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SUMMARY PLAN DESCRIPTION

for the

SOTERA HEALTH FLEXIBLE BENEFITS PLAN

Effective 2024

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for the
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I. Introduction

Sotera Health Holdings, LLC (the "Company") maintains the Sotera Health Flexible Benefits Plan (the "Plan") for the purpose of providing certain welfare and fringe benefits, such as medical, dental, vision, employee assistance, life and disability benefits, as well as a Cafeteria Plan with health and dependent care spending accounts and pre-tax contributions to health savings accounts, to eligible employees and their eligible dependents (the "Benefit Options").

The Plan is comprised of the Benefit Options identified in Appendix A, but you will only receive benefits under a Benefit Option in which you are eligible, and have elected (if an election is required), to participate.

This document highlights for you some important information about the Plan and, together with the separate booklets describing the Benefit Options provided to you by the Company or insurer in writing (as may be amended from time to time), is intended to serve as the summary plan description ("SPD") for the Plan for purposes of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Plan documents, insurance policies and certificates related to the Plan may be obtained at no cost upon request from the Plan Administrator.

To the extent there is any conflict between the official plan document, certificates or insurance policies and the terms of this SPD or a separate Benefit Option booklet, the terms of the plan document, certificates or insurance policies will control, except to the extent expressly noted otherwise in this document.

Important Notice Regarding Health Care Reform and the Marketplace

You now have the ability to purchase health coverage for yourself and your family members through the Health Insurance Marketplace (the "Marketplace"). If you purchase coverage through the Marketplace, you may be eligible for a premium tax credit to help pay for that coverage, but in most cases the tax credit is only available if the Company does not offer you coverage under a health plan that is "affordable" and provides "minimum value." The Company believes that the medical coverage provided under the Plan's major medical Benefit Options (the "Medical Plan") is affordable and provides minimum value. There are only certain times of the year that you can purchase coverage through the Marketplace unless you experience an event that allows you to purchase coverage through the Marketplace mid-year. You can find additional information regarding coverage available through the Marketplace at www.healthcare.gov or by calling 1.800.318.2596.

As required under the Affordable Care Act ("ACA"), each medical Benefit Option under the Plan also has a Summary of Benefits and Coverage ("SBC"), which will be separately delivered to you at the time of your initial enrollment and annually thereafter. The SBCs are based on templates required by law and are intended to standardize the description of medical Benefit Options so that you can easily compare those options. While the SBCs are concise "snapshots" of the medical Benefit Options, they are not intended to take the place of your SPD or the official plan document. Your eligibility and benefits will only be determined in accordance with and subject to the official plan documents, including the insurance policies and certificates, and the applicable SPD.

II. General Eligibility Requirements

A. Employees

To be eligible to participate in a Benefit Option under the Plan, you must be in a class of employees covered under the terms of such Benefit Option, classified as working a minimum of 24 hours per week, included on the Company's or a participating employer's payroll records as a regular employee in the United States for whom the Company or participating employer withholds taxes, and you must satisfy any waiting period or other requirement imposed for such Benefit Option, as set forth in the separate Benefit Option booklets provided to you (such as, with

respect to some Benefit Options, be actively at work on the date you become eligible). The following individuals are not eligible to participate in the Plan:

- Any individual who is classified as a leased or as an independent contractor (without regard to how the individual may be classified by a court or administrative agency);
- Casual employees, temporary employees, seasonal employees or interns, except pursuant to the rules adopted by the Company under the medical plan with respect to the ACA; or
- Any individual whose employment is covered by collective bargaining and with respect to whom inclusion in the Plan has not been specifically provided for in such agreement.

If you have been classified by the Company as ineligible and you are reclassified into an eligible class, either by action of the Plan Administrator or by a governmental or judicial authority, you will not be eligible to participate in any Benefit Option for the period of time you were excluded from the Plan, or any Benefit Option, because of such classification. However, you will be eligible to participate prospectively in the Plan and any Benefit Option, assuming all other eligibility requirements are met.

B. Dependents

The eligibility requirements for your dependents are described in the booklets for each Benefit Option. Not all Benefit Options are available to all eligible employees or their dependents. You should refer to those documents for additional details. It is your responsibility to review the definition of dependents that apply for each Benefit Option and to only enroll those individuals who meet the requirements for eligibility. It is also your responsibility to report a change in your dependent's eligibility to the Plan Administrator within 31 days of the change in status.

Eligibility Determinations

The Plan Administrator, in its sole discretion, will determine whether an individual that is enrolled is eligible to participate in the Plan. Any such determination made by the Plan Administrator shall be conclusive and binding on all parties involved.

You may be asked to provide proof of eligibility for your dependents upon enrollment. In addition, the Company reserves the right to audit at any time the status of your enrolled dependents to determine if they meet the eligibility criteria. If you cannot provide sufficient proof that an enrolled individual meets the eligibility criteria, he/she will be disenrolled from the Plan, possibly retroactively. Providing false or misleading information regarding a spouse or child, enrolling an individual who does not satisfy the eligibility criteria or failing to timely drop an enrolled individual when he/she no longer satisfies the eligibility criteria may constitute a misrepresentation. If the Company determines that a misrepresentation has occurred, it may also terminate or suspend your coverage, require repayment of the ineligible individual's prior claims, require payment of the total value of the ineligible individual's coverage or take other corrective action. There are special rules that limit the Company's ability to terminate your coverage and your dependent's coverage under the Medical Plan on a retroactive basis. These rules are discussed below.

The Company and Plan Administrator reserve the right to take appropriate action against any individual who knowingly provides false information for purposes of obtaining coverage under the Plan, including (but not limited to) termination from participation in the Plan, termination of employment and legal action. (Additional information is provided later in this SPD.)

III. Enrollment and Benefits

The terms and conditions of the Benefits Options, including the enrollment requirements, coverage effective date and benefits provided, are described in the booklets. In general, elections must remain in effect for the entire calendar year, except in limited circumstances. Please refer to the separate summary plan description for the Cafeteria Plan for important information regarding how to make elections and when election changes are permitted.

The Employee Assistance Program (EAP) – Workplace Options

All employees and their eligible dependents are automatically covered by the EAP. The EAP provides confidential counseling and referral resources through a contract for services at no cost to you. You may contact the EAP, Workplace Options, at 888-851-7032. Counseling support and crisis consultation is available 24 hours a day, seven days a week. EAP counseling services are available to you and your dependents and are limited to five in-person visits per problem or concern, per calendar year, with a local Workplace Option affiliated counselor. If more sessions are needed, covered persons may be referred to other health providers/professionals. Covered persons should also review the mental health benefits that may be available to them under their medical plan coverage. Some of the counseling services provided address:

- Family, relationship or marital problems
- Emotional well-being and life improvement issues
- Stress and anxiety with work or family
- Addiction and recovery
- Financial issues
- Certain legal issues not related to the Plan or to your employer
- Job stress
- Crisis situations
- Questions about child care or elder care

Refer to the Benefits Guide or contact Benefits at benefits@soterahealth.com.

Special Enrollment Rights

If you do not enroll yourself and your eligible dependents in the Medical Plan Benefit Option after you first become eligible or during the Annual Open Enrollment Period, you may be able to later enroll for such benefits under the special enrollment rules set forth under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is available if:

(i) you initially declined coverage because you had other health care coverage that you have lost through no fault of your own; or

(ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person.

In the former case, you must have given (in writing if a written statement was required at the time by the Plan Administrator and you were provided with a notice of that requirement and its consequences at that time) the alternative coverage as your reason for waiving coverage under the Medical Plan Benefit Option when you declined to participate. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all eligible dependents in the Medical Plan Benefit Option within 30 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child. Please contact the Plan Administrator for details or any questions you may have regarding special enrollment.

You may also be able to enroll yourself and your dependent in a group health plan pursuant to a special enrollment right created by the Children's Health Insurance Program Reauthorization Act of 2009. If you or your dependent is eligible for, but not enrolled, for coverage under the terms of a group health plan, you (and/or your dependent) may enroll for coverage if either of the following conditions is met:

(i) You or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and your (or your dependent's) coverage under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the group health plan not later than 60 days after the termination of such coverage; or

(ii) You or your dependent become eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or State child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under the group health plan not later than 60 days after the date you or your dependent is determined to be eligible for such assistance.

Special Benefit for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from a plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be.

Special Benefit for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs who already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Medical Benefit Program. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits.

Genetic Information Nondiscrimination Act of 2008

The Genetic Information Nondiscrimination Act of 2008 ("GINA") protects employees against discrimination based on their genetic information. Unless otherwise permitted, the Company and any participating employers may not request or require any genetic information from you or your family members.

Mental Health Parity

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

Discrimination Based on Health-Related Factors Prohibited

HIPAA prohibits health plans from discriminating against any participant or dependent in terms of eligibility to participate in the Plan based on a health-related factor. Accordingly, benefits provided under the Plan will be available to all similarly situated individuals. Any restriction on benefits will be applied uniformly to all similarly situated individuals and may not be directed at an individual based on a health-related factor. The Plan may (i) limit or exclude benefits that are experimental or are not medically necessary and (ii) require an individual to satisfy a deductible, copay, coinsurance, or other cost-sharing requirement in order to obtain a benefit, provided that all limits, exclusions, or cost-sharing requirements apply uniformly to all similarly situated individuals, and are not just directed at an individual based on a health-related factor.

HIPAA Privacy

HIPAA also requires that health plans protect the confidentiality of your protected health information. A complete description of your rights under HIPAA can be found in the Plan's Privacy Notice or, if appropriate, in the privacy notice provided by a Benefit Option insurer. To obtain a copy of the privacy notice, contact the insurer or, if you have questions or complaints about the privacy of your health information, contact the Plan Administrator.

Neither this Plan nor the Company or a participating employer will use or further disclose information that is protected by HIPAA except as necessary for treatment, payment, health plan operations and plan administration, or as permitted or required by law. The Plan has required all of its business associates to also observe HIPAA's privacy rules. The Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other employee benefit plan of the Company.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan, a Benefit Option insurer, or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

IV. Termination of Participation

A. Participant Coverage

Your participation with respect to a Benefit Option will end on the earliest of the following:

1. The date the Plan or the Benefit Option is terminated;

2. The date on which you terminate employment or otherwise cease to meet the eligibility requirements for the Benefit Option (certain benefits, such as under the medical, dental and vision plans, end on the last day of the month in which your termination occurs);

3. The date specified in the booklet or insurance policy for a Benefit Option;

4. The last day of the period for which contributions for the cost of coverage under the Plan have been paid if the contributions for the next period are not paid when due; and

5. Upon fraud or intentional misrepresentation of a material fact.

B. Dependent Coverage

Coverage for your dependent under a Benefit Option, if applicable, will end on the earliest of the following:

1. The date your coverage ends under the Plan or Benefit Option;

2. The last day of the period for which contributions for the cost of coverage under the Plan have been paid if the contributions for the next period are not paid when due;

3. The date your dependent stops being an eligible dependent under the Plan;

4. The date specified in the booklet or insurance policy for a Benefit Option; and

5. Upon fraud or intentional misrepresentation of a material fact.

C. Rescissions

Please note that in certain circumstances, such as fraud or material misrepresentation by you or any of your Dependents with respect to the Plan, as determined in the Plan Administrator's good faith discretion, coverage under the Plan may be terminated immediately and, in some cases, retroactively. However, special rules apply to the Medical Plan.

Once your coverage under the Medical Plan is effective, the Company cannot rescind your coverage under the Medical Plan unless you or a covered Dependent performs an act, practice or omission that constitutes fraud or unless you or a covered Dependent makes an intentional misrepresentation of a material fact. For this purpose, rescission is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuance of coverage is not a rescission if the cancellation or discontinuance of coverage has only a prospective effect. For example, your coverage under the Medical Plan can be rescinded if you file a fraudulent claim for benefits or you submit fraudulent information in order to enroll someone who is not eligible to participate. Nothing prevents the Company from cancelling or discontinuing coverage retroactively to the extent it is attributable to a failure to timely pay required contributions towards the cost of coverage. The Plan will provide you at least 30 days advance written notice if your Medical Plan coverage will be rescinded. Any rescission of medical coverage is subject to the claims procedures provided in the SPD for the Medical Plan.

D. COBRA Continuation Coverage

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires that the Plan offer employees and their eligible dependents the opportunity to continue health coverage (called COBRA coverage) at group rates in certain circumstances when coverage would otherwise be lost. References to "you" and "your" in this discussion are to the eligible employees who are covered under the Medical Plan or any other Benefit Option providing health benefits (other than the EAP), the health care FSA, as well as the dental and vision Benefit Options. Coverage under the EAP continues automatically for the COBRA period, at no cost to you.

COBRA coverage is a continuation of coverage under the applicable Benefit Options when coverage would otherwise be lost because of a "qualifying event." Specific qualifying events are identified below. COBRA coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Benefit Option because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA coverage are required to pay for that coverage on an after-tax basis.

1. Eligibility and Coverage

You will become a qualified beneficiary if you lose your coverage under the applicable Benefit Options because either one of the following qualifying events happens:

a. Your hours of employment are reduced; or
b. Your employment ends for any reason other than your gross misconduct.

Your covered spouse will become a qualified beneficiary if he or she loses coverage under the applicable Benefit Options because any of the following qualifying events happens:

a. You die;
b. Your hours of employment are reduced;
c. Your employment ends for any reason other than your gross misconduct; or
d. You and your spouse divorce.

Also, if you reduce or eliminate your spouse's coverage under the Plan in anticipation of a divorce, and a divorce later occurs, then the divorce may be considered a qualifying event for your spouse even though his or her coverage under the applicable Benefit Options was reduced or eliminated before the divorce.

Your dependent children will become qualified beneficiaries if they lose coverage under the applicable Benefit Options because any of the following qualifying events happens:

a. You die;
b. Your hours of employment are reduced;
c. Your employment ends for any reason other than your gross misconduct;
d. You and your spouse divorce; or
e. The child stops being eligible for coverage under the Plan as a "dependent child."

Children born to or placed for adoption with you during the continuation coverage period may also be added to your COBRA coverage and be qualified beneficiaries, as long as you have elected COBRA coverage for yourself. The coverage period will be determined according to the date of the qualifying event that gave rise to your COBRA coverage.

You and/or your dependent(s) will be able to continue coverage under the Health Care FSA Benefit Option only if the maximum benefit available for the remainder of the Plan Year is equal to or more than the maximum amount that you could be required to contribute to the health care FSA Benefit Option for the remainder of the Plan Year.

2. Required Notice of Qualifying Events

Under the law, you or a covered dependent (or a representative) has the responsibility to inform the Plan Administrator (or the COBRA administrator designated by the Company) of a divorce or a child's loss of dependent status under the Plan. This notice must be provided within 60 days after the later of the event or the date on which coverage would otherwise end because of the event. In addition, in the event of the birth or adoption of a child after the qualifying event, you must also provide notice of the birth or adoption of the child whom you wish to enroll in the Benefit Option. If additional documentation supporting the notice is requested and not provided within the time required by the administrator, the notice will not be considered timely and COBRA coverage will not be available. **If this notice is not timely and properly provided, the qualified beneficiary will not be permitted to elect COBRA continuation coverage.** Notice must be provided on the forms and in the manner required by the Plan Administrator; oral notice is not permitted.

3. COBRA Election Period

Each qualified beneficiary has an independent right to elect COBRA coverage for 60 days from the later of the date coverage is lost or the date of notification to elect COBRA coverage.

If you would like COBRA coverage, you must complete the election form provided to you and return it in the time and manner set forth in that notice. If mailed, the election form must be postmarked no later than sixty 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event. The following are not acceptable as COBRA elections and will not preserve your COBRA rights: oral communications, including in-person or telephonic statements about an individual's COBRA coverage, and electronic communications (other than faxed communications), including e-mail.

Special COBRA rights apply if you lose coverage because of termination of employment or a reduction in hours of employment and you qualify for a "trade readjustment allowance" or "alternative trade adjustment assistance" under a federal law called the Trade Act of 2002. Generally, in this situation, you will be entitled to a second opportunity to elect COBRA coverage for yourself and certain family members (if you did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after your initial loss of coverage. Eligible individuals can take a tax credit paid for qualified health insurance, including COBRA coverage. If you qualify or may qualify for assistance under the Trade Act, please contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act or you will lose these special COBRA rights. If you have questions about these Trade Act provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information is also available at www.doleta.gov/tradeact/.

When making the decision of whether to elect COBRA continuation coverage, you should consider that there may be other coverage options for you and your family, such as through the Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away. Being eligible for COBRA does not limit your eligibility for this coverage or a tax credit through the Marketplace. Before you decide to enroll in coverage offered through the Marketplace, you can see what premiums, deductibles and out-of-pocket costs will be. More information about the Marketplace is provided in Section 9 below. You should compare plans so that you can see which coverage is right for you. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

4. Description and Maximum Length of COBRA Coverage

If you continue coverage, you will receive coverage identical to that provided under the Benefit Option for similarly situated employees or family members. If the Company changes any regular group health plan benefits during your COBRA period, your COBRA coverage will be changed in the same manner. The maximum COBRA coverage periods are described below.

36-Month Period. When the qualifying event is your death, your divorce, or a dependent child losing eligibility as a dependent child, the maximum COBRA period is 36 months.

18-Month Period. When the qualifying event is the end of your employment or reduction in your hours of employment, the maximum COBRA period is generally 18 months. However, if you became entitled to Medicare benefits less than 18 months before your termination or reduction in hours of employment, COBRA coverage for other qualified beneficiaries may last until 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare 8 months before your employment terminates, COBRA coverage for your spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

If you become entitled to Medicare after submitting your election form, you must provide notice of your Medicare entitlement.

The maximum COBRA coverage period for your newborn or newly adopted child is measured from your original qualifying event. To be enrolled in COBRA continuation coverage, the child must satisfy the otherwise applicable Plan eligibility requirements. A person who becomes the spouse of a qualified beneficiary (including a new spouse of an employee) or dependent child of a qualified beneficiary (other than one born to or placed for adoption with an employee) during COBRA continuation is not a qualified beneficiary and may not extend COBRA if a second event results in the loss of COBRA coverage.

Disability extension: If you or anyone in your family covered under a Benefit Option through COBRA continuation coverage is determined by the Social Security Administration ("SSA") to be disabled, and you provide the required notice, you and your family members who are receiving COBRA coverage may be entitled to an additional 11 months of COBRA coverage, for a total maximum of 29 months. The SSA must determine that the disability started at some time before the 60th day of COBRA coverage, and the disability must last at least until the end of the regular 18-month period of continuation coverage. In addition, you or the disabled qualified beneficiary (or a representative) ***must provide notice in writing of the SSA's determination before the end of the 18-month period of COBRA coverage and within 60 days after the later of*** (1) the date the qualified beneficiary is determined to be disabled by the SSA; (2) the date you terminated or reduced your hours of employment; and (3) the date on which the qualified beneficiary would lose coverage under the Plan as a result of your termination or reduction in hours of employment. The procedures for providing this notice are described below in Section 7.

Second qualifying event extension: If your family experiences another qualifying event while receiving 18 months (or 29 months in case of a disability extension) of COBRA coverage, your spouse and dependent children can get additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given. This extension may be available to your spouse and any dependent children receiving continuation coverage if you die or divorce, or if your dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose such coverage under the Benefit Option

had the first qualifying event not occurred. In no event may a qualifying event give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. For cases of second qualifying events, the qualified beneficiary must provide notice in writing (as described in Section 7 below) within 60 days after the later of the date (1) of the second qualifying event; or (2) on which the qualified beneficiary would have lost coverage due to the second qualifying event if it had occurred before the first qualifying event.

Failure to provide timely and properly provide notice of a disability determination or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Health Care Flexible Spending Accounts. If you are entitled to elect COBRA to continue to participate in the health care FSA offered through the Cafeteria Plan because you have a positive account balance, coverage may continue only through the end of the calendar year in which the qualifying event occurs. Remember that if the reimbursements you have received are more than the contributions you have made when you lose coverage, you are not entitled to elect COBRA coverage with respect to the health care FSA.

5. Termination of COBRA Coverage

COBRA coverage will terminate before the end of the indicated time period if:

a. The qualified beneficiary receiving COBRA coverage becomes covered under another group health plan after electing COBRA (provided the plan does not have pre-existing condition exclusions affecting the covered individuals).
b. The qualified beneficiary receiving COBRA coverage becomes entitled to Medicare after electing COBRA coverage.
c. The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.
d. Coverage is extended beyond 18 months because of disability, and the SSA makes a final determination that the qualified beneficiary is no longer disabled.
e. The Company ceases to maintain a group health plan.

If, during the period of COBRA coverage, a qualified beneficiary becomes covered, after electing COBRA, under other group health plan coverage, you or the qualified beneficiary (or a representative) must provide notice in writing within 30 days of the later of: (1) the date the other coverage becomes effective, or (2) the exhaustion or satisfaction of any preexisting condition exclusions affecting the qualified beneficiary. If, during the period of COBRA coverage, a qualified beneficiary becomes entitled, after electing COBRA, to Medicare Part A, Part B, or both, you or the qualified beneficiary (or a representative of either) must provide notice in writing within 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If the SSA determines that a qualified beneficiary is no longer disabled, the right to a disability extension for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the date of the determination. The qualified beneficiary must provide notice in writing within 30 days after the SSA's determination that he or she is no longer disabled. The procedures for providing this notice are described below.

If notice of these events is not timely and properly provided, the qualified beneficiary's COBRA coverage may be terminated retroactively and the qualified beneficiary may be required to repay a portion of the benefits received.

A qualified beneficiary does not have to show that he or she is insurable to choose COBRA coverage. However, COBRA coverage is provided subject to the qualified beneficiary's eligibility for coverage. The Company reserves the right to terminate a qualified beneficiary's COBRA coverage retroactively if he or she is determined to be ineligible or upon fraud or misrepresentation.

6. Premium Payments

A qualified beneficiary who elects coverage will be charged a premium of no more than 102% of the total cost of providing coverage. The premium for a Social Security disabled person can be as much as 150% of the cost of coverage for the 19th through the 29th month of coverage.

Qualified beneficiaries will be notified of the cost of continuing benefits if he or she experiences a qualifying event. The qualified beneficiary will have 45 days from the election date to pay the first premium; after that, premiums will be due and payable on the first day of the month. The first premium should cover the premium due from the date coverage is lost through the date COBRA is elected, plus any monthly premium that becomes due during the 45 day payment period. There will be a 30 day grace period to pay each subsequent monthly premium.

If the initial premium payment is not made by the end of the 45 day payment period, the qualified beneficiary will lose all COBRA rights and coverage will not take effect. If a subsequent monthly premium payment is not received by the first day of the coverage period to which it applies (e.g., the first day of the month), COBRA coverage will be suspended as of that day and then retroactively reinstated if the monthly payment is received prior to the end of the 30 day grace period. If the premium is not paid prior to the end of the grace period, the qualified beneficiary will lose all COBRA rights.

Qualified beneficiaries will be notified of any changes in rates during the COBRA period.

7. Notice Procedures

As a condition of receiving COBRA coverage, you or your covered dependent (or a representative) must notify the COBRA Administrator when certain events occur which impact COBRA continuation coverage. These COBRA-related events include:

- Certain initial qualifying events
- Second qualifying events
- A qualified beneficiary's determination of disability or cessation of disability
- Enrollment in another group health plan while receiving COBRA coverage
- Medicare entitlement while receiving COBRA coverage

Notice of these events must be given in writing and must be mailed to the COBRA Administrator at the address provided. However, notice of the initial qualifying event must be provided to the Plan Administrator through the Benefits Department.

The notice must contain the name, address and phone number of the covered employee (or formerly covered employee) and/or each qualified beneficiary experiencing the COBRA-related event, employer's name, the COBRA-related event being reported, the date of such event and any other information specified in the COBRA forms provided to the qualified beneficiary at the time of the qualifying event. You may also be required to provide evidence that the COBRA-related event has occurred. Acceptable evidence is your signed certification that the event has occurred, except in the case of a Social Security disability determination.

For a Social Security disability determination, you must provide a copy of your Social Security Disability Award letter, or if you are no longer disabled, you must provide a copy of the Social Security's determination that you are no longer disabled. The notice must be postmarked no later than the applicable deadline for giving the notice, as described above.

Additional documentation supporting the Notice may be required. If such information is requested and it is not provided within the time required, the Notice will not be considered timely and continuation coverage may not be available.

If the Notice is timely and properly provided, the notice will be deemed to have been provided on behalf of all Qualified Beneficiaries who are required to give the notice.

8. Keep the Plan Informed

It is important that you keep your employer informed of any changes in the addresses of your family members. It is your responsibility to provide notice of a change in your marital status or a change in your address or that of any covered family member. You should also keep a copy, for your records, of any notices you send.

9. Health Insurance Marketplace

The Marketplace offers "one-stop shopping" to find and compare private health insurance options. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums and cost-sharing reductions (amounts that lower your out-of-pocket costs for deductibles, coinsurance, and copayments) right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you decide to enroll. Through the Marketplace you'll also learn if you qualify for free or low-cost coverage from Medicaid or the Children's Health Insurance Program (CHIP). You can access the Marketplace for your state at www.HealthCare.gov.

Coverage through the Health Insurance Marketplace may cost less than COBRA continuation coverage. Being offered COBRA continuation coverage won't limit your eligibility for coverage or for a tax credit through the Marketplace.

Time Limits on Enrolling in Marketplace Coverage: You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. That is because losing your job-based health coverage is a "special enrollment" event. After 60 days your special enrollment period will end and you may not be able to enroll until annual enrollment, so you should take action right away if you think that you may want Marketplace coverage. In addition, you may also enroll in Marketplace coverage annually during what is called an "open enrollment" period. The open enrollment period is the time during which anyone can purchase coverage through the Marketplace.

To find out more about enrolling in the Marketplace, such as when the next open enrollment period will be and what you need to know about qualifying events and special enrollment periods, visit www.HealthCare.gov.

Enrolling in COBRA Coverage May Temporarily Limit Your Options: If you sign up for COBRA continuation coverage, you can switch to a Marketplace plan during a Marketplace open enrollment period. You can also end your COBRA continuation coverage early and switch to a Marketplace plan if you have a Marketplace qualifying event such as marriage or birth of a child through something called a "special enrollment period." If, however, you terminate your COBRA continuation coverage early without a Marketplace qualifying event, you'll have to wait to enroll in Marketplace coverage until the next open enrollment period and could end up without any health coverage in the interim.

Once you've exhausted your COBRA continuation coverage and the coverage expires, you'll be eligible to enroll in Marketplace coverage through a special enrollment period, even if you enroll outside of the Marketplace open enrollment.

If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage under any circumstances.

10. Enrolling in Another Group Health Plan

You may be eligible to enroll in coverage under another group health plan (like a spouse's plan), if you request enrollment within 30 days of your loss of coverage under this Plan. If you or your dependent chooses to elect COBRA coverage instead of enrolling in another group health plan for which you're eligible, you'll have another opportunity to enroll in the other group health plan within 30 days of losing your COBRA coverage.

11. Factors to Consider when Choosing Coverage Options

When considering your options for health coverage, you may want to think about:

- Premiums: You can be charged up to 102% of total plan premiums for COBRA coverage (more if you qualify for an extension of coverage on account of a disability). Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive.

- Provider Networks: If you're currently getting care or treatment for a condition, a change in your health coverage may affect your access to a particular health care provider. You may want to check to see if your current health care providers participate in a network as you consider options for health coverage.

- Drug Formularies: If you're currently taking medication, a change in your health coverage may affect your costs for medication – and in some cases, your medication may not be covered by another plan. You may want to check to see if your current medications are listed in drug formularies for other health coverage.

- Service Areas: Some plans limit their benefits to specific service or coverage areas – so if you move to another area of the country, you may not be able to use your benefits. You may want to see if your plan has a service or coverage area, or other similar limitations.

- Other Cost-Sharing: In addition to premiums or contributions for health coverage, you probably pay copayments, deductibles, coinsurance, or other amounts as you use your benefits. You may want to check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

12. <u>If You Have Questions</u>

If you have questions concerning the Plan or your COBRA coverage rights, you should contact the COBRA Administrator identified in Article V below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit <u>www.healthcare.gov</u>.

E. USERRA Continuation Coverage

If you or your dependents lose coverage under the Plan due to your qualifying service in the uniformed services, you have the right to elect to continue such coverage under Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). To be entitled to USERRA rights, you must give advance notice of your service unless it is impossible or unreasonable under the circumstances to give such notice or giving such notice is precluded by military necessity. Service in the uniformed services includes duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service.

Your right to continued health coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply. The administrative policies and procedures, which govern your right to COBRA continuation coverage, also apply to your right to USERRA continuation coverage, with a few limited exceptions.

Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be tolled until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be tolled in this situation.

You are the only one that has the right to make an election under USERRA to continue health coverage for yourself and any covered dependents. Your covered dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA coverage on behalf of your covered dependents, your covered dependents will still have a right to elect to continue their health coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue health coverage for yourself (or your covered dependents) under USERRA, you must pay 102% of the total premium cost of the coverage elected at the same time as the premium for COBRA coverage is due. However, if your uniformed service period is less than 31 days, you are not required to pay more for health coverage than you would be required to pay as an active employee. USERRA continuation coverage will continue for 24 months following the date your leave of absence begins. However, your coverage will terminate earlier if any of the following events occurs:

- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued health coverage under COBRA.

V. Important Plan Information

A. General Information

Plan Name:	Sotera Health Flexible Benefits Plan (which is comprised of various Benefit Options, including medical, dental, vision, life insurance, disability, etc., as set forth in Appendix A)
Plan Number:	501
Plan Sponsor and Plan Administrator:	Sotera Health Holdings, LLC 9100 South Hills Boulevard Suite 300 Broadview Heights, OH 44147 630-928-1700
EIN of Sponsor:	47-4076134
Plan Year:	Calendar Year
Agent for Service of Legal Process:	Attention: VP Global Total Rewards Sotera Health Holdings, LLC 9100 South Hills Boulevard Suite 300 Broadview Heights, OH 44147
COBRA Administrator:	Benefit Continuation Department 888-993-4646 (Monday–Friday 8am – 8pm ET) benefitsupport@ascensus.com Address for Correspondence: PO Box 56027 Boston, MA 02205 Payments are to be mailed to: Benefit Continuation Department PO Box 56027 Boston, MA 02205
Claims Administrators:	Medical / Rx Claims UMR P.O. Box 30541 Salt Lake, City, UT 84130 866-920-1968 Dental Claims Guardian P.O. Box 2459 Spokane, WA 99210 800-541-7846

Vision Claims
VSP
3333 Quality Drive
Rancho Cordova, CA 95670
800-877-7195

Life and Disability Claims
Voya
P.O. Box 1548
Minneapolis, MN 55440
888-238-4840

Participating Employers:	In addition to the Company, Sterigenics U.S., LLC, Nelson Laboratories, LLC., Sterigenics Radiation Technologies, LLC, Sotera Health Services, LLC, , Sterigenics Radiation Technologies IN, Inc., Nelson Laboratories Bozeman, LLC and Regulatory Compliance Associates, Inc. participate in the Plan.

B. Type of Plan, Plan Administration

The Plan is a welfare benefit plan that provides medical, dental, vision, EAP, disability, accidental death and dismemberment, life insurance benefits, quantum health care coordination, critical illness, hospital indemnity, accident insurance, and a well-being program, as well as health care spending accounts through the Company's separate Cafeteria Plan. The Plan Administrator is responsible for administering the Plan and may retain third parties to provide administrative services with respect to administration of the Plan.

The Plan Administrator and each insurer, with respect to those matters that the insurer is authorized to handle for the insured Benefit Options under the Plan, have the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefits, and their decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority shall be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious). Benefits under the Plan will be paid only if the applicable claims administrator decides in its discretion that the claimant is entitled to them.

Unless otherwise specifically set forth in an insurance contract, policy or summary plan description governing a benefit provided under the Plan, a claimant must take all legal action pertaining to a claim within the earliest of the following: (a) one year following the date the claims administrator has made a final determination of the claim in accordance with the applicable claims procedures; (b) two years after the date the service or treatment was rendered; or (c) two years after the claim arose.

C. Welfare Plan Funding and Source of Contributions

The Company, participating employers and participants contribute toward the cost of benefits provided under the Plan. Insured benefits are funded solely through the insurer and are identified in Appendix A; in no event is the Company or any participating employer responsible for the payment of the insured benefits. Self-insured benefits are payable from the Company's general assets and are identified in Appendix A.

D. Qualified Medical Child Support Orders

Generally, qualified medical child support orders ("QMCSOs") are legal orders requiring a parent to provide medical support to a child (for example, in cases of legal separation or divorce). In order to qualify as a QMCSO, the

medical support order must be a judgment, decree or order that is issued by an appropriate court or administrative agency, which contains certain information. A QMCSO must be specific as to the plan, the participant whose child(ren) is (are) to be covered, the type of coverage, the child(ren) to be covered and the length of coverage. The QMCSO may not require a plan to provide coverage for any type or form of benefit, or any option, not otherwise provided under the terms of the plan. A copy of the QMCSO procedures for this Plan may be obtained, free of charge, by contacting the Plan Administrator.

E. Amendment and Termination of Plan

The Company expects to continue the Plan indefinitely, but it reserves the right to amend or terminate the Plan, or any of the Benefit Options provided under the Plan, at any time, in whole or in part, by action of the Company or its authorized delegate. The benefits provided and the cost of the benefits, including the amount paid by employees, may also change, or be eliminated from time to time. The Plan does not provide any vested benefits.

F. Claims Procedure and Obligations to Exhaust Administrative Remedies

A Plan participant or covered dependent has a right to file a claim for benefits under the Plan, ask if he or she has a right to any benefits under the Plan, or appeal the denial of a claim for benefits under the Plan. Please refer to each booklet for the Benefit Options for a detailed description of the claims and appeals procedures to such option.

You must use and fully exhaust all of your actual or potential rights under the administrative claims and appeals procedures for each Benefit Option by filing an initial claim and then seeking a timely appeal of any denial before bringing filing a civil suit under ERISA. The exhaustion requirement relates to claims for benefits, eligibility and to any other issue, matter, or dispute (including any plan interpretation or amendment issue). Legal action may not be brought until the claim's procedures are exhausted.

The Plan Administrator has the exclusive discretionary authority to determine if an individual is eligible to enroll in a Benefit Option. With respect to insured Benefit Options, the insurer has the exclusive discretionary authority to construe and to interpret the Plan and to determine the amount of such benefits, and its decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such authority will be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious).

With respect to self-insured Benefit Options, the Plan Administrator (or its designee) has the exclusive discretionary authority to construe and to interpret the Plan, to determine the amount of such benefits, and its decisions on such matters are final and conclusive. Any interpretation or determination made pursuant to such discretionary authority will be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion (i.e., arbitrary and capricious). Benefits under a self-insured Benefit Option will be paid only if the Claims Administrator (as defined below), which is typically the third-party administrator, acting as the Plan Administrator's designee, decides in its discretion that the claimant is entitled to them.

Generally, the insurers or third party administrators of the benefits provided under the Benefit Options have the responsibility and authority for making decisions about claims for benefits under each respective Benefit Option (the "Claims Administrators). ***The following is a description of the procedure for handling claims under the EAP or any Benefit Option where the booklet, certificate or separate summary plan description for such option does not describe the claims procedures. Please refer to the specific booklets for each Benefit Option first for important information about claims and appeals.***

Claims Other Than for Group Health Plan Benefits

In the absence of information to the contrary in the separate booklets or to the extent the booklets do not comply with ERISA, the following procedures will apply. If you file a claim, you generally will receive written notice of the determination within 45 days for disability plan claims and 90 days for all other claims, of the date the Claims Administrator receives the claim. You will be notified if additional information is needed to process the claim, and you then have 45 days to provide the requested information (or such other period provided to you). If, for reasons

beyond the control of the Claims Administrator, an extension of time is required to process the claim, you will receive written notice of the extension, an explanation of the circumstances requiring extension and the expected date of the decision prior to the end of the 45 day or 90 day period, as applicable. In no event will the extension exceed a period of an additional 15 days from the end of the 45 or 90 day period, as applicable.

If your claim is denied, in whole or in part, you will receive a written explanation of the denial that includes the specific reason or reasons for the denial, specific reference to the plan provision on which the denial is based, a description of additional information necessary to perfect the claim and a description of the Plan's claims review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under ERISA following an adverse determination on review. In addition, for disability claims, the written explanation will include (i) for disability claims filed after April 1, 2018, if applicable, an explanation for disagreeing with or not following the views of health care professionals or vocational experts, or with a disability benefit determination made by the Social Security Administration, (ii) the internal rules, guidelines, protocols, standards, or other similar criteria of the Plan that were relied upon in denying the claim (or a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist), and (iii) a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits, and, if applicable, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances (or a statement that such explanation will be provided free of charge upon request).

If you want your claim to be reconsidered, you must submit a written appeal to the Claims Administrator within 180 days of the date of the denial for disability claims and within 60 days for other claims. In connection with an appeal, you have the right to review pertinent documents, records, and other information relevant to your claim and to submit written comments, documents, records, and other information relevant to the appeal of your claim for benefits, in each case before any determination on reconsideration is issued. Copies of all information relevant to your claim will be provided free of charge by the Plan Administrator, upon request.

Your claim will be given a full and fair review. The decision on review will not give deference to the initial adverse claim determination and will be conducted by an individual who is not the same individual who made the initial adverse claim determination or a subordinate of such individual.

If you file an appeal of a claim denial, the decision regarding the appeal will be made by the Plan Administrator promptly, but not later than 45 days for disability claims and 60 days for other claims. When the appeal is decided, you will be notified in writing of the results of the review. This notice will contain (i) the specific reason or reasons for the denial; (ii) specific references to the Plan provision on which the denial is based; (iii) a statement of your right to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim; and (iv) a description of the Plan's voluntary appeal procedures and a statement of your right to bring a civil action under ERISA following an adverse determination on review. The notice for a disability claim shall also include the information described above for the initial claim notification and, for disability claims filed after April 1, 2018, a description of any contractual limitations period that applies to your right to bring a civil action under ERISA and its expiration date.

Claims for Group Health Plan Benefits

In the absence of information to the contrary in the separate booklets or to the extent the booklets do not comply with ERISA, the following procedures will apply for claims for group health plan benefits.

BENEFIT DETERMINATIONS

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the Claims Administrator within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The Claims Administrator will notify you within this 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the

45-day time frame and the claim is denied, the Claims Administrator will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the group health plan on which the denial is based, and provide the claim appeal procedures.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the Claims Administrator within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 5 days. After reviewing the revised Pre-Service Claim, the Claims Administrator will notify you of any additional information needed within 15 days and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the Claims Administrator receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The Claims Administrator's receipt of the requested information; or
- The end of the 48-hour period within which you were to provide the additional information if the information is not received within that time.

A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, and provide the claim appeal procedures.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the Claims Administrator will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Claim Denial Notices

If your claim for benefits is denied in whole or in part, you or your beneficiary will receive notification regarding the claim denial within the applicable time period described above. This denial notice will include the reasons for the denial, reference to the Plan provision supporting the denial, a description of the Plan's appeals procedures and other relevant information regarding the claim decision as required by Department of Labor Regulations.

How to Appeal a Claim Decision

If you disagree with a claim determination after following the above steps, you can contact the Claims Administrator in writing to formally request an appeal. If the appeal relates to a claim for payment, your request should include:

- The patient's name.
- The plan identification number.
- The date(s) of health care service(s).
- The provider's name.
- The reason(s) you believe the claim should be paid.
- Any documentation or other written information to support your request for claim payment.

Your appeal request must be submitted to the Claims Administrator within 180 days after you receive the claim denial. A qualified individual who was not involved in the decision being appealed will be appointed to decide the appeal. If your appeal is related to clinical matters, the review will be done in consultation with a health care professional with appropriate expertise in the field who was not involved in the prior determination. The Claims Administrator may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request and free of charge you have the right to reasonable access to and copies of, all documents, records, and other information relevant to your claim for benefits.

APPEALS DETERMINATIONS

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), the appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. For appeals of Post-Service Claims (as defined above), the appeal will be conducted and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. For procedures associated with Urgent Care Claims, see "Urgent Care Claim Appeals" below.

Please note that the Claims Administrator's decision is based only on whether or not benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the Claims Administrator as soon as possible.
- The Claims Administrator will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination, taking into account the seriousness of your condition.

The Claims Administrator has the exclusive right to interpret and administer the provisions of the Plan. The Claims Administrator's decisions are conclusive and binding.

Claim Appeal Denial Notices

If your claim for benefits is denied in whole or in part on appeal, you or your beneficiary will receive notification regarding the claim denial on appeal within the applicable time period described above. This notice will include the reasons for denial, reference to the Plan provision supporting denial, a description of the Plan's appeals procedures and other relevant information regarding the decision as required by Department of Labor Regulations.

External Review

If you exhaust all internal appeals procedures, have been denied continued coverage for an ongoing course of treatment or have an urgent care claim, you may be entitled to an external review of your claim. Please consult the Plan Administrator or Claims Administrator for further details.

Claims and Appeals Procedures Exhaustion

In any event, for all claims, you must use and fully exhaust all of your actual or potential rights under the administrative claims and appeals procedures for each Benefit Option by filing an initial claim and then seeking a timely appeal of any denial before bringing filing suit. The exhaustion requirement relates to claims for benefits, eligibility and to any other issue, matter or dispute (including any plan interpretation or amendment issue). For disability benefit claims filed after April 1, 2018, if the Plan fails to strictly adhere to all applicable requirements under the Department of Labor Regulations applicable to disability benefit claims, you will be deemed to have exhausted the administrative remedies available under the Plan.

G. Limitations on Legal Action and Restriction on Venue

If you would like to bring legal action after exhausting your administrative remedies, any such suit must be filed within (a) one year following the date the Claims Administrator has made a final determination of the claim in accordance with the applicable claims procedures (or, if applicable, the date of a final decision regarding external review); (b) two years after the date the service or treatment was rendered; or (c) two years after the claim arose (or in the case of a claim for benefits under an insured Benefit Option, the period designated in the applicable booklet). You should refer to the booklet(s) for the insured Benefit Options for additional information regarding any time limits on filing suit with respect to the insured Benefit Options.

In addition, unless specified otherwise in a booklet for an insured Benefit Option, all suits must be brought or filed in the United States District Court for the Northern District of Illinois. Failure to follow the administrative claims and appeals procedures in a timely manner will cause you to lose your right to sue regarding an adverse benefit determination.

H. Subrogration/Reimbursement

If you file a claim for benefits for medical expenses you have incurred which may be the responsibility of a third party, you may be required to reimburse the Plan from any recovery you receive. For example, if you are injured in an automobile accident which is not your fault, you may have to repay the Plan for the health benefits you collect from the third party responsible for the accident, or from his or her insurance company, or anyone else from which you receive payment for the accident. You must notify the Plan of any claim you may have against any third party as soon as you become aware of the claim, you must sign any subrogation/reimbursement agreement requested by the Plan, and you must cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on your behalf in pursuing payment from the third party.

For additional information about subrogation/reimbursement, contact the Plan Administrator.

I. ERISA Statement of Rights

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all 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 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 an updated SPD. The Plan 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.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependent children 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.

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 employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

- No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit that you are otherwise entitled to receive or exercising your rights under ERISA.

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 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. However, you may not file suit until you have exhausted the administrative remedies provided under the Plan.

- 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, 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.

APPENDIX A

1. The **Medical Plan** provides self-insured medical benefits which are administered by UMR. The benefits and various options under the Medical Plan are described in this document and in separate booklets prepared by UMR and the latest enrollment materials and may include an integrated health reimbursement arrangement.

2. The **Dental Plan** provides self-insured dental benefits that are administered by Guardian and are described in this document and in a separate SPD and the latest enrollment materials.

3. The **Vision Plan** provides insured vision benefits through a fully insured policy issued by VSP. The benefits provided under the Vision Plan and are described in this document and in separate booklets prepared by VSP and the latest enrollment materials.

4. The **Life, AD&D and Disability Plan** provides life, accidental death and dismemberment, and long-term disability benefits through fully insured policies. The benefits are described in this document and in separate participant booklets prepared by the insurer, Voya.

5. The **Employee Assistance Plan** provides self-funded employee assistance benefits administered by Workplace Options. The benefits provided under the EAP are described in this document and in separate participant information provided by the Company or the EAP provider, and the latest enrollment materials.

6. The **Cafeteria Plan** provides for pre-tax employee contributions to health and dependent care flexible spending accounts and allows for the pre-tax premiums for coverage under the medical, dental and vision plans and for pre-tax employee contributions to health savings accounts for certain eligible individuals. These benefits are described in a separate summary plan description.

7. The **Short-Term Disability Program** provides self-insured short-term disability benefits administered by Voya.