AMERICAN SENIOR COMMUNITIES, L.L.C.

MASTER WELFARE PLAN

Summary Plan Description

January 1, 2025

TABLE OF CONTENTS

PLAN INFORMATION

This document, when incorporated with the benefit booklets and certificates, and provider contracts, policies, and descriptions ("Benefit Documents"), constitutes this Plan's Summary Plan Description ("SPD") pursuant to the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

This SPD outlines your rights and responsibilities under the Plan and reflects the Plan's benefits under each benefit program ("Component Plans") as of January 1, 2025, which may change from time to time. You should keep this SPD with the Benefit Documents provided to you upon enrollment in each Component Plan. You also should share this SPD with any family members you have elected to cover under the Plan.

Plan Name:	American Senior Communities, L.L.C. Master Welfare Plan
Type of Plan:	Welfare Benefit Plan
Plan Year:	January 1 through December 31 of the same calendar year
Plan Number:	501
Effective Date of this SPD:	January 1, 2025
Original Effective Date of Plan:	January 1, 2002
Funding Method:	Funded through fully-insured contracts and self-insured arrangements
Source of Contributions:	From ASC's general assets, the American Senior Communities Employee Benefit Trust, and employee contributions, when required by ASC in its sole discretion
Employee Benefit Trust	*Certain Component Plan premiums are funded through the following employee benefit trust:* American Senior Communities Employee Benefit Trust 6900 South Gray Road Indianapolis, IN 46237 317-783-5461 FEIN: 35-6322836
Plan Sponsor and Plan Administrator:	American Senior Communities, L.L.C. 6900 South Gray Road Indianapolis, IN 46237 317-788-2500
Plan Sponsor's Employer Identification Number:	35-2077389
Agent for Service of Legal Process:	The agent for the service of legal process for the Plan is the Plan Sponsor at the address set forth above
Claims Administrators:	See Appendix B and the Benefit Documents associated with each Component Plan

For additional information regarding the Plan, contact ASC's VP of Employee Benefits at 317-788-2500 or MaryHedlund@asccare.com, or refer to the Benefit Documents for each applicable Component Plan. Copies of the Benefit Documents are available free of charge from ASC on request.

INTRODUCTION

Establishment and Purpose

American Senior Communities, L.L.C. ("ASC") maintains the American Senior Communities, L.L.C. Master Welfare Plan (the "Plan") for the exclusive benefit of, and to provide welfare benefits to, its eligible employees, their spouses and eligible dependents.

These benefits are provided under various insurance contracts entered into between ASC and insurance companies or service providers ("Issuers"), as well as through self-insured plans funded by the general assets of ASC and the American Senior Communities Employee Benefit Trust. The Benefit Documents for each Component Plan are incorporated herein by reference only to the extent they provide detailed descriptions regarding each Component Plan's eligibility rules, benefit descriptions, claims and appeal procedures, or other substantive provisions. This Summary Plan Description ("SPD") is not intended to give any substantive rights to benefits that are not already provided for in the Plan and the applicable Benefit Documents. Accordingly, if the terms of this SPD conflict with the terms of the Plan-related Benefit Documents, the terms of the Plan-related Benefit Documents will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this SPD with respect to the legal compliance requirements of ERISA and any other federal law, this SPD will control, unless superseded by applicable law.

Employee Benefit Trust

ASC has established the American Senior Communities Employee Benefit Trust ("Trust") as a tax-exempt organization pursuant to IRC Section 501(c)(9). ASC makes periodic contributions to the Trust toward the cost of certain benefits under the Plan. ASC pays fully-insured dental and vision premiums from the Trust. In addition, self-insured medical and prescription drug claims are processed by the designated claims administrator, who ASC then reimburses from the Trust.

Benefits

The Benefit Documents provided to you upon enrollment in the Component Plans listed in Appendix A will contain a complete description of the benefits available under this Plan and any limitations or exclusions applicable to those benefits.

For purposes of the Component Plans that qualify as group health plans, the applicable Benefit Documents describe the use of network providers, the composition of the network, and the circumstances, if any, under which coverages will be provided for out-of-network services. The directory of participating network providers is available free of charge by contacting the applicable Issuer at the website or member services phone number provided in the Issuer's Benefit Documents. The Issuer can also provide you with information on any conditions or limits on the selection of primary care providers or specialty medical providers that may apply under the Component Plan.

Flexible Spending Plan. ASC maintains a flexible spending plan that allows you to set-aside pre-tax dollars to pay for qualified health care expenses ("Health FSA") and/or qualified dependent care expenses ("Dependent Care FSA"). Review the FSA's separate summary plan description or other Benefit Documents for additional details on your FSA benefits.

Eligibility Rules

Please refer to Appendix C of this SPD to determine your and your dependents' eligibility for participating in the Component Plans. The specific Benefit Documents for the Component Plans may contain additional requirements with regard to dependent eligibility for such Component Plans and the terms under which you and your dependents may participate.

Eligibility Not Based on Health-Related Factors. The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") prohibits the Component Plans that are group health plans from discriminating with regard to eligibility, premiums, or contributions on the basis of specified health status-related factors: health status, medical condition (physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.

Eligibility Not Based on Pre-Existing Conditions. The Patient Protection and Affordable Care Act (often shortened to the Affordable Care Act) ("ACA") generally prohibits the Component Plans that are group health plans from denying coverage or excluding specific benefits from coverage due to an individual's pre-existing condition. A pre-existing condition includes any health condition or illness that is present before the coverage effective date,

regardless of whether medical advice or treatment was actually received or recommended.

Misrepresentation or Fraud. In the event a participant obtains benefits wrongfully due to intentional misrepresentation or fraud, the Plan Administrator, claims administrators, and Issuers/contract administrators reserve the right, to the extent permitted by law, to terminate a participant's benefits, deny future benefits, take legal action against such participant, and/or offset from any future benefits the value of benefits the Plan has paid relating to inaccurate information or misrepresentations provided to the Plan.

Employee Contributions

ASC, at its discretion, may require employee contributions as a condition of participation in any Component Plan. Each year, ASC will evaluate all costs and may adjust the cost of coverage during the next annual enrollment. You will be notified of any required contribution amounts in your enrollment materials prior to each Plan Year. You also may request a copy of any required contribution amounts from the Plan Administrator.

Pre-Tax Contributions. ASC may administer the Plan in accordance with Internal Revenue Code Section 125 and underlying regulations. This enables you to pay your share of premiums for certain Component Plans on a pre-tax basis, thereby lowering your cost to participate in the Plan. Note that you do not pay Social Security taxes on the pre-tax dollars used, which could result in a small reduction in your Social Security benefits at retirement.

Recovery of Overpayment. You must immediately repay any excess payments or reimbursements paid to you by the Plan in error. You must reimburse ASC for any liability ASC may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may reduce or suspend any further payments due or future benefits otherwise payable to you under the Plan and may take any other actions as may be permitted by applicable law, including offsetting your salary or wages accordingly.

Enrollment and Elections

Initial Enrollment. If you are eligible to participate in the Plan, you can become a participant by properly and timely calling the enrollment call center. If you do not timely enroll when you are first eligible, you must wait until the next open enrollment period unless one of the events permitting a change in your benefit elections occurs first.

Annual Open Enrollment. You may change your benefit elections (or enroll in the Plan if you did not enroll when first eligible) during each annual open enrollment period. You should review the enrollment materials provided to you and follow the instructions for enrolling or re-enrolling, as applicable. If you do not properly complete enrollment on a timely basis, your elections for the prior Plan Year may cease or remain the same for the subsequent Plan Year depending on the policies adopted and communicated by ASC for a particular Plan Year.

Special Enrollment. You may change your elections under the group health Component Plan if you have a Special Enrollment Right and you timely notify ASC. See the section called "Special Enrollment and Coverage Rights" below for more information.

Changing Elections. Federal law generally requires that an election made under the Plan remain in effect without modification for the entire Plan Year for which the election is made. You may, however, be able to revoke or change an election on account of, and consistent with, one of the "Qualifying Life Events" adopted by ASC, as permitted by federal law. Any election made on an after-tax basis may be changed in accordance with ASC's policy or any applicable Component Plan limitation.

See the "Permissible Election Changes" section of this SPD for a list of Qualifying Life Events. See the "Special Enrollment and Coverage Rights" section below for additional details on HIPAA special enrollment rights.

Special Enrollment and Coverage Rights

HIPAA Special Enrollment Rights

Group health plans must provide special enrollment opportunities ("Special Enrollment Rights") to certain employees, dependents, and qualified beneficiaries under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). Special enrollment is available in the following situations:

- The acquisition of a new spouse or dependent;
- A loss of other coverage in another group health plan, health insurance, Medicaid, or CHIP; or,
- Becoming eligible for a state premium assistance subsidy.

Special Enrollment Rights do not apply to "limited scope" dental or vision benefits or certain Health FSAs.

If you or your dependents become eligible for special enrollment and properly enroll in coverage during such special enrollment period, coverage generally will begin no

later than the first day of the calendar month following a timely enrollment request. However, if the special enrollment event is the birth of a newborn, or the adoption or placement for adoption of a dependent child, coverage will begin as of the date of birth, adoption, or placement for adoption. Any requests for special enrollment or to obtain more information should be directed to:

American Senior Communities, L.L.C.
Attn: Senior Director of Benefits
6900 South Gray Road
Indianapolis, IN 46237
317-788-2500

If you decline to enroll during the special enrollment period, you may be required to wait until the Plan's next annual open enrollment period to elect coverage.

Adding a New Spouse or Dependent. If your family grows as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Loss of Other Coverage in another Group Health Plan, Health Insurance, Medicaid, or CHIP. If you or your dependents were otherwise eligible to enroll in the Plan but declined coverage due to enrollment in another group health plan, health insurance, Medicaid, or Children's Health Insurance Plan ("CHIP"), you may be able to enroll yourself and your dependents in the Plan mid-Plan Year provided that you request coverage within the following timeframes:

- Within 31 days after your or your dependent's other group health/health insurance coverage ends due to a loss of eligibility (or if the other employer ceases to make contributions toward such coverage);
- If your or your dependent's other coverage is COBRA continuation benefits, within 31 days after the exhaustion of the entire applicable COBRA continuation period; or,
- Within 60 days after your or your dependent's Medicaid or CHIP coverage ends due to a loss of eligibility under the applicable program.

Becoming Eligible for a State Premium Assistance Subsidy. If you or your dependents are eligible to enroll in the Plan while simultaneously being eligible to enroll in Medicaid or CHIP, your state of residence may offer a premium assistance program ("PAP") that can help you pay for Plan coverage that would otherwise be unaffordable to you.

Once you or your dependents are accepted into your state's PAP, ASC must allow you to enroll in the Plan mid-Plan Year provided that you request coverage within 60 days of being determined eligible by the PAP**.**

For more information on the PAP or PAPs that may be available to you and your dependents as of January 31, 2024, go to:

Indiana:
Healthy Indiana Plan for low-income adults 19-64
Website: www.in.gov/fssa/hip/
Phone: 1-877-438-4479

All other Medicaid Website: www.in.gov/medicaid/
Phone 1-800-457-4584

The list of states that offer PAPs is updated bi-annually by the Department of Labor ("DOL"). To review the current list of states, go to https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. You also can contact the DOL at www.askebsa.dol.gov or call 1-866-444-EBSA (3272) for more information on Medicaid, CHIP, and PAPs.

Determine Your Medicaid/CHIP Eligibility. 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, contact your state's Medicaid or CHIP office or call 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply, including in the state's PAP (if available).

Coverage Options Available Through the Exchange. If you or your children are not eligible for Medicaid or CHIP, you won't be eligible for a PAP, but you may be able to buy affordable individual insurance coverage through a Health Insurance Marketplace ("Exchange"). For more information on the coverage options available to you through the Exchange, go to www.healthcare.gov.

Dependent Coverage under QMCSOs

The Plan may be required to cover your child(ren) due to a Qualified Medical Child Support Order ("QMCSO") even if you have not enrolled the child in the Plan. You may obtain a copy of ASC's procedures governing QMCSO determinations, free of charge, by contacting ASC's Senior Director of Benefits at 317-788-2500.

A QMCSO is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible under

the Plan, and that ASC determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you.

Continuation of Coverage Rights

See the "Continuation of Coverage Rights" section of this SPD for additional details on a participant's right to continue certain health care benefits under the Plan for a limited period of time following a loss of coverage due to a qualifying event such as voluntary or involuntary job loss, reduction in work hours, death, divorce, or other life events.

Cessation of Participation

Unless otherwise stated in the applicable Benefit Documents, your coverage will cease upon the earliest of the following:

- The date or end of the month (as applicable under each Component Plan) in which you cease to satisfy the eligibility requirements for a particular Plan benefit. This may result from your death, reduction in hours, or termination of active employment, or, if your hours of service are tracked under the ACA Look-back Measurement Method, it may result because you lose ACA-FT Status during a subsequent Standard Stability Period;

- The end of the period for which you paid your required contribution if the contribution for the next period is not paid when due;
- The date you report for active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") as described in the "Employees on Military Leave" section; or,
- The date that your coverage is terminated by amendment of the Plan, by whole or partial termination of the Plan, termination of the contract or agreement, or by discontinuance of contributions by ASC.

Coverage for your spouse and other dependents terminates when your coverage terminates. Their coverage will also cease for other reasons specified in the Benefit Documents for the Component Plan. In addition, their coverage will terminate:

- The date or end of the month on which your covered spouse or child is no longer considered an eligible dependent;
- The date, end of the month, or end of the Plan Year in which your dependent child attains a Component Plan's limiting age (unless the Component Plan allows For the continuation of coverage for a mentally or physically disabled child who is primarily dependent on you for support);

  The end of the pay period in which you stop making contributions required for dependent coverage; or,

  The date that a child is no longer covered under a QMCSO, if the child is not otherwise eligible to participate in the Plan.

Depending on the reason for termination of coverage, you and your covered spouse and dependent child(ren) may have the right to continue health coverage temporarily under COBRA. See the "Continuation Coverage Rights" Section of this SPD for additional details.

PERMISSIBLE ELECTION CHANGES

You generally cannot change your pre-tax benefit elections under the Plan or vary the salary reduction amounts that you have selected during the Plan Year. However, you may revoke a benefit election (including, but not limited to, an election not to receive benefits under the Plan) after the Plan Year has commenced and make a new election with respect to the remainder of the Plan Year if both the revocation and new election are on account of and consistent with a Qualifying Life Event (as described below).

Election and salary reduction changes shall be effective on a prospective basis only (i.e., election changes will generally become effective no earlier than the first day of the next calendar month following the date that the election change request was filed), except that an election change on account of a HIPAA Special Enrollment Right, attributable to the birth, adoption, or placement for adoption of a new dependent child may, subject to the provisions of the underlying group health plan, be effective retroactively back to the date of the qualifying event.

If you undergo a Qualifying Life Event, you must inform the Plan Administrator and complete the required change-in-coverage enrollment materials within 31 days after the occurrence of the Qualifying Life Event (or within 60 days in the case of a Special Enrollment Right due to loss of eligibility for Medicaid or Children's Health Insurance Program ("CHIP") coverage).

Any election made on an after-tax basis may be changed in accordance with ASC's policy or any applicable Component Plan limitation.

In the event of a conflict between the following provisions and the Internal Revenue Code ("IRC") Section 125 plan adopted by ASC, the IRC Section 125 plan shall control. The Plan Administrator reserves the right to determine whether an Employee has experienced a Qualifying Life Event and whether the Employee's requested election is consistent with such event.

Change of Status

Qualifying Life Events include a change of status due to one of the following events permitted under the rules and regulations adopted by the Department of the Treasury, but only if the Qualifying Life Event changes the individual's eligibility for the applicable benefit. These change in status rules apply to elections for all qualified benefits (e.g., accident or health coverage, group term life, Health FSA, Dependent Care FSA), except that election changes are generally not permitted for Health FSA or Dependent Care FSA benefits if the Qualifying Life Event is a change in residence:

- **Legal Marital Status**. Events that change an employee's legal marital status, including marriage, death of employee's spouse, divorce, legal separation, and annulment.
- **Number of Dependents**. Events that change the number of employee's dependents, including following birth, death, adoption, placement for adoption.
- **Employment status**. Any of the following events that change the employment status of the employee, the employee's spouse, or the employee's dependent: termination or commencement of employment; strike or lockout; commencement of or return from an unpaid leave of absence; or a change in worksite. In addition, if the eligibility conditions of this Plan or other employer-sponsored plan of the employee, spouse, or dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under the plan, then that change constitutes a change in employment under this subsection.
- **Dependent Satisfies or Ceases to Satisfy Eligibility Requirements**. Events that cause an employee's dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of attainment of age, change in student status, or any similar circumstance.
- **Residency Change**. A change in the place of residence of the employee, spouse, or dependent that results in a loss of eligibility for coverage (e.g. relocates outside the current plan's service area).
- **Qualifying Dependent**. For the Dependent Care Assistance Plan only, a dependent becoming or ceasing to be a "Qualifying Dependent" as defined under Code Section 21(b) shall also qualify as a Qualifying Life Event.

HIPAA Special Enrollment Rights

An employee may change an election for group health coverage during a Plan Year and make a new election that corresponds with HIPAA Special Enrollment Rights, including those authorized under the provisions of the Children's Health Insurance Program Reauthorization Act of 2009

(CHIP), as long as the employee meets the notice requirements. Special Enrollment Rights can occur when:

- You lose eligibility for coverage under a group health plan or other health insurance coverage (such as if you and your dependents lose coverage under your spouse's plan) or if your employer terminates contributions toward health coverage.
- You gain a new dependent through marriage, birth, adoption, or being placed for adoption.
- You or your dependents lose coverage under a CHIP or Medicaid or become eligible to receive premium assistance under those programs for group health plan coverage.

ACA Marketplace/Exchange Enrollment

Qualifying Life Events include the opportunity to enroll in the ACA Marketplace/Exchange or other plans that offer minimum essential coverage under the ACA. These Qualifying Life Events apply to elections for group health plan coverage that is not Health FSA benefit coverage and that provides minimum essential coverage under the ACA:

- **ACA Marketplace/Exchange Election**. You may elect to cancel contributions for and payment of your portion of the group health plan premiums if (1) you are eligible for a special enrollment period to enroll in a "qualified health plan" through an ACA Marketplace or (2) you are seeking to enroll in a qualified health plan through a Marketplace during the Marketplace's annual open enrollment period.
- **ACA Reduction in Hours**. You may elect to cancel contribution for and payment of the employee-paid portion of group health plan premiums if (1) you had been reasonably expected to average at least 30 hours of service per week and subsequently move to a position in which you are reasonably expected to average less than 30 hours of service per week, even if you continue to be eligible under your employer-sponsored group health plan; and (2) your revocation of the election of coverage under the group health plan corresponds to your (and any dependents') intended enrollment in another plan that provides ACA minimum essential coverage with the new coverage effective no later than the first day of the second month following the month in which the original coverage is revoked.

Change in Cost or Coverage

A change in cost or coverage, as follows, may allow an election change. The following Qualifying Life Events do not apply to the election of Health FSA benefits:

- **Change in Coverage under Another Employer's Plan**. You may make a new election if there is a change in coverage (for you, your spouse or your dependent) under a plan provided by another employer. Your new election must be on account of the change in the other employer's plan and correspond with that change. Among other things, this rule permits you to make election changes during another plan's open enrollment period.
- **Significant Coverage Decrease with or without Loss of Coverage**. If your coverage under a benefit is significantly curtailed or ceases during a Plan Year, you may revoke your election of such benefit and, in its place, elect to receive on a prospective basis coverage under another plan with similar coverage, or drop coverage prospectively if no similar coverage is offered.
- **Significant Improvement or Addition of a New Benefit**. If, during the period of your coverage, a new benefit package option or other coverage option is added, an existing benefit package option is significantly improved, or an existing benefit package option or other coverage option is eliminated, then you may elect the newly-added option, or elect another option if an option has been eliminated prospectively and make corresponding election changes with respect to other benefit package options providing similar coverage. In addition, if you are not participating in the Plan when these options are added or changed, you may opt to become a participant and elect the new or newly improved benefit package option.
- **Significant Cost Increase**. If the cost of one of your benefit options increases significantly, you may either make corresponding changes in your payments or revoke your elections and, in lieu thereof, receive on a prospective basis coverage under another benefit option with similar coverage, or drop coverage prospectively if there is no benefit package option with similar coverage.
- **Significant Cost Decrease**. If the cost of your benefit option decreases significantly, you may make corresponding changes in your payments. In addition, if you are not enrolled in the Plan and the cost of an option decreases significantly, you may elect coverage under the corresponding benefit package.
  - In addition, if the expenses for a Component Plan increase or decrease during a Plan Year, the Plan

may automatically increase or decrease accordingly your required periodic contribution for such health insurance benefits.

Other Situations

Other situations that may permit an election change:

- **Court Order**. A judgment, decree, or other order resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) that requires accident or health coverage for an employee's child or for a foster child who is a dependent of the employee. The employee may change his or her election to provide coverage for the child if the order requires coverage for the child under the Plan and may cancel coverage under the Plan for the child if the order requires the employee's spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.
- **Entitlement to Medicare or Medicaid**. If an employee or an employee's spouse or dependent who is enrolled in an employer-sponsored accident or health plan becomes enrolled under Part A or Part B of Medicare or under Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), the employee may make an election change to cancel or reduce coverage of that employee, spouse, or dependent under the accident or health Component Plan. In addition, if an employee or an employee's spouse or dependent who has been enrolled in such coverage under Medicare or Medicaid loses eligibility for such coverage, the employee may make an election to commence or increase his or her coverage or the coverage of his or her spouse or dependent, as applicable, under ASC's accident or health plan.
- **Loss of Coverage under Health Plan of a Governmental or Educational Institution**. If an employee or an employee's spouse or dependent is enrolled in a group health coverage sponsored by a governmental or educational institution and loses such coverage, the employee may make an election change to add coverage under a corresponding ASC plan. Group health coverage sponsored by a governmental or educational institution includes (but is not limited to) coverage under: a state children's health insurance program (SCHIP); a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; and a foreign government group health plan.
- **FMLA Leaves of Absence**. ASC will (a) allow an employee going on FMLA leave to either revoke or continue group health coverage; or (b) Insurance Benefits will continue as long as the employee continues to pay their regular portion of the insurance premiums on a bi-weekly basis and in a timely manner. In some cases the company can arrange a more suitable payment plan directly with the employee if they are unable to pay all of the normal premium, with the understanding that upon return to work, the employee will owe the remaining balances due. If the payment of the employee portion of premiums is more than 30 days late, the Company may discontinue the coverage upon notice to the employee. Benefits would end as of the last date premiums were paid through.
- **COBRA Premiums**. If the employee or the employee's spouse or dependent becomes eligible for continuation coverage under an employer's group health plan as provided in Code section 4980B or any similar state law, the employee may elect to increase contributions under the Plan in order to pay for the continuation coverage.
- **Correcting Discrimination Issues under the Code**. If ASC determines before or during a Plan Year that the Plan or one of its Component Plans will fail to satisfy any nondiscrimination requirement imposed by the Code or any limitation on benefits provided to highly compensated or key employees, ASC may decrease or revoke the elections of affected highly compensated or key employees to ensure compliance with such nondiscrimination requirements or benefit limitation.

COVERAGE DURING A LEAVE OF ABSENCE

You may be eligible to continue certain Plan benefits for yourself and your covered dependents for a period of time during an approved voluntary or involuntary leave of absence, subject to the leave policies and procedures adopted by ASC and to the extent prescribed by law. The type of leave you take determines the cost of your benefits (i.e., whether you can continue to pay the same contribution amounts toward your coverage or will need to pay the full premium cost). If you elect not to continue your benefits during your approved leave of absence or if you fail to timely pay for your benefits, your benefits may terminate for the duration of your leave.

Please refer to ASC's leave policies and procedures for a description of the different types of leaves of absence available, the maximum length and types of benefits available while on a leave of absence, employee contributions requirements, and the procedures for paying your share of premiums.

Family and Medical Leave Act

In the event ASC employs 50 or more individuals within a 75-mile radius, ASC will be subject to the Family and Medical Leave Act of 1993 ("FMLA"). FMLA generally allows eligible employees to take a specific amount of job-protected, unpaid leave for certain family and medical reasons.

If you take FMLA leave, you may continue your group health care coverage under the Plan (e.g. medical, dental, vision, Health FSA) for you and any covered dependents as long as you continue to pay your portion of the cost for your benefits during the leave.

- If you are being paid directly by ASC and ASC substitutes accrued paid time off ("PTO") for some of your unpaid FMLA leave days (e.g. both types of leaves run concurrently), your share of premiums will continue to be deducted from your pay (on a pre-tax basis, if applicable).
- If you take an unpaid leave of absence that qualifies under FMLA, you may continue to maintain your health care benefits on the same terms and conditions as though you were still an active employee by paying any normally required contributions for your health care benefits in accordance with ASC's FMLA policies and applicable law. If you do not make such payments, or do not make them in a timely manner, your health care coverage may cease. At least 15 days before cessation of your health care coverage, you will be provided with notice of the cancellation. Unless ASC has adopted a longer grace period, you will have 15 days from the date of the notice to make the required payment.

Any coverages that are terminated during your FMLA leave will be reinstated upon your return from leave without any evidence of good health or newly imposed waiting period so long as you make the required contributions. If you experience a change in status event while you are on leave, or upon your return from leave, you may make appropriate changes to your elections.

If you do not return to work at the end of your FMLA leave you may be entitled to COBRA continuation coverage. You also may be required to reimburse ASC for the cost of coverage provided to you while you were on unpaid FMLA leave (the cost equals the COBRA premium, without a 2% add-on), unless your failure to return to employment is due to a serious health condition, the need to care for a servicemember, or because of other circumstances beyond your control.

For additional information on FMLA leave, and for information on participant contributions to Plan coverage during FMLA leave, please contact the Plan Administrator.

Employees on Military Leave

Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you take a military leave under USERRA, whether for active duty or for training, you are entitled to extend your health care coverage (e.g. medical, dental, vision, Health FSA) for up to 24 months as long as you give ASC advance notice of the leave (unless military necessity prevents this, or if providing notice would be otherwise impossible or unreasonable). Your total leave, when added to any prior periods of military leave from ASC, cannot exceed five years. There are a number of exceptions, however, such as types of service that are not counted toward the five-year limit. Additionally, the maximum time period may be extended due to your hospitalization or convalescence following service-related injuries after your uniformed service ends.

If the entire length of the leave is 30 days or less, you will not be required to pay any more than the contributions required for active employees. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full amount necessary to cover an employee (and any amount for dependent coverage) who is not on military leave.

If you take a military leave, but your coverage under the Plan is terminated (e.g. you do not elect the extended coverage), when you return to work with ASC you will be treated as if you had been actively employed during your leave when determining whether an exclusion or waiting period applies to health care coverage under the Plan.

If you do not return to work at the end of your military leave you may be entitled to continue coverage under COBRA continuation coverage for the remainder of the COBRA continuation period, if any. Any continuation of coverage under USERRA will reduce the maximum COBRA continuation period for which you and/or your dependents may be eligible.

These rights apply only to employees and their dependents covered under the Plan before leaving for military service.

Applicable State or Municipal Law

ASC shall permit you to continue participation in the Plan as required under any applicable state or municipal law to the extent that such law is not pre-empted by federal law.

College Student Medical Leave ("Michelle's Law")

To the extent any Component Plan is a group health plan that requires certification of student status in order to maintain a dependent child's coverage, the Plan shall comply with Michelle's Law. A dependent child enrolled in an institution of higher education who loses his or her student status due to a medically necessary leave of absence shall be allowed to continue such Component Plan coverage for up to one year as measured from the first day of the leave of absence or from the date coverage would otherwise terminate due to the loss of student status, whichever is earlier.

The Plan must receive written certification from the child's physician confirming the serious illness or injury and the medical necessity of the leave or change in enrollment status (e.g. a switch from full-time to part-time student status).

CONTINUATION OF COVERAGE RIGHTS

In the event ASC employs 20 or more employees in the preceding year, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") will apply to certain Component Plans that are group health plans (e.g., medical, dental, vision, Health FSA). Nothing in this section is intended to expand your rights beyond COBRA's requirements or the requirements of any other applicable federal or state law.

COBRA coverage is a continuation of the Plan's COBRA-eligible benefits when your coverage would otherwise end due to a life event known as a "qualifying event" (as described below). After a qualifying event, COBRA coverage must be offered to each person who is a "qualified beneficiary," which may include you, your spouse, and/or your dependent children. If elected, you must pay the full cost of the COBRA coverage (including both employer and employee contributions) as described in the "Cost of COBRA Coverage" section.

If you are interested in receiving more information about your COBRA rights and obligations under the Plan, contact ASC's Senior Director of Benefits at 317-788-2500.

Other Coverage Options

Instead of enrolling in COBRA coverage, there may be other coverage options for you and your family members through the Health Insurance Marketplace (ACA Exchange), Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as coverage under your spouse's plan) through a special enrollment period. Some of these options may cost less than COBRA coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare instead of COBRA Coverage. In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

Qualifying Events for COBRA Coverage

Employee. If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events occurs:

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

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA coverage.

Spouse. If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct; or,
- You become divorced or legally separated from your spouse.

Dependent Children. Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a dependent child.

Notifying the Plan of a Qualifying Event

The Plan will offer COBRA coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. However, when the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries without notification that such a qualifying event has occurred.

You Must Notify the Plan Administrator of Certain Qualifying Events. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify ASC in writing within 60 days after the later of (1) the date of the qualifying event; or (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event. Your notice must provide the type of qualifying event, the date of the qualifying event, and the name and address of the employee, spouse or dependent who underwent the qualifying event. You must provide this notice to:

WEX Health
Attn: COBRA Administration
PO Box 2079
Omaha, NE 68103-2079
https://cobralogin.wexhealth.com
Email: cobraadmin@wexhealth.com
Phone: 866-451-3399

You may lose your right to elect COBRA continuation coverage if proper procedures are not followed within the time periods described.

COBRA Coverage Elections

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA coverage will be offered to each of the qualified beneficiaries who then will have an independent right to elect coverage. Covered employees may elect COBRA coverage on behalf of their spouses, and parents may elect COBRA coverage on behalf of their children.

If mailed, your election must be postmarked (or if hand delivered, your election must be received by the individual at the address specified on the election form) no later than 60 days after the date of the COBRA election notice provided to you at the time of the qualifying event (or, if later, 60 days after the date that Plan coverage is lost).

Please Note: If, at the time of the qualifying event, you were covered under benefits that are not protected by COBRA (e.g. life insurance, AD&D, disability), you may, depending on applicable state law, be eligible for state continuation coverage and/or be able to port or convert such benefits to an individual policy. If a conversion option is available in your state, you will be required to make the necessary arrangements directly with the applicable insurance Issuer.

Length of COBRA Coverage

The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the "Early Termination of COBRA Coverage" section below.

Employee Coverage. Under COBRA, employees themselves are only eligible for either:

- 18 months of coverage, due to termination of employment or a reduction in hours; or,
- 29 months of coverage, if a qualified beneficiary covered under the Plan is eligible for a disability extension (which occurs when the individual is determined to be disabled by the Social Security Administration before the 60th day of COBRA coverage and remains disabled for the initial 18 months of coverage). The 11-month extension begins at the conclusion of the original 18 months of coverage.

COBRA coverage will be available to the employee and any covered family members. Additionally, under USERRA, covered employees who enlist in the military or are called to active duty may have COBRA-like coverage rights for themselves and their dependents that last for up to 24 months.

Dependent/Qualified Beneficiary Coverage. Dependents who are qualified beneficiaries are eligible for the same coverage durations above, but their coverage may extend even further in certain situations:

- 36 months of coverage, due to losing dependent-child status under the plan;
- Up to 36 months of coverage, when the qualifying event is the employee's termination of employment or a reduction in hours and the employee became entitled to Medicare less than 18 months before the qualifying event (where the 36 months is measured from the date the employee became entitled to Medicare); or,
- Up to 36 months of coverage, when there is a second qualifying event during continuation coverage (the death of the covered employee; the divorce or separation of the employee and spouse; the covered employee becoming entitled to Medicare or loss of dependent-child status under the Plan), where the 36 months is measured from the original COBRA coverage start date.

  These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

Notification Requirement for Extensions. The extension of COBRA coverage due to a disability or a second qualifying event is available only if you notify ASC in writing within 60 days after each qualifying event. You must provide this notice to:

WEX Health
Attn: COBRA Administration

PO Box 2079
Omaha, NE 68103-2079
https://cobralogin.wexhealth.com
Email: cobraadmin@wexhealth.com
Phone: 866-451-3399

For the disability extension, the notice must be provided within 60 days of the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours. In addition, to be entitled to a disability extension, you must provide the notice within 18 months after the covered employee's termination of employment or reduction of hours.

You may lose your right to elect COBRA coverage if proper procedures are not followed within the time periods described.

Special COBRA Rule for Health FSAs. COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the Plan Year. Health FSA COBRA coverage will only last until the end of the Plan Year during which the qualifying event occurred. **The use-it-or-lose rule will continue to apply, so any unused funds (in excess of any carryover amount, if applicable) will be forfeited at the end of the Plan Year (and grace period if applicable) and the Health FSA COBRA coverage will be terminated**.

If applicable, any carryover funds remaining in a Health FSA account after the end of the Plan Year in which a qualifying event occurred will continue to be available to reimburse health care expenses until the qualified beneficiary's other COBRA coverage (e.g. medical, dental, vision) ends.

Early Termination of COBRA Coverage

COBRA coverage will automatically terminate before the end of the maximum coverage period if:

- Any required premium is not paid in full on time;
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
- A qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. Note that he or she must notify ASC in writing within 30 days after a qualified beneficiary becomes entitled to Medicare benefits or becomes covered under other group health plan coverage;
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. Note that you must notify ASC in writing within 30 days after the Social Security Administration determines that a qualified beneficiary is no longer disabled;
- ASC ceases to provide any COBRA-eligible group health plan coverage for its employees; or,
- For any reason the Plan would otherwise terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as for fraud).

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage, including both employee and employer contributions. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan ("Applicable Premium") (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage.

For self-insured group health benefits, the amount the Plan may charge for COBRA coverage will depend on the amount of Applicable Premium for such coverage. Applicable Premium may be equal to either:

- A reasonable estimate of the cost of providing coverage determined on an actuarial basis; or,
- The cost of coverage for the immediately preceding Plan Year (including claims costs, administrative expenses, stop-loss premiums, and stop-loss reimbursements) as adjusted for cost of living.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of any COBRA premium changes.

Payment for COBRA Coverage. If you elect COBRA continuation coverage, you do not have to send any payment with the COBRA election form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election (this is the date the envelope containing the payment is post-marked, if mailed). **If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all continuation coverage rights under the Plan**. You are responsible for making sure that the amount of your first payment is correct and paid in a timely manner.

After you make your first payment for COBRA coverage, you will be required to make periodic payments for each subsequent coverage period. The periodic payments can be made monthly. Under the Plan, each of these periodic payments for COBRA coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without a break. **The Plan will not send periodic notices of payments due for these coverage periods, so it's important to keep track of the due dates**.

Although periodic payments are due on the first of the month, you will be given a grace period of 30 days after the first day of the coverage period to make each payment. Your COBRA coverage will continue for each coverage period if payment for that period is made before the end of the grace period for that payment.

Plan Contact Information

In order to protect your and your dependent's rights, you should keep ASC informed of any changes in your address and the addresses of family members.

WEX Health
Attn: COBRA Administration
PO Box 2079
Omaha, NE 68103-2079
https://cobralogin.wexhealth.com
Email: cobraadmin@wexhealth.com
Phone: 866-451-3399

ADDITIONAL HEALTH PLAN PROVISIONS

The following additional health plan provisions apply to Component Plans that are group health plans. Note that the definition of the health plans subject to each law may vary. If you have any questions about which law or laws apply to your benefits, contact the Plan Administrator.

Title VII of the Civil Rights Act of 1964

Generally, benefits provided under a group health plan must be provided without regard to the race, color, sex (including pregnancy), national origin, or religion of the eligible employee and his or her eligible dependents. A group health plan cannot discriminate on the basis of: eligibility to receive coverage under the Plan; the terms and conditions on which coverage is provided; or, what an employee is charged for coverage.

In addition, under the Pregnancy Discrimination Act of 1978, group health plans must provide coverage for pregnancy, childbirth, and related medical conditions on the same basis as coverage for nonpregnancy-related conditions.

Newborns' and Mothers' Health Protection Act of 1996 ("Newborns' Act")

Group health plans and health insurance Issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and Issuers may not, under Federal law, require that a provider obtain authorization from the plan or the Issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, in order to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to provide the Plan with advance notice of services or providers related to the hospital stay. For information on precertification, contact your Plan Administrator.

Women's Health and Cancer Rights Act

In the case of an employee or dependent who receives benefits under the medical plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which a mastectomy has been performed, including nipple and areola reconstruction and re-pigmentation to restore the physical appearance of the breast;
- Surgery and reconstruction on the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment for physical complications of all stages of mastectomy, including lymphedemas.

Coverage for reconstructive breast surgery may not be denied or reduced on the grounds that it is cosmetic in nature or that it otherwise does not meet the coverage definition of "medically necessary." Benefits will be provided on the same basis as for any other illness or injury under the Plan.

Affordable Care Act

Certain group health plans are subject to provisions of the ACA. Notwithstanding anything in the Plan to the contrary, the Plan shall comply with the ACA and all applicable regulations, as may be amended from time to time. Nothing in this section is intended to expand your rights beyond ACA's requirements or the requirements of any other applicable federal or state law.

Patient Protections

Designation of Primary Care Provider and Pediatrician. If **a** group health plan requires or allows a participant to designate a primary care provider (including for dependent child(ren)), or if the plan automatically designates a primary care provider for a participant, then the participant has the right to designate any primary care provider who participates in the group health plan's network and who is available to accept the participant or participant's family members. For dependent children this means a physician (allopathic or osteopathic) who specializes in pediatrics (including pediatric subspecialties).

Direct Access to Obstetrical and Gynecological Care. A female participant, regardless of age, shall not need prior authorization from a group health plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in the Plan's network who specializes in obstetrics or gynecology.

Mandated Coverage

Preventive Care Services. Non-grandfathered group health plans subject to the preventive services coverage mandate must provide coverage for certain recommended preventive services without imposing any copayments, co-insurance, deductibles, or other cost-sharing requirements. If the attending provider determines that the service is medically necessary, a plan must provide coverage regardless of sex assigned at birth, gender identity, or gender of the individual, as recorded by the plan. Updated lists of the preventive services covered under this provision are available at https://www.healthcare.gov/coverage/preventive-care-benefits/.

Coverage for Clinical Trials. Non-grandfathered group health plans must provide benefit coverage (including physician charges, labs, x-rays, professional fees, and other routine medical costs) for certain routine patient costs for qualified individuals who participate in an approved clinical trial. Approved clinical trials must be covered for the treatment of cancer and other life-threatening diseases or conditions. If a participant experiences complications as a result of the clinical trial, any treatment of those complications must be covered on the same basis that the treatment would be covered for individuals not in the clinical trial.

Emergency Services and Surprise Medical Billing Protections

Effective as of January 1, 2022, certain group health plans are subject to additional patient protection provisions of the Consolidated Appropriations Act of 2021 ("CAA"). Notwithstanding anything in the Plan to the contrary, the Plan shall comply with the CAA and all applicable regulations, as may be amended from time to time. Nothing in this section is intended to expand your rights beyond CAA's requirements or the requirements of any other applicable federal or state law.

Any cost-sharing payments made by a participant for the following out-of-network emergency or nonemergency services must count towards the group health plan's in-network deductible (if applicable) and out-of-pocket maximum.

Emergency Services. A group health plan that covers emergency services generally must provide such services regardless of whether the provider is in- or out-of-

network and without requiring prior authorization. The group health plan generally cannot impose any cost-sharing requirement (i.e., copayment, coinsurance, deductible) greater than (or an administrative requirement/limitation more restrictive than) what would be imposed if the services were provided in-network.

Nonemergency Services. A group health plan that covers out-of-network nonemergency services performed in an in-network facility generally must cover such services without any cost-sharing requirement that is greater than would apply if provided in-network. However, the out-of-network provider is not prohibited from balance billing certain services so long as the participant receives prior notice and consents to the treatment.

Continuity of Care. When a group health plan provider ceases to be an in-network provider during a continuing care patient's ongoing course of treatment (as specified under the CAA) the plan generally must provide timely notice to the participant and potentially provide transitional care under the same terms and conditions as would have applied had no change occurred.

Mental Health Parity and Addiction Equity

All group health plans that provide both medical and surgical benefits, as well as mental health or substance use disorder benefits, shall provide such benefits subject to the following:

- The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits;
- The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Issuer's plan (or coverage) and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits; and,
- The Plan Administrator or Issuer must make available to participants or beneficiaries, upon request, the criteria for medical necessity determinations for mental health and substance use disorder benefits and provide the reason for any denial of reimbursement or payment for services.

Under the ACA, group health plans are prohibited from imposing annual or lifetime dollar limits on Essential Health Benefits, including mental health and substance use disorder services and behavioral health treatment.

Genetic Information Nondiscrimination Act

The Genetic Information Nondiscrimination Act of 2008 ("GINA") requires group health plans to not discriminate based on genetic information with respect to eligibility, premiums, and contributions. GINA generally prohibits employers with more than 15 employees from the collection or use of genetic information unless in an aggregate form that does not identify the individual. When GINA applies, genetic information is treated as Protected Health Information ("PHI") under HIPAA.

"Genetic information" includes any information about an individual's own genetic tests, the genetic tests of an individual's family members, and the manifestation of a disease or disorder in the individual's family members. For this purpose, a genetic test is any analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detects genotypes, mutations, or chromosomal changes (essentially, anything used to predict whether an individual has a predisposition to a disease, disorder, or pathological condition).

Wellness Program

ASC may offer one or more voluntary wellness programs or disease management programs (each a "Program") under this Plan that are reasonably designed to promote the health and wellbeing of covered individuals. Such Programs offer certain incentives or rewards for participation in a Program or for satisfying certain health standards. If ASC chooses to offer a Program or Programs, its terms and conditions will be communicated to you and it will be administered in compliance with all applicable laws.

CLAIMS AND APPEAL PROCEDURES

The following claims and appeal procedures must be followed by Plan participants ("Claimants") to obtain payment of benefits under the Plan, but only to the extent not otherwise provided in the applicable Component Plan's Benefit Documents. If the claims and appeal procedures in this section apply, they shall be construed and applied in a manner consistent with the ACA and the Department of Labor ("DOL") Regulation Section 2560.503-1 as in effect on the date the claim was received. To the extent that a conflict exists in the insurance contracts or administrative agreements, the provisions of the foregoing regulations will control.

For purposes of this Section, the term "Administrator" means the group insurance policy Issuer or self-insured plan contract administrator listed on Appendix A for the policy or Component Plan under which the claim has been filed.

Claims Procedures under Component Plans

The Benefit Documents provided by the Administrator for each Component Plan generally contain a detailed description of the Administrator's claims submission rules, claims and appeal procedures, and the member services contact information for any claims questions. Please refer to Appendix B for a listing of claims and claims appeal contacts, addresses, and phone numbers.

The Administrator will act as, or will designate, a claims administrator to decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim.

If the Administrator denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial ("Adverse Determination"). You may request a review of a denied claim by appealing to the Administrator. The Administrator will decide your appeal in accordance with its reasonable claims and appeal procedures, as required by ERISA (if ERISA applies) and other applicable law. In addition, certain group health plans must provide for external review procedures upon the exhaustion of your internal appeal process (e.g. review of your claim outside of the Plan), but only if the claim is related to medical judgment, rescission of coverage, or a determination that a treatment is experimental or investigational.

Unless specifically provided otherwise in a Component Plan, you must make a claim for benefits under the Plan and any Component Plan within one year after the date you incurred the expense that gives rise to the claim. It is your responsibility to make sure this requirement is met.

Reasonable claims and appeal procedures may not preclude an authorized representative (who has been appointed using a form that is made available by the Plan Administrator) from acting on your behalf in pursuing or appealing a benefit claim. You are responsible for providing the Administrator, claims administrator and/or ASC with your current address. The Plan Administrator, claims administrator and ASC do not have any obligation or duty to locate a person who is or may become entitled to benefits under the Plan except as required by applicable law.

Types of Claims

Under ERISA, a claim is a request for benefits made in accordance with a Component Plan's claims-filing procedures, including any request for a service that must be pre-approved. Questions concerning Plan benefits, coverage and eligibility questions, and other casual inquiries are generally not considered claims for benefits.

Group Health Claims

For purposes of group health plans subject to ERISA (e.g. medical, dental, vision), there are four types of health claims: Urgent Care, Pre-Service, Post-Service, and Concurrent Care ("Health Claims").

- Urgent Care Claim**.** An "Urgent Care Claim" is a claim (other than a post-service claim) for which the application of a non-urgent care timeframe could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed otherwise. The Component Plan must defer to an attending provider to determine if a claim for health benefits is urgent.
- Pre-Service Claim. A "Pre-Service Claim" is a non-urgent claim for a benefit under the Component Plan where the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

- Post-Service Claim. A "Post-Service Claim" is a claim for a benefit under the Component Plan after the services have been rendered.
- Concurrent Care Claim**.** A "Concurrent Care Claim" is a claim for which the Component Plan previously has approved a course of treatment over a period of time or for a specific number of treatments, and either the plan later reduces or terminates coverage for those treatments, or you request to extend coverage for those treatments. A concurrent care claim may be treated as an Urgent Care Claim, Pre-Service Claim, or Post-Service Claim, depending on when during the course of your care you file the claim.

Disability Claims

A "Disability Claim" subject to ERISA is a claim for benefits that requires you to prove a disability with respect to which the Component Plan makes its own determination of whether you are disabled, regardless of the type of plan under which the claim arises. However, if someone other than the Component Plan makes the determination of disability, for purposes other than the Component Plan's benefit determination (e.g., the Social Security Administration or a different benefit plan), the claim is not a Disability Claim. Disability Claims (including a total disability determination under the AD&D plan) shall be administered in accordance with new regulations, which are intended to ensure the independence and impartiality of Component Plan decisionmakers when determining a Disability Claim.

Other Non-Health Claims

The term, "Other Non-Health Claims," encompasses claims that are neither Health Claims nor Disability Claims. Examples include, but are not limited to, claims for benefits under Component Plans that are severance plans, life insurance plans, accidental death and dismemberment plans, business travel insurance plans, and long-term care plans.

Submission of Claims

Each Component Plan may place additional conditions on how and when a claim must be made, as well as require submission of specific information with claims, including medical information and coordination of benefits information. Each Component Plan's claims procedures shall contain a formalized system of administrative safeguards to ensure that claims are decided consistently with Plan documents and with past determinations in similar circumstances.

Special Notice for Incorrectly Filed Urgent Care or Pre-Service Claims. In the case of an incorrectly filed Urgent Care Claim or Pre-Service Claim, the Administrator will notify you as soon as possible but no later than 24 hours (Urgent Care) or five days (Pre-Service) following receipt by the Component Plan of the incorrectly filed claim. The notice may be written or oral unless you request a written notice and must include information regarding proper procedures to follow.

Notice of the Claim Determination

The Administrator must provide you with a notice of an Urgent Care or Pre-Service determination (whether adverse or not). If the Administrator decides in favor of the claim, the notice will include sufficient information to fully apprise you of the Component Plan's decision to approve the requested benefits.

For all initial claims, if the claims administrator of the Component Plan does not fully agree with your claim, you shall receive an adverse benefit determination ("Adverse Determination"), which is a denial, reduction, or termination of a benefit, or failure to provide or pay for (in whole or in part) a benefit. An Adverse Determination for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim may include a claim for benefits due to a rescission of coverage (generally a retroactive cancellation of coverage).

Timing of Initial Adverse Determinations

The time period for an initial Adverse Determination begins running when a claim is filed, even if the claim is incomplete. The original determination period for deciding certain claims (but generally not appeals) may be extended by the Administrator. However, there can be no extension unless an extension notice is provided to you *prior* to the end of the original determination period. The extension notice must indicate the matters beyond the control of the Component Plan that gave rise to the need for the extension and the date by which a determination is expected to be made.

The Administrator shall provide you with the Adverse Determination within the following timeframes:

Group Health Plan Claims:

- **Urgent Care Claim**: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Component Plan if all information was included with the claim. If the Urgent Care Claim is incomplete, the Administrator will notify you within 24 hours and you will

have a reasonable period of time, but no less than 48 hours to complete the claim. The Administrator will then decide the claim as soon as possible but no later than 48 hours after the earlier of the receipt of the specified information, or the end of the period of time provided to submit the specified information.

- **Non-Urgent Pre-Service Claim**: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for up to 15 days upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.
- **Post-Service Claim**. Within a reasonable time, but no later than 30 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for up to 15 days upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.
- **Concurrent Care Claim Related to Termination or Reduction of Treatment**. Within enough advance time to provide the Claimant with an opportunity to appeal and obtain a decision before the benefit at issue is reduced or terminated.
- **Concurrent Care Claim Related to Request for Extension of Treatment**. In the case of an Urgent Care Claim, within 24 hours after receipt of the claim by the Component Plan provided your request is made at least 24 hours prior to the end of the approved treatment. All other non-urgent claims will be treated as a new Non-Urgent Pre-Service or Post-Service Claim as applicable.

Disability Claims. Within a reasonable period of time, but not later than 45 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for two additional 30-day extension periods upon written notice to you. If the extension is due to an incomplete claim, you will have at least 45 days to provide the requested information.

Other Non-Health Claims. Within a reasonable period of time, but not later than 90 days after receipt of the claim by the Component Plan. The Administrator may extend the original period for an additional 90 days upon written notice to you.

Content of the Adverse Determination Notice

The Administrator must provide you with a written or electronic "Notice of Adverse Determination," except that the notice for an Urgent Care Claim may be provided orally (within the applicable timelines) so long as a written or electronic notice is provided to you within three days.

The Notice of Adverse Determination must be written in a manner calculated to be understood by you. In addition, the Notice for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim must be provided to you in a culturally and linguistically appropriate manner.

The Notice of Adverse Determination shall include the following information:

- The specific reason for the Adverse Determination;
- References to the specific Component Plan provisions on which the Adverse Determination is based;
- A description of any additional information needed to reconsider the claim and the reason this information is needed;
- A description of the Component Plan's review procedures and the applicable time limits; and,
- A statement of your right to bring a civil action under ERISA Section 502(a) after an appeal.

The Notice of Adverse Determination for a Health Claim, or a Disability Claim will include the following information:

- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to you by including a statement that the information is available free of charge upon your request. If applicable, the notice for Disability Benefits must include an explanation of why such internal guidelines or criteria do not exist.
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the determination, or a statement that such explanation will be provided free of charge upon your request; and,
- In the case of a Health Claim involving Urgent Care, a description of the expedited review process applicable to such claim.

The Notice of Adverse Determination for a Health Claim related to a non-grandfathered group health plan will include the following additional information:

- Information sufficient to identify the claim involved;

- A description of the Component Plan's standard, if any, used in denying the claim;
- A description of available internal appeals and external review procedures; and,
- Disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who can assist individuals with their claims.

The Notice of Adverse Determination for a Disability Claim will include the following additional information:

- A discussion of the decision, including the reasons for disagreeing with the views of treating professionals, medical or vocational experts consulted, or a disability determination made by the Social Security Administration; and,
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

Appealing a Denied Claim

If you disagree with an Adverse Determination after following the above steps, you or your appointed representative may formally request an appeal by following the Component Plan's appeal procedures as set forth in the Component Plan's Benefit Documents.

In the appeal, you may submit written comments, documents, records, and other information relating to the claim for benefits. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. In addition, for a Health Claim related to a non-grandfathered group health plan, you must be permitted to present evidence and testimony as part of the appeal process.

You may appeal any denial of a Health Claim or Disability Claim within 180 days (within 60 days for Other Non-Health Claims) of receipt of such a denial by submitting a written request for review to the Administrator. If you do not appeal in a timely manner, you lose your right to later object to an adverse determination on review ("Appeal Decision").

If the appeal relates to a claim for payment, your request should include, at minimum:

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

Full and Fair Review

The review of your claim shall take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered in the initial Adverse Determination. The Component Plan will identify, upon request to the Administrator, any medical experts or vocational experts whose advice was obtained on behalf of the Component Plan in connection with your Adverse Determination, without regard to whether the advice was relied upon in making the benefit determination.

The review of your appeal shall be conducted by an appropriate fiduciary of the Component Plan who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.

In the case of a Health Claim involving urgent care, you are entitled to an expedited review process pursuant to which you may submit a request for an expedited Appeal Decision orally or in writing and all necessary information shall be transmitted between you and the Component Plan by telephone, facsimile, or other available similarly expeditious method.

In deciding an appeal for a claim that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.

The Component Plan must provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Component Plan (or at the direction of the Component Plan) in connection with the claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notification of Appeal Decision is required to be provided to give you a reasonable opportunity to respond prior to that date. In addition, before the Administrator can issue

an Appeal Decision based on new or additional rationale for a Health Claim related to a non-grandfathered group health plan or a Disability Claim, you must be provided, free of charge, with the rationale, which must be provided to you as soon as possible and sufficiently in advance of the date on which the Appeal Decision is required to be provided to give you a reasonable opportunity to respond prior to that date.

Appeal Decision

If your claim on appeal is wholly or partially denied, the Administrator will provide you with a written notification of the Component Plan's Appeal Decision, within the required timeframes. In addition, the notice of the Appeal Decision for a Disability Claim, or a Health Claim related to non-grandfathered group health plan, must be provided in a culturally and linguistically appropriate manner.

Any determination by the Administrator or any authorized delegate shall be binding and final in the absence of clear and convincing evidence that the Administrator or delegate acted arbitrarily and capriciously.

Timing of the Appeal Decision

For purposes of this section, the period of time within which the Appeal Decision is required to be made shall begin at the time your appeal is filed in accordance with the Component Plan's procedures without regard to whether all the information necessary to make an Appeal Decision accompanies the filing.

Group Health Plan Claim. The Administrator shall provide you with the Appeal Decision within the following timeframes:

- **Urgent Care Claim.** As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal by the Component Plan.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal by the Component Plan.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 60 days after receipt of the appeal by the Component Plan**.**
- **Concurrent Care Claim.** Before treatment ends or is reduced, where the Adverse Determination is the decision to reduce or terminate concurrent care early, or, if the Component Plan denies your request to extend treatment, within the appropriate time period based upon the type of claim.

Disability Claim. The Administrator shall provide you with the Appeals Decision within 45 days after receipt of the appeal by the Component Plan.

All Other Non-Health Claim. The Administrator shall provide you with the Appeal Decision within 60 days after receipt of the appeal by the Component Plan.

Content of the Notice of Appeal Decision

The Administrator must provide you with a written or electronic notice of an Appeal Decision. The Notice of Appeal Decision must be written in a manner calculated to be understood by you. In addition, the Notice for a Health Claim related to a non-grandfathered group health plan, or a Disability Claim, must be provided to you in a culturally and linguistically appropriate manner. The Notice of Appeal Decision shall include the following information:

- The specific reason for the Appeal Decision;
- References to the specific Component Plan provisions on which the Appeal Decision is based;
- A statement regarding your right, on request and free of charge, to access and receive copies of documents, records, and other information relevant to the claim;
- A statement describing any additional, voluntary appeal procedures offered by the Component Plan and your right to obtain information about such procedures; and,
- A statement of your right to bring a civil action under ERISA Section 502(a);

For an Appeal Decision related to a Health Claim or a Disability Claim the notice will include:

- Specific references to the internal rules, guidelines, protocols, or other similar criteria on which the Adverse Determination is based. For Health Claims, such specific references may be made available to you by including a statement that the information is available free of charge upon your request. If applicable, the notice for Disability Benefits must include an explanation of why such internal guidelines or criteria do not exist; and,
- If the claim is denied based on medical necessity, experimental treatment, or similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the determination, or a statement that such explanation will be provided free of charge upon request.

The Notice of Appeals Decision for a Health Claim related to a non-grandfathered group health plan will include the following additional information:

- Information sufficient to identify the claim involved;
- A description of the Component Plan's standard, if any, used in in the Appeal Decision;
- A description of available internal appeals and external review procedures; and,
- Disclosure of the availability of and contact information for any applicable office of health insurance consumer assistance or ombudsman who can assist individuals with their claims.

The Notice of Appeal Decision for a Disability Claim will include the following additional information:

- A statement describing any applicable plan-imposed limitations period, including the calendar date when the limitations period will expire; and,
- A discussion of the decision, including the reasons for disagreeing with the views of treating professionals, medical or vocational experts consulted, or a disability determination made by the Social Security Administration.

Second Appeal

If specified in the Benefit Documents for each Component Plan or in documentation given to you by the claims administrator, you may be entitled to a second appeal following an adverse determination of your initial appeal. In such case, the second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal.

If a second appeal is provided by a Component Plan that is not a group health plan, the notification of the Appeal Decision with respect to the second appeal will be made in accordance with the same guidelines as those outlined above for the first appeal. If a second appeal is provided by a Component Plan that is a group health plan, the Appeal Decision with respect to any second appeal will be made according to the following schedule:

- **Urgent Care Claim**. As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- **Pre-Service Claim**. Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- **Post-Service Claim**. Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- **Concurrent Claim**. The response will be made in the appropriate time period based upon the type of claim: Pre-Service Urgent, Pre-Service Non-urgent or Post-Service.

Failure to Follow Claims Procedures

Generally, you are required to complete or exhaust a Component Plan's claims and appeal procedures as a prerequisite to filing a lawsuit for benefits. If your claim is related to a Component Plan that is a non-grandfathered group health plan or a plan that provides disability benefits, and the Component Plan fails to establish or follow a procedure that is consistent with the federal regulations, the Claimant will be deemed to have exhausted administrative remedies and the Claimant then may seek an external review (if applicable) or file suit under ERISA §502(a).

However, this will not apply if the error was de minimis, if the error does not cause harm to you, if the error was due to good cause or to matters beyond the Plan's control, if it occurs in context of good faith exchange of information, or if the error does not reflect a pattern or practice of noncompliance. You may request a written explanation of the violation from the Component Plan, and the Component Plan must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Component Plan to be deemed exhausted.

Group Health Plan External Review

If your internal appeal for a benefit provided by a Component Plan that is a non-grandfathered group health plan is denied, you may have the right to have the claim reviewed by an independent reviewer organization (IRO), not employed by the Component Plan, through an external review process. This applies to claims that involve medical judgment as determined by the external reviewer or a rescission of coverage. You will be allowed at least four months to file a request for external review after the receipt of the Adverse Determination or Appeal Decision. The external review decision is binding on you and the Component Plan, except to the extent other remedies are available under federal law.

Predispute Arbitration

In the event a Component Plan requires voluntary or mandatory predispute arbitration as the first step in a claims dispute for Plan benefits, DOL regulations (29 C.F.R. §2560.503-1) state that benefit claimants cannot be subjected to arbitration costs and any mandatory arbitration provision must not prevent claimants from exercising their statutory remedies or keep them from going to court to appeal an arbitrator's decision. Please review each Component Plan's Benefit Documents for any arbitration clause, if applicable.

Exhausting Administrative Remedies and Filing Suit

These claim and appeals procedures must be exhausted for all claims before you can bring any legal action. **If you do not make a claim or file an appeal in the manner and within the appropriate time period discussed in this SPD or, if applicable, the Benefit Documents of a Component Plan, you may lose the right to file suit in state or federal court.**

A lawsuit seeking benefits under this Plan must be brought within certain time limits as detailed in the "Legal Actions" section of this SPD and in accordance with all applicable laws.

PLAN ADMINISTRATION

In General

ASC is the "Plan Administrator" of the Plan and a "Named Fiduciary" within the meaning of such terms under ERISA. ASC is the Plan's agent for service of legal process.

ASC has the duty and discretionary authority to interpret and construe the Plan in regard to all questions of eligibility, the status and rights of any Plan participant under the Plan, and the manner, time, and amount of payment of any benefits under the Plan. Each employee shall, from time to time, upon request of ASC, furnish to ASC such data and information as ASC shall require in the performance of its duties under the Plan.

ASC may designate any individual, partnership, or other organization to carry out its duties and responsibilities with respect to the administration of the Plan. Such designation shall be in writing and such writing shall be kept with the records of the Plan.

ASC may adopt such rules and procedures as it deems desirable for the administration of the Plan, provided that any such rules and procedures shall be consistent with provisions of the Plan and ERISA.

ASC will discharge its duties with respect to the Plan (i) solely in the interest of persons eligible to receive benefits under the Plan, (ii) for the exclusive purpose of providing benefits to persons eligible to receive benefits under the Plan and of defraying reasonable expenses of administering the Plan, and (iii) with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of like character and with like aims.

Refund of Premium

For purposes of fully-insured Component Plans, where any refund of premium (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates) is determined to be plan assets attributable to participant contributions, such assets will be:

- Distributed to current Plan participants within 90 days of receipt; or,
- Used to reduce participants' portion of future premiums under the Plan; or,
- Used to enhance future benefits under the Plan; or,
- Used to pay Plan administrative expenses.

Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the costs to the Plan and the competing interest of participants, provided such method is reasonable, fair, and objective.

Privacy and Security of Information

Certain Component Plans provided under this Plan are health plans subject to the provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") including regulations affecting the maintenance, creation or use of Protected Health Information ("PHI") (as defined under HIPAA). Please refer to the Notice of Privacy Practices issued by the Plan for a description of how your medical information may be used and disclosed and how you can get access to this information.

Plan Amendment and Termination

ASC reserves the right to amend the Plan in whole or in part or to completely discontinue the Plan at any time, in its sole discretion. For example, ASC reserves the right to amend or terminate benefits, covered expenses, benefit copays, lifetime maximums, and reserves the right to amend the Plan to require or increase employee contributions. ASC also reserves the right to amend the Plan to implement any cost control measures that it may deem advisable.

Any amendment, termination or other action by ASC will be done in accordance with ASC's normal operating procedures.

STATEMENT OF ERISA RIGHTS

As a participant in the American Senior Communities, L.L.C. Master Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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 any collective bargaining agreements, and, if required by ERISA to be filed, a copy of the latest annual report (Form 5500 Series) filed by the Plan with the US. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

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) (if required by ERISA to be prepared) and updated SPD. The administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500 (Summary of Annual Report), if required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

You may be able to continue health care coverage for yourself or dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing your COBRA continuation coverage rights for details.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court after exhausting the Plan's claims procedures. 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.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. For more information about this statement or your rights under ERISA, including COBRA, ACA, HIPAA, and other laws affecting group health plans, or if you need assistance in obtaining documents from the Plan Administrator, contact the

nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website). For more information about the Marketplace, visit www.healthcare.gov.

You also may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. In addition, you may contact the Office of Outreach, Education, and Assistance, EBSA, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

OTHER IMPORTANT INFORMATION

Legal Actions

Any legal action relating to, arising out of, or involving the Plan shall be litigated in the state or federal court of proper jurisdiction in the State of Indiana.

Time limits exist for bringing lawsuits related to this Plan. The time limit for bringing any lawsuit that arises under or relates to this Plan or a Component Plan (other than claims for breach of fiduciary duty governed by Section 413 of ERISA) is as follows:

- Before bringing any lawsuit seeking benefits under a Component Plan, you must complete the applicable claims procedure set out in the Plan or the Component Plan (and you must comply with all applicable deadlines that are required by the Plan or Component Plan). **If you fail to properly exhaust the claims procedure, you will lose your right to file a lawsuit with respect to the claim.**
- In the case of a Component Plan that is self-insured by ASC, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits (such as claims for penalties, equitable relief, interference with protected rights, or production of documents; claims arising under state law; claims against nonfiduciaries; and claims for breach of fiduciary duty that are not governed by Section 413 of ERISA) must be brought within one year of the act or omission giving rise to the claim.
- In the case of a fully-insured Component Plan, the time period for bringing any lawsuit against the insurance company issuing such Component Plan or the Plan will be determined by the terms of the applicable Component Plan. If the Component Plan does not set forth such a time period, you must bring any lawsuit seeking benefits within the shorter of (i) one year from the date of the final appeal denial under the Plan's claims and appeals procedures or (ii) three years from the date of the services giving rise to the claim. All claims other than claims for benefits must be brought within one year of the act or omission giving rise to the claim.

Right of Reimbursement from Third Parties

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. Accordingly, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan and agree to sign a subrogation/reimbursement agreement that confirms your prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you or your covered dependents to any payment, amount, or recovery from a third party.

You and your covered dependents consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Non-Assignment of Benefits

Except as otherwise specifically provided in the Plan or required by law, benefits payable to you or your dependents under the Plan may not be assigned, transferred or in any way made over to another party. If and to the extent any assignment of benefits is permitted under any Component Plan, the Plan Administrator or the responsible fiduciary reserves the discretionary authority to determine whether any purported assignment of Plan benefits to a provider is valid. In other words, the Plan does not guarantee that any purported assignment will be valid under the terms of the Plan or any insurance contract.

Controlling Documents

The information contained in this SPD is a general discussion of the relevant provisions of the Plan found in the official Plan document, Trust documentation, and Component Plan Benefit Documents. In all events, the provisions of the official Plan document shall control with regard to all matters concerning the administration and operation of the Plan.

APPENDIX A

AMERICAN SENIOR COMMUNITIES, L.L.C. MASTER WELFARE PLAN
SUMMARY PLAN DESCRIPTION

Insurance Policy Issuers and Contract Administrators of Component Plans

This Appendix A reflects the Plan benefits as of January 1, 2025. The Benefit Documents for the following Component Plans are incorporated by reference herein. All subsequent updates to such Benefit Documents will supersede any earlier versions for the periods defined in the updated materials.

Fully-Insured Component Plans	Policy/Group No.	Type of Benefit
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333	10408	Dental – PPO
Aflac 2801 Devine Street Columbia, SC 29205	24830	Voluntary Worksite Benefits
Delta Dental P.O. Box 9085 Farmington Hills, MI 48333	10408	Vision
Lincoln Financial Group 8801 Indian Hills Drive Omaha, NE 68114-4066	01 0151494	Basic Life/AD&D Voluntary Life/AD&D
	01-0165863	Voluntary Short-Term Disability
	01 0151495	Long-Term Disability (with EAP)
SunLife One Sun Life Executive Park Wellesley Hills, MA 02481	956906	Stop Loss Insurance

Self-Insured Component Plans	Contract No.	Type of Benefit
Anthem 220 Virginia Avenue Indianapolis, IN 46204	W24110	Medical - PPO
TrueRx 2495 East National Highway Washington, IN 47501	9962	Prescription Drug *(for medical plan enrollees)*

Self-Insured Component Plans	Contract No.	Type of Benefit
Northwind Pharmaceuticals 4838 Fletcher Ave. Indianapolis, IN 46203		Diabetes Clinical Blueprint for prescription drugs and disease management for diabetes
Garner Health 296 Lafayette Street, Floor 5 New York, NY 10012		HRA
WEX Health 4321 20th Avenue South Fargo, ND 58103	28466	General-Purpose Health FSA

Non-ERISA Benefits. In addition to the above Component Plans, eligible employees are offered non-ERISA welfare benefits. Such non-ERISA benefits are not governed by ERISA or the "Statement of ERISA Rights" section of this SPD, and include the following benefit plan(s):

- Dependent Care FSA administered by WEX Health
- COBRA Administration through WEX Health

APPENDIX B

AMERICAN SENIOR COMMUNITIES, L.L.C. MASTER WELFARE PLAN SUMMARY PLAN DESCRIPTION

Claims Administrator Contact Information

Use the address and phone number provided on your ID Card if different.

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	Phone No.	Online
Medical	Anthem Attn: Claims Department PO Box 105187 Atlanta, GA 30348-5187	844 344 7409	www.anthem.com
Prescription Drugs	TrueRx Attn: Claims Department PO Box 431 Washington, IN 47501	866-921-4047	www.truerx.com
Prescription Drugs	Northwind Pharmaceuticals 4838 Fletcher Ave. Indianapolis, IN 46203	800-722-0772	www.nwpharma.com
Dental	Delta Dental Attn: Claims Department P.O. Box 9089 Farmington Hills, MI 48333 *Claims Appeals:* Same as above	800-524-0149	www.deltadentalin.com
Vision	VSP by Delta Vision Attn: Claims Department *Claims Appeals:* VSP Attn: Appeals Department P.O. Box 2350 Rancho Cordova, CA 95741	800-877-7195	www.deltadentalin.com
HRA	Garner Health 296 Lafayette Street Floor 5 New York, NY 10012		www.getgarner.com
Health FSA	WEX Attn: Claims Administration PO Box 2926 Fargo, ND 58108	866-451-3399	www.wexinc.com

Benefit Type	Claims/Claims Appeals Contact Information		
	Mailing Address	Phone No.	Online
Life/AD&D	Lincoln National Attn: Claims Department PO Box 2649 Omaha, NE 68103	800-423-2765	lincoln4benefits.com *Email claims to claims@lfg.com*
	Lincoln National	800-423-2765	lincoln4benefits.com

Disability	Attn: Claims Appeals PO Box 2609 Omaha, NE 68103		*Email claims to claims@lfg.com*
Voluntary Worksite Benefits	Aflac Attn: Claims Department PO Box 427 Columbia, SC 29202	800-992-3522	www.aflac.com

APPENDIX C

AMERICAN SENIOR COMMUNITIES, L.L.C. MASTER WELFARE PLAN SUMMARY PLAN DESCRIPTION

Eligibility and Participation Requirements

Employee Eligibility

An employee who is determined to be benefit-eligible as of his or her start date shall be offered coverage as of the Effective Date of Eligibility specified below.

Employee Class	Working Hours Requirement	Benefits Offered	Effective Date of Eligibility (Waiting Period)
All Employees	30 hours per week	All benefits listed on Appendix A	First day of the month on or after 60 days of full-time employment

Certain Component Plans may delay the effective date of your eligibility if you are not "actively-at-work" (e.g. at work performing all of the regular duties of your job). Any actively-at-work requirement imposed by a group health plan (as defined by HIPAA) will not apply if the reason you are not actively-at-work is due to a health condition.

Special Eligibility Rules for Variable Hour, Part-Time and Seasonal Employees

Certain employees who are hired into positions that are not initially benefit-eligible may become participants in the Plan by achieving Full-Time Status ("ACA-FT") under special eligibility rules for variable hour, part-time, and seasonal employees. In the event ASC adopts such rules, it intends to administer them in a manner consistent with the final regulations issued by the Department of Treasury related to the "Shared Responsibility" provisions of the ACA.

For purposes of these special eligibility rules (known as either the "Look-Back Measurement Method" or "Monthly Measurement Method"), a variable hour, part-time or seasonal employee will achieve ACA-FT status after averaging 130 or more hours of service per month (or 30 or more hours of service per week) during a period of time spanning a specific number of consecutive months ("Measurement Period"). Eligibility or ineligibility for benefits will last for a future specific number of consecutive months referred to as the "Stability Period." The maximum length of any Measurement Period or Stability Period shall not exceed 12-consecutive months.

If applicable, details regarding the Look-Back Measurement Method and/or Monthly Measurement Method adopted by ASC (e.g. the classes of employees it applies to, a description of each type of measurement period, breaks-in-services rules, and procedures used to count hours of service) are available upon request from ASC's Senior Director of Benefits.

Dependent Eligibility

Unless specified otherwise under the applicable Component Plan's Benefit Documents, coverage for dependents, if elected, begins on the date your coverage begins (provided you timely enroll them in coverage). If your family grows as the result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your new dependent(s) mid-Plan Year provided you enroll them in a timely manner after your corresponding Qualifying Life Event.

- Dependent Definitions. For purposes of eligibility and participation in this Plan, dependent definitions shall have the same meaning set forth in each applicable Component Plan's Benefit Documents which are incorporated by reference herein.

- Spousal Carve-Out for Medical Benefits. Spouses are eligible for medical benefits if they are either unemployed or thier employer does not offer a medical plan. You may be required to complete a Spousal Affidavit confirming your spouse's other coverage meets the standards adopted by ASC.
- Proof of Dependent Status. ASC reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by ASC shall be final, binding and conclusive on all parties claiming an interest in the Plan.
- Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Component Plan's Benefit Documents, in no event will an employee be covered under a Component Plan as both a participant and a dependent, or a dependent be covered under a Component Plan as a dependent of more than one participant.

Rehire Rule

The above eligibility waiting period for Plan benefits will be waived if an individual returns to a benefit-eligible position within 13 weeks from the date their Plan coverage ceased due to termination of employment or status change to part time.

- Proof of Dependent Status. ASC reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan. Documents requested may include (but are not limited to) copies of birth certificates, court orders, divorce decrees or marriage certificates as needed to establish dependent status. Dependent eligibility determinations made by ASC shall be final, binding and conclusive on all parties claiming an interest in the Plan.
- Dual Coverage Prohibited. Except as specifically provided otherwise in an applicable Component Plan's Benefit Documents, in no event will an employee be covered under a Component Plan as both a participant and a dependent, or a dependent be covered under a Component Plan as a dependent of more than one participant.

APPENDIX D

American Senior Communities, L.L.C. Master Welfare Plan
Summary Plan Description

Workers Compensation Leave and Other Leaves of Absence

This Appendix D sets forth ASC's internal leave policy as it pertains to the continuation of group health coverage. The ability to continue group health coverage while on a leave of absence may exceed the maximum periods set forth below if required under applicable state or federal law. To the extent this Appendix D is in conflict with ASC's internal leave policy, the internal leave policy will control. Payment options provided to an employee under this Appendix D will be established in accordance with Section 125 of the Internal Revenue Code, FMLA and ASC's internal policies and procedures regarding leaves of absence and will be applied uniformly to all employees.

Workers' Compensation

Group Health Insurance:
Employees who are on a leave of absence due to a work-related injury or illness covered by Worker's Compensation benefits are eligible to continue participation in group health insurance plan(s), subject to the terms outlined below.

Duration of Coverage:
While on a Workers' Compensation leave of absence, employees will continue to be eligible for group health insurance coverage under the same terms and conditions as if they were actively working. Coverage will be maintained for a period of up to six (6) months or as required by applicable federal and state laws, whichever is longer. Worker's Compensation leave will run concurrently with any FMLA and/or Non-FMLA Leave with maximum coverage, while on a leave of absence in a rolling 12-month period, of six (6) months.

Employee Contributions:
Employees on Workers' Compensation leave are required to continue paying their portion of the premiums for group health insurance coverage on a bi-weekly basis and in a timely manner. The employee must make arrangements with ASC's benefits administrator to remit payment directly.

Failure to Pay Premiums:
If an employee fails to pay the required contributions towards premiums during the leave, ASC reserves the right to suspend or terminate health coverage. Benefits would then end as of the last date premiums were paid through.

Reinstatement of Coverage:
Upon returning to work, employees will be reinstated in the group health insurance plan subject to any applicable waiting period, as long as they continue to meet the eligibility requirements. ASC will coordinate with the benefits provider to ensure reinstatement of coverage upon the employee's return.

FMLA (Family and Medical Leave Act)

Group Health Insurance:
During FMLA leave of absence an employee is entitled to continued group health plan coverage under the same conditions as if the employee had continued to work, subject to the terms outlined below.

Duration of Coverage:
While on an FMLA leave of absence employees will continue to be eligible for group health insurance coverage under the same terms and conditions as if they were actively working. Coverage will be maintained for a period of up to twelve (12) weeks or as required by applicable federal and state laws, whichever is longer. FMLA leave of absence may run concurrently with any Workers' Compensation Leave with maximum coverage, while on a Workers' Compensation leave of absence in a rolling 12-month period, of six (6) months.

Employee Contributions:
Employees on an FMLA leave of absence are be required to continue paying their portion of the premiums for group health insurance coverage on a bi-weekly basis and in a timely manner. Premium payments will be made through the same method as before the leave (e.g., payroll deduction). In the event of insufficient funds due to reduced earnings during the leave, the employee must make arrangements with the company's benefits administrator to remit payment directly. In some cases, ASC may arrange a more suitable payment plan directly with the employee if they are unable to pay all of their premium payments, with the understanding that upon return to work, the employee will owe the remaining balances due. ASC reserves the right to legally automatically deduct the amounts owed from future paychecks until the balance has been paid in full.

Failure to Pay Premiums:
If an employee fails to pay the required contributions towards premiums during the leave, ASC reserves the right to suspend or terminate health coverage as permitted under applicable federal law. Benefits would then end as of the last date premiums were paid through.

Reinstatement of Coverage:
Upon returning to work, employees will be reinstated in the group health insurance plan without any waiting period, as long as they continue to meet the eligibility requirements. ASC will coordinate with the benefits provider to ensure reinstatement of coverage upon the employee's return.

Other Leaves of Absence

Group Health Insurance:
Employees who are on approved Other Leaves of Absence (Non-FMLA Medical Leave, Personal Leave of Absence, Indiana's Military Family Leave Act, USERRA or Indiana Emergency Response leave of absence) are eligible to continue participation in the group health insurance plan(s), subject to the terms outlined below.

Duration of Coverage:
While on an Other Leaves of Absence, employees will continue to be eligible for group health insurance coverage under the same terms and conditions as if they were actively working. Coverage will be maintained for up to eight (8) weeks for any Non-FMLA Leaves of absence, up to four (4) weeks for any Personal Leave of absence, up to ten (10) days for any leave of absence taken under the Indiana Military Leave Act (IMLA), up to twenty-four (24) months for any leave of absence taken under the USERRA, to the extent required under USERRA or up to six (6) months for Indiana Emergency Response Leave.

Employee Contributions:
Employees on an Other Leaves of Absence are required to continue paying their portion of the premiums for group health insurance coverage on a bi-weekly basis and in a timely manner. Premium payments will be made through the same method as before the leave (e.g., payroll deduction). In the event of insufficient funds due to reduced earnings during the leave, the employee must make arrangements with the company's benefits administrator to remit payment directly. In some cases, ASC may arrange a more suitable payment plan directly with the employee if they are unable to pay all of their premium payments, with the understanding that upon return to work, the employee will owe the remaining balances due. ASC reserves the right to legally automatically deduct the amounts owed from future paychecks until the balance has been paid in full.

Failure to Pay Premiums:
If an employee fails to pay the required contributions towards premiums during the leave when they are due, ASC reserves the right to suspend or terminate health coverage. Benefits would then end as of the last date premiums were paid through.

Reinstatement of Coverage:
Upon returning to work, employees will be reinstated in the group health insurance plan without any waiting period, as long as they continue to meet the eligibility requirements. ASC will coordinate with the benefits provider to ensure reinstatement of coverage upon the employee's return.

American Senior Communities Health Reimbursement Arrangement Plan and Summary Plan Description

Garner Health Technology, Inc., Claims Administrator

American Senior Communities, LLC ("***Employer***") has established the American Senior Communities Health Reimbursement Arrangement Plan (the "***Plan***" or "***HRA***") effective January 1, 2025 (the "***Effective Date,***" also the "***Plan Year Start Date***").

This document (the "***Summary***") is both the Plan Document and the Summary Plan Description for the HRA. The HRA is offered in conjunction with, and intended to supplement, the major medical insurance coverage that is provided by Employer (the "***Group Health Plan***") to eligible employees and their dependents. The HRA subsidizes participating employees' cost-sharing obligations under the Group Health Plan for care received from certain health care providers, as outlined and explained in this Summary.

Your Employer has hired Garner Health Technology, Inc. ("***Garner***" or "***Garner Health***") to administer the HRA using a program (the "***Garner Program***") that utilizes data to identify the high-quality health care providers that participate in the Group Health Plan's provider network, based on those providers' past performance practicing evidence-based medicine and avoiding care that is medically inappropriate.

Your Employer has agreed to reimburse you for your out-of-pocket deductible, copay, and coinsurance expenses ("***Out-of-Pocket Medical Expenses***") through the HRA when you receive care from providers that have been recommended to you by Garner, up to the following limits:

- **Employee Only Plan: $3,000**
- **Employee & Spouse Plan: $6,000**
- **Employee & Children Plan: $6,000**
- **Employee & Family Plan: $6,000**

This Summary describes the basic terms and conditions of the HRA, including how it works and how it interacts with your Group Health Plan coverage.

Your participation in the HRA is completely voluntary. You are not required to participate in the HRA in order to enroll in the Group Health Plan. But if you choose not to participate, you will not receive benefits under the HRA.

1. Who is Eligible to Participate?

To be eligible to participate in the HRA (a "***Participant***"), you must be eligible for and enrolled as an employee in the Group Health Plan. If your Employer has multiple major medical insurance coverage options, then you will be automatically enrolled in the HRA if you select one of those options that is offered by your Employer in conjunction with the HRA. If your Employer offers any major medical insurance coverage options that are not offered in conjunction with the HRA, you will not be eligible to participate in the HRA if you choose one of those options. If you do not wish to be enrolled in the HRA, you may affirmatively waive coverage under the HRA on forms

provided by your Employer.

To receive reimbursement from the HRA for Out-of-Pocket Medical Expenses, you must first create an account with Garner by accessing the Garner app or website and agreeing to Garner Health's Terms of Service and Privacy Policy. Only Out-of-Pocket Medical Expenses that you incur *after* creating an account with Garner may qualify for reimbursement, subject to the additional requirements outlined below. Any costs or expenses that you incur before creating a verified account will remain ineligible for reimbursement. This is because the HRA is designed to reimburse Out-of-Pocket Medical Expenses that you incur only from health care providers that you find using the Garner website, smartphone app, or concierge services (the "***Garner Services***").

If you have family coverage under the Group Health Plan, each of your covered dependents (including your spouse) that are age 18 years or older must also create an account with Garner in order to submit Out-of-Pocket Medical Expenses for reimbursement under this HRA. Your covered dependents may not be able to create an account with Garner until you have already done so.

2. How Does the HRA Work?

Employees and their dependents who are eligible to participate in the HRA and have properly created accounts with Garner must first use the Garner Services to find recommendations for health care providers. Garner will keep track of which providers it has recommended to you and your eligible dependents, and will add them to your list of approved providers ("***Approved Providers***"). If you then book an appointment with any of those Approved Providers for yourself or for your covered dependents, the future Out-of-Pocket Medical Expenses that you incur with those Approved Providers, as well as certain additional Out-of-Pocket Medical Expenses as described in Section 3, below, will qualify for reimbursement under this HRA, up to the annual limits described above ("***HRA-Qualifying Expenses***"). Note: For Out-of-Pocket Medical Expenses to qualify for reimbursement they must have been incurred with a provider *after* that provider was added to your list of Approved Providers. Unless otherwise specified in Section 3 of this Summary, the HRA will not reimburse you for any Out-of-Pocket Medical Expenses, or other costs, related to treatment from health care providers who are not Approved Providers.

Additionally, for Out-of-Pocket Medical Expenses to qualify for reimbursement under this HRA, the underlying item or service must be covered by your Group Health Plan, and the provider must be in-network with the Group Health Plan. Garner will aim only to add providers to your list of Approved Providers that are within your Group Health Plan's provider network. But because your Group Health Plan may change its terms and network without notice to Garner, you should verify that any provider on your list of Approved Providers is still in-network before you receive any care from that provider. You should also confirm that all of the care (*e.g.*, procedures, tests) you receive is covered by your Group Health Plan, as any Out-of-Pocket Medical Expenses or other costs that you incur for care that is not covered by your Group Health Plan will not be eligible for reimbursement by the HRA.

Note that Garner reserves the right, at its discretion, to modify its methodology for determining which health care providers are recommended to you by the Garner Services, subject to any notification requirements provided by law.

Once you have participated in the Garner Program and incurred an expense that qualifies for reimbursement, Garner will automatically send you a reimbursement from the HRA. Alternatively,

you may use the Garner smartphone app or website to submit evidence that you have incurred an expense that qualifies for reimbursement; provided, however, that a claim for reimbursement that you manually submit may be denied if that same expense has already been automatically reimbursed from the HRA. The deadline for submitting claims through the smartphone app or the website is ninety (90) days after the date on which your annual deductible resets. Under limited circumstances, extensions of this deadline may be allowed when you received documentation of the expense after the deadline passed and when you had no ability to accelerate your receipt of the documentation. Reimbursements may be in the form of a check sent to you by mail, or via direct deposit, if you have set up direct deposit using the Garner smartphone app or website. You will have one hundred eighty (180) days from the date on which any reimbursement check was issued to deposit it. If you do not deposit a reimbursement check within one hundred eighty (180) days of its issue date, the check will be voided and you may lose the right to receive the reimbursement.

The HRA is a bookkeeping account that your Employer sets up for you when you register online for the Garner Program. The HRA is also a pre-tax benefit, so you should not be required to pay taxes on payments or reimbursements from the HRA for cost-sharing expenses.

3. HRA-Qualifying Expenses

This section further describes the kinds of medical expenses that qualify as HRA-Qualifying Expenses. If you have questions about a particular expense, please contact the Garner Health concierge service, which can be reached via online chat using the Garner Health website or smartphone app, or by phone at (866) 761-9586. Note that Garner reserves the right to modify its methodology for determining which Out-of-Pocket Medical Expenses qualify as HRA-Qualifying Expenses, subject to any notification requirements provided by law.

HRA-Qualifying Expenses are only those medical expenses that you incur at the direction of an Approved Provider during this Plan Year, and that are covered by, and in-network with, your Group Health Plan. Items and services that are not covered by the Group Health Plan, including for failing to meet pre-authorization or other administrative requirements, or are not in-network with your Group Health Plan, are not HRA-Qualifying Expenses.

Note that for an expense to become an HRA-Qualifying Expense, it must be incurred with, or at the direction of, an Approved Provider that was added to your list of Approved Providers *before* you incurred the relevant expense. If you incur an expense from a doctor and that doctor is added to your list of Approved Providers only *after* you incur the expense, it will not qualify for reimbursement under the HRA.

If an Approved Provider orders **durable medical equipment** for you, then any Out-of-Pocket Medical Expenses you incur for such equipment will be HRA-Qualifying Expenses, so long they meet the other requirements described herein.

If an Approved Provider orders **imaging or tests**, then any Out-of-Pocket Medical Expenses you incur for such imaging or tests will be HRA-Qualifying Expenses regardless of whether they are provided by an Approved Provider, *so long as the imaging or tests are non-invasive*, and so long they meet the other requirements described herein. If, however, the imaging or tests are invasive, then any Out-of-Pocket Medical Expenses you incur for such imaging or tests will only be HRA-Qualifying Expenses if the care is provided by an Approved Provider. If you have questions about what types of tests qualify as invasive or non-invasive, please contact the Garner Health concierge service, which can be reached via online chat using the Garner Health website or smartphone app,

or by phone at (866) 761-9586.

If you are involved in a care episode that is directed primarily by an Approved Provider, *and you are not in a position to decide which other doctors render you supporting or ancillary services during the care episode*, then the care you receive from such other in-network doctors will be treated as HRA-Qualifying Expenses (to the extent they are covered by the Group Health Plan and would otherwise qualify as HRA-Qualifying Expenses), even though those doctors are not Approved Providers. The initial decision of whether you are "in a position to decide which other doctors render your supporting or ancillary services during the care episode" is made by Garner as claims administrator, pursuant to Garner's policies and procedures.

> *For example: If you are receiving spine surgery from an Approved Provider, then the Out-of-Pocket Medical Expenses associated with care you receive from an anesthesiologist, radiologist, physician's assistant, or second surgeon who assists on the surgery will qualify for reimbursement under the HRA even though those other doctors were not previously approved by Garner.*

If you are involved in a care episode that is directed primarily by an Approved Provider*, and there is a break in care, such that you are in a position to decide which doctor to see next,* then Out-of-Pocket Medical Expenses you incur from any other doctors will only qualify for reimbursement by the HRA if those other doctors are added to your list of Approved Providers before you receive care from those other doctors. This is true even where an Approved Provider refers you to or recommends another doctor. To help ensure that Out-of-Pocket Medical Expenses from doctors you visit qualify for reimbursement by the HRA, you should contact the Garner Health concierge service before receiving services from any doctor whenever there is a break in care such that you are in a position to decide which doctor to see next. Note: The initial decision of whether there is a break in care and whether you are "in a position to decide which other doctor to see next" is made by Garner as claims administrator, pursuant to Garner's policies and procedures.

> *For example: If your primary care physician, who is an Approved Provider, recommends you see a specific spine surgeon, you are responsible for first making sure that that spine surgeon can also be added to your list of Approved Providers. To do this, you may find them in the Garner app or website or contact the Garner Health concierge services to determine whether they can be added to your list of Approved Providers. If the spine surgeon cannot be added to your list of Approved Providers and you choose to receive care from him/her/them anyway, then Out-of-Pocket Medical Expenses you incur in connection with care you receive from him/her/them will not qualify for reimbursement under the HRA. In order to avoid such situations, you should contact the Garner Health concierge service, which is available to help you quickly locate a spine surgeon who can be added to your list of Approved Providers and whose covered services would qualify for reimbursement under the HRA.*

If you have questions about how to proceed with your care in order make sure that your upcoming medical expenses will be HRA-Qualifying Expenses, please contact the Garner Health concierge service, which can be reached via online chat using the Garner Health website or smartphone app, or by phone at (866) 761-9586.

If you experience a medical emergency, please dial 911. The Garner Program is for medical expenses you can plan for and is not designed for emergency room visits. The Garner Program

will not cover your medical expenses incurred for emergency care.

4. Health Flexible Spending Accounts ("*FSAs*")

If you have a Health Flexible Spending Account (FSA), then special rules apply to your use of the HRA. Importantly, you may not be reimbursed for the same medical expense by both your FSA and the HRA. If you have already incurred expenses from Approved Providers, then you are encouraged to use your HRA coverage, if available, rather than your FSA coverage.

5. Is my Personal Health Information Protected?

Yes. Any personal health data made available to Garner or its contractors under the Garner Program will be subject to strict privacy and security requirements under the Health Insurance Portability and Accountability Act of 1996 ("***HIPAA***"). The HRA is a group health plan subject to the HIPAA Privacy Rule (the "***Privacy Rule***"). You can obtain a copy of the HRA's Notice of Privacy Practices (which summarizes the HRA's Privacy Rule obligations, your Privacy Rule rights, and how the HRA may use or disclose health information protected by the Privacy Rule) from the Plan Administrator.

6. When HRA Coverage Ends – COBRA

Coverage under the HRA automatically terminates upon termination of your Group Health Plan coverage. If you terminate employment, or if you or a family member lose coverage under the Group Health Plan because of an event such as a divorce or reduction in hours (a "***qualifying event***"), you or the family member or former spouse ("***qualified beneficiary***") may elect and pay for continuation of coverage in your Employer's Group Health Plan under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Because the HRA is integrated with the Group Health Plan and is contingent on coverage under the Group Health Plan, only those qualifying beneficiaries who elect COBRA continuation coverage for the Group Health Plan are eligible to elect and receive COBRA continuation coverage under the HRA. Loss of Group Health Plan COBRA coverage will also automatically terminate the qualified beneficiary's HRA COBRA coverage.

If you desire to elect COBRA coverage for the HRA, you may be required to do so separately from your election of COBRA coverage for the Group Health Plan, and you may need to pay an additional amount for continued HRA coverage. For more information about how COBRA works, and your COBRA continuation rights, see section below, titled, "Notice of COBRA Continuation Rights."

7. Overpayments from the HRA/Subrogation

If it is later determined that you received an overpayment from the HRA, or if you receive an erroneous payment from the HRA, you will be required to refund the overpayment.

If you do not refund the overpayment or erroneous payment, the Plan reserves the right to offset future reimbursement equal to the overpayment or erroneous payment, or, if that is not feasible, to withhold such funds from your pay, if permitted by applicable law. If all other attempts to recoup the overpayment/erroneous payment are unsuccessful, the Employer may include the amount on your W-2 as gross income. In addition, if the Employer determines that you have submitted a fraudulent claim to the HRA, the Employer may terminate your eligibility for the HRA and take any disciplinary employment actions permitted by applicable law, including termination of employment.

The HRA is entitled to subrogation to the same extent the Group Health Plan is. If the HRA reimburses a claim that is ultimately the responsibility of a third party, the HRA is entitled to subrogation up to the total amount paid by the HRA. Your Employer, as Plan Sponsor, is responsible for enforcing any such right of subrogation and you are required to notify your Employer to the extent a claim submitted to and paid by the HRA is the responsibility of a third party.

8. Claims and Appeals Procedures

If you disagree, in whole or in part, with whether you are entitled to reimbursement from your HRA, you may bring a claim for benefits. If that claim is denied, in whole or in part, you may file an appeal. Claims for services received during the Plan Year may be submitted at any time during the Plan Year and up to ninety (90) days after the date on which your annual deductible resets.

Step 1: *Claim denial is received from Garner.* If your claim is denied, in whole or in part, you will receive a Notice of Adverse Benefit Determination from Garner as soon as reasonably possible but no later than thirty (30) days after receipt of the claim. This period may be extended by Garner for up to fifteen (15) days if Garner believes that such an extension is necessary due to matters beyond its control and notifies you before expiration of the initial thirty (30) day period. Such notification shall describe the circumstances requiring the extension and the date by which Garner expects to render a decision. If the reason for the additional time is that you need to provide additional information, you will have forty-five (45) days from the request for additional information to obtain that information. The time period during which Garner must make a decision will be suspended until the earlier of the date that you provide the information or the end of the forty-five (45) day period.

Step 2: *Review your notice carefully*. Once you have received your notice from Garner please review it carefully. The Notice of Adverse Benefit Determination will contain:

- The specific reason or reasons for the adverse determination;
- Reference to the specific plan provisions on which the determination is based;
- Description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on review; and
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.

Step 3: *If you disagree with the decision, you may file an appeal.* If you do not agree with the decision of Garner, you may file a written appeal. You must file your appeal no later than one hundred eighty (180) days after receipt of the notice described in Step 1. You should submit all information identified in the notice of denial, as necessary, to perfect your claim and any additional information that you believe would support your claim. The following conditions apply to your

appeal:

- Review must be conducted by an "appropriate named fiduciary" who is not the same person that made the initial adverse benefit determination, nor that person's subordinate.
- If the plan considers or relies on any new or additional evidence or rationale in issuing an adverse determination, it must provide that information to you free of charge (and not only on request). The information must be provided as soon as possible and before a final decision so that you can respond to it.
- You have the right to review your claim file and present evidence and testimony as part of the internal claims and appeals process.
- The Plan must avoid conflicts of interest in claims and appeals. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator) must not be made based upon the likelihood that the individual will support the denial of benefits.

Step 4: *Appeal denial is received from Garner.* If the claim is again denied, you will be notified in writing no later than sixty (60) days after receipt of the appeal by Garner. A notice of adverse determination on appeal will include the following:

- The specific reason or reasons for the adverse determination;
- Reference to specific plan provisions;
- Statement that they can receive copies of all documents, records, relevant to claim;
- Statement of any voluntary appeal procedures and right to bring an action;
- Statement of what rule, protocol, etc. criterion was relied on; and
- A statement regarding voluntary alternative dispute resolution options through the local DOL or state insurance regulatory office.

Step 5: *Review your notice carefully.* You should take the same action that you took in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by Garner.

Step 6: *If you still disagree with Garner's decision, file a second level appeal.* If you still do not agree with Garner's decision, you may file a second appeal within sixty (60) days after receiving the first level appeal denial notice from Garner. You should gather any additional information that is identified in the notice, as necessary, to perfect your claim and any other information that you believe would support your claim. Second-level appeals should be sent directly to Garner according to the instructions provided in the notice of the denial of your first appeal. Garner will then provide your appeal request and all relevant information to the Employer for its review. Your Employer reserves the right to delegate the administration of the second level appeal process to a third party organization, and to review and adopt the third party organization's recommendation regarding the appeal. Once the Employer makes a final decision, Garner will notify you of the result. Such a decision will generally be provided to you within 30 days of a properly submitted request for a second appeal.

After exhaustion of the claims and appeals procedures provided under this Plan, nothing shall prevent any person from pursuing any other legal or equitable remedy otherwise available.

Important Claims and Appeals Information

Each level of appeal will be independent from the previous level (*i.e.*, the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal). On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. You cannot file suit in federal court until you have exhausted these appeals procedures.

9. Funding of the Plan

All of the amounts payable under this Plan shall be paid from the ASC Medical Trust. Nothing herein will be construed to require the Employer or the Plan Administrator to maintain any fund or to segregate any amount for the benefit of any Participant, and no Participant or other person shall have any claim against, right to, or security or other interest in any fund, account, or asset of the Employer from which any payment under this Plan may be made.

10. Establishment of HRA Account

The Plan Administrator will establish and maintain an HRA account with respect to each employee Participant and COBRA beneficiary but will not create a separate fund or otherwise segregate assets for this purpose. The HRA Account so established will merely be a recordkeeping account with the purpose of keeping track of contributions and available reimbursement amounts.

(a) Crediting of Accounts. Your HRA account will be credited at the beginning of each Plan Year with an amount equal to the applicable maximum dollar limit for the Plan Year.

(b) Debiting of Accounts. Your HRA account will be debited during each Plan Year for any reimbursement of HRA-Qualifying Expenses incurred during the Plan Year.

(c) Available Amounts. The amount available for reimbursement of HRA-Qualifying Expenses is the amount credited to your HRA account under subsection (a), reduced by prior reimbursements debited under subsection (b).

(d) Unused Amounts. Amounts that are credited to your account but unused during the Plan Year will not roll over for use in the following Plan Year.

11. Administration of the HRA

Your Employer is the Plan Administrator of the HRA. Garner has been retained as the nondiscretionary claims administrator for the HRA. You may contact Garner at:

Garner Health Technology, Inc., Claims Administrator
64 Bleecker Street #103
New York, NY 10012
(866) 761-9586
concierge@getgarner.com

12. Termination of Participation

Your participation in the HRA will end on the date of your termination of coverage under the Group Health Plan, or if earlier, upon the date of termination of the HRA by your Employer.

13. Amounts Remaining After Termination

Any amount remaining in your HRA account following your termination or other loss of eligibility for the HRA will be forfeited. Please refer to the "Notice of COBRA Continuation Rights" section

of this Summary Plan Description.

14. QMSCOs; Special Enrollment Rights

A court or administrative agency may issue an order requiring you to provide health coverage for your child. In most cases your child will already be an eligible family member, but such an order may require that all or part of your account in the HRA be used to reimburse qualifying medical expenses for your child. If such an order is submitted to your Employer, your Employer will determine whether the order meets the requirements to be considered a Qualified Medical Child Support Order or "QMCSO." If the order is a QMCSO, your child will be added to coverage if they are not already an eligible family member, and the Employer will follow other requirements of the order in administering the HRA. Your Employer will give you written notice if an order relating to coverage of your child is received and of the Employer's decision as to whether the order is a QMCSO.

Your eligible family members, who are also enrolled in the Group Health Plan, are automatically eligible for coverage under the HRA. You do not have to request special enrollment upon the addition of new family members, and the HRA will reimburse HRA-Qualifying Expenses as long as they are eligible family members at the time a medical expense is incurred.

15. Mid-Year Enrollment Changes

If you or a dependent loses coverage under the Group Health Plan mid-year, you or your dependent will also automatically lose coverage under the HRA (subject to any COBRA continuation benefits under the Group Health Plan, which, if elected, may require you to separately elect COBRA coverage for the HRA).

If you or a dependent gains coverage mid-year under the Group Health Plan, you or the covered dependent will also automatically be enrolled in the HRA, subject to your Group Health Plan being offered with the HRA, and subject to having to later register with Garner via the smartphone app or website in order to submit claims for HRA benefits.

Except for mid-year enrollment changes relating to changes to the Group Health Plan enrollment, you may not waive coverage under the HRA mid-year.

If your eligibility for the HRA is conditioned upon lack of other coverage through your spouse's employer or through the employer of a family member of which you are a dependent, you must notify your Employer within thirty-one (31) days of the date when you become (or cease to be) eligible for such other coverage, and your Employer will review your eligibility for the HRA. Failure to provide notice of a change in eligibility due to other coverage may be grounds for discipline, up to and including termination of employment.

16. Participation During a Leave of Absence

Coverage will continue under the HRA during a leave of absence in accordance with your Employer's leave policies and to the same extent coverage continues for your Group Health Plan. If you maintain eligibility under the Group Health Plan during a leave, you will continue to be eligible under the HRA. If you lose or drop coverage under the Group Health Plan in connection with a leave of absence, you will also lose coverage under the HRA.

If there is a conflict between the information provided in this section and your Employer's leave policies, your Employer's leave policies will control.

Paid Leave of Absence. Your HRA coverage and your contributions for the coverage will automatically continue during a leave of absence as long as you continue to receive pay and as long as you maintain eligibility under the Group Health Plan.

Unpaid Leave of Absence. Your right to continue HRA coverage during unpaid leave depends on the type of leave. If you do not elect to continue your HRA coverage at the beginning of your leave, you will not be able to submit medical expenses you incur during the leave for reimbursement. Rules regarding specific types of unpaid leave are as follows:

FMLA Leave. If your Employer has fifty (50) or more employees and you take FMLA Leave, your HRA coverage will continue if you choose to maintain your coverage under the Group Health Plan during this period pursuant to one or more methods your Employer will offer under that Plan. If you do not maintain your coverage under the Group Health Plan, your HRA coverage will be terminated, and expenses you incur while on leave will not be reimbursed. Upon return from FMLA Leave, your HRA account will be reinstated.

Military Leave. If you go on a qualifying military leave of absence as defined by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), you may elect to continue your Group Health Plan coverage for up to twenty-four (24) months during the military leave to the extent required by USERRA which will also continue your benefits under the HRA. USERRA continuation coverage information is provided in the "Other Legal Notices" section of this *Summary*. You may reinstate your coverage on return from leave to the extent required by USERRA. Contact the Plan Administrator for more information.

17. Notice of COBRA Continuation Rights

HRAs sponsored by employers with twenty (20) or more full-time employees are subject to COBRA. If your Employer is subject to COBRA, this section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the HRA. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose coverage under the HRA. It can also become available to other members of your family who are covered under the HRA when they would otherwise lose their coverage.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a thirty (30) day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of HRA coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this section. After a qualifying event, COBRA continuation coverage must be

offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the HRA is lost because of the qualifying event. Under the HRA, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the HRA because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the HRA because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the HRA as a "dependent child."

When is COBRA Coverage Available?

The HRA will offer COBRA continuation coverage to qualified beneficiaries only after your Employer has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer will be aware of the qualifying event and you will not have to notify your Employer.

Since the HRA is contingent on coverage under the Group Health Plan, only those qualifying beneficiaries who elect COBRA continuation coverage for the Group Health Plan are eligible to elect and receive COBRA continuation coverage under the HRA. Loss of Group Health Plan COBRA coverage will also automatically terminate the qualified beneficiary's HRA COBRA coverage.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a

dependent child's loss of eligibility for coverage as a dependent child), you must notify your Employer within thirty-one (31) days after the qualifying event occurs. You must provide this notice to the address set forth in this document. Your Employer must notify qualified beneficiaries of the option to continue coverage within fourteen (14) days of receiving notice of a qualifying event.

Qualified beneficiaries have forty-five (45) days from the date of choosing continuation to pay the first continuation charges, except that surviving dependents of a deceased employee have ninety (90) days to pay the first continuation charges. After this initial grace period, qualified beneficiaries must pay charges monthly in advance to your Employer to maintain coverage in force.

Charges for Continuation

Charges for continuation of coverage under the HRA will be equal to a premium determined by your Employer plus a two (2) percent administration fee (if the qualifying event for continuation is the employee's total disability, the administration fee is not required). Premiums are determined under section 4980B of the Internal Revenue Code. All charges are paid directly to your Employer. Your Employer will provide qualified beneficiaries, upon request, written verification of the cost of continuation coverage at the time of eligibility or at any time during the continuation period.

How is COBRA Coverage Provided?

Once your Employer receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. If your Employer terminates the HRA, COBRA continuation coverage for your HRA will not extend beyond the termination date.

Handling of Account Balance Upon Legal Separation/Divorce or Loss of Dependent Eligibility

If a qualifying event, such as legal separation, divorce, or loss of dependent eligibility, causes the family unit to separate, a qualified beneficiary will have a right to elect COBRA for the HRA (subject to electing COBRA coverage for the Group Health Plan) and the HRA account balance will be handled as follows:

- Upon such a qualifying event, the dependent losing coverage will be given the opportunity to elect an HRA tier that is appropriate (*e.g.*, a former-dependent spouse that previously had access to an "employee + spouse" HRA with a $6,000 annual allocation will, following a divorce from the covered employee, be allowed to select a "self-only" HRA with a $3,000 annual allocation upon electing COBRA). Similarly, the employee that retains eligibility will be able to elect an HRA tier that is appropriate (*e.g.*, a now-single divorced employee with no children that previously had access to a "employee + spouse" plan with a $6,000 annual allocation, will be allowed to select a "self-only" plan with a $3,000 annual allocation following the divorce).

- For the former dependent losing coverage, the available account balance in their new HRA will be the full amount available for their coverage tier (*e.g.*, the annual reimbursement accumulator will be reset to $0, and the account balance will be $3,000).
- For the employee retaining coverage, the available account balance will be the maximum amount available under their new coverage tier, less any expenses that were reimbursed prior to the separation, divorce, or loss of dependent eligibility (*e.g.*, if the couple had accumulated $500 of reimbursements before the divorce, then the employee spouse will have an account balance of $2,500).

If You Have Questions

Questions concerning your HRA or your COBRA continuation coverage rights should be addressed to the contact or contacts identified in this document. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep your Employer Informed of Address Changes

In order to protect your family's rights, you should keep your Employer informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your Employer.

Your Employer may offer COBRA under the HRA in coordination with other group health plans sponsored by Employer, if any, as a component of such plans.

18. Other Legal Notices

Uniformed Services Employment and Reemployment Rights Act (USERRA) Continuation Coverage. If you are called to active duty in the uniformed services, you may elect to continue coverage for you and your eligible family members under USERRA. This continuation right runs concurrently with your continuation right under COBRA and allows you to extend an 18-month continuation period to twenty-four (24) months. You and your eligible family members 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. Your eligible family members do not have independent election rights for USERRA continuation coverage so you must elect to continue coverage for USERRA coverage to be provided beyond any COBRA coverage period. You will be required to pay for USERRA continuation coverage.

HIPAA Privacy Rule Notice of Privacy Practices. The HRA is subject to the HIPAA Privacy Rule. You can obtain a copy of the HRA's Notice of Privacy Practices (which summarizes the HRA's Privacy Rule obligations, your Privacy Rule rights, and how the HRA may use or disclose health information protected by the Privacy Rule) from the Plan Administrator. Your Employer is the Plan Administrator of the HRA. HRA HIPAA privacy and security obligations are stated in a separate document(s), which are incorporated by reference.

Statement of ERISA Rights of HRA Participants.

As a Participant in the HRA, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all HRA Participants shall be entitled to:

Receive Information About Your HRA and Benefits.

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the HRA and a copy of the latest annual report (Form 5500 series) filed by the HRA with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the HRA and copies of the latest annual report (Form 5500 series) and the latest updated summary plan description. This *Summary* serves as the HRA Plan Document for this benefit. The Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health HRA Coverage. Continue health care coverage if there is a loss of coverage under the HRA as a result of a qualifying event. You or your eligible family members may have to pay for such coverage. Review this *Summary* for your HRA COBRA continuation rights.

Prudent Actions by HRA Fiduciaries. In addition to creating rights for HRA Participants, ERISA imposes duties upon the people who are responsible for the operation of this HRA. The people who operate your HRA, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other HRA 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 benefit provided under this HRA or exercising your rights under ERISA.

Enforce Your Rights. If your claim for a 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 HRA documents or the latest annual report from the HRA and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the HRA's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court

will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

*Assistance with Your Questions***.** If you have any questions about this HRA, 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 (formerly the Pension and Welfare Benefits 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.

19. Other Terms and Conditions

Company's Right to Terminate or Amend the HRA. Your Employer reserves the right and complete discretion to amend or terminate the HRA at any time and without notice.

No Guarantee of Employment. Participation in this HRA is not a guarantee of employment. All Employees are considered to be employed at the will of the Employer.

Amendment and Termination. This Plan has been established with the intent of being maintained for an indefinite period of time. Nonetheless, the Employer may amend or terminate all or any part of this Plan at any time for any reason.

Governing Law. This Plan shall be construed, administered and enforced according to the laws of the State of Indiana, to the extent not superseded by the Internal Revenue Code, ERISA or any other federal law.

Code and ERISA Compliance. It is intended that this Plan meets all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. This Plan shall be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of this Plan and the Code and/or ERISA, the provisions of the Code and ERISA shall be deemed controlling, and any conflicting part, clause or provision of this Plan shall be deemed superseded to the extent of the conflict.

No Guarantee of Tax Consequences. Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for you or your dependents under this HRA will be excludable from your gross income for federal, state or local income tax purposes.

No Guarantee of Medical Results. Garner's recommendation of health care providers should in no way be construed as medical advice or a substitute for medical advice. Neither Garner, the Plan or your Employer is guaranteeing that you or your covered dependents will have a positive experience or result by using an Approved Provider. Individual results and outcomes will vary. Neither Garner, the Plan or your Employer is liable for any claims arising out of the care provided by Approved Providers, or the acts or omissions of Approved Providers.

Emergencies. If you are experiencing a medical emergency, please call 911 before contacting Garner.

Non-Assignability of Rights. Your right to receive any reimbursement under this Plan shall not be alienable by your assignment or any other method and shall not be subject to claims by your creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Headings. The headings of the various Articles and Sections are inserted for convenience of reference and shall not be construed as defining or limiting the meaning or construction of any provision.

Severability. Should any part of this Plan subsequently be invalidated by a court of competent jurisdiction, the remainder of the Plan shall be given effect to the maximum extent possible.

Plan Administrator's Discretion. The Plan Administrator (and persons to whom it has delegated powers, to the extent of such delegation) has total and complete discretionary authority with respect to administration and interpretation of the HRA. Benefits under the HRA will only be paid if the Plan Administrator decides in its discretion that a claimant is entitled to them.

Customer Service

Questions?	Garner is available to answer your questions about your benefits and claims payments. Monday through Friday: 8:00 AM – 8:00 PM ET *Hours are subject to change without prior notice.*
Customer Service Telephone Number	1 (866) 761-9586
Garner Website	www.getgarner.com
Garner Mailing Address	64 Bleecker St. #103, New York, NY 10012

20. Administrative Information

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

Name of Plan: American Senior Communities Health Reimbursement Arrangement Plan

(HRA)

Plan Administrator's Employer Identification Number (EIN): 35-2077389

Plan Number: 501

Plan Year: January 1, 2025–December 31, 2025, and every anniversary thereof.

Agent for Service of Process: Service may be made on the Plan Administrator at the address listed below.

Type of Plan: The Plan is intended to qualify as a health reimbursement arrangement.

Type of Administration: The Plan Administrator pays applicable benefits from the ASC Medical Trust. The Plan is administered by employees of the Plan Sponsor and under an administrative services contract with Garner as the third-party administrator.

Funding: The Plan is paid for by the ASC Medical Trust.

Plan Administrator: American Senior Communities, LLC

6900 South Gray Road, Indianapolis, IN 46237

Plan Sponsor: American Senior Communities, LLC

6900 South Gray Road, Indianapolis, IN 46237

Named Fiduciary: American Senior Communities, LLC

6900 South Gray Road, Indianapolis, IN 46237

Third Party Administrator (claims administrator): Garner Health Technology, Inc., 64 Bleecker Street #103, New York, NY 10012.

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the American Senior Communities Health Reimbursement Arrangement Plan, this Plan is executed on October 25, 2024.

American Senior Communities, LLC

Signed: Mary Hedlund

Name: Mary Hedlund

Position: Sr. Director of Benefits

Date: 10/25/2024