SUMMARY PLAN DESCRIPTION (SPD)

FOR THE

LUTHERAN SENIOR SERVICES BENEFITS PLAN

(January 2018)

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LUTHERAN SENIOR SERVICES BENEFITS PLAN

ARTICLE I
INTRODUCTION

We are pleased to acquaint you with the Lutheran Senior Services Benefits Plan (the "Plan").

The welfare plan benefits provided by the Plan are subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA requires that each participant receive a Summary Plan Description ("SPD") intended to provide you with a summary of the more important provisions of the Plan. However, this SPD does not describe all of the rules and provisions of the Plan. ***If there is a discrepancy between this SPD and the legal Plan document, the Plan document will control.***

If you have any questions about your benefits or rights, please contact your Director of Benefits and Compensation.

ARTICLE II
GENERAL PLAN INFORMATION

Plan Name:	Lutheran Senior Services Benefits Plan
Plan Number:	501
Type of Plan:	Health and welfare benefit plan.
Plan Year:	January 1 and ending December 31.
Plan Sponsor:	Lutheran Senior Services 1150 Hanley Industrial Court St. Louis, Missouri 63144 314-968-9313
Plan Sponsor Tax Identification Number:	43-0654862
Participating Employers:	Cole County EIN: 43-1147326
Plan Administrator and Named Fiduciary:	Lutheran Senior Services 1150 Hanley Industrial Court St. Louis, Missouri 63144 314-968-9313

Claims Administrator:	Unless otherwise described in the Component Document, the claims administrator is the insurer or third party administrator identified in Benefit Program Appendix.
Sources of Contributions:	Employee contributions and Employer contributions.
Funding Medium:	Contributions under the Plan may consist of both Employer contributions and Employee contributions. Employee contributions for coverage are paid through payroll deduction.
Type of Administration:	Administered according to the Component Documents. Some benefits under the Plan are insured by one or more insurance companies. The Benefit Program Appendix describes the various benefits, whether they are insured or self-insured, and the identity of the insurance companies and third-party administrators. With respect to benefits under the Plan which are self-insured, those benefits may be administered by a third-party administrator, including an insurance company. In those cases where an insurance company has been hired to administer a self-insured plan, the insurance company does not insure or guarantee the benefits that it administers; see the Benefit Program Appendix for the identity of the third-party administrator(s). The Employer may maintain a stop-loss or reinsurance policy to protect the Employer against catastrophic loss under the comprehensive medical benefit program offered under this Plan. However, the stop-loss insurance merely reimburses the Employer for benefits it funds under the program, and is not to be construed as "insuring" the comprehensive medical benefits under the program.
Agent for Legal Process:	Service of legal process may be made upon the Plan Administrator.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

Who is eligible to participate in the Plan?

You are eligible to participate in the Plan and will be considered an "eligible employee" if you are a regular employee of an Employer and are regularly scheduled to work 30 or more hours per week. If it is unclear at hire date whether you will satisfy the 30-hour requirement, the Employer generally measures full-time status using a "lookback" period during which time your hours will be measured to see whether you work, on average, 30 or more hours per week. The Employer maintains a more detailed eligibility policy describing how full-time status is determined. This policy is available upon request, free of charge. Depending upon the benefit program, a lower or higher number of hours may be prescribed in the insurance certificate/benefit booklet for the applicable benefit program.

When does coverage become effective?

Your coverage will take effect after you: (1) satisfy any applicable waiting period as described in the insurance certificates/benefit booklets and any other enrollment materials for a benefit program provided by the company (generally the first day of the month in which you complete 90 days of full-time service); and (2) timely enroll for coverage (generally before your initial eligibility date or during the open enrollment period). If you fail to enroll before your initial eligibility date but you enroll during the calendar month in which you are initially eligible, coverage will be effective retroactive to your initial eligibility date.

Are my dependents eligible for coverage?

Yes, your dependents may be enrolled in coverage under the medical, dental, vision, dental, and supplemental life insurance benefits. Your eligible dependents generally include your legal spouse, dependent children (a natural child, stepchild, or legally adopted child/child placed for adoption). In general, you must elect coverage for yourself in order to elect coverage for your dependents.

The health care spending account (Health FSA) and any other benefit program providing medical care include additional rules relating to dependent eligibility, including the definition of a "child," when you may enroll eligible dependents for coverage, and residency requirements. As required by the Patient Protection and Affordable Care Act, your children under the age of 26 are eligible for coverage under the group health plan regardless of whether they are financially dependent on you, reside with you, are married, or are a student. If your dependent child is mentally or physically handicapped and depends on you for support, there is no age limit. The company may ask you to provide proof of dependent status.

New dependents (for example spouse, newborn or adopted child) may be enrolled in coverage within 31 days after first becoming a dependent. A new dependent who is your spouse, coverage begins the first day of the month following enrollment. For a new dependent child,

coverage begins the date the child becomes a dependent. New dependents who are not enrolled within 31 days will generally not be eligible for coverage until the next open enrollment period.

An eligible dependent does not include a person enrolled as an employee under the Plan or any person who is covered as a dependent of another employee covered under the Plan. If you and your spouse are both employed by the company, each of you may elect your own coverage (based on your own eligibility for benefits) or one of you may be enrolled as a dependent on the other's coverage, but only one of you may cover your dependent children. It is your responsibility to notify the company if your dependent becomes ineligible for coverage.

Can I change my benefits elections mid-year?

Generally, your elections are locked in for the applicable coverage period and may not be changed until the next open enrollment period. However, you may be allowed to modify your prior elections upon the occurrence of certain qualifying changes in status (e.g., marriage, divorce, birth of child, loss of other coverage) for certain benefits offered through the cafeteria program, as described in section 125 of the Internal Revenue Code. The group health plan is also subject to special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA).

When does my coverage and the coverage of my dependent terminate?

Except as otherwise specifically provided in the applicable component document, if your employment terminates with the employer on the 1st through the 15th day of the month, then your coverage under this Plan ends on the 15th of the month in which you terminate employment; if your employment terminates with the employer after the 15th day of the month, then your coverage under this Plan ends on the last of the month in which you terminate employment, the date you cease to be an eligible employee (unless otherwise required by law), or upon your death. Coverage may also end in the event of fraud or material misrepresentation (both of which are expressly prohibited by this Plan), or in the event of a failure to timely pay required premiums, contributions or any overpayments or mistaken payments from a benefit program.

Coverage for your covered dependents ends on the last day of the month in which he or she ceases to be a dependent. In the case of divorce, coverage ends on the date the divorce is final. Coverage will also end for you and your dependents on the date the company terminates the Plan or a benefit program, or, if earlier, the effective date you request coverage to be terminated for you and/or your covered dependent.

Coverage under some benefit programs may continue until the last day of the month in which your employment ends or in which you cease to be an eligible employee, as specified in the applicable insurance certificate/benefit booklet or other benefit program material.

What happens to my benefits when I am on leave?

When you are on a paid leave of absence, you are treated as an active employee for the purpose of benefits eligibility, meaning that you can continue to participate in the Plan on the same

basis as before your leave of absence, and your contributions will continue to be deducted from paychecks you receive during the paid leave.

When you are on unpaid leave of absence or on FMLA leave, you can maintain your benefits for the duration of your leave. While on your FMLA leave, you must pay the same portion of the premium during you FMLA leave as if you were not on leave and failure to do so may result in loss of benefits. At the end of your FMLA leave, you may be entitled to continuation of your group health benefits under COBRA if you do not return to work, and the company can recoup from you its cost of the benefits it provided during your leave.

ARTICLE IV
BENEFIT CHOICES AND CONTRIBUTIONS

What benefits are covered under the Plan?

The attached Benefit Program Appendix provides the list of benefits made available under the Plan. Because coverage under various benefit programs are consolidated into the Plan, more specific information may be described in the insurance certificates/benefit booklets issued by the carriers for benefit programs that are insured and provided pursuant to insurance certificates/benefit booklets issued by third party insurance carriers, and in booklets issued by the third party administrators for benefit programs that are not insured. Please consult those other documents or contact your Director of Benefits and Compensation if you have any questions.

How much do I have to pay for coverage?

The company will determine the amount, if any, that you and other eligible employees must pay for coverage. Those benefit programs that require contributions will be designated as optional, and the contributions rates will be separately communicated to you when you enroll in the Plan. The contributions rates are subject to change from time to time. The company will also determine whether such contributions rates are to be paid by you on a pre-tax or an after-tax basis.

Benefit programs that do not require contributions will be automatically available to you if you are eligible under the terms of the applicable benefit program.

ARTICLE V
HOW THE PLAN WORKS

The Plan combines a separate welfare plan program sponsored by the company and a cafeteria plan program designed to permit you to convert taxable wages into non-taxable benefits. There are two key parts to this Plan.

PART 1. WELFARE PLAN

The Plan provides the benefits listed in the Appendix. The benefits provided are outlined in separate benefit booklets. The Plan also allows you to pay for your portion of the premiums for coverage under the company's medical, dental and/or vision benefits on a pre-tax basis. Your contributions will be deducted in equal amounts from the paychecks you receive throughout the plan year. Your employer will withhold your premiums from each paycheck and, for insured benefits, will remit your contributions to the insurance carrier.

PART 2. HEALTH CARE SPENDING ACCOUNT (HEALTH FSA)

If you choose to enroll in the health care spending account, a flexible spending account (Health FSA) will be established for you. You may elect to have a portion of your salary credited to the account each plan year. The elected amount may not exceed the IRS maximum contribution limit for the year (or any other limit approved by the plan administrator), which the company will communicate to you in the annual enrollment materials ($2,650 for 2018).

You are not eligible for the Health FSA if you participate in a health savings account.

Your elected contribution will be automatically deducted in equal amounts from the paychecks you receive throughout the year and credited to your Health FSA. The amount you elect to contribute should be based on an estimate of eligible expenses you expect to incur during the plan year.

To benefit, the plan administrator may make available to you a credit or debit card to pay for your eligible medical care expenses under the Plan at the point of purchase, subject to certain requirements that will be communicated to you upon issuance of the credit or debit card. You are not required to use or obtain a credit or debit card to benefit under the Plan. You may submit eligible expenses incurred during the plan year (or corresponding grace period described below) and obtain reimbursement for those expenses from your account. Reimbursement of eligible medical care expenses is limited to the amount credited to your account. Any medical care expense incurred in excess of such amount will not be paid by the Plan. No payments will be issued to providers of service.

What happens to my account balance at the end of a plan year?

Each plan year has a "grace period" ending on the subsequent March 15. If you have a positive balance in your account at the end of a plan year, any expenses incurred during the corresponding grace period will be deemed to have been incurred in the prior plan year and will not affect the maximum reimbursable amount in the current plan year. If you do not claim all of the monies contributed to your account by the subsequent March 31 (deadline for submitting claims for expenses incurred during the closed plan year and its grace period), you may not carry it over to the next plan year. You will forfeit any unused amounts after the March 31 deadline.

Am I eligible to participate in the Health FSA during a leave of absence?

If you are enrolled in the Health FSA and go on a leave of absence, you will be deemed to have continued participation in the Health FSA unless you elect otherwise. Therefore, you will

continue to be eligible to claim reimbursement for expenses incurred before the effective date of your leave of absence.

What happens to my account if I terminate employment or lose coverage under the Plan?

If you are enrolled in the Health FSA and terminate employment or incur another qualifying event resulting in the loss of coverage, then you will have the right to continue your participation in the Health FSA until the end of the plan year in which the qualifying event occurred if you have a positive account balance. To continue your participation, you must timely elect continuation coverage and pay the required contributions for coverage. The Plan may impose a 2% administrative charge for your continued participation.

If you terminate employment but do not have a positive account balance in your Health FSA, then your participation in the Health FSA will end on your termination date. You should contact the claims administrator if any questions regarding your COBRA rights.

ARTICLE VI
CLAIMS PROCEDURES

All claims under the Plan must be timely submitted in writing to the persons or organizations designated by the plan administrator. Any reference to administrator in this Article means the insurance company in the case of insured benefit programs, or, if applicable, the claims administrator to whom the plan administrator has delegated authority and responsibility. Unless a shorter timeframe is provided for in the applicable benefit program, the Plan reserves the right to deny any claims not brought within six months of the date the claim was accrued.

What if I have a claim for Health FSA reimbursement?

Claims for Health FSA reimbursement may be submitted by using the forms available from the plan administrator.

What if I have a health care or disability claim?

To the extent that an insurance company for an insured benefit program is the administrator, the insurance company for the insured benefit program will have the responsibility for determining entitlement to benefits under the program and prescribing the claims procedures to be followed by participants and beneficiaries. The insurance company will act as a named fiduciary with respect to its benefit program and will have the full power to interpret and apply the terms of the benefit program. If an insurance carrier of a benefit program does not designate a party to perform these responsibilities, they will be performed by the company.

If you have a claim for eligibility, or if a benefit plan is not insured, you may file a claim in writing with the administrator in a form required by the administrator.

If your claim is for a health benefit, the administrator will make a decision on your claim (i) within 72 hours in the case of an urgent care claim; (ii) within 15 days for a pre-service claim,

unless special circumstances require an extension of up to 15 additional days; (iii) within 24 hours for a concurrent care claim relating to urgent care, or within a reasonable time before the termination or reduction of the termination for a concurrent care claim relating to non-urgent care; (iv) within 30 days in the case of a post-service claim, unless special circumstances require an extension of up to 15 additional days; and (v) within 45 days in the case of a disability claim, unless special circumstances require a first extension of up to 30 additional days and a second extension for special circumstances of up to 30 additional days (each such 30 day extension period will be tolled until the covered person responds to any information requested).

Written notice of the decision on your claim will be furnished promptly to you. If the claim is wholly or partially denied, the written notice will include:

- the specific reason or reasons for the denial;
- information sufficient to specifically identify the claim involved (including denial codes);
- references to specific Plan provisions on which the benefit determination is based;
- a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;
- 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 your claim;
- an explanation of the appeal procedure (in the case of an urgent care claim, a description of the expedited review process available to such claims);
- if an internal rule, guideline, protocol or similar criteria was relied upon in making the decision, either a copy of that document or a statement that such document was relied on and that a copy will be furnished (free of charge) upon request;
- if the decision was based on medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the Plan's terms to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- a statement disclosing the availability of, and contact information for, any applicable consumer assistance office or ombudsman established to assist individuals with claims and appeals questions; and
- a statement that you have the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

No later than 180 days after receipt of notice that the claim has been denied in whole or in part, (a) you may file with the administrator a written request for a review; (b) you may request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (c) you may submit written comments, documents, records, and other information relating to your claim for benefits.

Your claim will be reviewed without deference to the initial denial and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual. In deciding an appeal of any denial that is based in whole or part on medical judgment, the decision-maker will consider any information submitted by you and will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination will be identified and disclosed to you, without regard to whether the advice was relied upon in making the benefit determination.

As soon as practicable from the date you submitted the request for appeal, but not later than (i) 72 hours in the case of an urgent care claim; (ii) 30 days for a pre-service claim; (iii) 60 days for a post-service claim; and (v) 45 days in the case of a disability claim, the administrator will notify you in writing whether, upon review, the claim denial was upheld or reversed in whole or in part. In the case of a disability claim, if the administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 45-day period, such extension not to exceed 45 days from the end of the initial period.

If the denial of your claim is upheld upon review, the notification will include:

- the specific reason or reasons for the adverse benefit determination;
- information sufficient to specifically identify the claim involved (including denial codes);
- reference to the specific Plan provisions on which the benefit 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 your claim for benefits;
- an explanation of any voluntary appeal procedures offered by the Plan, if any;
- if an internal rule, guideline, protocol, or other similar criterion was relied on in upholding the claim denial, either a copy of that document or a statement that such document was relied on in making the adverse determination, and that a copy of such document will be provided to you free of charge upon request;
- if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided to you free of charge upon request;
- a statement that you may be eligible for external review; and
- a statement that you have the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

If you have a claim for benefits which is denied, you may bring a legal action with respect to a claim only if (a) all of the Plan's claim and review procedures have been timely pursued and exhausted, and (b) the action is commenced within two years after your initial claim or within six months from the date of the final claim decision on appeal, whichever comes first, or if shorter, the date specified in the benefit program.

For disability claims on or after April 1, 2018 (or a later effective date established by Department of Labor regulations), the following will apply:

- the claim will be decided in a way that ensures the independence and impartiality of Plan decision makers involved in the review process, including claims processors or medical experts) and avoids any conflicts of interest as set forth in Department of Labor Regulations under 29 CFR §2560.503-1;
- any new or additional evidence considered, relied on, or generated by the Plan or decision maker in connection with the claim will be disclosed to the claimant as soon as possible and in all cases before the Plan can issue an adverse benefit determination;
- any new or additional rationale relied on by the Plan or decision maker in connection with the claim will be disclosed to the claimant as soon as possible and in all cases before the Plan can issue an adverse benefit determination;
- all written notifications will be provided in a culturally and linguistically appropriate manner;
- if an internal rule, guideline, protocol, or other similar criterion does not exist regarding a disability claim determination, the written notification will include a statement to that effect in any written notification;
- all written notifications will include a discussion of the Plan's decision including, for example, the basis for disagreeing with the views of any disability determination by the Social Security Administration, treating physician or vocational professional, as applicable);
- if applicable, all written notifications will include an explanation of the scientific or clinical judgment used with respect to any claim denials based on medical necessity, experimental treatment, or other similar exclusions or limitations (or a statement that an explanation will be provided free of charge upon request); and
- all written notifications will include a statement regarding the claimants rights under ERISA Section 502(a), and include the calendar date when any limitations period will end.

What if I have a claim that is not related to health care or a disability?

If at any time you believe you that you are entitled to any benefits under the Plan, you must file the claim in writing with the administrator. The administrator will make a decision on your claim within 90 days, unless special circumstances require an extension of up to 90 additional days. Written notice of the decision on your claim will be furnished promptly to you. If no notice

of denial is provided within the time periods set forth above, your claim will be deemed to have been denied. If the claim is wholly or partially denied, the written notice will:

- the specific reason or reasons for the denial;
- references to the specific provisions of the Plan on which the denial is based;
- a description of any additional material or information necessary for you to perfect the claim and explanation of why such material or information is necessary;
- 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 your claim;
- an explanation of the appeal procedure; and
- a statement that you have the right to bring civil action under ERISA Section 502(a) following a denial upon appeal.

No later than 60 days after receipt of notice that the claim has been denied in whole or in part, (a) you may file with the administrator a written request for a review; (b) you may request, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and (c) you may submit written comments, documents, records, and other information relating to your claim for benefits.

Within 60 days after the filing of such a request for a review, the administrator will notify you in writing whether, upon review, the claim denial was upheld or reversed in whole or in part or will give you a written notice describing special circumstances which require a specified amount of additional time to reach a decision on the request for review. If the administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to you prior to the termination of the initial 60-day period. In no event will such extension exceed a period of 60 days from the end of the initial period. If the denial of your claim is upheld upon review, the notification will set forth:

- the specific reason or reasons for the adverse determination;
- references to the specific provisions of the Plan on which the denial 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 your claim;
- an explanation of the voluntary appeal procedures offered by the Plan, if any; and
- a statement that you have the right to bring civil action under ERISA Section 502(a) following a denial upon appeal, if the benefit program is subject to ERISA.

Is there a deadline for bringing a civil action?

Yes. You may not bring a civil action for benefits unless you (a) first exhaust all administrative remedies under the Plan, and (b) file the action no more than one year after the date of the final claim decision, or if shorter, the date specified in the benefit program.

ARTICLE VII
AMENDMENT AND TERMINATION

Can changes be made to the Plan after I join?

The company reserves the right to amend or terminate the Plan at any time, in whole or in part, without the consent of any person to prospectively, or retroactively, amend or modify this Plan and any benefit program from time to time in any manner it deems appropriate.

ARTICLE VIII
ADDITIONAL RULES AND REQUIRED DISCLOSURES FOR THE HEALTH CARE COMPONENT

COBRA. With respect to each benefit program that is a group health plan, any COBRA provision in the benefit program will govern. If the benefit program that is a group health plan does not contain a COBRA provision, each participant and his or her family members may have the right to purchase continuation coverage for a temporary period of time set forth in COBRA, provided coverage under the group health plan terminates due to certain COBRA qualifying events (such as termination of employment, reduction in work hours, divorce, death, or a child ceasing to meet the definition of dependent under the terms of the group health plan). In general, a participant or family member must elect COBRA continuation coverage within 60 days following the date of the qualifying event or, if later, the date notice of the qualifying event is provided to the individual. If continuation coverage is elected, the individual will be responsible for paying the full cost of continuation coverage plus an administrative fee. Refer to the COBRA provisions at the end of this SPD for an important COBRA notice.

Qualified Medical Child Support Orders. With respect to each benefit program that is a group health plan, the Plan will comply with terms of a "qualified medical child support order," which recognizes the right of a child of a participant to receive benefits for which the participants and beneficiaries generally are eligible to receive under the group health plan. Participants and beneficiaries may obtain a copy of the Plan's procedures relating to qualified medical child support orders upon request from the company.

Newborns' and Mothers' Health Protection. With respect to each benefit program that is a group health plan providing maternity benefits, the Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than the above periods. In any case, the group health plan will not require that a provider obtain authorization from the plan for prescribing a length of stay not in excess of the above periods. This maternity benefit coverage

will be subject to all other terms of the benefit program, such as deductibles, copays, and coinsurance.

Women's Health and Cancer Rights Act. To the extent any benefit program, which is a group health plan, provides benefits for mastectomies, it will provide, for an individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy, coverage for reconstruction on the breast on which the mastectomy was performed, surgery and reconstruction on the other breast to give a symmetrical appearance, and prosthesis and coverage for physical complications of all stages of the mastectomy, including lymphedemas. This mastectomy coverage will be subject to all other terms of the benefit program, such as deductibles, copays, and coinsurance.

Health Insurance Portability and Accountability Act (HIPAA). The health care component of the Plan will be subject to the special enrollment, pre-existing condition limitations, certification, nondiscrimination in health status, privacy, security, and electronic interchange provisions of the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA). This provision will be interpreted and applied to give a covered person only those rights as prescribed under HIPAA.

The Plan is also subject to HIPAA's privacy and security requirements. In general, HIPAA requires that your protected health information only be used for purposes related to your health care treatment, payment for health care and health care operations. HIPAA prohibits employers from intimidating or taking retaliatory action against any participant or beneficiary for exercising his or her HIPAA rights, or any requirement that he waive his or her HIPAA rights.

Family Medical Leave Act (FMLA). The company will maintain benefits under each benefit program that is a group health plan for an employee on an FMLA leave on the same terms and conditions as if the employee had continued to work. Unless otherwise specified in a benefit program, an employee on an unpaid leave of absence will be responsible for any required contributions on an after-tax, month-to-month basis.

Uniformed Services Employment and Reemployment Rights Act (USERRA). A participant who is performing service in the uniformed services and is covered under the Plan is entitled to continue coverage for himself and dependents if applicable, provided the participant elects to continue coverage for the period beginning on the date of the participant's absence for purposes of performing uniformed service begins, and ending on the earlier of: (a) 24-months later; or (b) the date on which the participant fails to return from service or to apply for a position of employment as provided in USERRA.

Mental Health Parity. Each benefit program that is a group health plan will comply with the requirements of the Mental Health Parity Act of 1996. This generally means that it will not place annual or lifetime maximums for mental health benefits that are lower than the annual and lifetime maximums for physical health benefits.

CHIPRA. CHIPRA provides you with a 60-day special enrollment right to enroll in a Component Benefit that is a group health plan under the following two circumstances: (1) your coverage or coverage of your dependent under Medicaid or a state-sponsored children's health insurance program ("CHIP") terminates due to loss of eligibility; and (2) you or your dependent becomes eligible for state financial assistance under Medicaid or CHIP to help pay for coverage under the Employer's group health plan(s).

ARTICLE IX
MISCELLANEOUS PROVISIONS

Can my benefits be assigned or transferred?

Unless specifically permitted under a benefit component document, no benefit, right, or interest under the Plan is subject to alienation, transfer, assignment, pledge, encumbrance or charge, seizure, attachment, or legal, equitable or other process. However, the Plan will comply with a qualified medical child support order as described in Article VII.

Are there limitations on my rights under the Plan?

Generally, yes. Neither the establishment nor the maintenance of the Plan will operate or be construed to obligate the company to continue the service of any employee, limit the right of an employer to discipline or discharge an employee, create a contract of employment with any employee, or give any person any legal or equitable right against the administrator, the company, or the employer.

What are the responsibilities and authority of the company?

The company has sole authority to control and manage the operation and administration of the Plan, and to interpret the provisions of the Plan. This authority includes the power to make determinations and necessary findings of fact regarding eligibility for participation in and coverage under the Plan or any benefit program that is not fully insured, and the types and amounts of benefits payable under the Plan. Decisions by the company may not be overturned unless found by a court to be arbitrary and capricious and having no foundation.

The company may delegate responsibilities for the operation and administration of the Plan. This delegation authority includes the power to employ persons to assist in fulfilling the plan administrator's responsibilities under the Plan, and designating fiduciaries and allocating fiduciary responsibilities under the Plan.

What are the responsibilities and authority of the insurers?

The insurance carrier for the fully-insured benefit program will have the responsibility for determining entitlement to benefits under the program and prescribing the claims procedures to be followed by participants and beneficiaries. The insurance company will act as a named fiduciary with respect to its benefit program and will have the full power to interpret and apply the terms of

the benefit program. If an insurance carrier of a benefit program does not designate a party to perform these responsibilities, they will be performed by the company.

What rights do I have under 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) with respect to the benefit programs that are subject to ERISA. ERISA provides that all plan participants are entitled to:

- **Receive Information About Your Plan and Benefits**

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

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated SPD. The administrator may impose 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.

- **Continue Group Health Plan Coverage**

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

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

- **Prudent Actions by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the 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 participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

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

- **Assistance with Your Questions**

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

Participant Cooperation

Circumstances may arise in which the company may require you to furnish information or pay an amount that directly or indirectly relates to participation in, or benefits paid or payable from a benefit program, including, but not limited to, information for the company to pursue a reinsurance or stop loss insurance claim. In consideration of the coverage provided by the benefit

program, you must fully cooperate, provide any and all information requested, execute any and all documents that will enable the company to access such information, and pay any amount due pursuant to a benefit program. If you fail to comply with this cooperation provision within the time period set by the company or provide false information in response to such request, payment of all benefits under the benefit program (whether or not they relate to the requested information or failure to pay) may be suspended and/or coverage may be terminated, either retroactively or prospectively in the company's discretion. In addition, the company may pursue any other remedy available to it, including obtaining an injunction to require cooperation, or recovering from you or your beneficiary damages for any loss incurred by it as a result of the failure to cooperate or make payment, or the provision of false information.

Right to Rebates and Recoveries

If you choose to participate in the Plan, you will not have any right to, or interest in, the assets of the company. To the extent an insurance carrier or other party pays any rebate (including medical loss ratio rebates), allowance, credit, settlement or other amount with respect to the Plan or an insurance policy (a "Recovery"), the Recovery will reduce or offset employer expenses and will not reduce, offset or be treated as being attributable to employee contributions or to any other amounts paid by participants or beneficiaries. If a Recovery exceeds employer expenses (as determined by the company), the Recovery will be retained solely by the employer, not to exceed the amount of contributions/premiums previously made by the employer to the Plan, minus any prior Recoveries received by the employer. Recoveries will not be considered assets of the Plan, and participants and beneficiaries will not be eligible to share in any Recovery.

BENEFIT PROGRAM APPENDIX

(Updated effective January 1, 2018)

The terms, conditions and limitations of the benefits offered under this Plan are contained in the Component Documents listed from time to time in this Appendix, which are incorporated in this Plan by reference.

Component Program	**Insured or Self-Insured**	**Insurance Carrier or Administrator**
Medical	Self-Insured	Anthem Blue Cross Blue Shield
Prescription Drug	Self-Insured	Express Scripts
Wellness	Self-Insured	Interactive Health
Dental	Insured	Delta Dental
Vision	Insured	EyeMed
Long Term Disability	Insured	Prudential
Short Term Disability	Insured	Unum
Group Term Life	Insured	Prudential
Supplemental Term Life	Insured	Prudential
AD&D	Insured	Prudential
Employee Assistance Plan (EAP)	Self-Insured	Mercy
Health FSA	Self-Insured	Discovery Benefits

AMENDMENT I AND SUMMARY OF MATERIAL MODIFICATION
to the
SUMMARY PLAN DESCRIPTION (SPD) FOR THE LUTHERAN SENIOR SERVICES BENEFITS PLAN

ARTICLE VII of Summary Plan Description (SPD) for the Lutheran Senior Services Benefits Plan ("the Plan") provides that the Employer may amend the Plan at any time. In accordance with the terms of such provision, the Plan is hereby amended as reflected in this document. This Amendment I supersedes any conflicting provision, predating the effective date of this Amendment I, of this Plan.

Now, therefore, the Plan is amended as follows:

A. Effective January 1, 2021, ARTICLE V HOW THE PLAN WORKS, PART 2. HEALTH CARE SPENDING ACCOUNT (HEALTH FSA) paragraph 1 is deleted in its entirety and replaced with the following.

If you choose to enroll in the health care spending account, a flexible spending account (Health FSA) will be established for you. You may elect to have a portion of your salary credited to the account each plan year. The elected amount may not exceed the IRS maximum contribution limit for the year (or any other limit approved by the plan administrator), which the company will communicate to you in the annual enrollment materials.

B. Effective January 1, 2021, the Benefit Program Appendix is deleted in its entirety and replaced with the following.

BENEFIT PROGRAM APPENDIX

(Updated effective January 1, 2021)

The terms, conditions and limitations of the benefits offered under this Plan are contained in the Component Documents listed from time to time in this Appendix, which are incorporated in this Plan by reference.

Component Program	Insured or Self-Insured	Insurance Carrier or Administrator
Medical	Self-Insured	Anthem Blue Cross Blue Shield
Prescription Drug	Self-Insured	Express Scripts
Wellness	Self-Insured	Virgin Pulse
Dental	Self-Insured	Delta Dental
Vision	Insured	EyeMed
Long Term Disability	Insured	Unum
Group Term Life	Insured	Unum
Supplemental Term Life	Insured	Unum
AD&D	Insured	Unum
Employee Assistance Plan (EAP)	Self-Insured	Mercy
Health FSA	Self-Insured	WEX

C. In all other respects, the Plan shall remain in effect.

In witness whereof, the undersigned has caused this Amendment I to be adopted effective as of the date(s) set forth herein.

LUTHERAN SENIOR SERVICES

By: Denis Thien Digitally signed by Denis Thien DN: cn=Denis Thien, o, ou, email=denis.thien@lsliving.org, c=US Date: 2021.08.04 10:40:03 -05'00'

Name: Denis Thien

Title: Dir. of Benefits & Compensation

Date: August 4, 2021

AMENDMENT II AND SUMMARY OF MATERIAL MODIFICATION
to the
SUMMARY PLAN DESCRIPTION (SPD) FOR THE LUTHERAN SENIOR SERVICES BENEFITS PLAN

ARTICLE VII of Summary Plan Description (SPD) for the Lutheran Senior Services Benefits Plan ("the Plan") provides that the Employer may amend the Plan at any time. In accordance with the terms of such provision, the Plan is hereby amended as reflected in this document. This Amendment II supersedes any conflicting provision, predating the effective date of this Amendment II, of this Plan.

Now, therefore, the Plan is amended as follows:

A. Effective July 1, 2021, the Benefit Program Appendix is deleted in its entirety and replaced with the following.

BENEFIT PROGRAM APPENDIX

(Updated effective July 1, 2021)

The terms, conditions and limitations of the benefits offered under this Plan are contained in the Component Documents listed from time to time in this Appendix, which are incorporated in this Plan by reference.

Component Program	**Insured or Self-Insured**	**Insurance Carrier or Administrator**
Medical	Self-Insured	Anthem Blue Cross Blue Shield
Prescription Drug	Self-Insured	Express Scripts
Wellness	Self-Insured	Quest Diagnostics
Dental	Self-Insured	Delta Dental
Vision	Insured	EyeMed
Long Term Disability	Insured	Unum
Group Term Life	Insured	Unum
Supplemental Term Life	Insured	Unum
AD&D	Insured	Unum
Employee Assistance Plan (EAP)	Self-Insured	Mercy
Health FSA	Self-Insured	WEX

B. In all other respects, the Plan shall remain in effect.

In witness whereof, the undersigned has caused this Amendment II to be adopted effective as of the date(s) set forth herein.

LUTHERAN SENIOR SERVICES

By: Denis Thien Digitally signed by Denis Thien DN: cn=Denis Thien, o, ou, email=denis.t@lutheranliving.org, c=US Date: 2021.08.04 10:39:08 -05'00'

Name: Denis Thien

Title: Dir. of Benefits & Compensation

Date: August 4, 2021