2026 Employee Benefits Guide

BENEFITING YOU

American Senior Communities
Where caring people make the difference.

Rev. 1/1/2026

Table of Contents

Determine Your Eligibility Date

2026 Insurance Benefits Start Chart		
Full-Time Start Date	Enrollment Deadline	Insurance Eligibility Date
This is the date you started a Full-Time position with the company.	This is the date you must call by to make your benefit enrollment.	This is the date your elected coverage would start.
10/4/2025 – 11/3/2025	12/30/2025 before 8:00PM EST	1/1/2026
11/4/2025 – 12/4/2025	1/30/2026 before 8:00PM EST	2/1/2026
12/5/2025 – 1/1/2026	2/27/2026 before 8:00PM EST	3/1/2026
1/2/2026 – 2/1/2026	3/31/2026 before 8:00PM EST	4/1/2026
2/2/2026 – 3/3/2026	4/30/2026 before 8:00PM EST	5/1/2026
3/4/2026 – 4/3/2026	5/29/2026 before 8:00PM EST	6/1/2026
4/4/2026 – 5/3/2026	6/30/2026 before 8:00PM EST	7/1/2026
5/4/2026 – 6/3/2026	7/31/2026 before 8:00PM EST	8/1/2026
6/4/2026 – 7/4/2026	8/31/2026 before 8:00PM EST	9/1/2026
7/5/2026 – 8/3/2026	9/30/2026 before 8:00PM EST	10/1/2026
8/4/2026 – 9/3/2026	10/30/2026 before 8:00PM EST	11/1/2026
9/4/2026 – 10/3/2026	11/30/2026 before 8:00PM EST	12/1/2026
10/4/2026 – 11/3/2026	12/30/2026 before 8:00PM EST	1/1/2027
11/4/2026 – 12/4/2026	1/29/2027 before 8:00PM EST	2/1/2027

Please review the chart above to confirm your enrollment deadline and insurance eligibility date. If you have any questions, please reach out to ASCBenefitsAdministrators@ASCCare.com.

You must call the Call Center at 1-855-288-1607, by your above listed Enrollment Deadline date, or you will waive participation in the plan. The Call Center is not open weekends or holidays. The Call Center also closes early on Christmas Eve and New Years Eve (actual and observed).

Welcome to American Senior Communities (ASC)! As a Full-Time employee (regularly scheduled and working at least 30 hours each week), you are eligible for certain Company-provided benefits. At American Senior Communities, we believe that our benefits and perks should make a difference – to you, your job, and the life you lead outside of work. By taking advantage of the plans offered through our benefits program, you can have a stronger financial well-being and peace of mind – whether you're single, married or have others depending on you.

Company Sponsored Benefits	Voluntary Benefits
Medical, Vision and Dental	Supplemental Term Life Insurance
Flexible Spending Accounts	Short-Term Disability Insurance
Free Basic Term Life Insurance	Critical Illness Insurance
	Accident Insurance
	Hospital Indemnity Insurance

Your eligibility date will be the first of the month on or after sixty (60) days of Full-Time employment. This Guide provides the information you need to choose and enroll in those benefits. The Enrollment Call Center can help you with questions about group health and voluntary benefits. You must contact the Enrollment Call Center before your enrollment deadline, or you will waive your rights to certain benefits.

Eligibility and Enrollment

Insurance Benefits Acknowledgement

The Insurance Benefits Acknowledgement Form was part of your on-boarding required documents if you are a New Hire or a Rehire. If you are changing from PT or PRN to FT, you must sign an Insurance Benefits Acknowledgement.

Free Basic Life Insurance

ASC provides Company-sponsored Group Term Life Insurance free to Full-Time employees. Coverage starts the first of the month on or after sixty (60) days of Full-Time employment. Name your beneficiary through the Enrollment Call Center. This ensures that your life insurance benefit is paid as you would like. The benefit is approximately equal to a multiple of your annual pay. You can change your beneficiary designation any time by contacting the Enrollment Call Center.

Group Health Enrollment

Enroll in group health and voluntary benefits through the Enrollment Call Center. If you do not enroll through the Enrollment Call Center by your enrollment deadline, you will waive your right to enroll in group health insurance until the next available Open Enrollment. Once you waive your right to sign up, your ability to enroll in the plans later is very restricted. Only certain limited, qualifying changes in your status may permit you to add, drop, or change coverage during the year, and only within 31 days of a qualifying event. See your Payroll/Benefits Coordinator immediately if you have a qualifying event and want to make a coverage change.

Generally, deductions begin the pay period in which your benefits begin. Group health deductions are made on a pre-tax basis. You will only pay for the days in the pay period that you have coverage. Always check the deductions on your paycheck. Coverage continues through your Last Date of Employment. Depending on when your Last Date of Employment falls, the premium deductions may be prorated on that paycheck. You will be offered the opportunity to continue coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Who is Eligible for the Group Health Plan?

Group health benefits are available for all employees hired and working in Full-Time status. In general, these benefits do not apply to employees working in temporary, PRN, voluntary or Part-Time status unless required by the Affordable Care Act. If you choose coverage for yourself, you may also cover your legal spouse and qualifying dependent children under the age of 26. Spouses who have access to medical coverage through their employer cannot be covered under the medical plan. Dependent children can include biological or adopted children, children for whom you have legal guardianship, and stepchildren.

How to Enroll

Carefully read this Guide. Wait until after your first paycheck as a Full-Time employee to ensure the Enrollment Call Center has your employment information. Complete your enrollment before the deadline outlined in the enrollment chart on page 2 of this Guide. Phone the Enrollment Call Center toll-free at 855-288-1607. The Call Center is open Monday – Friday from 9 a.m. to 8 p.m., EST. (closed holidays). Remember that once your election is in place, you may not be able to make changes unless you have a qualifying event (described on the next page).

If you do not enroll through the Enrollment Call Center by your deadline, you will be waiving participation in the plan.

Before you dial the Enrollment Call Center:

- Read the Guide; decide on the benefits you want and the questions you have.
- Allow plenty of time to speak with the Call Center enroller. We recommend you call from home, where you can have these materials and family members nearby in case questions come up during the call.
- You will need your date of birth (DOB) and social security number (SSN) to begin the call with the enroller. You will also need the names, dates of birth, and social security numbers of all dependents you plan to cover. If any of your dependents live at an address different from yours, you will also need that information.

Qualifying Events

Once you make your benefit choices, you can only make changes during the year if you have a qualifying/life event or at the next Open Enrollment.

Qualifying events may include marriage; divorce; eligibility for Medicare or Medicaid; birth or adoption of a child; change in child's dependent status; death of a spouse, child, or other qualified dependent; commencement or termination of adoption proceedings; or any other change that causes an involuntary loss of coverage elsewhere. Changes due to a qualifying event require proof of the event and you must submit the change paperwork within 31 days of the event. See the Payroll/Benefits Coordinator at your location if you have a qualifying event.

ASC Employee Benefits Portal

More information about employee benefits can be found on the ASC Employee Benefits Portal. The portal can be accessed from any smart phone, iPad, or laptop.

Employee Benefits Portal URL: ascom.mybenefitsinfo.com
Employee Benefits Portal link: https://ascom.mybenefitsinfo.com
Employee Benefits Portal QR Code:

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.

What you Need to Know about Using the Traditional Plan and the Blended Plan

1. Call the number on the back of your ID card, 855-258-6467, for any questions you have about how the medical plan works, what's covered and which ID card to use.

2. If you enroll in the Traditional Plan, you use the ID card with the Anthem logo for all services, doctors, hospitals, labs, and imaging.

3. If you enroll in the Blended Plan:

    a. Use the Physician & Ancillary Services Card with the Anthem logo anytime you see a physician or go to a laboratory.

    b. Use the AmeriBen card **without** the Anthem logo for hospitals and imaging services.

    c. Never pay more than your Explanation of Benefits (EOB) says you owe for a medical visit or service.

    d. Be sure to open all mail you receive from your providers or hospitals and make sure the amount they are billing you is the same as on your Explanation of Benefits (EOB), if it isn't, call the number on the back of your ID card and tell them you may have received a balance bill. AmeriBen will confirm if that is the case or not. If it is a balance bill, AmeriBen will transfer you to Imagine360 and they will explain what steps they are going to take to help you resolve it.

    e. Read all documents before you sign them and make sure you do not sign/agree to any kind of payment arrangement for a medical bill or service.

    f. Provider Access Team, Spring Tide Health, may reach out to you in the event a concern by a provider has been encountered.

4. If you live in Fort Wayne, Indiana, and Parkview Hospital is important to you for any facility service other than emergency services, you should consider enrolling in the Traditional Plan.

5. If you live in Richmond, Indiana, and Reid Health is important to you for any facility services other than emergency services, you should consider enrolling in the Traditional Plan.

6. If you encounter a concern, by a provider, hospital, lab, or imaging, please have them call the number on the back of your ID card: 855-258-6467.

Garner Health Benefit

The Garner Health Benefit is available for employees and their dependents enrolled in one of the American Senior Communities medical plans.

Garner is a free, innovative employee benefit that uses data analytics to help you find the highest quality doctors and helps cover out-of-pocket eligible medical expenses when you see Garner Top Providers. The 2026 maximum reimbursement amount for qualifying expenses is $3,500 for employee only coverage and $7,000 for employee plus any number of dependents coverage.

How does this benefit work?

Create a Garner account at https://app.getgarner.com/sign-in. Once you have an account, use the Garner Health website or mobile app to search for the very best doctors in your area. These Top Providers are automatically added to your list of approved providers as soon as they are visible on your screen. Once a Garner Top Provider is on your list of approved providers, you can get reimbursed for qualifying* out-of-pocket costs after your appointment.

*Your out-of-pocket medical costs will qualify for reimbursement if:

- You have created a Garner account and added the Top Provider to your list of approved providers prior to the date of service.
- The cost of your medical service was covered by your health insurance plan. (Check your health insurance plan.)
- The type of cost qualifies for reimbursement under your Garner Health plan. (Check the "Your benefit" page in the Garner Health app to learn more.)

Questions?

Message the Concierge through the Garner Health mobile app, online at getgarner.com, email concierge@getgarner.com, or call 866-761-9586.

More information about Garner Health and how to create an account can be found on the ASC Employee Benefits Portal (ascom.mybenefitsinfo.com).

Recommendations are based solely on independent analysis, not commissions or fees. Garner Health has no financial relationships with doctors.

Northwind Pharmaceuticals for Diabetic Medications

NORTHWIND
CLINICAL BLUEPRINTS®
800-722-0772

American Senior Communities offers the Diabetes Clinical Blueprint in partnership with Northwind Pharmaceuticals. With Clinical Blueprint participation, members enrolled in one of the ASC group medical plans will receive convenient pre-diabetes/diabetes kits that contain all necessary diabetes medications and supplies, along with exclusive access to health coaches, nurses, and pharmacists for additional support to help you stay on track with your health. ASC recognizes your commitment to the program by eliminating or lowering your co-pays while you are actively engaged with the Northwind team.

2026 Co-Pays for Pre-Diabetic & Diabetic Medications through Northwind Pharmaceuticals:

	Members Engaged in the Clinical Blueprint	Members NOT Engaged in the Clinical Blueprint (Pharmacy Only)
Brand Medications/Supplies Kit	$45 Co-Pay	$65 Co-Pay
Generic Medications/Supplies Kit	$0	$20 Co-Pay

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.

Free Life Insurance

At no cost to you, American Senior Communities provides a Basic Term Life Insurance benefit to Full-Time employees equal to a multiple of your annual pay.

Name your beneficiary for the free Basic Life Insurance by contacting the Enrollment Call Center. You can update your beneficiary this way at any time. If you fail to name a beneficiary, the plan will determine who receives the benefit.

401(k) Retirement Savings Plan

Employees become eligible to participate in the 401(k) Retirement Savings Plan immediately upon hire or rehire if they are 21 years of age or older. Once enrolled and a contribution percentage is elected, contributions will start being deducted from your paycheck as soon as administratively feasible. You will receive a 401(k) Retirement Guide from Transamerica as soon as possible after your hire date.

Enroll in the plan and set up beneficiaries online at https://transamerica.com/portal.ascretire or by downloading the Transamerica Retirement app on your mobile device. You can also call Transamerica at 800-755-5801.

Section 125 Plans

The premiums for your group health benefits (Medical, Dental, Vision) are automatically deducted on a pre-tax basis under the Section 125 plan rule.

The company also offers Flexible Spending Accounts (FSA) which are pre-tax savings plans to pay daycare expenses and out-of-pocket medical expenses. You may only enroll in FSAs during Open Enrollment or at the beginning of a plan year.

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About This Guide

This Guide describes the benefits available to employees effective January 1, 2026. It does not include all the details about benefit plan features and rules. Summary Plan Descriptions and insurance certificates have details and terms of your benefit plans. American Senior Communities reserves the right to change or discontinue any or all benefit programs or to change the cost of coverage at any time for any reason. Receiving this document is not a guarantee of employment or eligibility for benefits. If there is a discrepancy between this benefit guide and the Summary Plan Descriptions (SPDs) or the Certificates of Coverage, the SPDs and Certificates will be the governing documents.

Voluntary Benefits from Lincoln Financial Group

While the Company shares the cost of healthcare coverage with you, you may want additional insurance protection. During Open Enrollment, you can purchase voluntary, employee-paid benefits to round out your financial security plan. Premiums for voluntary benefits are deducted after-tax, and you can drop these benefits any time during the year by calling the Enrollment Call Center. **You must be at least 18 years of age to enroll in these benefits.**

Supplemental Term Life Insurance
You can buy voluntary, supplemental term life insurance for yourself and your dependents. View a short video about supplemental term life insurance at the Enrollment Website (ascom.thebeaconselect.com).

- Purchase coverage for yourself in increments of $10,000. Coverage is also available for your dependents.
- Certain levels or increases of coverage may be purchased without Evidence of Insurability. If Evidence of Insurability is required, you must register at **LincolnFinancial.com** using company code **AMSENCOM**. Select **Complete Evidence of Insurability** and follow the steps to complete the process.
- Cost depends on age and level of benefit chosen.
- Coverage can be continued if you leave employment.

Short-Term Disability Insurance
The Short-Term Disability plan from Lincoln provides coverage that pays cash benefits directly to you if you are suddenly unable to work. View a short video about short-term disability insurance at the Enrollment Website.

- Your benefit begins with the 15th day of illness or injury & continues for up to 11 weeks.
- **In some cases, a pre-existing condition limitation may apply, and that can affect payment of a claim.** The Enrollment Call Center can explain this provision; make sure you understand it.
- You can apply for a weekly benefit of up to $2,500, not to exceed 60% of annual salary.

Critical Illness Insurance
If a serious illness strikes, the last thing you need to worry about is how to pay the bills: car payments, rent or mortgage, utilities, and food. Critical Illness insurance pays you a cash benefit if you are diagnosed with a covered illness such as heart attack, stroke, or cancer – even if you receive benefits from other insurance.

- You can select up to $30,000 in coverage for yourself. Spousal coverage is available for up to $15,000. Child coverage has no additional cost; each dependent child is covered at 50% of the employee's benefit selected.
- You may receive a benefit of $100 per calendar year for certain health screenings.
- Cost depends on level of benefit and who is covered, as well as age at date of coverage.

2026 Critical Illness bi-weekly premium amounts are outlined in the chart below and continued onto the next page.

Employee – Non Tobacco	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Age 18-29	$1.05	$2.10	$3.14	$4.19	$5.24	$6.29
Age 30-39	$1.24	$2.47	$3.71	$4.95	$6.18	$7.42
Age 40-49	$1.93	$3.86	$5.79	$7.72	$9.65	$11.58
Age 50-59	$3.75	$7.50	$11.24	$14.99	$18.74	$22.49
Age 60+	$9.67	$19.33	$29.00	$38.67	$48.33	$58.00

Employee – Tobacco	$5,000	$10,000	$15,000	$20,000	$25,000	$30,000
Age 18-29	$1.33	$2.66	$3.98	$5.31	$6.64	$7.97
Age 30-39	$1.74	$3.47	$5.21	$6.94	$8.68	$10.41
Age 40-49	$2.81	$5.61	$8.42	$11.22	$14.03	$16.84
Age 50-59	$5.70	$11.40	$17.11	$22.81	$28.51	$34.21
Age 60+	$14.59	$29.19	$43.78	$58.38	$72.97	$87.56

Spouse – Non Tobacco	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000
Age 18-29	$0.58	$1.15	$1.73	$2.30	$2.88	$3.45
Age 30-39	$0.68	$1.37	$2.05	$2.73	$3.42	$4.10
Age 40-49	$1.02	$2.05	$3.07	$4.10	$5.12	$6.15
Age 50-59	$1.93	$3.85	$5.78	$7.70	$9.63	$11.55
Age 60+	$4.89	$9.77	$14.66	$19.55	$24.43	$29.32

Spouse – Tobacco	$2,500	$5,000	$7,500	$10,000	$12,500	$15,000
Age 18-29	$0.72	$1.44	$2.15	$2.87	$3.59	$4.31
Age 30-39	$0.93	$1.87	$2.80	$3.73	$4.67	$5.60
Age 40-49	$1.46	$2.93	$4.39	$5.85	$7.32	$8.78
Age 50-59	$2.90	$5.81	$8.71	$11.62	$14.52	$17.43
Age 60+	$7.35	$14.70	$22.05	$29.40	$36.75	$44.10

Accident Insurance

Accident Insurance can help protect you and your family from the high costs of an accident. It provides on & off-the-job coverage if you or your covered dependent suffers a covered injury. This coverage pays you a lump sum cash benefit to help manage the costs of emergency medical care, long-term rehab, and unexpected expenses along the way. Below are the Accident Insurance bi-weekly premiums for 2026:

Employee Only	Employee + Spouse	Employee + Child	Employee + Family
$5.46	$8.71	$9.97	$13.22

Hospital Indemnity Insurance

Hospital Indemnity insurance pays you a cash benefit if you or your covered dependent visit a hospital due to a covered illness or injury. You may receive a benefit of $50 per calendar year for certain health screenings. The charts below show the core hospital benefits and the 2026 bi-weekly premiums for the Hospital Indemnity insurance.

Core Hospital Benefits	
Hospital Admission	$1,000 per day for 2 days per calendar year
Hospital Confinement Daily	$200 per day for 30 days per calendar year, starting on day 2 of confinement
Hospital ICU Admission	$2,000 per day for 1 day per calendar year
Hospital ICU Confinement Daily	$400 per day for 30 days per calendar year, starting on day 2 of confinement
Newborn Care	$500 per day for 1 day per calendar year
Pre-Existing	None

Employee Only	Employee + Spouse	Employee + Child(ren) (one parent family)	Employee + Family
$8.23	$17.56	$12.49	$22.74

Definitions of Important Benefit Terminology

Ancillary Services: Supportive or diagnostic measures that supplement and support a primary physician, nurse, or other healthcare provider in treating a patient. Some examples include diagnostic testing, imaging tests, physical therapy, and laboratory services.

Balance Billing: Occurs when providers bill a patient for the difference between the amount they charge and the amount that the patient's insurance approves. If you receive a bill from a provider/facility for a different amount owed from what your Explanation of Benefits states that you owe, contact AmeriBen immediately at: 855-258-6467.

Co-Insurance: Co-insurance is both you and the Plan sharing a percentage of the expense. Co-insurance applies once you meet your deductible; then you and the Plan each pay a percentage of the remaining cost.

Co-Pay: Co-pay is a flat dollar amount you pay for certain medical services. The Medical and Vision Plans have co-pays.

Deductible: The dollar amount you are responsible for paying before the Plan will pay anything. Deductibles apply to both Medical Plans and to the Dental Plan as well. For services that don't use co-pays, you must meet your deductible before the plan begins to pay its share of the bill. Compare deductibles in each plan.

Eligible Dependents: You may cover certain family members under the benefit plans. These are your eligible dependents for medical, dental, and vision: 1) Your legal spouse. Medical Plan coverage (only) is not available to your spouse if your spouse works and is eligible for medical coverage at his/her job. 2) Your children – your children may include biological children, adopted children, stepchildren, and children for whom you have legal guardianship. Children may be covered up until the end of the month they reach age 26 unless they continue to be an IRS eligible dependent due to a disability. "Eligible Dependents" may differ under the voluntary, supplemental benefits through Lincoln Financial Group. Check with the Enrollment Call Center for more information. Tell the Enrollment Call Center if your dependents live at a different address than you.

Employee Premium: Insurance companies charge a monthly premium for each covered employee. The cost depends on which plan and what level of coverage (single, employee-plus-child, family) the employee chooses. The Company pays a large percentage of the monthly premium, but employees are responsible for paying part of the premium with paycheck deductions. The employee's premium amount is divided evenly among the twenty-six pays each year. **Employees are responsible for paying any missed premium amounts.**

Explanation of Benefits: An explanation of benefits (EOB) is an insurance company's statement that describes the costs involved for visits to your doctor or clinic. The EOB lets you know a claim has been filed, along with details of the costs. An EOB is not a bill.

Facility Services: Costs related to receiving care in a hospital or healthcare facility. Examples are hospital and facility charges and advanced imaging services.

Flexible Spending Accounts: A Flexible Spending Account (FSA) lets you save pre-tax money for certain Health Care and/or Dependent Care expenses. An FSA allows you to save money to pay for expenses that aren't eligible for payment under any other benefit plan. You must re-enroll in FSAs every year; flex account balances do not roll over to a new calendar year.

Out-of-Pocket: The amount you pay during the year for medical expenses. It includes your co-pays, deductibles, and co-insurance amounts.

Preventative Services: Care that keeps you healthy and catches problems early. Examples are annual physicals, screenings, vaccines, and well-child visits.

Professional Service: Care provided by doctors and other healthcare professionals. Examples are office visits with family physicians, internists, pediatricians, or general practitioners.

Reference Based Pricing: A reimbursement method that uses Medicare reimbursement rates (or a derived equivalent) as a reference and prices claims based on a multiple of that rate.

Specialty Care: Care from doctors who focus on a specific area of medicine. Examples are cardiology, dermatology, and orthopedics.

Summary Plan Description: Summary Plan Descriptions (SPD's) contain more detailed information about the plans.

Summary of Benefits and Coverage: The Summary of Benefits and Coverage (SBC) follows the federal guidelines for comparing the Company's two medical plans under similar claim situations, to help you decide which plan is best for you. The comparisons are not cost estimators. SBCs are included in this Guide.

American Senior Communities
Summary of Benefits and Coverage (SBC)

Traditional Medical Plan

Blended Medical Plan

Garner Health HRA

This section is called the Summary of Benefits and Coverage (SBC). It helps you compare the coverage and benefits among the medical plan options. These are examples, not cost estimators. Please read the complete example to make sure you fully understand how the plans work.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit engage.ameriben.com or call 1-855-258-6467. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-258-6467 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$4,000	$8,000	
	Per family:	$8,000	$16,000	
Are there services covered before you meet your deductible?	**Yes.** Network office visits, preventive care services, and urgent care.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Per participant:	$6,000	$12,000	
	Per family:	$12,000	$24,000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, and out-of-network transplants.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-855-258-6467 for a list of network providers. **Yes, for prescription drugs:** True Rx. For a list of retail and mail pharmacies, log on to www.TrueRx.com or call 1-866-921-4047.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Anthem LiveHealth Online** $5 co-payment per visit, deductible waived **Other** $30 co-payment per visit, deductible waived	50% co-insurance after deductible	Includes virtual visits.
	Specialist visit	**Anthem LiveHealth Online** $5 co-payment per visit, deductible waived **Other** $60 co-payment per visit, deductible waived	50% co-insurance after deductible	
	Preventive care/screening/ immunization	No Charge	50% co-insurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		True Rx Preferred Pharmacies and TrueRx Mail Order (You will pay the least)	CVS/Walgreens/Rite-Aid (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.TrueRx.com	Generic drugs	**Thirty (30) Day Supply** $15 co-payment **Ninety (90) Day Supply Mail Order** $30 co-payment	**Thirty (30) Day Supply** $30 co-payment	There is not a deductible for prescription drugs. Mail-order prescription drugs are limited to a ninety (90) day supply through True Rx Mail Order. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.TrueRx.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. Additional services for specialty drugs may be available through an external vendor.
	Preferred brand drugs	**Thirty (30) Day Supply** $30 co-payment, then 30% coinsurance up to $65 **Ninety (90) Day Supply Mail Order** $70 co-payment	**Thirty (30) Day Supply** $60 co-payment, then 30% coinsurance up to $130	
	Non-preferred brand drugs	**Thirty (30) Day Supply** $50 co-payment, then 30% coinsurance up to $85 **Ninety (90) Day Supply Mail Order** $130 co-payment	**Thirty (30) Day Supply** $100 co-payment, then 30% coinsurance up to $170	
	Specialty drugs	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Physician/surgeon fees	25% co-insurance after deductible	50% co-insurance after deductible	
If you need immediate medical attention	Emergency room care	$400 co-payment per visit after deductible, then 25% coinsurance		**Non-emergency use is not covered.**
	Emergency medical transportation	25% co-insurance after deductible		——————none——————
	Urgent care	$80 co-payment per visit, deductible waived	50% co-insurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-insurance after deductible	50% co-insurance after deductible	**Limited to the semi-private room rate.** **Inpatient Rehabilitation Calendar Year Maximum:** one hundred twenty (120) days
	Physician/surgeon fees	25% co-insurance after deductible	50% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit** $30 co-payment, deductible waived **Other** 25% co-insurance after deductible	50% co-insurance after deductible	Includes virtual visits, partial hospitalization, and intensive psychiatric day treatment. .
	Inpatient services	25% co-insurance after deductible	50% co-insurance after deductible	Includes residential treatment.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	**Initial Visit** $30 co-payment per pregnancy, deductible waived **Subsequent Visits** No Charge	50% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% co-insurance after deductible	50% co-insurance after deductible	
	Childbirth/delivery facility services	25% co-insurance after deductible	50% co-insurance after deductible	
If you need help recovering or have other special needs	Home health care	25% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum:** ninety (90) visits, including private-duty nursing and therapy part of the home health care plan. Home infusion therapy and home dialysis will not apply towards this maximum.
	Rehabilitation services	25% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum:** forty-eight (48) visits, combined
	Habilitation services	25% co-insurance after deductible	50% co-insurance after deductible	
	Skilled nursing care	25% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum:** one hundred twenty (120) days
	Durable medical equipment	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Hospice services	25% co-insurance after deductible	50% co-insurance after deductible	Coverage limited to plan participants with a life expectancy of less than twelve (12) months.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	——————none——————
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Routine eye care (adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Chiropractic care
  Calendar Year Maximum: twenty-five (25) visits
- Hearing aids
  Lifetime Maximum: $2,000 per ear
- Non-emergency care when traveling outside the U.S., **limited to Global Core**, please refer to www.bcbsglobalcore.com.
- Private-duty nursing **(only as part of home health care)**
- Routine foot care
  (only as medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan Administrator at 6900 South Gray Road, IN 46237. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

You may also contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-855-258-6467

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? No
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6467.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6467.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6467.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6467.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$5,930**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,770**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit engage.ameriben.com or call 1-855-258-6467. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-855-258-6467 to request a copy.

Important Questions	Answers			Why This Matters:
What is the overall deductible?		**Network**	**Non-Network**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
	Per participant:	$4,000	$8,000	
	Per family:	$8,000	$16,000	
Are there services covered before you meet your deductible?	**Yes.** Network office visits, preventive care services, and urgent care.			This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**			You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?		**Network**	**Non-Network**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
	Per participant:	$6.000	$12.000	
	Per family:	$12.000	$24.000	
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, health care this Plan doesn't cover, and out-of-network transplants.			Even though you pay these expenses, they don't count toward the out-of-pocket limit.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

Important Questions	Answers	Why This Matters:
Will you pay less if you use a network provider?	**Yes, for medical:** Anthem. See www.anthem.com or call 1-855-258-6467 for a list of network providers. **Yes, for prescription drugs:** True Rx. For a list of retail and mail pharmacies, log on to www.truerx.com or call 1-866-921-4047.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	**Anthem LiveHealth Online** $5 co-payment per visit, deductible waived **Other** $30 co-payment per visit, deductible waived	50% co-insurance after deductible	Includes virtual visits.
	Specialist visit	**Anthem LiveHealth Online** $5 co-payment per visit, deductible waived **Other** $60co-payment per visit, deductible waived	50% co-insurance after deductible	
	Preventive care/screening/ immunization	No Charge	50% co-insurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. Then check what your plan will pay for.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a test	Diagnostic test (x-ray, blood work)	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Imaging (CT/PET scans, MRIs)	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		True Rx Preferred Pharmacies and TrueRx Mail Order (You will pay the least)	CVS/Walgreens/Rite-Aid (You will pay the most)	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.truerx.com	Generic drugs	**Thirty (30) Day Supply** $15 co-payment **Ninety (90) Day Supply Mail Order** $30 co-payment	**Thirty (30) Day Supply** $30 co-payment	There is not a deductible for prescription drugs. Mail-order prescription drugs are limited to a ninety (90) day supply through True Rx Mail Order. Not all prescription drugs are covered. To determine if a specific drug is covered under your plan, log into your account at www.truerx.com. If you obtain prescription drugs from a non-network pharmacy, you will be required to pay the full cost of the prescription and then submit for reimbursement. Additional services for specialty drugs may be available through an external vendor.
	Preferred brand drugs	**Thirty (30) Day Supply** $30 co-payment, then 30% coinsurance up to $65 **Ninety (90) Day Supply Mail Order** $70 co-payment	**Thirty (30) Day Supply** $60 co-payment, then 30% coinsurance up to $130	
	Non-preferred brand drugs	**Thirty (30) Day Supply** $50 co-payment, then 30% coinsurance up to $85 **Ninety (90) Day Supply Mail Order** $130 co-payment	**Thirty (30) Day Supply** $100 co-payment, then 30% coinsurance up to $170	
	Specialty drugs	Not Covered	Not Covered	

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Physician/surgeon fees	25% co-insurance after deductible	50% co-insurance after deductible	
If you need immediate medical attention	Emergency room care	$400 co-payment per visit after deductible, then 25% coinsurance		**Non-emergency use is not covered.**
	Emergency medical transportation	25% co-insurance after deductible		——————none——————
	Urgent care	$80 co-payment per visit, deductible waived	50% co-insurance after deductible	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	25% co-insurance after deductible	50% co-insurance after deductible	**Limited to the semi-private room rate.** **Inpatient Rehabilitation Calendar Year Maximum:** one hundred twenty (120) days
	Physician/surgeon fees	25% co-insurance after deductible	50% co-insurance after deductible	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Office Visit** $30 co-payment, deductible waived **Other** 25% co-insurance after deductible	50% co-insurance after deductible	Includes virtual visits, partial hospitalization, and intensive psychiatric day treatment. .
	Inpatient services	25% co-insurance after deductible	50% co-insurance after deductible	Includes residential treatment.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you are pregnant	Office visits	**Initial Visit** $30 co-payment per pregnancy, deductible waived **Subsequent Visits** No Charge	50% co-insurance after deductible	Cost sharing does not apply for preventive services. Depending on the type of services, a co-payment, co-insurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	25% co-insurance after deductible	50% co-insurance after deductible	
	Childbirth/delivery facility services	25% co-insurance after deductible	50% co-insurance after deductible	
If you need help recovering or have other special needs	Home health care	25% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum:** ninety (90) visits, including private-duty nursing and therapy part of the home health care plan. Home infusion therapy and home dialysis will not apply towards this maximum.
	Rehabilitation services	25% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum:** forty-eight (48) visits, combined
	Habilitation services	25% co-insurance after deductible	50% co-insurance after deductible	
	Skilled nursing care	25% co-insurance after deductible	50% co-insurance after deductible	**Calendar Year Maximum:** one hundred twenty (120) days
	Durable medical equipment	25% co-insurance after deductible	50% co-insurance after deductible	——————none——————
	Hospice services	25% co-insurance after deductible	50% co-insurance after deductible	Coverage limited to plan participants with a life expectancy of less than twelve (12) months.
If your child needs dental or eye care	Children's eye exam	Not Covered	Not Covered	——————none——————
	Children's glasses	Not Covered	Not Covered	
	Children's dental check-up	Not Covered	Not Covered	——————none——————

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (adult)
- Infertility treatment
- Long-term care
- Routine eye care (adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Abortion (except in cases of rape, incest, or when the life of the mother is endangered)
- Chiropractic care
  Calendar Year Maximum: twenty-five (25) visits
- Hearing aids
  Lifetime Maximum: $2,000 per ear
- Non-emergency care when traveling outside the U.S., **limited to Global Core**, please refer to www.bcbsglobalcore.com.
- Private-duty nursing **(only as part of home health care)**
- Routine foot care
  (only as medically necessary)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. You may also contact the Plan Administrator at 6900 South Gray Road, IN 46237. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

You may also contact the third party administrator (TPA) to assist the plan administrator with claims adjudication. The TPA's name, address, and telephone number are:

AmeriBen
Attention: Appeals Coordination
P.O. Box 7186
Boise, ID 83707
1-855-258-6467

Does this plan provide Minimum Essential Coverage? Yes
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? Yes
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-855-258-6467.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-258-6467.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 1-855-258-6467.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-258-6467.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

* For more information about limitations and exceptions, see the plan or policy document at engage.ameriben.com.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care*)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work*)
Specialist visit (*anesthesia*)

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$10
Coinsurance	$1,900
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$5, 930**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Durable medical equipment (*glucose meter*)

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$900
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$1,400**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$4,000
Specialist copayment	$60
Hospital (facility) cost sharing	25%
Other cost sharing	25%

This EXAMPLE event includes services like:
Emergency room care (*including medical supplies*)
Diagnostic test (*x-ray*)
Durable medical equipment (*crutches*)
Rehabilitation services (*physical therapy*)

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,700
Copayments	$70
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,770**

The **plan** would be responsible for the other costs of these EXAMPLE covered services.

We're here for you – in many languages

The law requires us to include a message in all of these different languages. Curious what they say? Here's the English version: "You have the right to get help in your language for free. Just call the Member Services number on your ID card." Visually impaired? You can also ask for other formats of this document.

Spanish
Usted tiene derecho a obtener asistencia en su idioma sin cargo. Llame al número de Servicios para Miembros que figura en su tarjeta de identificación ¿Tiene alguna deficiencia visual? También puede solicitar este documento en otros formatos.

Chinese
您有權免費獲得使用您的語言提供的協助。只需撥打印於您的 ID 卡上的會員服務部電話號碼即可。視力障礙？您也可以索取本文件的其他格式。

Vietnamese
Quý vị có quyền nhận trợ giúp bằng ngôn ngữ của mình, miễn phí. Quý vị chỉ cần gọi đến số điện thoại của Ban Dịch vụ Thành viên trên thẻ ID của quý vị. Quý vị bị khiếm thị? Quý vị cũng có thể yêu cầu các định dạng khác của tài liệu này.

Korean
귀하는 귀하의 언어로 된 도움을 무료로 받을 권리가 있습니다. 귀하의 ID 카드에 있는 가입자 서비스 번호로 전화하십시오. 시각 장애인이신가요? 다른 형식으로 된 이 문서를 요청하실 수 있습니다.

Tagalog
May karapatan kang makakuha ng tulong na nasa iyong wika nang libre. Tawagan lang ang numero ng Member Services na nasa iyong ID card. May kapansanan sa paningin? Maaari ka ring humingi ng iba pang mga format ng dokumentong ito.

Russian
У вас есть право на бесплатное получение помощи на вашем родном языке. Просто позвоните в отдел обслуживания участников по номеру, указанному на вашей идентификационной карте. У вас проблемы со зрением? Вы также можете запросить этот документ в других форматах.

French Creole
Ou gen dwa jwenn èd nan lang ou gratis. Jis rele nimewo Sèvis Manm ki sou Kat ID ou a gratis Gen pwoblèm vizyèl? Ou ka mande tou pou lòt fòma nan dokiman sa a.

Arabic
لك الحق في الحصول على هذه المعلومات والحصول على المساعدة بلغتك مجانًا. فقط اتصل برقم خدمات الأعضاء الموجود على بطاقة هويتك. هل تعاني من ضعف البصر؟ يمكنك أيضًا طلب تنسيقات أخرى لهذه الوثيقة.

French
Vous avez le droit d'obtenir de l'aide dans votre langue gratuitement. Appelez simplement le numéro du Services membres figurant sur votre carte d'identité. Vous êtes une personne malvoyante ? Vous pouvez également demander à accéder à ce document dans d'autres formats.

Persian
شما حق دارید به زبان خود به صورت رایگان کمک بگیرید. فقط با شماره خدمات اعضا مندرج در کارت عضویت خود تماس بگیرید. آیا دچار اختلال بینایی هستید؟ همچنین می‌توانید فرمت‌های دیگر این سند را درخواست کنید.

Armenian
Դուք իրավունք ունեք անվճար օգնություն ստանալու ձեր լեզվով: Պարզապես զանգահարեք ձեր ID քարտի վրա գտնվող Անդամների սպասարկման համարին: Տեսողության խանգարում ունեցո՞ղ եք: Կարող եք նաև խնդրել այս փաստաթղթի այլ ձևաչափեր:

Japanese
あなたにはあなたの言語で無料で支援を受ける権利があります。IDカードに記載されている会員サービス番号にお電話ください」視覚障害をお持ちですか？他の形式でこの文書を要求することもできます。

Italian
Hai il diritto di ricevere assistenza gratuita nella tua lingua. Basta chiamare il numero del Servizio Membri presente sulla tua tessera identificativa. Hai problemi di vista? È possibile richiedere anche altri formati di questo documento.

German
Sie haben das Recht, kostenlose Hilfe in Ihrer Sprache zu erhalten. Rufen Sie einfach die Nummer des Mitgliederservices auf Ihrer

ID-Karte an. Sehbehindert?
Sie können dieses Dokument auch in anderen
Formaten anfordern.

Polish
Masz prawo do bezpłatnej pomocy w swoim języku. Wystarczy zadzwonić pod numer Biura Obsługi Klienta podany na karcie identyfikacyjnej. Masz wadę wzroku? Możesz również poprosić o inne formaty tego dokumentu.

Pennsylvania Dutch
Du hoscht's Recht fer Hilf griege in dei Schprooch fer nix. Duh yuscht die Member Services Number uffrufe uff dei
ID Card. Hoscht Druwwel fer sehne? Du kannscht des
do Schreiwes in en differnter Weg griege so as du's
besser sehne kannscht.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. Members can get reasonable modifications as well as free auxiliary aids and services if you have a disability. We don't discriminate, on the basis of race, color, national origin, sex, age or disability. For people whose primary language isn't English (or have limited proficiency), we offer free language assistance services like interpreters and other written languages. Interested in these services? Call the Member Services number on your ID card for help (TTY/TDD: 711) or visit our website. If you think we failed in any areas or to learn more about grievance procedures, you can mail a complaint to: Compliance Coordinator,
P.O. Box 7186 Boise, ID 83707, or directly to the U.S. Department of Health and Human Services, Office for
Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201. You can also call 1-800- 368-1019 (TDD: 1-800-537-7697) or visit https://ocrportal.hhs.gov/ocr/portal/lobby.jsf

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
American Senior Communities HRA Plan (Garner Health as Administrator)

Coverage Period: January 1, 2026–December 31, 2026
Plan Type: HRA (Integrated with Major Medical Plans:)
Coverage for: Individual or Family

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, contact your employer or call Garner Health at 1-866-761-9586. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary or call 1-866-761-9586 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	Although this HRA does not itself have a deductible, it is integrated with an employer-sponsored major medical group health plan which may have an overall deductible. (See the SBC or the group health plan).
Are there services covered before you meet your deductible?	Not applicable.	This HRA Plan is not subject to a deductible. The HRA Plan reimburses medical expenses you incur for medical care by health care providers that are recommended or approved through Garner Health's website, smart phone application, or concierge service, up to the balance of your HRA amount. It does not reimburse medical expenses you incur for medical care by health care providers that are not recommended or approved by Garner.
Are there other deductibles for specific services?	No.	The HRA Plan is integrated with an employer-sponsored group health plan which may have a deductible, including other deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not applicable.	The HRA Plan can only reimburse you up to the amount in your HRA account.
What is not included in the out-of-pocket limit?	Not applicable.	The HRA Plan can only reimburse you up to the amount in your HRA account.
Will you pay less if you use a network provider?	It depends.	The HRA Plan will only reimburse medical expenses you incur from a network provider that is recommended or approved through Garner Health's website, smart phone application or concierge service, up to the balance of your HRA account. Out-of-network providers are not recommended or approved by Garner Health and no reimbursement will be available from your HRA account.
Do you need a referral to see a specialist?	It depends.	This HRA Plan is integrated with an employer-sponsored group health plan. If the employer-sponsored group health plan requires a referral to see a specialist, then in order to be reimbursed up to the balance of your HRA account, you will need to (1) obtain a referral, and (2) select a specialist that is recommended or approved through Garner Health's website, smart phone application, or concierge service.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	0-100%	N/A	This HRA Plan is integrated with an employer-sponsored group health plan. If this service is covered by the group health plan, you may be reimbursed up to the balance of your HRA account for eligible out-of-pocket deductible, copay, and coinsurance expenses. To be eligible for reimbursement for this type of medical expense, you must use the Garner Health's website, smart-phone application, or concierge service to receive an in-network doctor recommendation or approval before you incur the out-of-pocket expenses with that doctor.
	Specialist visit	Same as above.	Same as above.	Same as above.
	Preventive care/screening/ immunization	Same as above.	Same as above.	Same as above.
If you have a test	Diagnostic test (x-ray, blood work)	Same as above.	Same as above.	This HRA Plan is integrated with an employer-sponsored group health plan. If this service is covered by the group health plan, you may be reimbursed up to the balance of your HRA account for eligible out-of-pocket deductible, copay, and coinsurance expenses. To be eligible for reimbursement for this type of medical expense, you must use the Garner Health's website, smart-phone application, or concierge service to receive an in-network doctor recommendation or approval before you incur the out-of-pocket expenses with that doctor. If a diagnostic test or imaging is non-invasive, then the eligible out-of-pocket expenses will qualify for reimbursement by the HRA if the test or imaging was ordered by a Garner-recommended or Garner-approved provider. If the test or imaging is invasive, then any out-of-pocket expenses will only qualify for reimbursement if the provider of the test is recommended to you by Garner, or approved by Garner, prior to the date of service.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				If you have questions about what types of tests qualify as invasive or non-invasive, please contact the Garner Health concierge service via online chat using the Garner Health website or smartphone app, or by phone at (866) 761-9586.
	Imaging (CT/PET scans, MRIs)	Same as above.	Same as above.	Same as above.
If you need drugs to treat your illness or condition	Generic drugs	N/A. No coverage is available from your HRA account for this type of medical event	N/A. No coverage is available from your HRA account for this type of medical event	This HRA Plan is integrated with an employer-sponsored group health plan, which may cover some of the out-of-pocket expenses related to drugs. However, no coverage is available from your HRA account for this type of medical event.
	Preferred brand drugs	Same as above	Same as above	Same as above.
	Non-preferred brand drugs	Same as above	Same as above	Same as above.
	Specialty drugs	Same as above	Same as above	Same as above.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	(Same as if you visit a health care provider's office or clinic.)	(Same as if you visit a health care provider's office or clinic.)	This HRA Plan is integrated with an employer-sponsored group health plan. If this service is covered by the group health plan, you may be reimbursed up to the balance of your HRA account for eligible out-of-pocket deductible, copay, and coinsurance expenses. To be eligible for reimbursement for this type of medical expense, you must use the Garner Health's website, smart-phone application, or concierge service to receive an in-network doctor recommendation or approval before you incur the out-of-pocket expenses with that doctor.
	Physician/surgeon fees	Same as above.	Same as above.	Same as above.
If you need immediate medical attention	Emergency room care	N/A	N/A	This HRA Plan is integrated with an employer-sponsored group health plan, which may cover some of the out-of-pocket expenses related to immediate medical attention. However, no coverage is available from your HRA account for this type of medical event.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Emergency medical transportation	Same as above.	Same as above.	Same as above.
	Urgent care	Same as above.	Same as above.	Same as above.
If you have a hospital stay	Facility fee (e.g., hospital room)	(Same as if you visit a health care provider's office or clinic.)	(Same as if you visit a health care provider's office or clinic.)	This HRA Plan is integrated with an employer-sponsored group health plan. If this service is covered by the group health plan, you may be reimbursed up to the balance of your HRA account for eligible out-of-pocket deductible, copay, and coinsurance expenses. To be eligible for reimbursement for this type of medical expense, you must use the Garner Health's website, smart-phone application, or concierge service to receive an in-network doctor recommendation or approval before you incur the out-of-pocket expenses with that doctor.
	Physician/surgeon fees	Same as above.	Same as above.	Same as above.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Same as above.	Same as above.	Same as above.
	Inpatient services	Same as above.	Same as above.	Same as above.
If you are pregnant	Office visits	Same as above.	Same as above.	Same as above.
	Childbirth/delivery professional services	Same as above.	Same as above.	Same as above.
	Childbirth/delivery facility services	Same as above.	Same as above.	Same as above.
If you need help recovering or have other special health needs	Home health care	Same as above.	Same as above.	Same as above.
	Rehabilitation services	Same as above.	Same as above.	Same as above.
	Habilitation services	Same as above.	Same as above.	Same as above.
	Skilled nursing care	Same as above.	Same as above.	Same as above.
	Durable medical equipment	Same as above.	Same as above.	Same as above.
	Hospice services	Same as above.	Same as above.	Same as above.
If your child needs dental or eye care	Children's eye exam	N/A. No coverage is available from your HRA account for this type of medical event.	N/A. No coverage is available from your HRA account for this type of medical event.	This HRA Plan is integrated with an employer-sponsored group health plan, which may cover some of the out-of-pocket costs related to this type of medical event. However, no coverage is

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information*
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				available from your HRA account for this type of medical event.
	Children's glasses	Same as above.	Same as above.	Same as above.
	Children's dental check-up	Same as above.	Same as above.	Same as above.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Any expense payable through another source (such as your employer's group medical plan plan).
- Any service or procedure your employer's group medical plan does NOT cover.
- Any service or procedure your employer's group medical plan does NOT cover.
- Any services or supplies beyond the amount in the HRA Account or services or supplies that are not reimbursable (even if they meet the definition of medical care) under the Internal Revenue Code Section 213.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

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Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. Other coverage options may be available to you, too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318- 2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: [insert applicable contact information from instructions].

Does this plan provide Minimum Essential Coverage? **No**, however, this plan is integrated with a group health plan that may provide minimum essential coverage.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **No**, however, this plan is integrated with a group health plan that may meet the minimum value standards. If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **N/A**
- **Hospital (facility) *[cost sharing]*** **N/A**
- **Other *[cost sharing]*** **N/A**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	**N/A**
Copayments	**N/A**
Coinsurance	**N/A**
What isn't covered	
Limits or exclusions	**N/A**
The total Peg would pay is	**N/A**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well- controlled condition)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **N/A**
- **Hospital (facility) *[cost sharing]*** **N/A**
- **Other *[cost sharing]*** **N/A**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	**N/A**
Copayments	**N/A**
Coinsurance	**N/A**
What isn't covered	
Limits or exclusions	**N/A**
The total Joe would pay is	**N/A**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- **The plan's overall deductible** **$0**
- **Specialist *[cost sharing]*** **N/A**
- **Hospital (facility) *[cost sharing]*** **N/A**
- **Other *[cost sharing]*** **N/A**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	**N/A**
Copayments	**N/A**
Coinsurance	**N/A**
What isn't covered	
Limits or exclusions	**N/A**
The total Mia would pay is	**N/A**

**** This HRA plan does not cover specific services the way a major medical health plan does. Instead, it reimburses eligible out-of-pocket deductible, copay, and coinsurance expenses that are incurred pursuant to your employer-sponsored major medical group health plan, and that are considered eligible for reimbursement under Section 213 of the Internal Revenue Code, up to the amount available in the HRA, and pursuant to the requirements described in the plan document. The employer's group health plan (integrated with the HRA plan) would be responsible for the other costs of these EXAMPLE cover**

2026 Annual Notices
Important Legal Notice Affecting Your Health Plan Coverage

Important Notice from American Senior Communities, LLC About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with American Senior Communities and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. American Senior Communities has determined that the prescription drug coverage offered by the American Senior Communities Master Welfare Plan is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the American Senior Communities Master Welfare Plan. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
3. You can keep your current coverage from American Senior Communities Master Welfare Plan. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current prescription drug coverage with American Senior Communities, since it is employer-sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however, you also may pay a higher premium (a penalty) because you did not have creditable coverage under American Senior Communities Master Welfare Plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

Since the coverage under American Senior Communities Master Welfare Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your

premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage if You Decide to Join a Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current American Senior Communities coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current American Senior Communities coverage, be aware that you and your dependents will not be able to get this coverage back.

For More Information About This Notice or Your Current Prescription Drug Coverage
Contact the person listed on the next page.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Group Name changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	10/1/2024
Name of Entity/Sender:	American Senior Communities, LLC.
Contact--Position/Office:	Benefits Office
Address:	6900 South Gray Road, Indianapolis, IN 46237
Phone Number:	317-788-2500

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 (WHCRA)

Enrollment Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call Anthem at **833-578-4441.**

Annual Notice

Do you know your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services, including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Anthem at **833-578-4441** for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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).

NEW HEALTH AND INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

Beginning in 2014, a new way to buy health insurance was created: the **Health Insurance Marketplace**. To assist you as you evaluate options for yourself and your family, this notice provides some basic information about the Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance through the Marketplace runs from November 1st through December 15th of the previous year. For coverage beginning January 1, 2026, the Marketplace open enrollment period will begin on November 1, 2025, and end on December 15, 2025. After December 15th, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I save money on my health insurance premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that does not meet certain standards. The savings on your premium that you may be eligible for depends on your *household* income.

Does employer health coverage affect eligibility for premium savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% (as adjusted annually, after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.)

NOTE: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may also lose the employer contribution (if any) to the employer-offered coverage. Also, this employer's contribution – as well as your employee contribution to employer-offered coverage – is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How can I get more information?

For more information about coverage offered by your employer, please check your Summary Plan Description or contact *the Benefits Office at 317-788-2500.*

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **www.healthcare.gov** for more information, as well as an online application for Marketplace health insurance coverage and contact information for a Health Insurance Marketplace in your area.

SPECIAL ENROLLMENT ANNUAL NOTICE

This notice is being provided to make certain that you understand your right to apply for group health coverage. You should read this notice even if you plan to waive health coverage at this time.

Loss of Other Coverage

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

Example: You waived coverage under this Plan because you were covered under a plan offered by your spouse's employer. Your spouse terminates employment. If you notify your employer within 31 days of the date coverage ends, you and your eligible dependents may apply for coverage under this Plan.

Marriage, Birth or Adoption

If you have a new dependent because of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, or placement for adoption.

Example: When you were hired, you were single and chose not to elect health insurance benefits. One year later, you marry. You and your eligible dependents are entitled to enroll in this Plan. However, you must apply within 30 days of the date of your marriage.

Medicaid or CHIP

If you or your dependents lose eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a premium assistance subsidy under Medicaid or CHIP, you may be able to enroll yourself and your dependents. You must request enrollment within 60 days of the loss of Medicaid or CHIP coverage or the determination of eligibility for a premium assistance subsidy.

Example: When you were hired, your children received health coverage under CHIP, and you did not enroll them in this Plan. Because of changes in your income, your children are no longer eligible for CHIP coverage. You may enroll them in this Plan if you apply within 60 days of the date of their loss of CHIP coverage.

For More Information or Assistance

To request special enrollment or obtain more information, please contact the *Benefits Office at 317-788-2500.*

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

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium

assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

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

GEORGIA – Medicaid	MASSACHUSETTS – Medicaid and CHIP
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: (678) 564-1162, Press 2	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
INDIANA – Medicaid	**MINNESOTA – Medicaid**

Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
IOWA – Medicaid and CHIP (Hawki)	**MISSOURI – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https: www.mymaineconnection.gov/benefits/s?language=enUS Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**SOUTH DAKOTA - Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**

Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://www.coverva.dmas.virginia.gov/learn/premium-assistance/health-insuranc-premium-payment-hipp-programs Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid and CHIP	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov CHIP Phone: 1-800-986-KIDS (5437)	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
SOUTH CAROLINA – Medicaid	**WYOMING – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

HIPAA Model Privacy Notice

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records	• You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee to provide this information.
Ask us to correct health and claims records	• You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. • We may say “no” to your request, but we will tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (ex: home or office phone) or to send mail to a different address. • We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.
Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations. • We are not required to agree to your request, and we may say “no” if it would affect your care.
Get a list of those with whom we have shared information	• You can ask for a list (accounting) of the times we have shared your health information for six (6) prior years to the date you ask, who we shared it with, and why. • We will include all disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one (1) accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights have been violated	• You can complain if you feel we have violated your rights by contacting as at American Senior Communities Benefit Department at 6900 South Gray Road, Indianapolis, IN 46237.
	• You can file a complaint with the US Department of Health & Human Services Office for Civil Rights by any of the following methods.
	  ○ Send a letter to: US Dept. of Health & Human Services Office of Civil Rights, 200 Independence Avenue, SW, Washington DC 20201.
	  ○ Call: 1.877.696.6775.
	  ○ Visit: www.hhs.gov/ocr/privacy/hipaa/complaints.
	• We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to	• Share information with your family, close friends, or others involved in payment for your care. • Share information in a disaster relief situation. • Contact you for fundraising efforts. *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases, we *never* share your information unless you give us written permission:	• Marketing purposes. • Sale of your information.

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Help manage the health care treatment you receive	• We can use your health information and share it with professionals who are treating you. Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.
Run our organization	• We can use and disclose your information to run our organization and contact you when necessary. • **We are not allowed to use generic information to decide whether we will give you coverage and the price of that coverage**. This does not apply to long-term care plans. Example: We use health information about you to develop better services for you.
Pay for your health services	• We can use and disclose your health information as we pay for your health services. Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan	• We may disclose your health information to your health plan sponsor for plan administration. Example: Your company contracts with us to provide a health plan and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We must meet many conditions in the law before we can share your information for these purposes. For more information visit: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues	• We can share health information about you for certain situations such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications ○ Reporting suspected abuse, neglect, or domestic violence ○ Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health & Human Services if it wants to see that we are complying with federal privacy law.
Respond to organ and tissue donation requests and work with a medical examiner or funeral director	• We can share health information about you with organ procurement organizations. • We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government request	• We can use or share health information about you: ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With health oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time by notifying us in writing that you have changed your mind.

For more information see: www.hhs/gov/ocr/privacy/hipaa/understanding/consumers/noticeapp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, and we will mail a copy to you.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're <u>never</u> required to give up your protection from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

Discrimination is Against the Law

American Senior Communities complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

American Senior Communities does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

American Senior Communities:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).

- Provides free language assistance services to people whose primary language is not English, which may include:
-
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact your community's Executive Director or General Manager.

If you believe your community has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

American Senior Communities Compliance Department
6900 South Gray Road
Indianapolis, IN 46237
317-788-2500
Compliance@ASCCare.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the American Senior Communities Compliance Department is available to help you. If you would like to report your grievances anonymously, the American Senior Communities Hotline can be reached at 1-888-788-2502 or www.ASCHotline.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

This notice is available at American Senior Communities' website: www.ASCCare.com

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

	Language	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-888-788-2502 (TTY: 1-800-877-8339) or speak to your provider.
1	Spanish/Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-888-788-2502 (TTY: 1-800-877-8339) o hable con su proveedor.
2	Chinese/中文	注意：如果您说[中文]，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 1-888-788-2502（文本电话：1-800-877-8339）或咨询您的服务提供商。
3	German/Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-888-788-2502 (TTY: 1-800-877-8339) an oder sprechen Sie mit Ihrem Provider.
4	Pennsylvanian Dutch/Deitsch	Wann du Druwwel hoscht fer Englisch verschtehe, kenne mer epper beigriege fer dich helfe unni as es dich ennich eppes koschte zeelt. Mir kenne dich helfe aa wann du Druwwel hoscht fer heere odder sehne. Mir kenne Schtofft lauder mache odder iesier fer lese un sell koscht dich aa nix. Ruf 1-888-788-2502 (TTY: 800-877-8339) uff odder schwetz mit dei Provider.
5	Burmese/မြန်မာ	သတိပြုရန်- သင်က မြန်မာဘာသာစကား ပြောဆိုပါက၊ အခမဲ့ ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို ရနိုင်ပါသည်။ အသုံးပြုနိုင်သော ဖော်မတ်များဖြင့် အချက်အလက်များ ဖော်ပြပေးရန် သင့်လျော်သော အရန်အကူအညီများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ ရရှိနိုင်ပါသည်။ 1-888-788-2502 (TTY: 1-800-877-8339) သို့ဖုန်းခေါ်ပါ သို့မဟုတ် သင်၏ ဆောင်ရွက်ပေးသူနှင့် စကားပြောပါ။
6	Arabic/العربية	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانا. اتصل على الرقم 1-888-788-2502 (1-800-877-8339) أو تحدث إلى مقدم الخدمة".

7	Korean/한국어	주의: [한국어]를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 1-888-788-2502 (TTY: 1-800-877-8339)번으로 전화하거나 서비스 제공업체에 문의하십시오.
8	Vietnamese/ Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-888-788-2502 (Người khuyết tật: 1-800-877-8339) hoặc trao đổi với người cung cấp dịch vụ của bạn.
9	French/Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-888-788-2502 (TTY : 1-800-877-8339) ou parlez à votre fournisseur.
10	Japanese/日本語	注：日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル（誰もが利用できるよう配慮された）な形式で情報を提供するための適切な補助支援やサービスも無料でご利用いただけます。1-888-788-2502（TTY：1-800-877-8339）までお電話ください。または、ご利用の事業者にご相談ください。
11	Dutch/ Nederlands	LET OP: als je Nederlands spreekt, zijn er gratis taalhulpdiensten voor je beschikbaar. Passende hulpmiddelen en diensten om informatie in toegankelijke formaten te verstrekken, zijn ook gratis beschikbaar. Bel 1-888-788-2502 (tty: 1-800-877-8339) of spreek met je provider.
12	Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-888-788-2502 (TTY: 1-800-877-8339) o makipag-usap sa iyong provider.
13	Russian/ РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-888-788-2502 (TTY: 1-800-877-8339) или обратитесь к своему поставщику услуг.
14	Panjabi/ਪੰਜਾਬੀ	ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਪੂਰਕ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫ਼ਤ ਵਿੱਚ ਉਪਲਬਧ ਹੁੰਦੀਆਂ ਹਨ। 1-888-788-2502 (TTY: 1-800-877-8339) ‘ਤੇ ਕਾਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਪ੍ਰਦਾਤਾ ਨਾਲ ਗੱਲ ਕਰੋ।
15	Hindi/हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-888-788-2502 (TTY: 1-800-877-8339) पर कॉल करें या अपने प्रदाता से बात करें।


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