Summary Plan Description

METROPOLITAN COMMUNITY SERVICES

Premium Only Plan

SUMMARY PLAN DESCRIPTION

Metropolitan Community Services
dba: Metropolitan Community Services
Premium Only

PLAN PROVISIONS

Effective Date:	January 1, 2016; however, the Plan has been amended and restated effective **January 1, 2024**
Plan Year:	January 1, 2024 - December 31, 2024
Eligibility:	Group Insurance Benefit Accounts: The first of the month following sixty (60) days; Regularly scheduled thirty (30) hours per week or more
Eligible Expenses:	Qualified Group Insurance Premiums Qualified Optional Benefits Health Savings Account (HSA) Contributions Single - $4,150 Family - $8,300 Additional catch-up Contribution for Participants Over age 55 - $1,000 maximum
Employee Funding:	Through payroll deduction – Pre-taxed
Plan Administrator/ and Legal Process	Metropolitan Community Services 7900 Excelsior Blvd Ste 200 Hopkins, Minnesota 55343 (952) 658-8995 Federal ID #: 46-1868140
Other Participating Entity:	None
Administrative Agent:	Flyte HCM 11975 Portland Ave S, Ste. 130 Burnsville, Minnesota 55337 (952) 746-0000

PREMIUM ONLY ACCOUNT
QUESTIONS AND ANSWERS

INTRODUCTION

The purpose of this Premium Only Plan Summary is to insure that each eligible employee has a working knowledge of how to obtain the advantages of the payroll tax reductions authorized by Congress and regulated by the Internal Revenue Service.

The Summary Plan Description describes the basic features of the Plan, how it operates, and how you can get the maximum advantage from it. It is only a summary of the key parts of the Plan, and a brief description of your rights as a participant. To make maximum use of this Plan, be sure to proceed through this description carefully, so that you can make informed decisions that are right for you.

The Premium Only Plan is sponsored by your Employer as a company benefit.

If there is a conflict between the underlying Plan and this Summary Plan Description, the intention is for the Plan Documents to govern.

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1. What is a Premium Only Plan?

It is an Employer sponsored plan that permits employees to pay for "Health and Welfare Expenses" tax free. This benefit is available only to Eligible Employees, Spouses, Children and other tax Dependents of Employer(s) that sponsors this Plan.

2. What are Health and Welfare Expenses?

Group Insurance Premiums: which may include premiums for Health, Dental, Vision and Cancer Insurance as offered by your Employer that you are paying for by payroll deduction.

3. If I can claim Expenses on my 1040 Tax Return, what is the benefit of this Plan?

Tax Reduction: Although you can claim some of the above expenses on your 1040 Tax Form, only a small percentage of these expenses are deductible and the deduction is only available if the total expenses exceed a certain percent of your income. Whereas, as a participant in the Premium Only Plan, every dollar you pay for these expenses is one hundred percent (100%) tax deductible. You reduce the amount of State, Federal and Social Security taxes withheld from your paychecks thus increasing your net spendable income.

4. What is a "Plan Year"?

Normally, a Plan Year is a twelve (12) calendar month period starting on the first day of a month specified by your employer and ending twelve (12) calendar months later. Employers

may elect to have a Short Plan Year when they first introduce this benefit; after which, all subsequent Plan Years will be twelve (12) calendar months. The Plan Year for Metropolitan Community Services is January 1, 2024 to December 31, 2024.

5. What is the "Open Enrollment Period"?

The Open Enrollment Period is the period during which you have an opportunity to participate in the Plan by signing and returning an individual Election Statement to your Employer. You will be notified by your Employer of the timing and duration of the Open Enrollment Period, which is typically during the full month prior to the start of the new Plan Year.

6. How do I sign up for this Benefit Plan?

During the Open Enrollment Period, you will be provided an "Election Statement" which must be completed and submitted to your payroll office or Plan Administrator in order to participate in the Plan.

Group Insurance Premium Example: If you currently have a deduction for your Group Insurance (including health), your premium obligation is automatically pre-taxed unless otherwise indicated. Inform your payroll department if you do not wish to have the deduction made on a pre-tax basis.

Health Savings Account (HSA) Contributions: You must be a participant in the high deductible health plan coverage offered by the Employer and otherwise meet the criteria to be eligible to make these contributions. You will specify the amount of HSA Contributions that you wish to pay for with your salary reduction. This amount will be deducted pre-tax from your payroll check. You can change your HSA Benefit election at any time.

7. How much can I set aside for these expenses?

It varies with each different category of expense:

Group Insurance Premium - Exact premium
Health Savings Account – Single - $4,150 maximum; Family - $8,300 maximum

Note: You are not allowed to pay for the same health expenses under both the Health FSA and HSA Plan. To be eligible to make HSA Contributions, you can only participate in the Health FSA Plan on a limited basis - only Vision and Dental expenses can be claimed and paid through the Health FSA Plan.

8. How will these Expenses be deducted from my paycheck?

This may vary depending on payroll accounting systems. Any Group Insurance Premium and/or HSA Contribution you elect will be deducted proportionally from each paycheck.

9. How much would I save in taxes?

Typically, the average taxpayer saves up to thirty percent (30%) on State, Federal and Social Security withholding taxes on the amounts contributed to the Plan.

10. Where does the money I have deducted go?

Your deduction for Group Insurance Premiums goes directly to the appropriate insurance company each month, so your share of the premium(s) will be tax free. The deductions for HSA Contributions are forwarded by the Employer directly to your HSA trustee/custodian.

11. Can I change my Election during the Plan Year?

The only time you can change an election is if there is a major change in family status or employment. If your health coverage is through a group plan sponsored by your Employer, any minor premium changes will be automatically passed through to you. You must submit a written request to the Plan Administrator for approval within thirty (30) days of the change in family status or employment event. For a complete description of the status change rules, please refer to the last section of this Summary entitled “Irrevocability of Election.”

12. Can I enroll in the Plan after the start of the Plan Year?

As a current employee of Metropolitan Community Services, you must enroll as a participant prior to the start of this Plan Year or wait until the start of the following Plan Year. However, if you are hired during the Plan Year, you can join the Plan within a special enrollment period after meeting the eligibility requirements set by your employer.

13. Can I quit the Plan during the Plan Year?

In general, under the IRS “Irrevocability of Election” rules, you may not stop a pre-tax deduction. Once you enroll, you are obligated to maintain the requirements of the Plan for the full Plan Year. However, you are allowed to “change” an election if there is a major change (also known as “qualifying event”) in family status or employment. For further clarification see Q&A 16 of this summary and the last section of this Summary entitled “Irrevocability of Election”.

14. What happens to my benefits if I take a Leave of Absence under the FMLA rules?

If you go on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then you may revoke an existing election for group health plan coverage and make such other election for the remaining portion of the period of coverage. Subject to your Employer’s policy, if you wish to continue coverage you may have up to three payment options:

a) prepay the contribution obligations on a pre-tax basis (provided the leave doesn’t straddle two Plan Years);

b) make monthly contributions sent in by specified date (pre-tax if you are receiving compensation continuation, otherwise after-tax); or

c) if your Employer allows this option, make catch up contributions after returning from leave.

As a practical matter, employees on paid FMLA leave will usually choose the second option, while employees on unpaid FMLA leave usually prefer the first or third option. More information about your choices during an FMLA leave is available from your Employer.

15. What happens if I go on military leave?

If you are covered under USERRA, you are entitled to continue your medical and dental coverage while you are on military leave for up to twenty-four (24) months. You also are entitled to continue to elect to pay your share of the cost of coverage for these benefits on a pre-tax basis through this Plan to the extent that you have taxable compensation payable during the leave. The cost of continuing your coverage can be no more than one hundred two percent (102%) of the applicable Plan premiums/costs.

In order to maintain the above coverages during your military leave, you must notify the Employer that you intend to take a leave of absence for services in the uniformed services and that you intend to continue your coverage under these Plans. Please contact your Employer for more information.

16. What happens if my employment is terminated?

If your employment is terminated during the Plan Year, then your active participation in the Plan will cease and you will not be able to make any more contributions to the Plan for Group Insurance Benefits, or HSA Contributions. You may have the opportunity to extend benefits for Group Health Insurance per COBRA or state continuation rules if applicable.

For information about obtaining distributions from your HSA at any time after termination of employment, contact the trustee/custodian of your HSA established and maintained outside of the Plan.

17. Can I claim reimbursed expenses or salary reductions as deductions on my Tax Return?

No. By participating in the Premium Only Plan, you have already claimed these tax deductions and received tax savings in each and every paycheck throughout the Plan Year.

18. Will my Social Security benefits be reduced due to my lower contributions?

They may be. One of the factors that determine how much your Social Security benefits will be is based on income for five (5) highest paid years. To give you some idea of the possible reduction, if you reduced your taxable income by $100 per month for five (5) years during your highest paid years, your retirement income might be reduced about $15 per month. By

participating in the Plan, you will experience about a thirty percent (30%) current tax reduction on the amounts contributed to the Plan which may be more valuable than the retirement income.

19. What if I don't have any Group Insurance Premium and/or HSA Contribution expenses or do not wish to participate in those benefits?

By stating you do not currently have Group Insurance Premium and/or HSA Contribution expenses on your Section 125 Premium Only Plan Salary Reduction Agreement. This is required as record of proof that as an eligible employee you were provided the opportunity to participate and declined.

Any further questions should be directed to your assigned Plan Administrator. Your appointed Plan Administrator will act as primary interpreter of the Plan to issue rules, amendments and judgments to insure the Plan compliance with IRS regulations. If you have any questions regarding the effect of this Plan on your tax status you should seek counsel of your tax or legal advisor. The official Premium Only Plan Document is on file at your employer's administrative offices. You may review it at any time during normal business hours. You may obtain a copy by submitting a written request to your assigned Plan Administrator and payment of an appropriate fee. The official Premium Only Plan Adoption Agreement is also on file with the Plan Document and is available on the same terms. The Agreement will identify Eligibility Standards, Plan Year, Expense Categories available for deduction, Maximum deductible amounts for each category, plus the name, address and telephone number of your assigned Plan Administrator.

STATEMENT OF ERISA RIGHTS

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

1. Receive Information About Your Plan and Benefits

a. Examine without charge, at the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, which may include 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.

b. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, which may include 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.

c. Receive a summary of the Plan's annual report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. Continue Medical Coverage

Continue medical coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for the rules governing your continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating certain rights for the Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (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 Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting all administrative remedies under the Plan. In addition, if you should 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 after first exhausting all administrative remedies under the Plan. If it should happen that the 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 that your claim is frivolous.

5. 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, 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 Northwest, 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.

HIPAA PRIVACY RIGHTS

Under another provision of HIPAA, group health plans (including the Health FSA) are required to take steps to ensure that certain "protected health information" (PHI) is kept confidential. You will receive a separate notice from Flyte HCM that outlines its health privacy policies, including with regard to electronic PHI.

APPLICABLE STATUTE PROVISIONS

Employees and plan participants may have rights and protections under various employee benefits laws. The Plan will comply with the provisions of the FMLA, COBRA, USERRA and HIPAA to the extent such laws apply to the Plan.

TERMINATION, REHIRE AND LEAVE OF ABSENCE

Employees reentering within less than thirty (30) days from termination receive the "step back" provision wherein their previous election is reinstated. Beyond thirty (30) days, new hire election criteria applies. Employees on extended Leave of Absence who lose benefits eligibility must make new elections upon reaching eligibility.

IRREVOCABILITY OF ELECTION

Except as described below in this section, a Participant's election under the Plan is irrevocable for the duration of the Plan Year to which it relates. In other words, unless an exception applies, the Participant may not change any election for the duration of the Plan Year regarding: participation in this Plan; Salary Reduction amounts; or election of particular account plan benefits.

The exceptions to the irrevocability requirement, which would permit a Participant to make a midyear election change in benefits and/or Salary Reduction amounts for the Premium Payment Reduction, are as set forth below. You may always make changes to your HSA Contribution election per your company policy.

(a) **Change in Status**. A participant may change or terminate his or her actual or deemed elections under the Plan upon the occurrence of a Change in Status, but only if such change or termination is made on account of and corresponds with a Change in Status that affects coverage eligibility of a Participant, a Participant's Spouse, or a Participant's Dependent (referred to as the general consistency requirement). The Plan Administrator (in its sole discretion) shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a Change in Status. Assuming the general consistency requirement is satisfied, a requested change must also satisfy the following specific consistency requirements in order for a Participant to be able to alter his or her election based on that change.

(1) Loss of Dependent Eligibility. For a change in Status involving a Participant's divorce, annulment or legal separation from a Spouse, the death of a Spouse or a Dependent, or a Dependent's ceasing to satisfy the eligibility requirements for coverage, a Participant may only elect to cancel accident or health insurance coverage for the Spouse involved in the divorce, annulment, or legal separation, the deceased Spouse or Dependent, or the Dependent that ceased to satisfy the eligibility requirements. Canceling coverage for any other individual under these circumstances would fail to correspond with that Change in Status. Notwithstanding the foregoing, if the Participant, the Participant's Spouse (but not ex-spouse) or the Participant's Dependent becomes eligible for COBRA (or similar health plan continuation coverage under state law) under the Employer's Plan, then the Participant may increase his election to pay for such coverage.

(2) Gain of Coverage Eligibility Under Another Employer's Plan. For a Change in Status in which a Participant, a Participant's Spouse, or a Participant's Dependent gains eligibility for coverage under another employer's cafeteria plan (or another employer's qualified benefit plan) as a result of a change in marital status or a change in employment status, a Participant may elect to cease or decrease coverage for that individual only if coverage for that individual becomes effective or is increased under the other employer's plan.

(b) **HIPAA Special Enrollment Rights**. If a Participant's Spouse or a Participant's Dependent is entitled to special enrollment rights under a group health plan, as required by Case 9801 (f), and medical coverage was declined under the group health plan because of outside medical coverage and eligibility for such coverage is subsequently lost due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of the maximum COBRA period, or if a new Dependent is acquired as a result of marriage, birth, adoption, or placement for adoption, then a Participant may revoke a prior election for health or accident coverage and make a new election (including salary reduction election), provided that the election corresponds with such special enrollment rights. For purposes of this provision: (1) an election to add previously eligible Dependents as a result of the acquisition of a new Spouse or Dependent child shall be considered to be consistent with the special enrollment right; and (2) a HIPAA special enrollment election attributable to the birth or adoption of a new Dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively, (up to thirty (30) days).

(c) **Certain Judgments, Decrees and Orders**. If a judgment, decree, or order (an "order") resulting from a divorce, legal separation, annulment or change in legal custody (including a qualified medical child support order) requires accident or health coverage for a Participant's Dependent Child (including a foster child who is a Dependent of the Participant), a Participant may (1) change his or her election to provide coverage for the Dependent child (provided that the Order requires the Participant to provide coverage); or (2) change his or her election to revoke coverage for the Dependent child if the Order requires that another individual (including the Participant's Spouse or former Spouse) provide coverage under that individual's plan.

(d) **Medicare and Medicaid**. If a Participant, a Participant's Spouse, or a Participant's Dependent who is enrolled in a health or accident benefit under this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may prospectively reduce or cancel the health or accident coverage of the person(s) becoming entitled to Medicare or Medicaid. Further, if a Participant, a Participant's Spouse, or a Participant's Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, then the Participant may respectively elect to commence or increase the health or accident coverage.

(e) **Change in Cost**.

(1) Automatic Decrease or Increase for Cost Decreases and Insignificant Cost Increases. If the Participant's share of the premium for the Health Insurance Plan decreases during a Plan Year or increases by an insignificant amount, then the Salary Reductions under each affected Participant's election shall be prospectively decreased or increased to reflect such change. The Plan Administrator, on a reasonable and consistent basis, will automatically effectuate this prospective decrease or increase in affected employees' Salary Reduction contributions. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether increases in costs are insignificant; based upon all the surrounding facts and circumstances (including, but not limited to, the dollar amount or percentage of the cost change.

(2) Significant Cost Increase. If the Participant's cost for a Benefit Package Option significantly increases during a Plan Year, the Participant may either make a corresponding prospective increase in his or her Salary Reduction contributions or may revoke his or her election and in lieu thereof, receive on prospective basis coverage under another Benefit Package Option providing similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether a substitute Benefits Package Option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(f) **Change in Coverage**.

(1) Significant Curtailment or Cessation of Coverage. If the Plan Administrator determines that coverage under the Health Insurance Plan is significantly curtailed or ceases during a Plan Year, an affected participant may revoke his or her election under the Plan. In that case, an affected Participant may make a new election on a prospective basis for coverage under another Benefit Package Option providing similar coverage. Coverage under an accident or health plan is deemed "significantly curtailed" only if there is an overall reduction in coverage so as to constitute reduced coverage to Participants generally. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a curtailment is "significant" and whether a substitute Benefits Package Option constitutes "similar coverage" based upon all the surrounding facts and circumstances.

(2) Addition or Elimination of Benefit Package Option Providing Similar Coverage. If during a Plan Year the Plan adds or eliminates a Benefits Package Option or other coverage option, an affected Participant may elect the newly added option, (or elect another option if an option has been eliminated) prospectively on a pre-tax basis and make corresponding election changes with respect to other Benefit

package Options providing similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether other Benefits Package Options constitute "similar coverage" based upon all the surrounding facts and circumstances.

(3) Change in Coverage of Spouse or Dependent under their Employer's Plan. To avoid "election lock", a Participant may make a prospective election change that is on account of and corresponds with a change made under the Plan of the Spouse's, former Spouse's or Dependent's employer, so long as (a) the cafeteria plan or qualified benefits plan of the Spouse's, former Spouse's, or Dependent's employer permits its participants to make an election change that would be permitted under the proposed or final IRS regulations under Code 125; or (b) the Plan permits Participants to make an election for a Plan Year period of coverage that is different from the Plan Year period of coverage under the cafeteria plan or qualified benefits plan the Spouse's, former Spouse's, or Dependent's employer. The Plan Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the plan of the Spouse, former Spouse's, or Dependent's employer.

A participant entitled to make a new election under this Section must do so within thirty (30) days of the event described above. An employee who was eligible to elect Health Insurance Plan coverage with Salary Reductions, but who declined to do so during the initial election period or any Open Enrollment Period, may do so within thirty (30) days of the occurrence of an event described above, but only if the election under the new Salary Reduction Agreement is made on account of and is consistent with the event. Subject to the provisions of the underlying group health plan, elections made to add medical coverage for a newborn or newly-adopted Dependent child pursuant to a HIPAA special enrollment right may be retroactive for up to thirty (30) days. All other new elections shall be effective no sooner than the first day of the payroll period immediately following the date the Participant files his or her new Salary Reduction Agreement with the Plan Administrator. Elections made pursuant to this Section shall be effective for the balance of the Plan Year in which the election is made unless a subsequent event (described above) allows a further election change.