Please note: This form along with ALL supporting documentation must be submitted within 31 days of the event.

American Senior Communities, L. L. C. Master Welfare Plan
2024 Employee Enrollment / Change Form

Plan Sponsor: AMERICAN SENIOR COMMUNITIES, L.L.C.	Group Number: W24110	Effective Date of Coverage (For Benefits/Payroll Use):
Facility Name:	Facility Number:	Employee ID Number:

Email Address:	Name: Last	First	MI
Address:	City	State	Zip

Date of Birth: / /	Gender: ☐ M ☐ F	Marital Status:	Home Telephone Number: ( )

Select a Medical Plan Coverage Level:

Standard Plan	Pay Saver Plan
☐ Employee Only $74.00	☐ Employee Only $22.00
☐ Employee + Spouse $392.50	☐ Employee + Spouse $279.30
☐ Employee + 1-2 Children $294.30	☐ Employee + 1-2 Children $216.40
☐ Employee + 3+ Children $430.50	☐ Employee + 3+ Children $321.90
☐ Family $539.30	☐ Family $396.00
☐ Waive - I do not want Medical coverage	☐ Waive - I do not want Medical coverage

Select a Dental Plan Coverage Level:	Select a Vision Plan Coverage Level:
☐ Employee Only $4.98	☐ Employee Only $1.41
☐ Employee + Spouse $11.20	☐ Employee + Spouse $7.36
☐ Employee + Children $13.37	☐ Employee + Children $5.62
☐ Family $27.40	☐ Family $12.49
☐ Waive - I do not want Dental coverage	☐ Waive - I do not want Vision coverage

Home Office HR Comments ONLY:

I hereby certify that my benefit election choices are true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. By submitting my benefit choices, I acknowledge that I am authorizing my employer to take pre-tax deductions from my paychecks to pay for my benefit costs.

Employee Signature Date

COMPLETE THIS SECTION TO CONFIRM INFORMATION IF ELECTING DEPENDENT COVERAGE

Name: Gender: ☐ M ☐ F
SSN: - - Date of Birth: / / Relationship to Employee:
Coverage Elected: ☐ Medical ☐ Dental ☐ Vision

Name: Gender: ☐ M ☐ F
SSN: - - Date of Birth: / / Relationship to Employee:
Coverage Elected: ☐ Medical ☐ Dental ☐ Vision

Name: Gender: ☐ M ☐ F
SSN: - - Date of Birth: / / Relationship to Employee:
Coverage Elected: ☐ Medical ☐ Dental ☐ Vision

Name: Gender: ☐ M ☐ F
SSN: - - Date of Birth: / / Relationship to Employee:
Coverage Elected: ☐ Medical ☐ Dental ☐ Vision

Name: Gender: ☐ M ☐ F
SSN: - - Date of Birth: / / Relationship to Employee:
Coverage Elected: ☐ Medical ☐ Dental ☐ Vision

Name: Gender: ☐ M ☐ F
SSN: - - Date of Birth: / / Relationship to Employee:
Coverage Elected: ☐ Medical ☐ Dental ☐ Vision

I hereby certify that the dependent information is true and correct. I understand that coverage will not be effective until all questions regarding eligibility for coverage have been satisfactorily resolved. I am certifying that any covered dependent(s) in the group health plans are eligible, and I agree to be personally responsible for reimbursing the plan for any claims paid for my dependent(s) if he/she is identified as being an ineligible dependent. Finally, I am also authorizing my employer to use and send necessary personal information, including Protected Health Information under HIPAA, to my selected benefit vendors and providers in order to initiate and support my coverage elections.

Employee Signature Date

Medical Insurance with Anthem (Visit anthem.com for provider network information.)

Medical Plan Options	Standard Plan	Pay Saver Plan
Per-Pay Premium Deduction from Paycheck		
□ Employee Only	$74.00	$22.00
□ Employee + Spouse*	$392.50	$279.30
□ Employee + 1 or 2 Children*	$294.30	$216.40
□ Employee + 3 or More children*	$430.50	$321.90
□ Family*	$539.30	$396.00
Deductible		
□ Employee Only	$2,500	$5,250
□ Employee + Family	$5,000	$10,500
Coinsurance	25% In-Network 50% Out-of-Network	30% In-Network 50% Out-of-Network
Annual In-Network Out-of-Pocket Maximum		
□ Employee Only	$5,500	$6,450
□ Employee + Family	$11,000	$12,900
Office Visit		
□ Anthem LiveHealth Online Telemedicine Co-Pay	$5 Co-Pay	$5 Co-Pay
□ Primary Care Co-Pay	$30 Co-Pay	$30 Co-Pay
□ Specialist Co-Pay	$30 Co-Pay	$60 Co-Pay
□ Urgent Care Co-Pay	$60 Co-Pay	$80 Co-Pay
Inpatient/Outpatient Hospitalization	Deductible then Coinsurance	
Emergency Room	$400 Co-Pay then Deductible and Coinsurance	
Preventative Care □ Annual Checkups □ Wellness Mammograms □ Preventative Colonoscopies	Covered at 100%	
Prescriptions — Retail (30 day supply)		
□ Generic	$15 Co-Pay	$15 Co-Pay
□ Preferred Brand	$30 Co-Pay +30% (max. $65)	$30 Co-Pay +30% (max. $85)
□ Non-Preferred Brand	$50 Co-Pay +30% (max. $85)	$50 Co-Pay +30% (max. $110)
Prescriptions filled at CVS/Walgreens/Rite-Aid		
□ Generic	$30 Co-Pay	$30 Co-Pay
□ Preferred Brand	$60 Co-Pay +30% (max. $130)	$60 Co-Pay +30% (max. $130)
□ Non-Preferred Brand	$100 Co-Pay +30% (max. $170)	$100 Co-Pay +30% (max. $170)
Prescriptions — Mail Order (90 day supply)		
□ Generic	$30 Co-Pay	$30 Co-Pay
□ Preferred Brand	$70 Co-Pay	$110 Co-Pay
□ Non-Preferred Brand	$130 Co-Pay	$160 Co-Pay
The pharmacy benefit does not cover specialty drugs. Consult our pharmacy benefit manager, TrueRx, for questions about your pharmacy needs: 866-921-4047 or customerservice@TrueRx.com.		

*See Definitions section for more information on Eligible Dependents

See Important Notices About Your Medical Plan Coverage for more detailed information about the Medical plans and your rights.

Dental Insurance by Delta Dental (find dental providers at www.deltadentalin.com)

Features	Delta Dental PPO and Premier Dentist	Non-Participating Dentist (subject to balance billing)*
Per-Pay Premium Deduction from Paycheck Employee Only Employee + Spouse** Employee + Children** Family**	 $4.98 $11.20 $13.37 $27.40	
Deductible □ Employee Only □ Employee + Family	 $150 $450	 $150 $450
Annual Benefit Max. - Classes I, II & III	$1,000	$1,000
Orthodontic Lifetime Max. - Class IV	$1,000	$1,000
Class I Benefits - Preventative (2 cleanings per year) □ Diagnostic & Preventive Services □ X-rays	Plan Pays 100% Deductible Waived	Plan Pays 100% Deductible Waived
Class II Benefits - Basic □ Oral Surgery □ Minor Restorative Services □ Emergency Palliative Treatment □ Periodontics & Endodontics	Deductible First then Plan Pays 80%	Deductible First then Plan Pays 80%
Class III - Major □ Prosthodontics □ Major Restorative Services	Deductible First then Plan Pays 50%	Deductible First then Plan Pays 50%
Class IV - Ortho □ Orthodontics - limited to dependent children under the age of 19	Plan pays 50% to $1,000 Lifetime Max Deductible Waived	Plan pays 50% to $1,000 Lifetime Max Deductible Waived

* When you receive services from a Nonparticipating Dentist, the percentages in this column indicate the portion of Delta Dental's Nonparticipating Dentist Fee that will be paid for those services. This amount may be less than what the Dentist charges or Delta Dental approves, and you are responsible for that difference.

**See Definitions section for more information on Eligible Dependents

Vision Insurance by VSP through Delta Dental

VSP Vision Insurance covers eye exams, prescription lenses and frames, and contact lenses. For a complete list of covered services, see the Summary Plan Description. To search for providers, you can go to www.vsp.com/eye-doctor or call Customer Service toll free at 800.877.7195.

Coverage Tier	Employee Per-Pay Premium Rate	
□ Employee Only □ Employee + Spouse □ Employee + Children □ Family	$1.41 $7.36 $5.62 $12.49	
Frequency □ Exam □ Frames □ Lenses and Contact Lenses	12 Months 24 Months 12 Months	
Features	**In-Network**	**Out-of-Network**
Eye Exam	$10 copay	Plan pays up to $45
Contact Lens □ Fitting and Follow-up	Up to $60	No discount available for out-of-network providers
Frames	Retail $130 allowance, with an extra $20 allowance on featured designer brands for frames. 20% savings on any amount above the retail allowance.	Plan pays up to $70
Standard Lenses Single Vision Bifocal (lined) Trifocal (lined) Lenticular	Single vision, lined bifocal, lined trifocal, or lenticular lenses are Covered in Full after the material co-pay of $10. Polycarbonate lenses are covered in full for children after the material co-pay of $10.	Plan pays up to $30 Plan pays up to $50 Plan pays up to $65 Plan pays up to $100
Contact Lenses (in lieu of eyeglasses) Medically Necessary	$130 Allowance Covered in full after co-pay	Plan pays up to $105 Plan pays up to $210

American Senior Communities, L.L.C. Master Welfare Plan
Spousal Carve Out Questionnaire

The medical plan offered to you under the American Senior Communities, L.L.C. Master Welfare Plan ("ASC Plan") requires that spouses of employees must elect medical coverage under their (the spouse's) employer-sponsored health plan as soon as it is available to them. This form must be filled out completely if you are enrolling your spouse in medical coverage under the ASC Plan.

1. Is your spouse employed?
   ☐ Yes ☐ No

   Employer Name ____

   Telephone No. ____

2. Does your spouse's employer offer medical insurance?
   ☐ Yes ☐ No

3. Has your spouse's employer offered medical insurance to your spouse?
   ☐ Yes ☐ No

4. Is your spouse enrolled in that plan?
   ☐ Yes ☐ No

   If No, why not? ____

If your spouse is eligible for his/her employer's medical plan, then your spouse is not eligible for medical coverage under the ASC Plan. (Spouses who both work for American Senior Communities or an affiliated employer that participates in the ASC Plan can each select coverage individually or together under one of the spouses. Please indicate if both spouses work for American Senior Communities or an affiliated employer)

Employee Acknowledgement

If my spouse's eligibility changes in the future and he/she becomes eligible for medical coverage through his/her employer, I am responsible for notifying the plan administrator, American Senior Communities, and completing a new Spousal Carve Out Questionnaire and Anthem Enrollment Form within 31 days of the employment status change.

I understand that failure to notify the plan administrator, American Senior Communities, of my spouse's eligibility change or falsifying my spouse's employment status is fraud and a material misrepresentation and may result in financial penalty, denial of claims, and disciplinary action up to termination of employment. In addition, it may result in disenrollment of my spouse, which may be retroactive to the date as of which my spouse became ineligible for plan coverage, as determined by the plan administrator and subject to the plan's provisions on rescission of coverage.

____
Print Employee Name

____ ____________________________
Employee Signature Date