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

American Senior Communities, L. L. C. Master Welfare Plan
2026 Employee Enrollment / Change Form

Plan Sponsor: AMERICAN SENIOR COMMUNITIES, L.L.C.		Group Number: L15393	Effective Date of Coverage (For Benefits/Payroll Use):
Facility Name:		Facility Number:	Employee ID Number:
Email Address:	Name: Last	First	MI
Address:	City	State	Zip
Date of Birth: / /	Gender: ☐ M ☐ F	Marital Status:	Home Telephone Number: ( )

Select a Medical Plan Coverage Level:

Traditional Plan		Blended Plan
☐ Employee Only $84.36		☐ Employee Only $23.10
☐ Employee + Spouse $439.00		☐ Employee + Spouse $312.82
☐ Employee + 1-2 Children $309.00		☐ Employee + 1-2 Children $227.22
☐ Employee + 3+ Children $452.00		☐ Employee + 3+ Children $338.00
☐ Family $566.24		☐ Family $415.80
☐ Waive - I do not want Medical coverage		☐ Waive - I do not want Medical coverage

Select a Dental Plan Coverage Level:		Select a Vision Plan Coverage Level:
☐ Employee Only $6.32		☐ Employee Only $1.52
☐ Employee + Spouse $14.23		☐ Employee + Spouse $7.93
☐ Employee + Children $16.98		☐ Employee + Children $6.06
☐ Family $34.80		☐ Family $13.49
☐ Waive - I do not want Dental coverage		☐ Waive - I do not want Vision coverage

Home Office HR Comments ONLY:

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

Employee Signature Date

COMPLETE THIS SECTION TO CONFIRM INFORMATION IF ELECTING DEPENDENT COVERAGE

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

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

Employee Signature Date

Medical and Prescription Drug Insurance

(review the details of both plan options prior to making a medical plan decision)

Medical Plan Options	Traditional Plan (Anthem Network)	Blended Plan (Anthem Network for physician visits. Reference Based Pricing for facility visits.)
Per-Pay Premium Deduction from Paycheck		
□ Employee Only	□ $84.36	□ $23.10
□ Employee + Spouse*	□ $439.00	□ $312.82
□ Employee + 1 or 2 Children*	□ $309.00	□ $227.22
□ Employee + 3 or More Children*	□ $452.00	□ $338.00
□ Family*	□ $566.24	□ $415.80
Deductible		
□ Employee Only	□ $4,000	□ $4,000
□ Employee + Dependents	□ $8,000	□ $8,000
Coinsurance	25% In-Network 50% Out-of-Network	25% In-Network 50% Out-of-Network 25% (facility services)
Annual In-Network Out-of-Pocket Maximum		
□ Employee Only	□ $6,000	□ $6,000
□ Employee + Dependents	□ $12,000	□ $12,000
Office Visit		
□ Anthem LiveHealth Online Telemedicine Co-Pay	□ $5 Co-Pay	□ $5 Co-Pay
□ Primary Care Co-Pay	□ $30 Co-Pay	□ $30 Co-Pay
□ Specialist Co-Pay	□ $60 Co-Pay	□ $60 Co-Pay
□ Urgent Care Co-Pay	□ $80 Co-Pay	□ $80 Co-Pay
Inpatient/Outpatient Hospitalization	Deductible then Coinsurance	Deductible then Coinsurance
Emergency Room	$400 Co-Pay then Deductible then Coinsurance	$400 Co-Pay then Deductible then Coinsurance
Preventative Care		
□ Annual Checkups	□ Covered at 100%	□ Covered at 100%
□ Wellness Mammograms	□ Covered at 100%	□ Covered at 100%
□ Preventative Colonoscopies	□ Covered at 100%	□ Covered at 100%
Prescriptions – Retail (30-day supply)**		
□ Generic	□ $15 Co-Pay	□ $15 Co-Pay
□ Preferred Brand	□ $30 Co-Pay + 30% (max $65)	□ $30 Co-Pay + 30% (max $65)
□ Non-Preferred Brand	□ $50 Co-Pay + 30% (max $85)	□ $50 Co-Pay + 30% (max $85)
Prescriptions filled at CVS/Walgreens/Rite-Aid**		
□ Generic	□ $30 Co-Pay	□ $30 Co-Pay
□ Preferred Brand	□ $60 Co-Pay + 30% (max $130)	□ $60 Co-Pay + 30% (max $130)
□ Non-Preferred Brand	□ $100 Co-Pay + 30% (max $170)	□ $100 Co-Pay + 30% (max $170)
Prescriptions – Mail Order (90-day supply)**		
□ Generic	□ $30 Co-Pay	□ $30 Co-Pay
□ Preferred Brand	□ $70 Co-Pay	□ $70 Co-Pay
□ Non-Preferred Brand	□ $130 Co-Pay	□ $130 Co-Pay
The pharmacy benefit does not cover specialty drugs. Consult the Pharmacy Benefit Manager, trueRx, for questions about your pharmacy needs: 866-921-4047 or customerservice@trueRx.com.		

*See "Definitions of Important Benefit Terminology" in this Guide for more information on Eligible Dependents and other terminology related to your health benefits .

****Diabetic and pre-diabetic prescription medications** are sourced through **Northwind Pharmaceuticals**. More information on Northwind Pharmaceuticals and the cost of these medications can be found in this Guide.

More information about how the **Blended Plan** uses **Reference Based Pricing** can be found in this Guide.

See "Important Notices About Your Medical Plan Coverage" in this Guide for more detailed information about the medical plans and your rights.

Out-of-Pocket medical spend may be reduced by using the Garner Health benefit, which may provide reimbursement for qualifying medical services when you see a Garner Top Provider. More information about Garner Health can be found in this Guide and on the ASC Employee Benefits Portal (ascom.mybenefitsinfo.com).

For more information on the Medical Plans contact AmeriBen: 855-258-6467 or https://Engage.AmeriBen.com.

More Information about the Medical Plans

Traditional Medical Plan

The Traditional Medical Plan uses the Anthem Network. You will have one insurance card to use for all services under this plan.

TrueRx is the pharmacy for this Medical Plan for all medications except diabetes medications. All diabetes medications are filled by Northwind Pharmaceuticals.

Specialty drugs are not covered under the plan. Aurora Health is the pharmacy advocacy program to use for specialty medications. To learn more about Aurora Health, visit the Employee Benefits Portal (ascom.mybenefitsinfo.com) or contact Aurora Health at 833-759-6096. After enrollment, register online at https://www.AuroraHealth.us/register.

Garner Health is a free benefit that can help reduce your out-of-pocket eligible medical expenses such as co-pays and deductibles when you see a Garner Top Provider. See the Garner Health Benefit section of this Guide.

Blended Medical Plan

The Blended Medical Plan uses both the Anthem Network and Reference Based Pricing.

The Anthem Network coverage is for physician services such as primary care/specialty physician visits and lab work. You will use an Anthem insurance card for these services.

Reference Based Pricing is used for all facility services such as hospital stays, skilled nursing, and advanced imaging services. You will use the card without the Anthem logo for these services. Reference Based Pricing lowers the cost of service by using the Medicare Standard Price as a foundation for the charges.

TrueRx is the pharmacy for this Medical Plan for all medications except diabetes medications. All diabetes medications are filled by Northwind Pharmaceuticals.

Specialty drugs are not covered under the plan. Aurora Health is the pharmacy advocacy program to use for specialty medications. To learn more about Aurora Health, visit the Employee Benefits Portal (ascom.mybenefitsinfo.com) or contact Aurora Health at 833-759-6096. After enrollment, register online at https://www.AuroraHealth.us/register.

Garner Health is a free benefit that can help reduce your out-of-pocket eligible medical expenses such as co-pays and deductibles when you see a Garner Top Provider. See the Garner Health Benefit section of this Guide.

For more information about both plans, please call the Enrollment Call Center at 855-288-1607.

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

Coverage Tier	Employee Per-Pay Premium Rate
□ Employee Only	□ $6.32
□ Employee + Spouse*	□ $14.23
□ Employee + Children*	□ $16.98
□ Family*	□ $34.80

Features	Delta Dental PPO and Premier Dentist	Non-Participating Dentist (subject to balance billing)**
Deductible □ Employee Only □ Employee + Dependents	□ $150 □ $450	□ $150 □ $450
Annual Benefit Maximum – Classes I, II & III	$1,000	$1,000
Orthodontic Lifetime Maximum – Class IV	$1,000	$1,000
Class I Benefits – Preventative □ Diagnostic & Preventative (2 cleanings per year) □ X-Rays	Plan Pays 100%, Deductible Waived	Plan pays 100%, Deductible Waived
Class II Benefits – Basic □ Oral Surgery □ Minor Restorative Services □ Emergency Palliative Treatment □ Periodontics & Endodontics	Deductible first, then Plan pays 80%	Deductible first, then Plan pays 80%
Class III Benefits – Major □ Prosthodontics □ Major Restorative Services	Deductible first, then Plan pays 50%	Deductible first, then Plan pays 50%
Class IV – Orthodontics □ Orthodontics – limited to dependent children who are 18 years of age and under	Plan pays 50% up to $1,000 Lifetime Maximum, Deductible Waived	Plan pays 50% up to $1,000 Lifetime Maximum, Deductible Waived

*See "Definitions of Important Benefit Terminology" in this Guide for more information on Eligible Dependents.

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

Vision Insurance – VSP through Delta Dental
(find a provider at www.vsp.com/eye-doctor or call Customer Service toll free at 800-877-7195)

Coverage Tier	Employee Per-Pay Premium Rate
□ Employee Only	□ $1.52
□ Employee + Spouse*	□ $7.93
□ Employee + Children*	□ $6.06
□ Family*	□ $13.49

Service	Frequency
□ Exam	□ 12 Months
□ Frames	□ 24 Months
□ Lenses	□ 12 Months
□ Contact Lenses (in lieu of frames & lenses)	□ 12 Months

Features	In-Network	Out-of-Network
Eye Exam	$10 Co-Pay	Plan pays up to $45
Contact Lens		
□ Fitting and Evaluation (once every 12 months)	Plan pays up to $60	No discount available for out-of-network providers
Frames	$10 Material Co-Pay, then $130 Allowance	Plan pays up to $70
Standard Lenses		
□ Single Vision	$10 Material Co-Pay	Plan pays up to $30
□ Bifocal (lined)	$10 Material Co-Pay	Plan pays up to $50
□ Trifocal (lined)	$10 Material Co-Pay	Plan pays up to $65
□ Progressive	$10 Material Co-Pay	Plan pays up to $50
□ Lenticular	$10 Material Co-Pay	Plan pays up to $100
Elective Contact Lenses (in lieu of frames and lenses)**	$130 Allowance	Plan pays up to $105
Medically Necessary Contact Lenses	$10 Material Co-Pay	Plan pays up to $210

Additional In-Network Features	
Frames Discount Over Allowance	An extra $20 allowance on featured designer brands for frames. 20% savings on any amount above the retail allowance.
Additional Pair	20% savings on unlimited additional pairs of prescription glasses and/or non-prescription sunglasses from any VSP network provider within 12 months of exam.
LASIK	Average 15% off the regular price, or 5% off the promotional price; discounts only available from contracted facilities.

*See "Definitions of Important Benefit Terminology" in this Guide for more information on Eligible Dependents.

**Elective contact lenses are provided in lieu of all other lens and frame benefits. When contact lenses are obtained, you will not be eligible for lenses and frames again for 12 months.

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

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

1. Is your spouse employed?
   ☐ Yes ☐ No

   Employer Name _____

   Telephone No. _____

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

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

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

   If No, why not? _____

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

Employee Acknowledgement

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

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

_____

Print Employee Name

_____ _____

Employee Signature Date