirements.

Dependent Life and 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 Benefit Booklets in Appendix A for additional eligibility requirements.

Health Care FSA and Limited Use FSA

For purposes of the Health Care FSA and Limited Use FSA your dependents include:

- Your legally married spouse;
- Your children who have not attained age 27 as of the end of the taxable year, regardless of student status, whether they are married or live with you and regardless of whether you provide any financial support;
- Your mentally or physically disabled adult dependent children who live with you and who are primarily dependent on you for support; and
- Any other person (including a domestic partner) who meets the Internal Revenue Service (IRS) definition of a tax dependent (without regard to the income limit), which means an individual whose primary residence is your home, who is a member of your household, for whom you provide more than one-half of their support, and who is not the qualifying child (as defined under the Internal Revenue Code) of the employee or any other individual. (Note, an employee can treat another

person's qualifying child as a qualifying relative if the child satisfies the other requirements listed here and if the other person isn't required to file a tax return and either doesn't file a return or files one only to get a refund of withheld income taxes. For example, this could allow tax-free health coverage for the children of an employee's non-working domestic partner.) It is your responsibility to confirm the tax status of your dependents, including reimbursing expenses for a domestic partner, with your tax advisor.

Dependent Care FSA

Under IRS regulations, "eligible dependents" for the Dependent Care FSA include:

- A child under age 13 who is your qualifying child (as defined under the Internal Revenue Code);
- A disabled spouse who lives with you for more than one half the year; and
- Any other relative or household member who receives more than one-half of his or her support from you, resides in your home, is physically or mentally unable to care for him or herself, and who is not the qualifying child of you or any other individual.

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;
- Your parent or your domestic partner's or spouse's parent.

Important Information about Domestic Partner Benefits

BrightSpring covers both same and opposite-sex spouses and domestic partners. However,

Under the BrightSpring self-insured and fully-insured options, you will be able to enroll a domestic partner, including a civil union spouse, if you complete an affidavit provided by the Benefits Support Center and you and your partner meet either of the following requirements:

- **A same-sex or opposite-sex domestic partnership by government registration or a civil union spouse as defined by state law**. You and your partner have entered into a valid domestic partnership registered with a governmental entity or you and your partner's relationship satisfies the definition and procedures applicable to a "civil union" under the laws of the applicable state, county or municipality.

  And/Or

- **A same-sex or opposite-sex domestic partnership by "company registry."** You and your domestic partner attest that you meet 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.
  - Neither of you are not consenting to the partnership under force, duress or fraud.
  - Your relationship is not in violation of any laws applicable to the benefit.

In addition, to the extent that BrightSpring 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, you may be able to cover a domestic partner as defined by that Equal Benefits Ordinance. If this type of Ordinance applies to you, you will be notified.

Tax Consequences of Domestic Partner Benefits

If you elect Medical, Dental and Vision coverage for your eligible domestic partner and his or her eligible children, you will be asked if they are your federal tax dependents at the time of enrollment. If you do not indicate that they are your federal tax dependents, you will still pay the contributions for domestic partner coverage on a pre-tax basis and the amount you contribute and the amount BrightSpring contributes toward your domestic partner's coverage will be treated as imputed income. The amount of your imputed income will be added to your paycheck each payroll period and will be subject to income tax withholding. In addition, BrightSpring will include the annual amount of this imputed income on your Form W-2 at the end of each year. Before enrolling your domestic partner and his or her eligible children, you should talk to your tax advisor about the tax implications for you.

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 as described below, the IRS currently treats as imputed income to you 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.

In general, a domestic partner (or his or her child) who is a member of your household qualifies as your tax dependent for health benefit purposes if:

- He or she receives more than 50% of his or her financial support from you;
- He or she lives with you (shares a personal residence) for the full tax year (except for temporary reasons such as vacation, military service or education);
- He or she is a citizen, national or legal resident of the United States; or a resident of Canada or Mexico; or is a child being adopted by a US citizen or national;
- He or she is not a section 152 qualifying child dependent on another taxpayer's filed return or is a section 152 qualifying child dependent on another taxpayer's return where the filing is only to obtain a refund of withheld income taxes; and
- Your relationship is not in violation of any local laws.

You are advised to 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.

In general, state income tax treatment of domestic partner benefits is the same as the federal income tax treatment. However, certain benefits for domestic partners and their children who are not your federal tax dependents may be eligible for special state income tax treatment in a few select states. Please speak to your tax advisor regarding whether your domestic partner and his or her children, if any, qualify for the special state income tax treatment. If they do qualify, you must immediately notify the Benefits Department at BrightSpring in writing of this special state income tax status.

Additional Eligibility Information

Additional information regarding how and when you and your eligible dependents become eligible to participate in the benefits referred to in this summary and any conditions and limitations to eligibility are contained in the Benefit Booklets listed in Appendix A provided by the applicable insurance companies and/or service providers.

Qualified Medical Child Support Orders

The Plan may be required to cover your child due to a Qualified Medical Child Support Order (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, 805 N. Whittington Parkway, Louisville, KY 40222 or calling 1-800-866-0860 and choosing option 7.

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 participant 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.

ENROLLMENT

NEW EMPLOYEES

If you begin working in a classification of employees eligible for the benefits below, when you begin working at BrightSpring, you will receive the information necessary to enroll in the Plan, if applicable.

If you are Full-Time and otherwise eligible, you will be automatically enrolled in the following:

- Basic Life
- Basic AD&D
- Employee Assistance Plan (EAP)
- Short-Term Disability
- Long-Term Disability

If you are Full-Time, you must affirmatively enroll yourself and your eligible dependents within 31 days of your eligibility date (within 30 days of your date of hire, if you reside in Hawaii) for:

- Medical
- Dental
- Vision
- Supplemental Life
- Dependent Life
- Supplemental AD&D
- Voluntary Short-Term Disability
- Health Care FSA
- Limited Use FSA
- Dependent Care FSA
- Group Pre-Paid Legal
- Voluntary Long-Term Disability
- Voluntary Accident Insurance
- Voluntary Critical Illness Insurance
- Voluntary Hospital Indemnity Insurance

If you elect Medical coverage under a HDHP and are otherwise eligible, BrightSpring allows you to make pre-tax contributions to a Health Savings Account. If you and your eligible dependents do not enroll in Medical, Dental, Vision, Health Care FSA, Limited Use FSA or Dependent Care FSA coverage within the required timeframe specified above, you will have to wait until the next open enrollment period to enroll, unless you experience a change in status that would allow a change in coverage.

Please refer to the applicable Benefit Booklets in Appendix A for additional details on eligibility. Although enrollment may be automatic, coverage may not be automatic.

If you do not enroll for Supplemental Life, Dependent Life, or Short-Term Disability (Voluntary) or Voluntary Long-Term Disability (for hourly employees only) 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 for Group Pre-Paid Legal, Supplemental AD&D, Voluntary Accident Insurance, Voluntary Critical Illness Insurance or Voluntary Hospital Indemnity Insurance coverage when you are first eligible, you may enroll mid-year if you have a change in status.

Your coverage under the Plan will begin as stated in the “Eligibility for Benefits” section above. Your eligible dependents’ coverage under the Plan will begin on the same date if you make the necessary elections within the time period required.

If you enroll yourself or a dependent in the Medical, Dental, Vision, Health Care FSA, Limited Use FSA, and/or Dependent Care FSA 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 the birth or adoption (or placement for adoption).

If you enroll on time, your coverage will begin on the later of the following: the date you enroll or the date you satisfy the eligibility requirements.

Current Employees

Open enrollment is held every fall. This is your opportunity to enroll, change, or drop coverage. Changes are effective on January 1 following open enrollment. You’ll receive information, including instructions on how to enroll, before open enrollment each year.

CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS

If you are regularly scheduled to work 30 hours per week or more, you pay your share of the cost of Medical, Dental and Vision coverage on a pre-tax basis (see below for more information). The level of contribution is determined by the Company.

Contributions to the Health Care FSA, Limited Use FSA and Dependent Care FSAs are also made on a pre-tax basis. If you wish to enroll, you will be required to 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 a Health Savings Account.

If you are enrolled in Supplemental Life, Dependent Life, Supplemental AD&D, Short-Term Disability (Voluntary), Group Pre-Paid Legal, Voluntary Long-Term Disability (for hourly employees only), Voluntary Accident Insurance, Voluntary Critical Illness Insurance or Voluntary Hospital Indemnity Insurance coverage, you pay the cost for coverage on a post-tax basis. Contributions are deducted from your paychecks based on your elected level of coverage.

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.

Employees who are on leave and not receiving regular paychecks must make any required contribution directly to the BrightSpring Benefits Support Center at ResCare P.O. Box 3682 Carol Stream, IL 60132-3682. Coverage will be cancelled if not paid by the due date or the end of the legally required grace period.

MAKING CHANGES TO YOUR COVERAGE DURING THE YEAR

In general, the benefit plans and coverage levels you choose when you first enroll will be maintained for the remainder of the plan year. Elections you make at open enrollment generally remain in effect for the following plan year (January 1 through December 31).

HIPAA SPECIAL ENROLLMENT EVENTS

If you decline enrollment for Medical benefits 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 domestic partners) in the Medical benefits provided under this Plan 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 to the Plan as described in the "*Change in Status*" section. 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) that 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, call 1-844-896-0169 or make your election changes via the web at www.brightspringbenefits.com.com.

CHANGES IN STATUS

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

You may be able to make changes to your Supplemental Life, Dependent Life, or Voluntary Short-Term Disability or Voluntary Long-Term Disability elections during the plan year if you have a change in status, but you will have to provide evidence of insurability.

Voluntary Benefits Mid-Year Changes

You may be able to make changes to your Group Pre-Paid Legal, Supplemental AD&D, Voluntary Accident Insurance, Voluntary Critical Illness Insurance or Voluntary Hospital Indemnity Insurance elections if you have a change in status.

Medical, Dental, Vision and Flexible Spending Account Mid-Year Changes

You may be able to change your Medical, Dental, Vision and Health Care FSA, Limited Use FSA, and Dependent Care FSA elections during the plan year if you experience a change in status.

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

Please note that in order to change your benefit elections due to a change in status, you may be required to show proof verifying that these events have occurred (e.g., copy of 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 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 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 group health plan coverage 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, 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 Affordable Care Act'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.
- **Enrollment in a health plan offered through the public Marketplace:** If you 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 may drop group health plan coverage under this Plan, even if you remain eligible for coverage under this Plan. You (and any dependents whose coverage is dropped at this time) must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the last day your

coverage under this Plan is dropped. You are not permitted to change your Dental, Vision, Health Care FSA, Limited Use FSA, or Dependent Care FSA elections because you intend to enroll in a plan offered through the public Marketplace.

Consistency Requirements for Changes in Status

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 public Marketplace, the changes you make to your coverage 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 all 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 the health plan, you may cancel health coverage only for that dependent child(ren). You may not cancel coverage for yourself or other covered dependents.

Other Events that Allow You to Change Elections

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 elections within 31 days of the event (60 days for CHIP/Medicaid) by notifying the Benefits Support Center.

QMCSOs

If a Qualified Medical Child Support Order (QMCSO) requires the Plan to provide coverage to your child, then the Plan Administrator 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 the Plan Administrator that such other person actually provides the coverage for the child.

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 the Company 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 are additional situations in which you may 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 spouse or 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 this Plan.

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 Flexible Spending Account 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.

QUALIFYING EVENT NOTIFICATION

If you experience a change in status as described in this section, you must notify the BrightSpring Benefits Support Center 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 calling 1-844-896-0169 or by making your election changes via the web at www.brightspringbenefits.com.com.

In order to preserve your dependent's COBRA rights, you must notify the Plan, as noted above, within 60 days in the event of divorce or in the event your child ceases to meet the eligibility requirements for benefit coverage. For more information about your duty to notify the Plan in such an event, see the *COBRA* section of this SPD.

COVERAGE DURING LEAVE OF ABSENCE

The sections below describe benefit continuation for two specific types of leave: Family and Medical Leave of Absence and Active Military Leave of Absence. For more information about any type of leave of absence including payments, contact the Benefits Support Center at 1-844-896-0169.

FMLA LEAVE

The federal Family and Medical Leave Act (FMLA) allows eligible employees to take a specific amount of unpaid leave for serious illness, the birth or adoption of a child, to care for a spouse, child, or parent who has a serious 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, 805 N. Whittington Parkway, Louisville, KY 40222 or call 1-800-866-0860.

If you take an FMLA leave, you may continue your group health coverage (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, you 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, Short-Term Disability (Voluntary), Group Pre-Paid Legal, Voluntary Long-Term Disability Insurance (hourly employees), Voluntary Accident Insurance, Voluntary Critical Illness Insurance, and Voluntary Hospital Indemnity Insurance 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 Flexible Spending Account 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 (see "*COBRA*" section below).

MILITARY LEAVE

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). This continuation coverage is pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). 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 maximum time period 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.

All other coverages will continue during your military leave. 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. (See COBRA section) 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.

WHEN COVERAGE ENDS

Your coverage will terminate on the earliest of the following dates:

- 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 for the Health Savings Account, Life (Basic, Supplemental & Dependent), AD&D (Basic & Supplemental), Short-Term Disability, Voluntary Short Term Disability , Long-Term Disability, Voluntary Long-Term Disability and Flexible Spending Account (Health & Dependent Care) benefits is your termination date. All other benefits will terminate at the end of the pay period coinciding with your termination date except that in the event of your death, all coverage will cease as of that date. This may result from reduction in hours, or termination of active employment, or it may result because you average fewer than 30 Hours of Service during a Standard Measurement Period, and are not eligible for Medical benefits during the subsequent, corresponding Standard Stability Period; and
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained in the "*Military Leave*" section above.

Other circumstances that can result in the termination, reduction, loss or denial of benefits (for instance, exclusions for certain medical procedures) are described in the Benefit Booklets listed in Appendix A.

Coverage for your spouse and other dependents (including your domestic partner) terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Booklets. In addition, their coverage will terminate:

- For your dependent child, for Medical, Dental and Vision coverage, the end of month in which he or she attains age 26 (unless he or she is mentally or physically disabled and primarily depends on you for support);
- The day on which your legally married spouse, child, domestic partner or domestic partner's child is no longer considered an eligible dependent (for example, date of divorce);
- In the case of the death of a dependent, his or her coverage will end as of that date;
- The end of the pay period in which you stop making contributions required for dependent coverage; or
- For children covered pursuant to a QMCSO, coverage will end as of the date that the child is no longer covered under a QMCSO.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) might have the right to continue health coverage temporarily under COBRA (see COBRA section below) or under a conversion right under a particular benefit plan. Refer to your Benefit Booklets for more information on conversion.

COBRA

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, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children who lose coverage for certain specified situations.

Federal law does not recognize your domestic partner as your spouse and a domestic partner is not recognized as a COBRA qualified beneficiary. However, BrightSpring will extend COBRA-like coverage

to your domestic partner and his or her covered children. 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 and your spouse and dependent children, and what you need to do to protect the right to receive it. COBRA applies to Medical, Dental, Vision, EAP and Health Care Flexible Spending Account benefits. COBRA does not apply to any other benefits offered under the Plan or by BrightSpring (such as Life, LTD, or AD&D benefits). The Plan provides no greater COBRA rights than what COBRA requires—nothing in this Summary Plan Description is intended to expand your rights beyond COBRA's requirements.

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.

WHAT IS COBRA COVERAGE

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 the BrightSpring, COBRA coverage will be offered to each person losing group health coverage under the Plan who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA 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 participants 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 participants 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.

The pronoun "you" in the following paragraphs regarding COBRA refers to each person covered under the Plan who is or may become a qualified beneficiary.

WHO IS COVERED

Employees

If you are an employee of BrightSpring, you will have the right to elect COBRA if you lose your group health coverage under the Plan because of either one of the following qualified events:

- A reduction in your hours of employment with BrightSpring or
- The termination of your employment with BrightSpring (for reasons other than gross misconduct on your part).

Spouse

If you are the spouse of an employee of BrightSpring, you will have the right to elect COBRA (or COBRA-like coverage if you are a domestic partner) if you lose your group health coverage under the Plan because of any of the following qualifying events:

- The death of your spouse;

- The termination of your spouse's employment with BrightSpring (for reasons other than your spouse's gross misconduct) or reduction in your spouse's hours of employment with BrightSpring; or
- Divorce 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.

Dependent Children

If you are a dependent child of an employee, you will have the right to elect COBRA if you lose your group health coverage under the Plan because any of the following qualified events:

- The death of the parent-employee;
- The termination of the parent-employee's employment with BrightSpring (for reasons other than the employee's gross misconduct) or reduction in the employee's hours of employment;
- The parent-employee's divorce; or
- You, the dependent child, cease to meet the definition of a "dependent child" under the Plan.

FMLA

If you take a leave of absence that qualifies under the Family and Medical Leave Act (FMLA) and do not return to work at the end of the leave, you (and your spouse and dependent 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 the employee does not return to work at the end of the leave.

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.

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 Contact Information) 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 new qualified beneficiary, and birth certificate or adoption decree.

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.

WHEN IS COBRA COVERAGE AVAILABLE

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 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 (see contact information below) 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.

HOW TO ELECT COBRA

To elect COBRA coverage, you must complete the election form that is part of the Plan's COBRA election notice and mail it to the COBRA Administrator.

An election notice will be provided to qualified beneficiaries at the time of the qualifying event.

Under federal law, 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 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 return your election form waiving 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 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 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.

Coverage

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 (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). See "Duration of COBRA," below, for a description of the duration of COBRA coverage for the Health Care FSA or Limited Use FSA.

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 plan participant or beneficiary who is not receiving COBRA coverage.

The amount of your COBRA premiums may change from time to time 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.

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

If mailed, your payment is considered to have been made on the date that it is postmarked. 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 up 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.

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 a maximum of 18 months. For all other qualifying events, the law requires that you be given the opportunity to maintain COBRA coverage for a maximum of 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 $610 (indexed) 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 above maximum periods 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. If a qualified beneficiary is determined by the Social Security Administration to be disabled and 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 become 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 contract 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 or hand deliver this notice to the COBRA Administrator at the address listed below under Contact Information.

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 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, 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 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 participant). 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, marriage license or letter from a university or institution indicating a change in student status.

You must mail this notice to the COBRA Administrator at the address listed below under Contact Information.

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 group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid on time (within the applicable grace period);
- 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 participant 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 the Affordable Care Act and 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.

ARE THERE OTHER COVERAGE OPTIONS BESIDES COBRA CONTINUATION COVERAGE?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance 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:

COBRA Administrator:
BrightSpring
Benefits Support Center
P.O. BOX 3681
Carol Stream, IL 60132-3681
www.rescarebenefits.com
(844) 340-4808

Plan Administrator:
BrightSpring Benefits Department
805 N. Whittington Parkway
Louisville, KY 40222
800-866-0860

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.

KEEP YOUR PLAN INFORMED OF 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.

CONVERTING COVERAGE AFTER TERMINATION

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 HMO or insurance company.

COVERED AND NON-COVERED SERVICES

Refer to the Benefit Booklets in Appendix A provided by your applicable insurance company and/or service provider for a specific listing of covered and non-covered services under your benefits.

SPECIAL RIGHTS RELATED TO MEDICAL BENEFITS

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).

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.

DESIGNATION OF PRIMARY CARE PROVIDERS

If you are enrolled in a medical option that requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in the medical option's network and who is available to accept you or your family members. Until you make this designation, one may be designated for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Claims Administrator. You may obtain contact information for your medical options by calling the Benefits Support Center at 1-844-896-0169.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from any medical option Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact medical plan option Claims Administrator.

IN-NETWORK PREVENTIVE CARE REQUIREMENTS UNDER THE AFFORDABLE CARE ACT

The medical options cover a wide array of in-network preventive, routine care items and services. Under the Affordable Care Act, your medical options, including prescription drug, must offer certain in-network preventive care items and services to you with no cost sharing (i.e., no copayments, coinsurance or deductible). In-network preventive care items and services that must be provided without cost sharing change periodically—for example, statins for adults that meet specific criteria (generally ages 40 to 75 years with specific risk factors) must be provided in-network without cost sharing. Information about what in-network preventive care items and services must be provided at no cost to you under the Affordable Care Act is available at https://www.healthcare.gov/preventive-care-benefits/. You should also contact your medical plan administrator to confirm.

In-network preventive care items and services with no cost sharing include a number of screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations, counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as a specialist consultation, bowel preparation medications, anesthesia, and polyp testing) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.

For women, the medical options also will cover in-network, with no cost sharing, an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods and counseling as prescribed for women; breastfeeding support, supplies and counseling (including lactation counseling services); and screening and counseling for interpersonal and domestic violence. In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing and counseling and if at low risk for adverse medication effects may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your physician prescribes this type of medication to reduce your risk of breast cancer, contact your prescription drug vendor, to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer.

NOTE: The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting and other limitations for a recommended preventive care service. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

MINIMUM ESSENTIAL COVERAGE

For purposes of the Affordable Care Act, the Company offers minimum essential coverage (medical coverage) to virtually all eligible employees. This coverage also is considered “affordable” and it meets “minimum value.” As a result, if you enroll in coverage through a government Exchange, also referred to as the Health Insurance Marketplace, and request a premium tax credit, you may not be eligible for the premium tax credit due to the Company’s offer of coverage. You should refer to the Health

Insurance Marketplace notice that you were previously provided or contact the Benefits Support Center if you are considering enrolling in a Marketplace plan.

In-Network Annual Out-Of-Pocket Maximum

As required by the Affordable Care Act, your total in-network out-of-pocket costs, including copays and prescription drug expenses under the medical options available to you, will not exceed $7,500 for individual coverage and $15,000 for family coverage in 2023 . Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copays, coinsurance, and eligible prescription drug expenses. Out-of-pocket expenses that do not apply toward your in-network, out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, non-essential health benefits, and out-of-network items and services.

Note: The out-of-pocket expense maximum is different for any medical option that is an HSA compatible HDHP. For example, for 2023, the out-of-pocket expense maximum for an HSA compatible HDHP is $7,050 (individual coverage) and $14,100 (family coverage).

“Family coverage” means any coverage tier other than “Employee Only.”

Please refer to the medical/prescription drug Benefit Booklet outlined in Appendix A or contact the Benefits Support Center or Claims Administrator for more details around this complex limit, including the limit that applies to you under your medical option design.

Provider Nondiscrimination

The medical options offered to you will not discriminate against an eligible health care provider based on his or her license or certification to the extent the provider is acting within the scope of his or her license or certification under state law. This rule is subject to certain limitations and does not require the medical plan options to accept all types of providers into a network.

Coverage for Individuals Participating in Approved Clinical Trials

You are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact the Claims Administrator for details.

HEALTH SAVINGS ACCOUNT (HSA)

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

- You maintain enrollment in a HDHP medical option.
- You cannot be enrolled in Medicare (Part A and/or Part B) or any other health coverage (*excluding dental, vision, preventive care and a Limited Use FSA*), such as a medical plan maintained by your spouse’s employer.
- You cannot be claimed as a dependent on any other person’s tax return.

For your convenience, BrightSpring is including a summary of HSA rules. However, 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 and is not subject to ERISA. For HSA information, you should contact the BrightSpring Benefits Support Center at 1-844-896-0169 (Option 1 for Spending Accounts).

What Are the Advantages of Participating in the HSA?

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 plan expenses that require you to pay

out-of-pocket, such as deductibles, copays, or coinsurance. It may even be used to pay for, among other things, certain medical expenses not covered under the medical plan design. 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.

How Does the HSA Work?

To open an HSA, you must sign up during your initial enrollment period or any subsequent open enrollment period and be enrolled in one of the HDHP medical options. All contributions made by you are placed into your HSA, as well as are owned and controlled by you, subject to any reasonable administrative restrictions imposed by the trustee. Contributions can be made to your HSA beginning on the first day of the month you are enrolled in the Health Savings Account until the earlier of:

- The date on which you file taxes for that year; or
- The date on which the contributions reach the contribution maximum.

Note that if coverage under an HDHP medical option terminates, no further contributions may be made to the HSA.

How Much Can I Contribute to the HSA?

The contribution maximum is either the single or family limit set by the IRS and are indexed each year. For 2023, the limits are $3,850 for self-only coverage and $7,7500 for other than self-only coverage. Individuals between the ages of 55 and Medicare entitlement age may contribute additional funds monthly to their HSA up to $1,000 for 2023. The maximum limits set by the IRS may be found on the IRS website at www.irs.gov. The Plan will follow IRS indexing for HSA contribution maximums for future plan years. Note: Amounts that exceed the contribution maximum are not tax-deductible and will be subject to an excise tax unless withdrawn as an “excess contribution” prior to April 15th of the following year.

If you enroll in an HSA during the plan year (i.e., not on January 1) you will still be allowed to contribute the maximum amount. When you enroll in the HSA after January 1 (for example to due to gaining eligibility under the plan, the amount you can contribute is either:

- Prorated, which means you divide the maximum HSA contribution by 12 months and contribute that amount each month that you are enrolled in the HDHP with the HSA; or
- The maximum HSA contribution amount provided that you are HSA-eligible on December 1 and maintain HDHP coverage throughout a subsequent 13-month testing period (e.g., you are enrolled in HDHP coverage with the HSA December 1, 2022 through December 31, 2023).

What Expenses Can HSA Funds be Used For?

The funds in your HSA will be available to help you pay your or your eligible tax dependents out-of-pocket costs under the medical plan, including annual deductibles and coinsurance. You may also use your HSA funds to pay for medical care that is not covered under the medical plan design but is considered a deductible medical expense for federal income tax purposes under Section 213(d) of the Internal Revenue Code. “Qualified health expenses” only include the medical expenses of you and your eligible tax dependents for group health plan purposes.

If you receive any additional medical services not covered by the Plan and you have funds in your HSA, you may use the funds in your HSA to pay for those medical expenses. If you choose not to use your HSA funds to pay for any Section 213(d) expenses that are not Covered Health Services, you will still be required to pay the provider for services. The monies paid for these additional medical expenses will not count toward your annual deductible or out-of-pocket maximum.

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

Can HSA Funds be Used to Pay for Premiums?

In general, you may not use your HSA to pay for other health insurance premiums without incurring a tax. However, you may use your HSA to pay for COBRA premiums and Medicare premiums.

Will Unused HSA Funds Rollover and Be Available for Use During Subsequent Plan Years?

Yes. If you do not use all of the funds in your HSA during the plan year, the balance remaining in your HSA will roll-over from year to year.

What Happens if I leave the Company or Am No Longer Eligible to Contribute to the HSA?

If your employment terminates for any reason, or you are no longer eligible to contribute to the HSA, the funds already in your HSA will continue to be owned and controlled by you, whether or not you elect COBRA coverage for the HDHP.

If you elect COBRA, the HSA funds will be available to assist you in paying your out-of-pocket costs under the medical plan and COBRA premiums while COBRA coverage is in effect.

Can HSA Funds be Transferred?

If you choose to transfer the HSA funds from one account to another eligible account, you must do so within 60 days from the date that HSA funds are distributed to you to avoid paying taxes on the funds.

When Using My HSA for Qualified Medical Expenses, Do I Need to Keep Receipts and Records of Those Transactions?

Yes, please be sure to keep your receipts and medical records. However, if you cannot demonstrate that you used your HSA to pay qualified health expenses, you may need to report the distribution as taxable income on your tax return. BrightSpring and Optum Bank will not verify that distributions from your HSA are for qualified health expenses. Consult your tax advisor to determine how your HSA affects your unique tax situation.

Additionally, the IRS may request receipts during a tax audit. Neither BrightSpring nor the Claims Administrator are responsible or liable for the misuse of HSA funds by, or for the use of HSA funds for non-qualified health expenses.

Do I Need to Know My HSA Balance Before Withdrawing Funds?

It is important for you to know the amount in your HSA account prior to withdrawing funds. You should not withdraw funds that will exceed the available balance. Upon request from a health care professional, Optum Bank and/or the financial institution holding your HSA funds may provide the health care professional with information regarding the balance in your HSA. At no time will Optum Bank provide the actual dollar amount in your HSA, but they may confirm that there are funds sufficient to cover an obligation owed by you to that health care professional. If you do not want this information disclosed, you must notify the Claims Administrator and the financial institution in writing.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

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 (see the “Limited Use FSA” section below).

This section explains how the Health Care FSA allows you to pay for certain health care expenses with pre-tax dollars. By participating, you will receive in health 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.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed above.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than $3,050 for 2023 (as indexed by the IRS) of your own money to your Health Care FSA.

ELIGIBLE EXPENSES

The Health Care FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the plan year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay, and which are not covered by any plan.

This may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for medical, dental, and vision expenses that are not reimbursed by another plan so long as they are medical expenses that you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Health Care FSA include expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. 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.

Over-the-counter medications (except insulin) are not eligible for reimbursement without a prescription. You will need a doctor's prescription indicating that the medications are medically necessary in order to be reimbursed from the Health Care FSA. Insulin may be reimbursed without a prescription. You may still submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

Below is a partial list of expenses eligible for reimbursement under the Health Care FSA:

- 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 for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

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
  - Premiums paid for Medicare
  - Premiums paid for long term-care insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Over-the-counter drugs or items without a prescription unless specifically permitted under applicable law or regulation.
- Cosmetic procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- 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.

- Long term care expenses

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.

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

CARRYOVER AMOUNTS

If you have a balance left in your Health Care FSA after the claim run out period (i.e., March 30th of the following year), you may carryover up to $610 (indexed) of any remaining balance. If you have less than $610 remaining, you can carryover up to the amount of your unused balance. The unused balance cannot be cashed out. Any amounts in excess of $610 will be forfeited. You may elect to opt out of the carryover provision during open enrollment.

If you enroll in the HDHP option with an HSA for the new plan year, your carryover amounts will automatically be placed into a Limited Use FSA, described below, if you elect to enroll in the FSA.

You may not use money in your Health Care FSA to pay dependent day care expenses and vice versa. You may not switch money between the Health Care FSA and the Dependent Care FSA.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a plan year must be submitted to the Claims Administrator within 90 days after the plan year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Health Care Flexible Spending Account is Your Spending Account.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT (“LIMITED USE FSA”) BENEFITS

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 medical expenses that are considered to be for 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 high deductible health plan. Please contact the Claims Administrator for more information.

COVERED DEPENDENTS

You may submit health care expenses incurred by you, your spouse, and your tax dependents as listed in the *Eligible Dependents* section above.

CONTRIBUTION LIMITS

You may contribute any whole dollar amount of not more than $3,050 for 2023 (as indexed) of your own money to your Limited Use FSA.

ELIGIBLE EXPENSES

The Limited Use FSA is an account that allows you to put money aside to reimburse yourself for "eligible" health care expenses. Expenses must be incurred during the plan year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill. You may submit bills for any expense for medical care, as defined in Section 213 of the Internal Revenue Code (except long-term care premiums and expenses associated with long-term care and other health care premiums), which you are obligated to pay, and which are not covered by any plan. However, medical expenses (that are not dental or vision expenses) are not considered eligible under the Limited Use FSA except to the extent they are preventive and/or are for medical expenses incurred after you have met the IRS minimum required deductible for HSA-eligible high deductible health plans.

"Eligible" health care expenses may include amounts that are not paid by your employer-sponsored health care plan, such as deductibles, co-payments, expenses in excess of plan dollar limits, or those which exceed customary and reasonable fees. You may also submit bills for dental, and vision expenses that are not reimbursed by another plan so long as they are considered medical expenses that you could have claimed on your individual income tax return (Form 1040).

Expenses eligible to be reimbursed from the Limited Use FSA include "preventive" care expenses for the diagnosis, cure, treatment or prevention of disease, and for treatments affecting any part or function of the body. Preventive care 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.

Over-the-counter medications (except insulin) are not eligible for reimbursement without a prescription. You will need a doctor's prescription indicating that the medications are medically necessary in order to be reimbursed from the Limited Use FSA. Insulin may be reimbursed without a prescription. You may still submit claims for equipment, supplies and diagnostic devices, such as bandages, crutches or blood sugar test kits, obtained over-the-counter if they are used for the diagnosis, treatment or prevention of disease.

Below is a partial list of expenses eligible for reimbursement under the Limited Use FSA:

- Medical Expenses (to the extent they are preventive or are incurred after you reach the IRS minimum required deductible for HSA-eligible high deductible health plans)
  - 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 for health care can be claimed. Transportation costs do not include the cost of any meals and lodging while away from home and receiving health care treatment.

INELIGIBLE EXPENSES

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

- Medical Expenses that are not considered dental or vision care, preventive, or are incurred before you have met the IRS minimum required deductible for HSA-eligible high deductible health plans.
- Premiums
  - Premiums paid by the employee, a spouse or other dependents for coverage under any health plan
  - Premiums paid for Medicare
  - Premiums paid for long term-care insurance
  - Premiums paid for policies that provide coverage for loss of earnings, accidental death, loss of limbs, loss of sight, etc.
- Over-the-counter drugs or items without a prescription unless specifically permitted under applicable law or regulation.
- Cosmetic procedures that are strictly cosmetic, such as electrolysis, teeth bleaching, hair transplants or plastic surgery is not an expense for medical care.
- 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.
- Long-term care expenses.

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

These are general examples of reimbursable expenses and excludible expenses. Actual claims must satisfy the Internal Revenue Code rules for tax deductibility. For more information, contact the Claims Administrator.

CARRYOVER AMOUNTS

If you have a balance left in your Limited Use FSA after the claim run out period (i.e., March 30th of the following year), you may carryover up to $610 (indexed)0 of any remaining balance. If you have less than $610 remaining, you can carryover up to the amount of your unused balance. The unused balance cannot be cashed out. Any amounts in excess of $610 will be forfeited. You will have opted out of the carry over provision during open enrollment if you do not enroll in the Limited use FSA for the new plan year.

If you have carryover amounts but elect to enroll in an HDHP medical option for the next plan year, the carryover amounts can continue to be held in your Limited Use FSA. You may contribute to an HSA and also elect to contribute to the Limited Use FSA in the same plan year.

You may not use money in your Limited Use FSA to pay dependent day care expenses and vice versa. You may not switch money between the Limited Use FSA and the Dependent Care FSA.

FILING A CLAIM

When you incur eligible health care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator. If your claim is greater than the amount of money in your account, you will still be reimbursed for the total amount of your claim up to the maximum amount you elected to contribute to your account. Thereafter, you must still continue making contributions on a regular basis.

All claims for a plan year must be submitted to the Claims Administrator within 90 days after the plan year. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator.

The Claims Administrator for the Limited Use FSA is Your Spending Account.

You may be able to use a debit card for your reimbursable expenses. Your vendor will send you instructions about how your debit card works.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT BENEFITS

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.

This section explains how 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.

QUALIFIED DEPENDENTS

Your dependents who qualify for the dependent care reimbursement account include your children under age 13, your spouse and other tax dependents as listed in the *Eligible Dependents* section above.

CONTRIBUTION LIMITS

The IRS limits the amount you may contribute to your Dependent Care FSA. There is an overall annual maximum of $5,000 (or $2,500 each if you and your spouse file separate income tax returns). But another limitation also applies. If you or your spouse earns less than the above amounts, the maximum contribution you can make is the lesser of your or your spouse's annual earnings.

For example: During 2018, Mary will earn $41,500 from her job. Her husband will earn $3,600 from his job. Mary's reimbursement from her Dependent Care FSA will be limited to $3,600. She can choose to contribute no more than $300 a month ($300 x 12 = $3,600) to her account.

For purposes of the IRS limit, your spouse will have a presumed income if your spouse is a full-time student or disabled and incapable of self-care. For each month that your spouse is a full-time student or is incapacitated, your spouse's income is presumed to be the greater of your spouse's actual income (if any) or $250. If you have two or more qualified dependents, the presumed income is the greater of your spouse's actual income (if any) or $500 a month.

ELIGIBLE EXPENSES

Eligible expenses for reimbursement under the Dependent Care FSA include expenses incurred for the care of your qualified dependents:

- In your home;
- In another person's home;
- At a licensed nursery school, day camp (not overnight camp) or qualified day care center. A day care center will qualify if it meets state and local requirements and provides care and receives payment for more than 6 people who do not reside there; or
- At a specialty day camp (e.g., soccer camp, computer camp).

Expenses must be incurred in order to allow you—or if you're married, you and your spouse—to work or if your spouse is disabled and unable to care for him/herself or is a full-time student for at least 5 months of the year. To be eligible, expenses must have been incurred during the plan year and while you were covered under the Plan. An expense is considered incurred when the care or service is provided—not when your provider issues a bill, nor when you receive or pay that bill.

If the care is provided in your home or the home of another person, the care provider must not be claimed as a dependent on your tax return and must be age 19 or older (determined as of the close of the taxable year). An adult dependent must spend at least 8 hours a day in your home in order for expenses for caring for that person to be eligible for reimbursement. Services must be for the physical care of the child, not for education, meals, etc., unless incidental to the cost of care.

INELIGIBLE EXPENSES

You cannot use the money in your Dependent Care FSA to pay for:

- General "baby-sitting" other than during work hours
- Care or services provided by:
  - Your children under age 19 (whether or not they are your tax dependents)
  - Anyone you (or your spouse if you are married) can claim as a dependent for federal income tax purposes
- Nursing home care
- Overnight camp
- Private school tuition
- Expenses for education (kindergarten and above)
- Expenses that would not otherwise be eligible to be credited on your federal income tax return

- The cost of transportation between the place where day care services are provided and your home unless such transportation is furnished by the dependent care provider.
- Expenses incurred while you are off from work for any reason. However, if you pay your dependent care provider on a weekly or longer basis, dependent care expenses incurred during a temporary absence from work for illness or vacation may be eligible.
- Expenses for which you claim an IRS child care credit when you file your tax return.

The IRS does not allow you to claim a credit for the same expenses on your income tax return for which you are reimbursed under the Dependent Care FSA.

USE OR LOSE

It is important that you not contribute more than the dependent care expenses that you are sure to incur. IRS regulations stipulate that you must use the full amount of money in your Dependent Care FSA for expenses incurred during the plan year or forfeit what remains. You must incur eligible expenses by December 31 in order for them to be eligible for reimbursement. Your request for reimbursement must be filed within 90 days after the plan year in which funds are allocated to your Dependent Care FSA for expenses incurred during the plan year. **Any funds remaining in your account after that date will be forfeited.**

With this **"use or lose"** rule, it is extremely important that you carefully plan your contributions to your Dependent Care FSA. Set aside only as much as you expect to claim during the plan year or you will lose it.

You may not use money in your Dependent Care FSA to pay health care expenses and vice versa. You may not switch money between the two accounts.

FILING A CLAIM

When you incur eligible dependent care expenses, you may submit a claim form along with the invoice or receipt for such expense. Reimbursement for submitted claims will be paid as soon as administratively practicable by the Claims Administrator.

All claims for a plan year must be submitted to the Claims Administrator within 90 days after the plan year ends. Any claims for reimbursement after that date will not be considered for reimbursement by the Claims Administrator. If you terminate or lose eligibility during the year, you must file any claims within 90 days of your termination or ineligibility date.

The Claims Administrator for the Dependent Care FSA is Your Spending Account.

SPECIAL RULES AFFECTING DEPENDENT CARE FSAS

Several special rules apply to Dependent Care FSAs. You should consider the following paragraphs, as they may affect the amount you choose to contribute to this account:

The IRS requires that the maximum amount you can take as a child care tax credit for dependent care expenses be deducted—dollar for dollar—by any reimbursements you receive from your Dependent Care FSA. ***Some employees will receive more tax advantages by taking the dependent care tax credit, while others will do better by contributing to the Dependent Care FSA. Please consult your tax advisor or carefully review your situation before making a choice.***

The money in your Dependent Care FSA must be used to pay for dependent care expenses that allow you and your spouse to work. However, this rule does not apply if your spouse is disabled and incapable of self-care or a full-time student at an accredited institution for at least five months each year. See Contribution Limits above for more information.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication #503 for more information. A copy of that publication can be obtained at www.irs.gov.

CLAIMS AND APPEALS PROCESS

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 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.

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 the BrightSpring Benefits Specialist. To file an eligibility claim, you must request a Claim Initiation Form from the Benefits Support Center. You must return the form to the BrightSpring Benefits Specialist at the address on the form.

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 BrightSpring Benefits Specialist's receipt of your Claim Initiation 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 BrightSpring Benefits Specialist's receipt of your Claim Initiation Form, or
- For all other benefits, within 90 days of the BrightSpring Benefits Specialist's receipt of your Claim Initiation 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 claims, 90 days.

The BrightSpring Benefits Specialist will notify you of the deadline to submit additional information, if applicable. If your claim is approved, the BrightSpring Benefits Specialist 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 Eligibility Claims Committee. All decisions by the Eligibility Claims Committee 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 Eligibility Claims Committee'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.

Filing a Benefits Claim

The claims filing procedures are set forth in the Benefit Booklets, which are listed in Appendix A. In general, any participant or beneficiary 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 Claims Administrators. When the Claims Administrator receives your claim, it will be responsible for reviewing the claim and determining how to pay it on behalf of the Plan.

To ensure proper filing of claims, refer to the claims filing procedures that are set forth in the Benefit Booklets.

Claims Administrators—Self-Insured	
Certain Medical benefits, the Health Care FSA, and Limited Use FSA are self-insured and the TPA has the fiduciary responsibility for determining whether you are entitled to benefits and authorizing payment. Benefits are paid out of the general assets of the Company and are not guaranteed under a contract or policy of insurance.	
Medical	Imagine Health
Express Scripts (Rx)	
Health Care FSA and Limited Use FSA	Your Spending Account | www.rescarebenefits.com P.O. Box 64030 The Woodlands, TX 77387-4030 1-844-340-4808

Claims Administrators and Claims Fiduciaries—Fully Insured
BrightSpring provides the following benefits under the Plan through contracts with the insurance companies listed below. Certain Medical, Dental, Vision, Life, Supplemental Life, Dependent Life, AD&D, Short-Term Disability, Long-Term Disability, Employee Assistance Plan, Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance, and Voluntary Hospital Indemnity Insurance benefits of the Plan are guaranteed under contracts of insurance with the insurance companies listed below. The insurance companies administer claims for those benefits and are solely responsible for providing benefits.

Medical	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 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 Kaiser Washington | www.kp.org/wa Send claims to: Kaiser Permanente P.O. Box 34585 Seattle, WA 98124-1585 Send appeals to: Kaiser Permanente ATTN: Manager, Consumer Appeals P.O. Box 34593 Seattle, WA 98124-1585 1-888-901-4636 Kaiser Colorado Kaiser Northwest Blue Cross Blue Shield of Michigan 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 Allegiance | www.askallegiance.com Allegiance Life & Health Insurance Company, Inc. P.O. Box 1762 Miles City, MT 59301-1762 1-800-877-1122

Dental	Delta Dental | www.deltadentalky.com 10100 Linn Station Rd. Louisville, KY 40223 Best Life Dental Plan P.O. Box 19721 Irvine, CA 92623-9721
Vision	UnitedHealthcare www.myuhcvision.com 1-800-638-3120
Basic, Supplemental & Dependent Life and Basic & Supplemental Accidental Death and Dismemberment (AD&D)	MetLife | www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-638-6420
Short-Term Disability (Core and Voluntary)	MetLife | www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-300-4296
Long-Term Disability (Core for salaried employees and Voluntary for hourly employees)	MetLife | www.mybenefits.metlife.com Group Policy Number: 101688-1-G 1-800-858-6506
Employee Assistance Plan	ComPsych |
Group Pre-Paid Legal	MetLife | www.legalplans.com 1-800-821-6400
Voluntary Accident Insurance	Voya | www.voya.com/claims Group Policy Number: 69584-0CAC Claims: 1-855-730-2902 Customer Service: 1-877-236-7564
Voluntary Critical Illness Insurance	MetLife | www.metlife.com Group Policy Number: 0101688 1-800-438-6388
Voluntary Hospital Indemnity Insurance	
Anthem FlexHour Plan	
Anthem Part Time Short Term Disability and Term Life Insurance	

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. Please contact the Claims Administrator/insurer for details. See the Benefit Booklets for more information.

For Medical benefits, the Plan will comply with additional claims and appeals rules required under the Affordable Care Act. You will be notified if any of these new rules impact your claim. These rules will not apply to Dental, Vision, Health Care FSA or Limited Use FSA claims.

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.

INITIAL CLAIM DETERMINATION

For each of the Plan options, 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 Claims Administrator for the benefit at issue. The timeframes on the following pages 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.

For Medical claims, the notice 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 processes;
- 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 processes; and
- Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

If the Claims 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 Claims Decisions

Time frames generally start when the Plan receives a claim. (See the special rule for "concurrent care" decisions to limit previously-approved treatments.) 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, (including Prescription Drug) 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 (*whether adverse or not*) 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 (*whether adverse or not*) 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 determinatio n must be provided by the Plan within a reasonable period of time, but no later than 90 days.

	Medical, (including Prescription Drug) 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 circumstanc es 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 intial 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 intial 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
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.

APPEALING A CLAIM

The following section generally describes the Plan's internal claim appeals process. The appeals process of fully insured health plans may vary somewhat. Please see your Benefit Booklets for more information on fully insured health benefits.

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 Claims 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 Claims Administrator will forward the appeal request to the appropriate named fiduciary for review. The review will be conducted by the Claims 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 Department of Labor (DOL) 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 Claims 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 Claims 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 Claims 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 Claims Administrator must provide you with any new or additional evidence considered, relied upon, or generated by the Medical Plan (or at the direction of the Plan) in connection with the claim. This evidence will be provided at no cost to you and will be given 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 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 minimus*, 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 Claims 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.

For Medical claims, the notice 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 processes; and
- Depending on where you live, you may be able to receive the denial notice in Spanish, Tagalog, Chinese, or Navajo.

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.

Legal Action

Before pursuing legal action for benefits under the Plan, you must first exhaust the Plan's internal claim review and appeal procedures. Additionally, any lawsuit you bring for Plan benefits must be filed within 12 months of the denial of your appeal.

Time Frames for Appeals Process

The claims appeals procedures for a specific benefit are set forth in the Benefit Booklets for that benefit. Please consult the Benefit Booklet for the specific benefit involved. Where not otherwise covered by the Benefit Booklets, the following procedures will apply. The time frame for filing an appeal starts when you receive written notice of 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 (Including Prescription Drug), 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 (not eligibility 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.

Medical Plans				
	Urgent Care Claims*	Non-Urgent Care Pre-Service Claims*	Non-Urgent Care Post-Service Claims*	"Concurrent Care" Decision to Reduce Benefits
Issue written notice to claimant	1 business day.	1 business day.	1 business day If involves urgent care, immediately.	Immediately.
• 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).		
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 Claims Administrator within 48 hours.	Oral notice within 72 hours. IRO must provide written confirmation of decision to the claimant and the Claims Administrator within 48 hours.

ACTS OF THIRD PARTIES

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's 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 Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation and/or offset your future benefits in the event that 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.

Recovery of Overpayment

Whenever payments have been made exceeding the amount necessary to satisfy the provisions of this 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 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.

Non-assignment of Benefits

Plan participants 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 participant's child if required by a Qualified Medical Child Support Order. In addition, subject to the written direction of a Plan participant, all or a portion of benefits provided by the Plan may, at the option of the Plan, and unless a participant 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 participant, 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.

Misstatement of Fact

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

REFUNDS OR REBATES

Any premium refunds, rebates, or commissions that won't be retained by brokers under any Plan benefit and which relate to premiums or payments by participants 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. To the extent a rebate or refund relates to premiums paid by an Employer, that portion of the rebate or refund shall be retained by the Employer and shall not be Plan assets required to be used for the benefit of participants. The portion of any rebate or refund relating to the premiums paid by participants shall be used for the benefit of participants as described above, or refunded to participants, and may be so used for some or all participants in the Plan when the rebate or refund is received or used. The Plan does not require identification of participants that may have participated when the refund was created.

ADMINISTRATIVE INFORMATION

Below is key information you need to know about your benefit plans:

Plan Name	BrightSpring Health Services Welfare Benefit Plan BrightSpring Health Services Section 125 Cafeteria Plan
Plan Number	501 (Welfare Plan); 504 (Cafeteria Plan)
Plan Sponsor	Res-Care, Inc. d/b/a BrightSpring Health Services 805 N. Whittington Parkway Louisville, KY 40222 800-866-0860
Employer Identification Number	61-0875371
Plan Administrator	Res-Care, Inc. d/b/a BrightSpring Health Services 805 N. Whittington Parkway Louisville, KY 40222 800-866-0860 OR CONTACT: BrightSpring Benefits Support Center P.O. Box 3681 Carol Stream, IL 60132-3681 844-340-4808

Participating employer(s)	All BrightSpring domestic companies participate in the Plan unless specifically excluded by Plan amendment. To the extent that BrightSpring acquires additional companies, eligible employees will be notified if they are eligible for benefits as described in this SPD. Contact the Benefits Support Center to determine whether a particular BrightSpring affiliate is a participating employer in the Plan described in this SPD and to request that affiliate's address.
Agent for Service of Legal Process	The agent for service of legal process is the Plan Administrator. Res-Care, Inc. d/b/a BrightSpring Health Services Plan Administrator c/o Benefits Department 805 N. Whittington Parkway Louisville, KY 40222 800-866-0860
Plan Year	January 1 through December 31

Plan Type	Welfare benefit plan providing the following types of benefits: ▪ Medical/Prescription Drug ▪ Dental ▪ Vision ▪ Employee Assistance Plan (EAP) ▪ Short-Term Disability (STD)—Core and Voluntary ▪ Long-Term Disability (LTD) – Non-contributory and Voluntary ▪ Basic Life Insurance ▪ Supplemental Life Insurance ▪ Dependent Life Insurance ▪ Basic Accidental Death and Dismemberment (AD&D) ▪ Supplemental AD&D ▪ Health Care FSA ▪ Dependent Care FSA* ▪ Limited Use FSA ▪ Health Savings Account* ▪ Group Pre-Paid Legal ▪ Voluntary Accident Insurance ▪ Voluntary Critical Illness Insurance ▪ Voluntary Hospital Indemnity Insurance *Although the Dependent Care FSA and HSA are described in this SPD, they are not subject to ERISA.
Source of Contributions	The cost of Medical coverage is shared by BrightSpring and its employees enrolled in this coverage. BrightSpring pays 100% of the cost of the EAP, Core Short-Term Disability, Non-Contributory Long Term Disability to eligible groups, Basic Life, and AD&D coverage. Employees pay 100% of the Dental, Vision, Supplemental Life, Dependent Life, Short-Term Disability (Voluntary), Long-Term Disability (Voluntary) for hourly employees, Supplemental AD&D, Group Pre-Paid Legal, Voluntary Accident Insurance, Voluntary Critical Illness Insurance, and Voluntary Hospital Indemnity Insurance coverage and contributions to the Health Care FSA, Limited Use FSA and Dependent Care FSA. BrightSpring does not match any employee contributions to an HSA. The Plan Administrator will notify employees 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.

PLAN DOCUMENT

This document is intended merely as a summary of the official Plan document(s). In the event of any disagreement between this summary and the official Plan document(s), as they may be amended from time to time, the provisions of the Plan document(s) will govern.

PLAN AMENDMENT AND TERMINATION

BrightSpring reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time. For example, and in accordance with applicable law, BrightSpring reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. BrightSpring also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by BrightSpring will be done in accordance with BrightSpring's normal operating procedures. Amendments may be retroactive to the extent necessary to comply with applicable law. No amendment or termination shall reduce the amount of any benefit otherwise payable under the Plan for charges incurred prior to the effective date of such amendment or termination.

If a benefit option is terminated and surplus assets remain after all liabilities have been paid, such surplus shall revert to BrightSpring to the extent permitted under applicable law, unless otherwise stated in the applicable Plan document.

PLAN ADMINISTRATION

BrightSpring is responsible for the general administration of the Plan and will be the fiduciary to the extent not otherwise specified in this SPD, the Plan document or in a Benefit Booklet. BrightSpring has the discretionary authority to construe and interpret the provisions of the Plan and make factual determinations regarding all aspects of the Plan and its benefits, including the power to determine the rights or eligibility of employees and any other persons, and the amounts of their benefits under the Plan, and to remedy ambiguities, inconsistencies or omissions. Such determinations shall be conclusive and binding on all parties. A misstatement or other mistake of fact will be corrected when it becomes known, and BrightSpring will make such adjustment on account of the mistake as it considers equitable and practicable, in light of applicable law. Neither the Plan Administrator nor BrightSpring will be liable in any manner for any determination made in good faith.

BrightSpring may designate other organizations or persons to carry out specific fiduciary responsibilities for BrightSpring in administering the Plan including, but not limited to, the following:

- Pursuant to an administrative services or claims administration agreement, if any, the responsibility for administering and managing the Plan, including the processing and payment of claims under the Plan and the related recordkeeping;
- The responsibility to prepare, report, file and disclose any forms, documents, and other information required to be reported and filed by law with any governmental agency, or to be prepared and disclosed to employees or other persons entitled to benefits under the Plan; and
- The responsibility to act as Claims Administrator and to review claims and claim denials under the Plan to the extent an insurer or administrator is not empowered with such responsibility.

By entering into a service agreement with an insurance company or benefits administration firm, the Administrator has delegated to such insurance company or administration firm the Administrator's discretionary authority to interpret the terms of the applicable plan and to determine benefit eligibility thereunder, and to carry out other administrative functions, all to the extent stated in the service agreement. By purchasing an insurance policy, the Administrator has delegated to the insurance

company the Administrator's full and final discretionary authority to interpret the terms of the applicable policy and determine benefits, if any, thereunder. Once the claims and appeal process of the plan has been fully exhausted, a participant may bring a claim or action in a court of law in accordance with ERISA, but any such claim or action must be filed with the court no later than 12 months from the date of the final adverse decision on appeal.

POWER AND AUTHORITY OF THE INSURANCE COMPANY

For all insured benefits under this Plan, benefits 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
- The insurance company also has the authority to require employees and beneficiaries to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Questions

If you have general questions regarding the Plan, please contact the Plan Administrator. However, if you have questions concerning eligibility for and/or the amount of benefits payable under the Plan, please refer to the applicable Benefit Booklet listed in Appendix A or contact the applicable insurance company or Claims Administrator. If you have an ID card for a plan, you may also use the contact information on the back of that card.

ERISA

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, Benefit Booklets and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and 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 this summary annual report (SAR).

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.

NOTICE OF NONDISCRIMINATION AND ACCESSIBILITY REQUIREMENTS UNDER SECTION 1557 OF THE AFFORDABLE CARE ACT

DISCRIMINATION IS AGAINST THE LAW

BrightSpring Health Services ("BrightSpring") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. BrightSpring does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

BrightSpring provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters, and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters, and
  - Information written in other languages.

If you need these services, contact the Compliance department at 1-800-866-0860, Option 6

If you believe that BrightSpring has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

BrightSpring Health Services Compliance Department
805 N. Whittington Parkway
Louisville, KY 40222

Phone: 1-800-866-0860, Option 6
Fax: 502-638.7920
Email: compliance@rescare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the BrightSpring Health Services Compliance department at the phone numbers or email addresses listed above.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al. If you need these services, contact the Compliance department at 800-866-0860.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電. If you need these services, contact the Compliance department at 800-866-0860.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa. If you need these services, contact the Compliance department at 800-866-0860.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số. If you need these services, contact the Compliance department at 800-866-0860.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le. If you need these services, contact the Compliance department at 800-866-0860.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. If you need these services, contact the Compliance department at 800-866-0860. 번으로 전화해 주십시오.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: If you need these services, contact the Compliance department at 800-866-0860.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
(رقم هاتف الصم والبكم:
If you need these services, contact the Compliance department at 800-866-0860.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните If you need these services, contact the Compliance department at 800-866-0860:

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele. If you need these services, contact the Compliance department at 800-866-0860.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero. If you need these services, contact the Compliance department at 800-866-0860.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para. If you need these services, contact the Compliance department at 800-866-0860.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। If you need these services, contact the Compliance department at 800-866-0860. पर कॉल करें।.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer If you need these services, contact the Compliance department at 800-866-0860.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます. If you need these services, contact the Compliance department at 800-866-0860. まで、お電話にてご連絡ください。.

APPENDIX A—BENEFIT BOOKLETS

This summary should be read in combination with the insurance contracts, member handbooks, certificates of coverage or evidence of coverage documents (together and individually referred to as Benefit Booklets) provided by the insurance companies and service providers.

The Benefit Booklets are intended to describe the BrightSpring benefits available to you as an employee of BrightSpring, and, when read with this summary, are intended to meet ERISA's SPD requirements.

Please see the Benefit Booklets for details of Plan benefits.

For additional information or for copies of the Benefit Booklets, please contact the BrightSpring Benefits Support Center at 844-896-0169.

Coverage	Benefit Booklet Name
Medical & Prescription Drug	i360 $900 PPOPlan i360 $1,850 HDHP with HSA i360 $3,000 HDHP with HSA i360 $3,500 PPO i360 $4,500 HDHP with HSA Express Scripts Prescription Drug Program HDHP Express Scripts Prescription Drug Program PPO Kaiser Foundation Health Plan, Inc. Northern California Kaiser Foundation Health Plan, Inc. Southern California HMSA Preferred Provider Plan 2010 / Rx and Vision Rider (HI Employees Allegiance SM Life & Health Insurance Company (MT Employees) Kaiser Foundation Health Plan of Washington Evidence of Coverage Kaiser Foundation Health Plan of Colorado Evidence of Coverage Kaiser Foundation Health Plan of Northwest Evidence of Coverage Blue Cross Blue Shield of Michigan Anthem FlexHour Medical Plan
Dental	Delta Dental Preventive Plan Summary Delta Dental PPO Plus Plan Summary BEST Life and Health Insurance Company (MT Employees)
Vision	UnitedHealthcare Vision Certificate of Coverage – High Plan

Coverage	Benefit Booklet Name
	UnitedHealthcare Vision Certificate of Coverage – Low Plan
Employee Assistance Plan	ComPsych
Basic Life Insurance Supplemental Life Insurance Dependent Life Insurance Accidental Death and Dismemberment Insurance Voluntary Accidental Death and Dismemberment Insurance	MetLife Basic Life Insurance, Supplemental Life Insurance, Accidental Death & Dismemberment Insurance, Voluntary Accidental Death and Dismemberment Insurance Certificate Number 8, 9, 10
Anthem Part-Time Short Term Disability Anthem Part-Time Term Life Insurance	
Short-Term Disability (Core) Voluntary Short-Term Disability	MetLife Disability Income Insurance: Short Term Benefits Certificate Number 1, 2, 3
Long-Term Disability (non-contributory for eligible employees)	MetLife Disability Income Insurance: Long Term Benefits Certificate Number 7, 8, 9
Group Pre-Paid Legal	METLAW® Summary Plan Description (My Benefits)
Voluntary Accident Insurance	Group Accident Insurance Certificate of Coverage
Voluntary Critical Illness Insurance	MetLife Critical Illness Insurance Certificate of Insurance
Voluntary Hospital Indemnity Insurance	

APPENDIX B—ADDITIONAL INFORMATION ABOUT THE LOOKBACK METHOD

GLOSSARY OF DEFINED TERMS RELATED TO THE LOOKBACK METHOD

Break in Service. A Break in Service occurs when you are not credited with an Hour of Service for a period of more than 30 days. If the period during which you are not credited with an Hour of Service is 13 consecutive weeks or more, you will be treated as having terminated employment and rehired, and therefore may be treated as a new employee. If the period during which you are not credited with Hour of Service is less than 13 consecutive weeks, you will be treated as a continuing employee upon your resumption of services for BrightSpring.

The Plan Administrator, at its discretion, may also determine whether you will be treated as a new employee or a continuing employee using the Rule of Parity. Under the Rule of Parity, you will be treated as a new employee if you have a period of at least four consecutive weeks during which you are not credited with an Hour of Service, if the period without an Hour of Service is greater than your immediately preceding period of employment.

Hours of Service. Hours of Service means any hour for which you are paid, or entitled to payment, for (1) the performance of duties for BrightSpring or a participating employer that offers the Plan to its employees, or (2) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. Hours of Service does not include:

- Hours for which your compensation is considered non-US source income;
- Hours worked as a volunteer; or
- Hours worked as part of a Federal Work-Study Program.

An hour of overtime counts as one hour of service, regardless of the rate you are paid.

Initial Measurement Period. Initial Measurement Period means the period beginning with the first pay period that begins in the month following the day you start work and ending 11 months later.

Initial Stability Period. Initial Stability Period will begin on the first day of the month that begins on or after 13 months after the anniversary of your start date.

> Example: If you are hired on January 28, 2021, your Initial Measurement Period will begin on February 11, 2022 and will end on January 10, 2023. If you average 30 hours per week during that 11-month period, you will be eligible for the medical benefits beginning March 1, 2023 and ending February 28, 2024.

New Employee. You are considered a new employee for purposes of the Lookback Method if you have been employed for less than one full Standard Measurement Period, or you are treated as a new employee following a Break in Service that lasts for 13 consecutive weeks or more.

Part-Time, Variable Hour Employee. You are considered a Part-Time, Variable Hour Employee if you are reasonably expected, at the time of hire to work fewer than 30 hours per week or at the time of hire, BrightSpring cannot reasonably determine if you will work 30 or more hours per week. Individuals who are specifically listed as excluded do not fall within this definition.

Seasonal Employee. Seasonal Employees customarily work six months or less, beginning at approximately the same time annually. If you are classified as a Seasonal Employee, you will be treated the same as a Part-Time, Variable Hour Employee even if you are reasonably expected, at the time of hire, to work 30 or more hours per week.

Special Unpaid Leave. Special Unpaid Leave means unpaid leave that is subject to FMLA, USERRA or unpaid leave on account of jury duty.

Standard Measurement Period. Standard Measurement Period means the 12-month period beginning with the payroll period that includes each October 3 and ending with the payroll period ending immediately before October 2.

Standard Stability Period. Standard Stability Period means the plan year immediately following the end of a Standard Measurement Period. The plan year is the 12-month period from January 1 through December 31 of the same year.