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, 2026 (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: $3,500**
- **Employee & Spouse Plan: $7,000**
- **Employee & Children Plan: $7,000**
- **Employee & Family Plan: $7,000**

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 Savings Accounts ("*HSAs*") and Health Flexible Spending Accounts ("*FSAs*")

If you are enrolled in a Group Health Plan that is a high deductible health plan ("***HDHP***"), as defined by the Internal Revenue Service, and is offered by your Employer alongside an HSA, then the HRA will only reimburse HRA-Qualifying Expenses that you incur after you reach the minimum statutory deductible during the plan year for an HSA-eligible high deductible health plan, as set by the Internal Revenue Service. This minimum statutory deductible may change from year to year and your Employer, as Plan Administrator, provides its employees with information on the current minimum statutory deductible during open enrollment as well as upon request. For plan years beginning in 2025, for example, the IRS has increased the minimum spend requirement to $1,650 if you are enrolled in an individual HDHP and $3,300 if you are enrolled in a family HDHP. For plan years beginning in 2026, the minimum spending requirement is $1,700 for selfonly coverage, and $3,400 for family coverage.

If you are enrolled in a Group Health Plan that is a HDHP and is offered by your Employer alongside an HSA, by using the Garner Services you certify that you will not submit expenses for reimbursement from the HRA that were incurred before you have met the minimum statutory deductible for your plan year. Additionally, you may not be reimbursed for the same medical expense by both your HSA and the HRA.

Note that only Out-of-Pocket Medical Expenses that are covered by your HDHP may be counted towards this minimum statutory deductible. Thus, if your Group Health Plan does not cover any portion of out-of-network expenses, then no out-of-network expenses may be counted towards your minimum deductible. If, however, your Group Health Plan does cover some portion of out-of-network expenses, then only the portion of your Out-of-Pocket Medical Expenses associated with those covered expenses may be counted towards the minimum statutory deductible.

If you have an 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. There is no trust or other fund from which benefits are paid.

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
169 Madison Ave STE 15492
New York, NY 10016
(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 (30) 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 sixty (60) 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 ten (10) 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 $7,000 annual allocation will, following a divorce from the covered employee, be allowed to select a "self-only" HRA with a $3,500 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 $7,000 annual allocation, will be allowed to select a "self-only" plan with a $3,500 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 $3,500).

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 $3,000).

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.garnerhealth.com
Garner Mailing Address	169 Madison Ave STE 15492, New York, NY 10016

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) (Standard Plan)

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

Plan Number: 501

Plan Year: January 1, 2026–December 31, 2026, 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 Employer out of the Employer's general assets. There is no trust or other fund from which Benefits are paid.

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., 169 Madison Ave STE 15492, New York, NY 10016

Employer hereby adopts the American Senior Communities Health Reimbursement Arrangement Plan, as of January 1, 2026.

Signature: Mary Hedlund

Name: Mary Hedlund

Title: VP Employee Benefits

Date: 2/26/2026