SUMMARY PLAN DESCRIPTION
OF THE

Lockstep Technology Group, LLC Health and Welfare Benefit Plan

Originally Effective January 1, 2015
Amended and Restated Effective January 1, 2026

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INTRODUCTION

Lockstep Technology Group, LLC (hereinafter the "Employer") maintains the Lockstep Technology Group, LLC Health and Welfare Benefit Plan (the "Plan") for the exclusive benefit of Employees who meet the eligibility requirements. The Plan is a large, single plan that provides a variety of benefits. Those benefits are referred to herein as "Components." Some of the Components are subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and provisions of the Internal Revenue Code of 1986, as amended ("Code"). This Summary Plan Description ("SPD") describes the requirements imposed by ERISA and the Code, and describes the administrative framework for all of the benefits that are provided. This document and its Exhibits, including the certificates of coverage issued by the insurance companies and the summary plan descriptions issued by the third-party administrators and/or Plan Administrator, constitute the SPD for each of the Components to the extent required by ERISA § 102.

Important: This SPD is only a summary of the key parts of the Plan, and a brief description of your rights as a Participant of a Component benefit. Be sure to proceed through this SPD carefully, so that you can make informed decisions that are right for you.

The Plan provides benefits through the following Components, as described in Exhibit B:

Lockstep Technology Group, LLC Medical Plan
Lockstep Technology Group, LLC Dental Plan
Lockstep Technology Group, LLC Vision Plan
Lockstep Technology Group, LLC Group Life/AD&D Plan
Lockstep Technology Group, LLC Supplemental Life/AD&D Plan
Lockstep Technology Group, LLC Long-Term Disability Plan
Lockstep Technology Group, LLC Short-Term Disability Plan
Lockstep Technology Group, LLC Employee Assistance Program (EAP)
Lockstep Technology Group, LLC Worksite Benefits
Lockstep Technology Group, LLC Health Flexible Spending Account (FSA)

Each of these Components is summarized in a certificate of coverage booklet issued by an insurance company or a summary plan description issued by the third party administrators and/or Plan Administrator. A copy of each certificate of coverage or summary plan description is available upon request. Contact your Plan Administrator. ***This document plus the Exhibits and Attachments together are the SPD for the Plan. It is very important to check the Parts of Exhibit B relating to each Component Benefit.***

Important: Benefits under each Component are provided pursuant to an insurance contract and/or pursuant to a governing plan document adopted by the Employer. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

PART I.
GENERAL INFORMATION ABOUT THE PLAN

1.1 What is the purpose of the Plan?

The purpose of the Plan is to provide certain Employees with an opportunity to receive certain benefits as part of an employee welfare benefit plan, as further described herein. You are being provided this document to give you an overview of the Plan and to address certain information that may not be addressed in the Exhibits.

1.2 When did the Plan take effect?

This Plan was originally adopted effective January 1, 2015. This SPD has been amended and restated effective January 1, 2026.

It operates on a "Plan Year" running from January 1 through December 31. It is important to note that some Components of the Plan may operate on a different Plan Year than the ERISA Wrap Plan Year identified above.

1.3 Who can participate in the Plan?

Each Employee of the Employer shall be eligible to participate in the Plan upon meeting the eligibility requirements (e.g., hourly work requirements, etc.) of any one of the applicable Components identified in Exhibit B. These employees are called "Eligible Employees." Those Eligible Employees who actually participate in one or more Components of the Plan are called "Participants." There are certain exceptions. They are described in the underlying Plan document. You will be notified if you fall within one of those exceptions.

"Employee" means a common-law employee of the Employer, except that the term "Employee" does not include any common-law employee who is a leased employee (including, but not limited to, an individual defined in Internal Revenue Code § 414(n)), or any common-law employee who is an individual classified by the Employer as a contract worker, independent contractor, temporary employee or casual employee, whether or not any such person is on the Employer's W-2 payroll. The term "Employee" also does not include any individual who performs services for the Employer but who is paid by a temporary or other employment agency or any employee covered under a collective bargaining agreement unless the collective bargaining agreement so provides. The term "Employee" includes "former employees" for the limited purpose of allowing continued eligibility for benefits as provided hereunder after an employee ceases to be employed by the Employer.

To determine whether you are eligible to participate in a Component identified in Exhibit B, please read the eligibility information contained within the Exhibit for the applicable Component.

1.4 When do I become a Participant?

For newly Eligible Employees, participation may begin as described in each of the Components identified in Exhibit B. Participation dates may vary based upon the Component and classification of an Eligible Employee.

Special rules that limit entrance apply if you do not become a Participant in any of the Components identified in Exhibit B when first eligible. For some Components, you may become a Participant at the start of any subsequent Plan Year, subject to any applicable evidence of insurability requirements imposed by the Components. Other Components do not have regular entry dates.

In addition, with certain Components, you may begin participation at other times under certain circumstances. For example, see the description of HIPAA Special Enrollment that applies to the Component providing group health coverage described in Exhibit B.

1.5 Can others be covered through me?

Depending upon the terms and conditions of a particular Component, you may be able to have certain family members (e.g., child, spouse, etc.) covered through you. In order for other persons to be covered through you, you must be (and remain) a Participant in the Plan and under the particular Component(s).

1.6 What are the conditions of participation?

As a condition of participation and receipt of benefits under the Plan, you agree to:

(a) Observe all Plan rules and regulations;

(b) Consent to inquiries by the Plan with respect to any provider of services involved in a claim under the Plan;

(c) Submit to the Plan all notifications, reports, bills, and other information that the Plan may reasonably require;

(d) Agree to repay any overpayments or incorrect payments received through the Plan; and

(e) Agree to provide required proof or documentation regarding eligibility within thirty (30) days of the request.

Failure to do so may impact your ability to participate in the Plan (including the Components).

1.7 When does participation end?

Participation in the Plan ends when you are no longer covered under any of the Components, regardless of the reason. In general, participation in any of the Components identified in Exhibit B continues until you elect not to participate, you are no longer an Eligible Employee, the Component terminates, you fail to make contributions in a timely manner, or your participation is terminated for cause. In most cases, benefit coverage ends on the last day of the month in which such an event occurs. However, different Components may have different "last day of coverage" rules depending upon the type of benefit and the reason for the cessation of participation. Furthermore, if you fail to make contributions in a timely manner, coverage may end on the last day of the last month for which you made the full contribution and there are other situations (e.g., fraud) in which coverage may be terminated retroactively (i.e., rescinded) when allowed by applicable law.

With respect to others who are covered through you, their coverage typically ceases if your coverage ceases. In addition, there may be other reasons that their coverage may end independently of whether your coverage ends (e.g., cease to meet the definition of dependent child).

1.8 How do I enroll and make benefit elections?

The Employer, in its capacity as Plan Administrator, will provide you with the means necessary to enroll and make elections for the Components identified in Exhibit B, including information about the costs of the various Component benefits.

For additional information regarding enrollment and benefit elections for a Component identified in Exhibit B, please read the information contained within the Exhibit applicable to the particular Component(s).

1.9 Can I change my election in a Component of the Plan during the Plan Year?

Whether a change in coverage under a particular Component can occur during the Plan Year depends upon the terms and conditions (1) of the Component, and (2) to the extent you pay for any portion of the cost of coverage on a pre-tax basis, the Employer's cafeteria plan under Section 125 of the Code (reflected in a separate document).

Note: If you are interested in making a change in coverage under a Component of this Plan, it is very important to check the Exhibit B Part relating to that Component. And, if you pay your share of the cost of coverage through the Employer's cafeteria plan, you need to check that plan's terms and conditions regarding changes during the Plan Year.

1.10 Must I make contributions to receive coverage and, if so, who holds the contributions I pay for a Component benefit?

The Employer may require you to pay all or a portion of the cost of coverage under a Component. If so, the Employer will notify you of the applicable contribution rates. Your required contributions (if any) may be made on a pre-tax basis if allowed under the Employer's cafeteria plan. If pre-tax contributions cannot be made through the cafeteria plan, you must make after-tax contributions. Such contributions are generally due by the first day of each month unless the Employer has agreed to another payment schedule, as identified in Exhibit A. A contribution grace period will be provided if one is required under applicable law or one is needed to ensure an offer of coverage has been made in accordance with Treas. Reg. § 54.4980H-3(g).

Your contributions towards the cost of coverage are held in the Employer's general assets. There is no separate trust. The contributions are held as part of the Employer's general assets until they are used to provide coverage under a Component (e.g., forwarded to the insurance carrier, used to pay benefits, etc.).

1.11 What happens when there is an insurance company refund?

Any refund provided to the Employer by an insurance company that has issued an insurance contract for any Component provided under the Plan will be allocated in accordance with the then prevailing United States Department of Labor (DOL) guidance. As a Participant in the Plan, you may directly benefit from such a refund. The portion of the refund allocated to Participants will be (i) used solely for the benefit of the Participants participating in the Component with respect to which the refund was provided, and (ii) returned to such Participants in a manner allowed by applicable law (e.g., to provide a refund, a premium holiday, an increase in benefits, etc.), as determined by the Plan. The portion of the refund allocated to Participants will be returned to the Participants no later than three (3) months following the date on which the Employer receives such refund from the insurance company.

1.12 What are the tax consequences to me?

Just because benefits are provided by your Employer under this Plan does not necessarily mean they are provided on a tax favored basis to you. Depending upon a variety of factors (including the type of benefit, the amount of the benefit, characteristics of the Eligible Employees and Participants, characteristics of those covered through Participants (e.g., children, spouse, etc.), etc.), the value of the benefit may or may not result in taxable wages to you.

1.13 Will I have any administrative costs under the Plan?

No. The entire cost of administering the Plan is paid by the Employer.

1.14 How long will the Plan remain in effect?

Although the Employer expects to maintain the Plan (including each of the Components) indefinitely, the Employer has the right to amend or terminate the Plan in whole or in part at anytime. It is also possible that future changes in state or federal laws may require that the Plan be amended or terminated accordingly. You will be informed if changes are made to the Plan.

1.15 How are claims determined?

ERISA requires certain rules to be followed regarding the determination of claims for benefits (e.g., format, time frames, notifications, etc.). What rules apply in a particular situation depend upon a variety of factors (including the type of benefit, whether it is provided on an insured or self-insured basis, etc.). The underlying Plan document provides the overall structure for determining claims while many of the specifics of the particular Component are described in the Exhibit relating to that Component. It is intended that the claims procedures be in conformance with the applicable ERISA requirements.

Special note regarding the Medical Plan Component. With respect to the Lockstep Technology Group, LLC Medical Plan Component of the Plan, the Patient Protection and Affordable Care Act ("PPACA") also requires certain rules to be followed. The specifics of these rules and their application to the Medical Plan Component of the Plan are described in the Plan document and also in **Exhibit B-1. Affordable Care Act Compliance Policy** and its attachments for that Component (and subsequent changes to that Exhibit and its attachments). It is intended that the claims procedures be in conformance with the applicable PPACA requirements.

1.16 Can I assign my right to benefits under the Plan?

In general, benefits payable under the Plan (including any Component) cannot be assigned. However, with respect to particular Components, you may have limited rights to assign benefits to providers of health care services.

PART II.
CONTINUATION COVERAGE

2.1 What are my continuation rights under COBRA?

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") requires most employers to offer Employees and their families (spouse and/or dependent children) the opportunity to pay for a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where health coverage under an employer sponsored group health plan(s) would otherwise end. There is no requirement that a person be insurable to elect continuation coverage. However, a person who continues coverage may have to pay all of the premium for the continuation coverage. Medical, Dental, Vision, Employee Assistance Program (EAP), Health Flexible Spending Account (FSA) benefits shall be operated consistent with COBRA and pursuant to COBRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge.

2.2 What are my continuation rights under USERRA?

If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible dependents under Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") for a period of up to 24 months. You and your eligible dependents qualify for this extension if you are called into active or reserve duty, whether voluntary or involuntary, in the Armed Forces, the Army National Guard, the Air National Guard, full-time National Guard duty (under a federal, not a state, call-up), the commissioned corps of the Public Health Services and any other category of persons designated by the President of the United States. This continuation right is similar to, and runs concurrent with, your continuation rights under COBRA (if any). The Medical, Dental, Vision, Employee Assistance Program (EAP), Health Flexible Spending Account (FSA) benefits shall be operated consistent with USERRA and pursuant to USERRA policies and procedures contained in a separate document, which is incorporated by reference into the Plan and this SPD and is available to you upon request, at no charge.

2.3 What are my continuation and/or conversion rights for group health plan coverage under state law?

Some, but not all, states require continuation and/or conversion of group health insurance upon certain events. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by your Employer. If you have not been provided this information, you should contact the Employer.

2.4 What are my continuation and/or conversion rights for group term life insurance coverage under state law?

Some, but not all, states require continuation and/or conversion of group-term life insurance. The Life and AD&D Plan (Exhibit B) ***may*** be subject to these state requirements. If provided under applicable state law, your continuation and/or conversion rights, and the rights of those who are covered through you, are described in the separate materials that have been provided to you either directly by the carrier (the insurance company) or by the Employer. If you have not been provided this information, you should contact the Employer.

PART III.
STATEMENT OF ERISA RIGHTS

As a Participant in this Plan (including any Components), you are entitled to certain rights and protections under ERISA.

Receive Information About Your Plans and Benefits. ERISA provides that all Participants shall be entitled to:

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

(b) Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this Summary Annual Report ("SAR").

COBRA Rights. As a Participant in the Plan, you are entitled to continue health coverage for yourself, your spouse or your dependents if there is a loss in 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 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 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 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 thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

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

Very Important: Exhaustion of Administrative Procedures Required; Statute of Limitations. The right to maintain a court action is subject to the Plan's requirements that administrative procedures be completed first. This is called exhaustion of administrative remedies. ***Failure to exhaust administrative procedures may preclude you from bringing an action in court***. Furthermore, if you intend to initiate legal action related to the Plan, including legal action for benefits under the Plan pursuant to Section 502(a) of ERISA, you must do so within two (2) years after receipt of a notification of an adverse benefit determination at the final level of appeal provided under the Plan. If, due to special circumstances, you were not required to exhaust your administrative remedies, legal action must be brought within two (2) years of the date the relevant claim for benefits was submitted to the Plan. You may not bring legal action after the expiration of the applicable limitations period. These deadlines for bringing a legal action apply unless a different time period is provided in Part of Exhibit B applicable to the Component with respect to which the action is being brought.

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 HIPAA, 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.

EXHIBIT A. Employer and Plan Information

PART I. Employer Details

Employer and Plan Sponsor:	Lockstep Technology Group, LLC 190 Technology Parkway, Suite 125 Peachtree Corners, GA 30092 Phone: 678-444-4590
Employer Business Type:	LLC/LLP
Employer Identification Number (EIN):	26-2991351
State of Incorporation:	Georgia
Employer subject to ERISA?	Yes
Commonly Controlled Entities:	N/A

PART II. General Plan Information

Name of Plan:	Lockstep Technology Group, LLC Health and Welfare Benefit Plan
Plan Year:	January 1 through December 31
Plan Number:	501
Effective Date of Plan:	January 1, 2026
Original Effective Date of Plan:	January 1, 2015
Type of Plan:	The Plan provides comprehensive Medical, Dental, Vision, Group Life/AD&D, Supplemental Life/AD&D, Long-Term Disability, Short-Term Disability, Employee Assistance Program (EAP), Health Flexible Spending Account (FSA) and benefits and is considered a "Health and Welfare Benefit Plan" under ERISA. The Plan provides Worksite Benefits, which may or may not be subject to ERISA.
Plan Administrator:	Lockstep Technology Group, LLC 190 Technology Parkway, Suite 125 Peachtree Corners, GA 30092 Phone: 678-444-4590

Agent for Service of Legal Process:	Lockstep Technology Group, LLC 190 Technology Parkway, Suite 125 Peachtree Corners, GA 30092 Phone: 678-444-4590 Legal process may also be served on the Plan Administrator.
Named Fiduciary:	Lockstep Technology Group, LLC 190 Technology Parkway, Suite 125 Peachtree Corners, GA 30092 Phone: 678-444-4590

PART III. Additional Plan Details

COBRA Administrator:	Lockstep Technology Group, LLC 190 Technology Parkway, Suite 125 Peachtree Corners, GA 30092 Phone: 678-444-4590

PART I. Carrier/Administrator Details

Policy Name	Insurer/Administrator	Funding	Policy/Plan Year
Medical	Surest PO Box 211758 Eagan, MN 55121 Phone: 866-683-6440	Fully Insured	1/1 - 12/31
Medical	UnitedHealthcare Insurance Company PO BOX 740800 Atlanta, GA 30374 Phone: 866-314-0335 Website: www.uhc.com	Fully Insured	1/1 - 12/31
Dental	UnitedHealthcare Dental Claims P.O. Box 30567 Salt Lake City, UT 84130 Phone: 866-801-4409	Fully Insured	1/1 - 12/31
Vision	UnitedHealthcare Spectera P.O. Box 30978 Salt Lake City, UT 84130 Phone: 800-638-3120	Fully Insured	1/1 - 12/31
Basic Life and AD&D	UnitedHealthcare Specialty Benefits PO Box 31328 Salt Lake City, UT 84131 Phone: 888-299-2070	Fully Insured	1/1 - 12/31
Voluntary Life and AD&D	UnitedHealthcare Specialty Benefits PO Box 31328 Salt Lake City, UT 84131 Phone: 888-299-2070	Fully Insured	1/1 - 12/31
Long-Term Disability	UnitedHealthcare Specialty Benefits PO Box 31328 Salt Lake City, UT 84131 Phone: 888-299-2070	Fully Insured	1/1 - 12/31
Short-Term Disability	UnitedHealthcare Specialty Benefits PO Box 31328 Salt Lake City, UT 84131 Phone: 888-299-2070	Fully Insured	1/1 - 12/31
Employee Assistance Program (EAP)	UnitedHealthcare 13625 Technology Drive Eden Prairie, MN 55344 Phone: 877-660-3806	Fully Insured	1/1 - 12/31
Voluntary "Worksite" Benefits	UnitedHealthcare Specialty Benefits PO Box 31328 Salt Lake City, UT 84131 Phone: 888-299-2070	Fully Insured	1/1 - 12/31
Health Flexible Spending Account (FSA)	Paylocity Benefit Administration Technologies Inc. PO Box 7410394 Chicago, IL 60674 Phone: 800-631-3539	Self Insured	1/1 - 12/31

PART II. Specific Plan/Policy Information

Policy/Plan Name	Eligibility	Waiting Period	Coverage Ends	Spouse/Dependent Coverage	Premium Payment	COBRA	ERISA
Medical	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Pre-tax	Yes	Yes
Medical	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Pre-tax	Yes	Yes
Dental	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Pre-tax	Yes	Yes
Vision	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Pre-tax	Yes	Yes
Basic Life and AD&D	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	No Spouse or Dependent Coverage	Employer Paid	No	Yes
Voluntary Life and AD&D	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Post-tax	No	Yes
Long-Term Disability	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	No Spouse or Dependent Coverage	Employer Paid	No	Yes
Short-Term Disability	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	No Spouse or Dependent Coverage	Employer Paid	No	Yes
Employee Assistance Program (EAP)	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Employer Paid	Yes	Yes
Voluntary "Worksite" Benefits	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of the month in which eligibility ends	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Post-tax	No	See Note below chart
Health Flexible Spending Account (FSA)	Full Time employees working 30 hours per week	First of the month following 30 days after date of hire	Last day of employment	Legal Spouse and Dependent Child(ren) Registered or Non-Registered Domestic Partner	Pre-tax	Yes	Yes

NOTE: Worksite Benefits are not always subject to ERISA, however, they could be depending on certain circumstances. Refer to Component Benefit documents or contact the Plan Administrator for more details on the ERISA status of the Worksite Benefit(s) offered.

Lockstep Technology Group, LLC Health and Welfare Benefit Plan

Provisions under the Affordable Care Act

Purpose. The Purpose of this Affordable Care Act Compliance Policy ("ACA Compliance Policy") is to describe the methods established by the Employer, Lockstep Technology Group, LLC to remain compliant with the Affordable Care Act regulations regarding eligibility for health benefits.

The Patient Protection and Affordable Care Act ("PPACA" or "ACA") imposed rules for Applicable Large Employers ("ALE") that include, but are not limited to, definition and calculation of hours of service, classification of employees, eligibility determinations for health plans, and providing standards for plan affordability. The method(s) outlined in this policy apply specifically to benefit plans offering medical coverage.

Look-Back Measurement Period

1. Special Definitions

Capitalized words and phrases used in this Exhibit shall have the meaning set forth below unless a different meaning is clearly required by the context. If a capitalized word or phrase used in this Exhibit is not defined below, the definitions contained in Article II of the Plan shall apply.

For purposes of this ACA Compliance Policy, the following special definitions will apply:

(a) **Administrative Period** means an optional period after the end of a Measurement Period – and before the beginning of the Stability Period associated with the Measurement Period – during which the Employer can perform administrative tasks, such as calculating the hours worked for the Measurement Period, determining eligibility for coverage, providing enrollment materials to eligible employees, and conducting open enrollment activities.

(b) **Applicable Large Employer** means an employer that employed an average of at least 50 Full-Time Employees (including Non-Full-Time Employees ("Full-Time Equivalent" or "FTE") averaging at least 30 hours per week) during the preceding calendar year.

(c) **Employee** has the meaning set forth in the Plan.

(d) **Full-Time Employee** means an employee who averages at least 30 hours of service per week or 130 hours of service for the calendar month.

(e) **Hour of Service** means (1) each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the company; (2) each hour for which an Employee is paid, or entitled to payment, by the Employer for a period of time during which no duties are performed (e.g., paid vacation, holiday, illness, disability, layoff, jury duty, military leave, paid leave of absence); and (3) each hour of unpaid leave that is subject to FMLA, USERRA, or on account of jury duty.

(f) **Initial Administrative Period** is the Administrative Period that follows the Initial Measurement Period and precedes the Initial Stability Period.

(g) **Initial Measurement Period** is the Measurement Period used for New Employees.

(h) **Initial Stability Period** is the Stability Period that begins after the completion of the Initial Measurement Period and Initial Administrative Period, if applicable, during which the full-time or part-time status achieved during the Initial Measurement Period shall apply.

(i) **Look-Back Measurement Method ("LBMM")** means the method in which an employee's full-time status during the stability period is based on their hours of service averaged over a preceding period, referred to as the measurement period.

(j) **Measurement Period** means the period of time during which Hours of Service are calculated to determine eligibility for the Plan health (i.e., medical) benefit(s) by determining whether the Employee has averaged at least 30 hours per week. There are two types of measurement periods: Standard Measurement Period and Initial Measurement Period.

(k) **New Employee** means an Employee who has not been employed for one complete Standard Measurement Period (i.e., an Employee in their Initial Measurement Period), or an Employee who was rehired after expiration of the parity period established for the plan.
(l) **Ongoing Employee** means an Employee who has been employed for at least one complete Standard Measurement Period, or an Employee who was rehired within the parity period established for the Plan.
(m) **Part-Time Employee** means an employee who works less than 30 hours per week.
(n) **Patient Protection and Affordable Care Act ("PPACA" or "ACA")** means the comprehensive health care reform law enacted on March 23, 2010, that provides numerous rights and protections making health coverage more accessible and affordable and imposes requirements on applicable Employers to offer affordable health coverage to Full Time Employees.
(o) **Seasonal Employee** means an employee who is hired into a position that works for 6 months or less annually.
(p) **Stability Period** means the period that follows, and is associated with, a particular measurement period. An Employee's full-time or part-time status (determined based on hours credited during the measurement period) generally is locked in for the full stability period, regardless of the Employee's actual hours worked during the Stability Period (provided that the Employee continues to be an employee during the Stability Period (and any Administrative Period, if applicable)).
(q) **Standard Administrative Period** is the Administrative Period that follows the Standard Measurement Period for Ongoing Employees.
(r) **Standard Measurement Period** is the measurement period used for Ongoing Employees.
(s) **Standard Stability Period** is the Stability Period that begins after the completion of the Standard Measurement Period and Standard Administrative Period, if applicable, during which the full-time or part-time status achieved during the Standard Measurement Period shall apply.
(t) **Special Unpaid Leave** means unpaid leave subject to the Family and Medical Leave Act OF 1993 (FMLA) or to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) or on account of jury duty.
(u) **Variable Hour Employee** means an employee for which the Employer cannot determine that the employee is reasonably expected to work, on average, at least 30 hours per week.

2. Measurement Method.

Employees that are not hired into employment categories that may be reasonably expected to work a specific number of hours on average each week, also known as Variable Hour Employees, must have their hours worked measured and tracked to determine eligibility for health benefits. This tracking is done by the Plan Administrator using a measurement method, which has certain rules for the calculations applied to determine benefit eligibility.

The Employer has elected to use the Look-Back measurement method to determine whether each Variable Hour Employee has sufficient Hours of Service to obtain Full-Time status for purposes of group health plan coverage, based on rules adopted by the Internal Revenue Service (IRS) to comply with the Patient Protection and Affordable Care Act ("ACA"). Under this method, the Employer calculates the Hours of Service worked by each Variable Hour Employee in a prior period (i.e., the "measurement period") to determine the status of the Employee that shall apply in a future period (i.e., the "stability period"). The Employer may utilize an additional time period (i.e., the "administrative period") between the measurement and stability periods to complete administrative functions such as determining which Employees are eligible for coverage and enrolling Employees in coverage. To prevent gaps in coverage the administrative period may overlap with the prior year's stability period, during which time the Employee's classification of Full-Time or Part-Time status obtained during the prior year's measurement period shall continue to apply. Determination of Full-Time status will be made by the Plan Administrator, in its sole and absolute discretion, in accordance with the Plan and the applicable Employer Shared Responsibility provisions of the ACA and its accompanying regulations.
For all Variable Hour Employees in the group Variable Hour Employees, the Look-Back Measurement Method will apply to both New Employees and Ongoing Employees.

New Employees

New Employees will have their Hours of Service counted during an Initial Measurement Period of 4 months to determine whether they have worked an average of at least 30 hours per week if, based on the facts and circumstances at the Employee's date of hire, the Employer cannot determine whether the Employee is reasonably expected to work 30 hours per week (e.g., Variable Hour Employees, Seasonal Employees). If the Employee satisfies the requirement and averages at least 30 hours worked per week, the Employee will then be offered health coverage by the end of the Initial Administrative Period, which may last up to 30 days. The coverage will then be effective for the entire duration of the Initial Stability Period, which lasts 12 months. Conversely, if the Employee does not satisfy the requirement and averages less than 30 hours worked per week, the Employee may not be offered health coverage after the Initial Measurement Period and will remain ineligible for the duration of the Initial Stability Period.

Each New Employee will have an Initial Measurement, Administrative, and Stability Period. Afterward, the Employee will be considered an Ongoing Employee and the Standard Measurement, Administrative, and Stability Periods will apply.

Ongoing Employees

Ongoing Employees will have their Hours of Service counted during the Standard Measurement Period of 4 months to determine whether they have worked an average of at least 30 hours per week during the measurement period. The Standard Measurement Period will generally begin and end on the same dates each calendar year, and the beginning of the Standard Stability Period will generally align with the beginning of the benefit Plan Year. If the Employee satisfies the requirement and averages at least 30 hours worked per week, the Employee will then be offered health coverage by the end of the Standard Administrative Period, which may last up to 30 days after the close of the Standard Measurement Period. The coverage will then be effective for the entire duration of the Standard Stability Period, which lasts for 12 months. Conversely, if the Employee does not satisfy the requirement and averages less than 30 hours worked per week, the Employee may not be offered health coverage after the Standard Measurement Period and will remain ineligible for the duration of the Standard Stability Period.

3. Change in Status

Special rules apply when an Employee experiences a change in employment status, depending on whether they are considered a new or ongoing employee and the circumstances surrounding the change in status. The rules for the Look-back Measurement Method are complex and this is simply a general overview of how some of the rules apply. More complex rules may apply to your situation.

New Employees

The Look-back Measurement Method includes a special rule for Variable Hour Employees who experience a change in employment status during their Initial Measurement Period. This rule applies when an Employee changes from a Part-Time position to a Full-Time position and requires the Employer to provide coverage to the Employee (a) four calendar months following the change in employment status or (b) at the end of the Initial Measurement Period, including the Initial Administrative Period (if any), provided that the Employee averaged 30 hours of service per week during the Initial Measurement Period.

Ongoing Employees

Generally, the Look-back Measurement Method provides that Full-Time employee status in a stability period is based on Hours of Service in the previous applicable measurement period. If an Ongoing Employee has a change in employment status during a stability period, the change will not impact their Full-Time (or non-Full-Time) status during the remainder of the stability period in which the status change took place. Instead, that change in employment status will impact the Hours of Service applied to the current Standard Measurement Period.

Rehired Employees. If an Employee has a period of 13 weeks or longer (26 weeks if the Employer is an academic institution) during which the Employee was credited zero Hours of Service, then the Employee may be treated as an Employee whose employment was terminated and who is a New Employee, not an Ongoing Employee, upon resuming services for the Employer. The Employee will need to complete the applicable waiting period before becoming eligible for benefits again.

If an Employee has a period of less than 13 weeks (26 weeks if the Employer is an academic institution) during which the Employee was credited zero Hours of Service, then the Employee will be treated as an ongoing Employee. The Employer must offer health plan coverage as of the first day that the rehired Employee is credited with an Hour of Service, on the first day of the calendar month following the day the Employee first received credit for an Hour of Service or, if later, as soon as administratively feasible.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.