Summary Plan Description

The Marcus Corporation
Flexible Spending Account Plan

Effective: January 1, 2024
Group Number: 925047

FLEXIBLE SPENDING ACCOUNT PLAN

Notice To Employees

This booklet describes the Employer-sponsored Flexible Spending Account Plan ("Plan") as of January 1, 2024.

The Marcus Corporation has entered into an arrangement with United Healthcare Services, Inc., Minnetonka, MN ("UnitedHealthcare") under which UnitedHealthcare will process reimbursements and provide certain other administrative services to the Plan.

UnitedHealthcare does not insure the benefits described in this booklet.

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PLAN HIGHLIGHTS

Under the Plan, you can elect to establish two Flexible Spending Accounts ("FSAs"). These accounts let you make before-tax contributions from your salary, which can then be used to reimburse yourself for Eligible Expenses.

The **Health Care Spending Account ("HCSA")** is a type of FSA used for reimbursement of Eligible Health Care Expenses (defined in the ***Health Care Spending Account*** section), including certain medical and dental expenses for you, your spouse, your dependent children, and any other dependents as determined by The Marcus Corporation and in compliance with the Internal Revenue Code (IRC).

The **Dependent Care Spending Account ("DCSA")** is a type of FSA used for reimbursement of Eligible Dependent Care Expenses (defined in the ***Dependent Care Spending Account*** section), such as day care.

You can elect to participate in either the HCSA, the DCSA, or both.

Each Plan year (January 1 through December 31) you can contribute to your HCSA and/or DCSA, and then, during the Plan year, you can receive reimbursement from the appropriate account for Eligible Expenses that are not otherwise reimbursed. Contribution levels are set forth as described under Section, *Contributions*.

WHO IS ELIGIBLE AND HOW TO START YOUR FLEXIBLE SPENDING ACCOUNT

Who is Eligible

A regular full-time employee of the Plan Sponsor who is scheduled to work at his or her job at least 30 hours per week is eligible to participate in the Plan.

When You May Enroll

You may elect to participate in the Plan during your first 31 days of employment or during any subsequent annual enrollment period. If timely elected, the Plan will be effective on the day immediately following the completion of a waiting period. The waiting period is described below:

Marcus Hotels and Resorts and its subsidiaries	
Hilton/Pfister Operating Engineers:	As collectively bargained
Full-time hourly associates:	One month from date of hire
Full-time salaried associates:	One month from date of hire
Hourly variable/part-time associates who work an average of at least 30 hours per week:	One month following six months of service

Marcus Theaters Corporation and its subsidiaries	
Full-time hourly associates:	One month from date of hire
Full-time salaried associates:	One month from date of hire
Hourly variable/part-time associates who work an average of at least 30 hours per week:	One month following six months of service
Marcus Corporation	
Full-time hourly associates:	One month from date of hire
Full-time salaried associates:	One month from date of hire
Hourly variable/part-time associates who work an average of at least 30 hours per week:	One month following six months of service

If you do not elect to participate in the Plan during your first 31 days of employment, you must wait until the next annual Open Enrollment period to elect to participate in the Plan, unless you have experienced a qualified change in status. (Refer to the Section, *Changing Your Contribution Amounts*.) You will need to enroll each year, even if you enrolled in the Plan the year before.

How to Enroll

You elect to participate in the Plan by going online to the Benefit Enrollment system and making your elections within 31 days of your eligibility. If you do not enroll within 31 days, you will need to wait until the next annual Open Enrollment to participate in the Plan.

Each year during annual Open Enrollment, you have the opportunity to review and change the amount of before-tax dollars you wish to contribute to the HCSA, the DCSA, or both. Any changes you make during Open Enrollment will become effective the following January 1.

CONTRIBUTIONS

Each year, you must decide on the amount of before-tax dollars you want to contribute to the accounts. Please note that these accounts are not "funded". Rather, the amount you elect to "contribute" remains in the employer's general assets until claims are reimbursed. You may contribute to the HCSA or DCSA, or both, however, amounts contributed to one account cannot be used to reimburse expenses under the other account. You should carefully estimate your Eligible Health Care and Dependent Care Expenses, collectively referred to throughout this booklet as "Eligible Expenses", for the upcoming Plan year because IRS regulations require that you forfeit any unused funds remaining in either account after the end of the Plan year.

You have until March 1 of the next year to request reimbursement for Eligible Expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account termed. Any such Eligible Dependent Care Expenses must be submitted on or before March 1 of the Plan year following your termination.

For the Health Care Spending Account, you may elect to contribute between $0 and $3,200 a year.

For the Dependent Care Spending Account, you may each elect to contribute between $0 and $5,000, or if you are married and filing separately for federal income tax purposes, you may each elect to contribute up to $2,500 a year. If you or your spouse's earned income is less than $5,000 per year, the amount that you can contribute is reduced to the amount of your or your spouse's earned income.

CHANGING YOUR CONTRIBUTION AMOUNTS

IRS regulations do not permit you to stop or change the amount you contribute to a flexible spending account during the Plan year, unless you meet one of the following conditions:

A. With regard to both a HCSA and a DCSA, one of the following changes in status events occurs:

   - An event that results in a change in your legal marital status, including your marriage, the death of your spouse, or your divorce, legal separation or annulment.
   - An event that results in a change in the number of your dependents, including birth, adoption, placement for adoption or death of a dependent.
   - An event that results in a change in the employment status of you, your spouse or dependent, including termination or commencement of employment, a strike or lockout, the commencement of or return from an unpaid leave of absence.
   - An event that causes your dependent to satisfy or cease to satisfy the eligibility requirements due to the attainment of age, student status or any similar circumstances, as provided under the HCSA or DCSA.

B. For individuals who participate in a HCSA, the following additional events will enable you to change your election:

   - If you become entitled to Medicare or Medicaid, you may elect to revoke your HCSA coverage. If you lose coverage under Medicare or Medicaid, you may increase your coverage.
   - If the FSA Plan Sponsor and/or The Marcus Corporation receives a judgment, decree or order resulting from your divorce, legal separation, annulment or change in legal custody that requires group health coverage for your dependent child then the FSA Plan Administrator and/or The Marcus Corporation may:

- ♦ Change your election to provide coverage for that child, if the order requires you to provide coverage for the child under the HCSA, or
- ♦ Permit you to cancel your child's coverage under the HCSA, if the order requires your former spouse to provide coverage.

C. For individuals who participate in a DCSA, the following events, in addition to those in (A.) above will enable you to change your election:

- A change in your dependent care provider.
- A significant increase or decrease in the cost of the dependent care, but only if the dependent care provider that imposes the cost change is not related to you.

You must notify The Marcus Corporation within 31 days of above change in status events to request a change in coverage. No change in election will be permitted after 31 days.

The above rules are intended to be consistent with the IRS regulations under Sections 125 and 129 of the Internal Revenue Code, and to the extent there is any inconsistency, those regulations shall control.

Any new election hereunder must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your HCSA election). As used herein, "dependent" means a tax dependent under Section 152 of the Internal Revenue Code.

Changes in contribution amounts made during the Plan year are effective as of the first of the month following the date that you timely notify The Marcus Corporation of the change in status.

HEALTH CARE SPENDING ACCOUNT

Eligible Health Care Expenses

To be eligible for reimbursement from your HCSA, the health care expenses must be:

- ■ Incurred for medical care, defined in Section 213(d) of the Internal Revenue Code for amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body including prescription medicine and drugs and over-the-counter medicine and drugs prescribed by a health care provider.
- ■ Incurred while you are participating in the HCSA.
- ■ Incurred during the Plan year.

Please note
Any reimbursement you receive through your HCSA can not be reimbursed under any other plan covering health benefits, including a spouse's or dependent's plan.

Below is a partial list of the types of health care expenses eligible for reimbursement from your HCSA. Generally, Eligible Health Care Expenses are those for which you could have claimed a tax deduction on an itemized federal income tax return (without regard to any threshold limitation) including any copayment, coinsurance or deductible amounts.

A more comprehensive list of Eligible Expenses is available at **www.myuhc.com**. Some guidance regarding what constitutes eligible medical expenses (including additional examples) is provided in IRS Publication 502 which is available from any regional IRS office, IRS website **www.irs.gov** or by phone at 1-800-TAX-FORM (1-800-829-3676).

Eligible Medical Expenses

- Copayments, Coinsurance and Deductible amounts;
- Routine physical exams;
- Routine lab and x-rays performed for medical reasons;
- Birth control items prescribed by your doctor;
- Childbirth classes;
- Cardiac rehabilitation classes;
- Drug abuse treatment centers;
- Sterilization unless prohibited by law;
- Other qualified 213(d) medical expenses not covered by the underlying medical plan.

Eligible Vision Expenses

- Routine eye examinations;
- Eye glasses;
- Contact lenses, including all necessary supplies and equipment.

Eligible Hearing Expenses

- Routine hearing examinations;
- Hearing aids and repairs;
- Cost and repair of special telephone equipment for the deaf.

Eligible Dental Expenses

- Copayments, Coinsurance and Deductible amounts;
- Preventive Care;
- Exams, cleanings, x-rays, root canals and bridges;
- Dentures and fillings.

Eligible Prescription Drugs

- Copayments, Coinsurance and Deductible amounts;
- Cost for allowable prescription drugs.

Ineligible Expenses

The partial list below includes examples of expenses that are not eligible for reimbursement:

- Expenses incurred for cosmetic surgery or other similar procedures, unless the procedure is necessary to improve deformities directly related to a congenital condition, a personal injury or a disfiguring disease.
- Expenses for custodial care in a nursing home.
- Insurance premiums, including Medicare Part B premiums, long term care premiums, and other payments or contributions for health coverage (such as contributions for coverage under an employer-sponsored group health plan or HMO or other health plan).
- Expenses incurred for general good health (such as vitamins and other dietary supplements, and toothpaste).
- Expenses incurred before the effective date of your account.
- Over the counter non-prescription drugs and medicines incurred for medical care (such as allergy medicines, antacids, cold medicines and pain relievers), unless prescribed by a health care provider.

In addition, as with any other expense reimbursed under an employer-sponsored medical or dental plan, health expenses reimbursed through your HCSA cannot be claimed as deductions on your income tax return.

DEPENDENT CARE SPENDING ACCOUNT

Eligible Dependent Care Expenses

Eligible Dependent Care Expenses that can be reimbursed from your DCSA are expenses incurred for household and dependent care services that enable you and (if married) your spouse to be gainfully employed, which generally means working or actively looking for work.

If your spouse has no earned income, you cannot use a DCSA unless your spouse is physically or mentally incapable of caring for himself or herself, is looking for work or is a full-time student for at least five months during the Plan year.

To qualify for reimbursement, Dependent Care Expenses cannot exceed your earned income or, if married, the earned income of the lesser earning spouse. Earned income (including any self-employment earnings) is generally the remaining salary after all pre-tax salary reductions have been made. If you are married and your spouse is physically or mentally incapable of caring for himself or herself or is a full-time student, the IRS considers your spouse to have a monthly income of $250 (as adjusted from time to time) if you have one dependent, or $500 (as adjusted from time to time) if you have two or more dependents, for each month that your spouse is incapable of caring for himself or herself or is a full-time student.

Dependent Care Expenses must be incurred for a qualified dependent. Qualified dependents are:

- A dependent under federal tax law who is a child under age 13; or

- A spouse of a participant, if the spouse is physically or mentally incapable of caring for himself or herself and has the same principal place of abode as the taxpayer for more than one-half of such taxable year; or
- A dependent under federal tax law who is physically or mentally incapable of caring for himself or herself; provided that such dependent lives in your home for more than one-half of the year, if you provide over one-half of the individual's support for the taxable calendar year.

Eligible Dependent Care Expenses include, but are not limited to, the following expenses if not otherwise excluded:

- Expenses for care at a day care center and day care transportation that complies with all applicable state and local regulations.
- Expenses for licensed nursery school fees.
- Expenses for care provided by a housekeeper, babysitter or other person in your home who primarily cares for eligible children or an eligible adult dependent.
- Expenses for care provided by a relative who cares for your qualified dependents, so long as that relative is over the age of 19 and is not your dependent under federal tax law.
- Expenses for care for a qualified dependent age 13 or over, including a spouse or adult dependent, who is physically or mentally incapable of caring for himself or herself. If you are claiming reimbursement for care outside your home for such dependent, the dependent must spend at least 8 hours each day in your home.
- Expenses for care at a day camp to which you send your children (under age 13) during school vacations so that you and your spouse, if you are married, can be gainfully employed or attend school full-time.

Dependent Care Tax Credit vs. Dependent Care Spending Account

Some employees may be eligible to claim a dependent care tax credit on their federal income tax return. This credit is available for the same types of expenses as the DCSA. However, the IRS requires that the dependent care tax credit be reduced, dollar for dollar, by the amount reimbursed under a Dependent Care Flexible Spending Account. In other words, you cannot use expenses reimbursed through the DCSA to claim the tax credit.

For more information about how the dependent care tax credit works, see IRS Publication No. 503. In addition, because each employee's situation is different, you may want to consult with a tax advisor before deciding whether to use the tax credit or the DCSA.

HEALTH CARE SPENDING CARD DEBIT MASTERCARD®

You will be provided with a Health Care Spending Card Debit MasterCard® that may be used to pay for certain Eligible Expenses directly from your HCSA. The Health Care Spending Card Debit MasterCard® allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®. Use of the Health Care Spending Card Debit MasterCard® is voluntary.

Important
You should familiarize yourself with the specific products and services that are eligible for card use based on this Plan. Go to **myuhc.com** to learn how to get the most out of your Health Care Spending Card Debit MasterCard®.

Receiving Your Health Care Spending Card Debit MasterCard®

You will automatically receive two Health Care Spending Card Debit MasterCard®s. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® to order additional cards.

Activating Your Health Care Spending Card Debit MasterCard®

If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available real-time upon activation of the card within the first Plan year. However, for future Plan years the funds will not be available for use until the effective date of the future Plan year.

If you decide not to activate the Health Care Spending Card Debit MasterCard®, simply destroy and discard both cards. However, you can be reimbursed for Eligible Expenses by completing a paper reimbursement form available from The Marcus Corporation or found on **myuhc.com** and as described under Section, *Requesting a Reimbursement from Your Flexible Spending Account*.

Please note
If you activate your card prior to the Plan effective date, you cannot use your card until the Plan effective date.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard® or your Health Care Spending Card Debit MasterCard® number can be entered online or on an order form, similar to using a credit card number. You can even use your Health Care Spending Card Debit MasterCard® to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers, and retail pharmacy counters.

You may choose to use your Health Care Spending Card Debit MasterCard® for mail order prescriptions or for eligible over-the-counter (OTC) supplies and materials by going to an online pharmacy at Drugstore.com via **myuhc.com**. Additionally, your Health Care Spending Card Debit MasterCard® can be used at Walgreen's retail stores or at participating retailers as described under the Section, *Retailers with Inventory Information Approval System (IIAS)*.

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter 'credit' on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS, therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®, because certain payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases real-time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described under Section, *Health Care Spending Account*. A claim number is assigned to the transaction.

Eligible Expenses Reimbursed through the Health Care Spending Card Debit MasterCard®

Your card can be used for certain Eligible Health Care Expenses including prescription copayments or out-of-pocket responsibility, eligible over-the-counter (OTC) supplies, materials, prescribed OTC medicines and copayments at locations such as doctor, dentist, eye doctor, clinic, hospital or other care providers associated with medical, dental, vision at UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. Your card can only be used for copayments at medical physician locations, not for other patient financial responsibilities such as coinsurance and deducible. In this situation, please advise your physician to only process the copayment amount on your card, otherwise the transaction will be denied. Although coinsurance and deductibles are generally considered eligible FSA expenses, they are not valid card transactions. You will need to submit a claim form for reimbursement as described under Section, *Requesting a Reimbursement from your Flexible Spending Account.*

Please note
You may be able to use your Health Care Spending Card Debit MasterCard® to pay for prescribed OTC medicines if you take your OTC prescription to a pharmacist to be filled and have a prescription number assigned. Or you may purchase prescribed OTC medicines using another form of payment, such as cash or a personal credit card. If it is an Eligible Expense under your Plan, you can manually submit for reimbursement. Non prescribed OTC medicines are not an Eligible Expense subject to reimbursement.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® with transactions amounts greater than the funds available in your HCSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HCSA, the HCSA balance of $10 will be authorized towards the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. **Note:** not all providers or merchants accept partial authorization.

Retailers with Inventory Information Approval System (IIAS)

IRS regulations require that retailers comply with IRS Inventory Information Approval System (IIAS) swipe technology as a method to identify and substantiate Eligible Health Care Expenses, per Section 213(d) of the Internal Revenue Code. The IIAS allows you to use your Health Care Spending Card Debit MasterCard® to pay for 213(d) Eligible Health Care Expenses without having to provide any additional documentation or request reimbursement after a purchase is made, as transactions will be verified at the point of sale and payment will be made right from your HCSA. Additionally, IIAS compatibility allows you to use your Health Care Spending Card Debit MasterCard® at participating retailers to pay for both Ineligible Expenses and Eligible Health Care Expenses on the same transaction with Eligible Health Care Expenses being approved via the Health Care Spending Card Debit MasterCard® and remaining Ineligible Expenses may be paid using another form of payment. When you use your card at participating retailers, Eligible Health Care Expenses will be identified and noted on your receipt. You will not have to submit receipts for reimbursement as long as the purchases are made at a participating retailer and you use your Health Care Spending Card Debit MasterCard®. IRS guidelines still require you to save your itemized receipts as part of your tax records. You can see a full list of participating retailers at http://www.sig-is.org. If you go to a non-Participating retailer you can still buy Eligible Health Care Expenses that don't provide itemized sales receipts, however you will need to pay using another form of payment, and then submit receipts for reimbursement as described under the Section, *Requesting a Reimbursement from your Flexible Spending Account.*

Monthly Health Statements and FSA Yearly Statements

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement which will include your card activity. You will also be able to view card transactions on **www.myuhc.com**. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

Getting help 24 hours a day is easy.

Simply call our toll-free number at 1-866-755-2648 available 24 hours a day.
- Learn your account balance.
- Report a lost or stolen card.
- Order extra cards and more.

Go onto **myuhc.com** anytime.
- Learn your account balance.

REQUESTING A REIMBURSEMENT FROM YOUR FLEXIBLE SPENDING ACCOUNT

If you do not activate your Health Care Spending Card Debit MasterCard® or choose not to use your card, you will need to submit a reimbursement form, called a request for withdrawal, to be reimbursed from your HCSA and/or DCSA for the Eligible Expenses that have been incurred. A request for withdrawal form is available from The Marcus Corporation or can be found on **www.myuhc.com**.

For reimbursement from your HCSA, you must include proof of the expenses incurred. Proof can include a bill, invoice, or an Explanation of Benefits (EOB) from any group medical/dental/vision plan under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical, dental and vision plans, for example, charges by surgeons, doctors and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical/dental/vision plans are made.

For reimbursement from your DCSA, you must submit proof of the services rendered, such as a bill, receipt, or invoice and Social Security or Tax Identification Number of the care provider.

Only expenses which are incurred while you are a participant in the Plan may be reimbursed from a Flexible Spending Account. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account termed. In addition, expenses which are incurred during one Plan year cannot be reimbursed from funds contributed to your HCSA or DCSA during another Plan year. An expense is considered incurred when services are provided, not when you are billed or when you pay for care.

You can submit a reimbursement form at any time. You will be reimbursed for Eligible Expenses as long as the amount requested from either account is at least $25, except for reimbursement with respect to the last month of the Plan year. Amounts below $25 will be accumulated and processed with future payments.

If you have established a HCSA, your total annual contribution amount is available immediately. You can request reimbursement for Eligible Expenses up to your annual contribution amount as soon as such Eligible Expenses have been incurred.

If you have established a DCSA, only the amounts you have actually contributed to the account are available for reimbursement. If you request reimbursement for more than what you have in your account, you will receive only the amount in your account. As additional contributions are made to your account, outstanding reimbursements will be processed automatically.

Requests for withdrawal will be accepted and processed through March 1 of the following year for expenses incurred during the Plan year. For the DCSA, if your employment terminates you can continue to request reimbursement for Eligible Dependent Care Expenses incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date against what is in your DCSA balance at the time of termination. The dates of service must fall within the Plan year in which the DCSA account termed. Any such Eligible Dependent Care Expenses must be submitted on or before March 1 of the Plan year following your termination.

In accordance with IRS regulations, amounts contributed to your HCSA or DCSA during the Plan year but remaining in your account at the end of the processing period (March 1 of the following year) cannot be returned to you or used to reimburse expenses incurred in a subsequent Plan year. These amounts are forfeited.

Important
Myuhc.com includes many features such as the options to:
- View Explanation of Benefits/Health Statements
- Utilize a savings calculator for FSA
- View your FSA summary page detailing contributions and amount left in your FSA
- View your FSA Claims Summary including claim transaction details

CLAIMS PROCEDURES

Claim Denials and Appeals

If Your Claim is Denied

If a claim for benefits is denied in part or in whole, you may call UnitedHealthcare at the number on your Health Care Spending Card Debit MasterCard® card before requesting a formal appeal. UnitedHealthcare will try to resolve the issue over the phone, however, if you are not satisfied you have the right to file a formal appeal as described below.

How to Appeal a Denied Claim

If you wish to appeal a denied claim, you must submit your appeal in writing within 180 days of receiving the denial. This written communication should include:

- the patient's name and ID number as shown on the ID card;

- the provider's name;
- the date of medical service;
- the reason you think your claim should be paid; and
- any documentation or other written information to support your request.

You or your Dependent may send a written request for an appeal to:

UnitedHealthcare – Appeals
Attn Appeals
P.O. Box 981512
El Paso, TX 79998-1512

Review of an Appeal

UnitedHealthcare will conduct a full and fair review of your appeal. The appeal may be reviewed by:

- an appropriate individual(s) who did not make the initial benefit determination; and
- a health care professional who was not consulted during the initial benefit determination process.

Once the review is complete, if UnitedHealthcare upholds the denial, you will receive a written explanation of the reasons and facts relating to the denial.

Filing a Second Appeal

Your Plan offers two levels of appeal. If you are not satisfied with the first level appeal decision, you have the right to request a second level appeal from The Marcus Corporation within 60 days from receipt of the first level appeal. The Marcus Corporation must notify you of the benefit determination within 30 days after receiving the completed appeal.

Note: Upon written request and free of charge, any covered persons may examine documents relevant to their claim and/or appeals and submit opinions and comments. The Marcus Corporation will review all claims in accordance with the rules established by the U.S. Department of Labor. The Marcus Corporation's decision will be final.

The table below describes the time frames in an easy to read format which you and UnitedHealthcare are required to follow.

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
If your claim is incomplete, UnitedHealthcare must notify you within:	**30 days**
You must then provide completed claim information to UnitedHealthcare within:	**45 days** after receiving an extension notice*
If UnitedHealthcare denies your initial claim, they must notify you of the denial:	

Claim Denial and Appeals	
Type of Claim or Appeal	**Timing**
▪ if the initial claim is complete, within:	**30 days**
▪ after receiving the completed claim (if the initial claim is incomplete), within:	**30 days**
You must appeal the claim denial no later than:	**180 days** after receiving the denial
UnitedHealthcare must notify you of the first level appeal decision within:	**30 days** after receiving the first level appeal
You must appeal the first level appeal (file a second level appeal) within:	**60 days** after receiving the first level appeal decision
The Marcus Corporation must notify you of the second level appeal decision within:	**30 days** after receiving the second level appeal

*UnitedHealthcare may require a one-time extension of no more than 15 days only if more time is needed due to circumstances beyond their control.

WHEN PARTICIPATION ENDS

You will cease to participate in the Plan as of the earlier of:

- The date on which the Plan terminates.
- The date your employment with the Company ends.
- The date you cease to be an eligible employee.
- The date you fail to make a required contribution under the terms of the Plan.
- The date you retire, unless the plan is available for retired persons and you are eligible for the plan.

Health Care Spending Account

You may submit a claim for reimbursement of Eligible Expenses which were incurred during the Plan year of employment termination, as long as those expenses were incurred prior to the date of your termination. Any such claims must be submitted on or before March 1 of the next Plan year.

The requirements of the Consolidated Omnibus Budget Reconciliation Act ("COBRA") may apply to the Health Care Spending Account Plan. You should call The Marcus Corporation to find out whether this Plan is subject to COBRA. If the Plan is subject to COBRA see "Optional Continuation Coverage under your Health Care Spending Account (COBRA)".

Optional Continuation Coverage Under Your Health Care Spending Account (COBRA)

This optional continuation coverage only applies if it has been made available by The Marcus Corporation. The Marcus Corporation may be required to offer this continuation coverage in certain cases as a result of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). This provision is intended to comply with the law and any pertinent regulations, and its interpretation is governed by them. Ask The Marcus Corporation to find out if and how this continuation coverage and continuation coverage under USERRA described below applies.

In no event will UnitedHealthcare be obligated to provide continuation coverage to a participant if The Marcus Corporation or its designated plan administrator fails to perform its responsibilities under federal law. These responsibilities include but are not limited to notifying the participant in a timely manner of the right to elect continuation coverage and notifying UnitedHealthcare in a timely manner of the participant's election of continuation coverage.

In general, COBRA continuation coverage must be offered with respect to a participant's HCSA if the participant has a positive balance in such account at the time of a qualifying event such as termination of employment (other than by reason of gross misconduct) or reduction in work hours. A "positive balance" for this purpose generally means that the contributions made to the account prior to the qualifying event exceed the eligible claims for reimbursement submitted prior to the qualifying event. If this COBRA continuation coverage is available to a participant who experiences a qualifying event and continuation coverage is elected by the participant, such coverage will cease at the end of the Plan year in which the qualifying event occurs and coverage cannot be continued into the next Plan year. Premiums for such continuation coverage (i.e., contributions to the account) will be paid by the participant on an after-tax basis unless otherwise permitted by The Marcus Corporation on a uniform and consistent basis plus a 2% administrative fee or other cost as permitted by law.

Uniformed Services Employment and Reemployment Rights Act

An employee who is absent from employment for more than 30 days by reason of service in the Uniformed Services may elect to continue Plan coverage for the employee and the employee's dependents in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended (USERRA).

The terms "Uniformed Services" or "Military Service" mean the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

If qualified to continue coverage pursuant to the USERRA, employees may elect to continue coverage under the Plan by notifying the Plan Administrator in advance, and providing payment of any required contribution (i.e., contributions to the account) for the HCSA. If an

employee 's Military Service is for a period of time less than 31 days, the employee may not be required to pay more than the regular contribution amount (i.e., contributions to the account), for continuation of the HCSA.

An employee may continue Plan coverage under USERRA for up to the lesser of:

- the 24 month period beginning on the date of the employee's absence from work; or
- the day after the date on which the employee fails to apply for, or return to, a position of employment.

Regardless of whether an employee continues the HCSA, if the employee returns to a position of employment, the employee's HCSA and that of the employee's eligible dependents will be reinstated under the Plan. No exclusions or waiting period may be imposed on an employee or the employee's eligible dependents in connection with this reinstatement, unless a Sickness or Injury is determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of military service.

You should call the Plan Administrator if you have questions about your rights to continue the HCSA under USERRA.

UnitedHealthcare is not The Marcus Corporation's designated Plan Administrator and does not assume any responsibilities of a Plan Administrator pursuant to federal law.

Dependent Care Spending Account

You may submit claims for the Eligible Expenses you have incurred until the earlier of the date your DCSA balance is exhausted or the end of the Plan year following your employment termination date, against what is in your DCSA balance at the time of termination. Any such claims must be submitted on or before March 1 of the next Plan year.

IMPORTANT ADMINISTRATIVE INFORMATION: ERISA

This section includes information on the administration of the Plan, as well as information required of all Summary Plan Descriptions by ERISA. While you may not need this information for your day-to-day participation, it is information you may find important.

Please note
The DCSA is not subject to ERISA. Only the HCSA is subject to **ERISA and the terms** described below.

Plan Sponsor and Administrator

The Marcus Corporation is the Plan Sponsor and Plan Administrator of the The Marcus Corporation Welfare Benefit Plan and has the discretionary authority to interpret the Plan. You may contact the Plan Administrator at:

Plan Administrator – FSA Plan
The Marcus Corporation
100 East Wisconsin Avenue
Milwaukee, WI 53202
(414) 905-1280

Claims Administrator

UnitedHealthcare is the Plan's Claims Administrator. The role of the Claims Administrator is to handle the day-to-day administration of the Plan's coverage as directed by the Plan Administrator, through an administrative agreement with the Company. The Claims Administrator shall not be deemed or construed as an employer for any purpose with respect to the administration or provision of Benefits under the Plan Sponsor's Plan. The Claims Administrator shall not be responsible for fulfilling any duties or obligations of an employer with respect to the Plan Sponsor's Plan.

You may contact the Claims Administrator by phone at the number on your ID card or in writing at:

United Healthcare Services, Inc.
9900 Bren Road East
Minnetonka, MN 55343

Agent for Service of Legal Process

Should it ever be necessary, you or your personal representative may serve legal process on the agent of service for legal process for the Plan. The Plan's Agent of Service is:

Agent for Legal Process - FSA Plan
The Marcus Corporation
100 East Wisconsin Avenue
Milwaukee, WI 53202
(414) 905-1280

Legal process may also be served on the Plan Administrator.

Other Administrative Information

This section of your SPD contains information about how the Plan is administered as required by ERISA.

Type of Administration

The Plan is a self-funded welfare Plan and the administration is provided through one or more third party administrators.

Plan Name:	The Marcus Corporation Welfare Benefit Plan
Plan Number:	506
Employer ID:	39-1139844
Plan Type:	Welfare benefits plan
Plan year:	January 1, 2024 – December 31, 2024
Plan Administration:	Self-Insured
Source of Plan Contributions and Funding:	The Plan is funded out of the general assets of the Plan Sponsor based on the salary reduction elections made by participating Employees

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants shall be permitted to:

- receive information about Plan Benefits;
- examine, without charge, at the Plan Administrator's office and at other specified worksites, all documents governing the HCSA – including pertinent insurance contracts, trust agreements, collective bargaining agreements (if applicable), and a copy of the latest annual report (Form 5500 series) filed with the Internal Revenue Service or the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration; and
- obtain copies of all documents that govern the operations of the HCSA and other Plan information, including insurance contracts and collective bargaining agreements (if applicable), and copies of the latest annual reports (Form 5500), and updated Summary Plan Descriptions, by writing to the Plan Administrator. The Plan Administrator may make a reasonable charge for copies.

You can continue HCSA benefits 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 to understand the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties on the people who are responsible for the operation of the Plan. The people who operate your Plan, who are called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your union, or

any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan Benefit or exercising your rights under ERISA.

If your claim for a Plan Benefit under the HCSA 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. See Section, *Claims Procedures*, for details.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the plan document 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 for 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, and you have exhausted the administrative remedies available under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court. If it should happen that the Plan's 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.

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 write to the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W. Washington, DC 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 at (866) 444-3272.