FIVE STAR SENIOR LIVING INC.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Amended and Restated as of October 1, 2020

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ARTICLE 1

THE PLAN

1.1 Establishment. Five Star Senior Living Inc. (the "Company") hereby amends and restates, effective as of October 1, 2020 and as part of the Five Star Senior Living Inc. Benefits Plan (the "Benefits Plan"), a health care expense reimbursement plan for the benefit of its eligible Employees, which will be known as the Five Star Senior Living Inc. Health Care Flexible Spending Account (the "Health Care Reimbursement Plan"). The Health Care Reimbursement Plan is a Health Benefits Contract under the Benefits Plan. This document describes the features of the Benefits Plan that are unique to the Health Care Reimbursement Plan. Other features of the Health Care Reimbursement Plan are located in the policies, documents and rules governing the Benefits Plan.

1.2 Purpose. The purpose of the Health Care Reimbursement Plan together with the Benefits Plan is to provide eligible Employees the opportunity to use before-tax dollars to pay for eligible health care expenses as hereinafter described. The Health Care Reimbursement Plan is intended to comply with the provisions of Sections 125, 105 and 106 of the Code and all regulations and rulings thereunder (collectively, the "Health Care Rules") and will be interpreted and administered in a manner consistent with those rules.

ARTICLE 2

DEFINITIONS

Whenever used in the Health Care Reimbursement Plan, the following words and phrases will have the meanings set forth below unless the context plainly requires a different meaning, and when the defined meaning is intended, the term is capitalized. Capitalized terms not defined below have the meaning set forth in the Benefits Plan.

2.1 "Carryover Amount" has the meaning set forth in Section 4.2.

2.2 "Coverage Period" has the meaning set forth in Section 4.2.

2.3 "Form" has the meaning set forth in Section 3.3.

2.4 "Grace Period" has the meaning set forth in Section 4.2.

2.5 "Health Care Expenses" means amounts paid by a Participant for any of the following expenses incurred by the Participant or his Dependent, and not reimbursed by insurance or otherwise:

(a) For the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;

(b) For transportation primarily for and essential to medical care referred to in subparagraph (a); and

(c) All other expenses that are considered to be for medical care within the meaning of Section 105(b) of the Code, except premium costs for an accident and health benefits plan not maintained by the Employer.

The term Health Care Expenses will not include any expenses not eligible for reimbursement as medical expenses pursuant to Section 106(f) of the Code.

2.6 "Health Care Reimbursement Account" means a bookkeeping account maintained by the Administrator for each Participant for the sole purpose of recording Payroll Contributions that the Participant elects in connection with the Health Care Reimbursement Plan, and the reimbursement amounts provided to the Participant.

2.7 "Health Care Reimbursement Plan" means the Five Star Senior Living Inc. Health Care Flexible Spending Account, as amended from time to time.

2.8 "Health Care Rules" has the meaning set forth in Section 1.2.

2.9 "Participant" means an Employee who satisfies the participation conditions of Article 3.

2.10 "Payroll Contribution" means the amount that a Participant elects to have withheld from Compensation in accordance with Article 3. In the event an individual continues to participate in the Health Care Reimbursement Plan pursuant to COBRA Continuation Coverage, contributions by the individual will also be considered "Payroll Contributions."

ARTICLE 3

ELIGIBILITY AND PARTICIPATION

3.1 Eligibility. Each Employee who is eligible to participate in the Health Care Reimbursement Plan as of October 1, 2020 will remain eligible to participate under this amended and restated Health Care Reimbursement Plan. Employees hired after the Effective Date who are regularly scheduled to work at least 30 hours per week will be eligible to participate as of the date they are eligible to participate in the Benefits Plan.

Employees who contribute to (or whose spouse contributes to) any HSA will be eligible to participate in the Health Care Reimbursement Plan on only a limited basis (permitting reimbursement of dental and vision expenses and preventive care expenses only). The Administrator will apply the preceding limitation in a manner that provides, to the maximum extent possible, limited coverage so as to permit continuing contributions to the HSA, including

limiting any Carryover Amount to the purposes set forth in this paragraph or permitting the Participant to waive any Carryover Amount.

3.2 Commencement of Participation. An Employee that satisfies the eligibility requirements of Section 3.1 may become a Participant on the Effective Date or, if later, the date they satisfy the eligibility requirements of Section 3.1 or, with the permission of the Administrator, as soon as practicable after a Change in Status. Any Employee may become a Participant on any Anniversary Date after the Employee's fulfillment of the eligibility requirements of Section 3.1.

3.3 Participation Conditions. As a condition to participation and receipt of benefits under the Health Care Reimbursement Plan, the Participant agrees to:

(a) Furnish an enrollment form (a "Form") to participate in the Health Care Reimbursement Plan and supply any other pertinent information that the Employer or the Administrator reasonably requires;

(b) Observe all rules and regulations of the Health Care Reimbursement Plan;

(c) Consent to inquiries by the Administrator with respect to any provider of services involved in a Claim under the Health Care Reimbursement Plan;

(d) Submit to the Administrator all reports and other information that the Administrator may reasonably require; and

(e) Designate a portion of the Participant's Compensation as Payroll Contributions to the Health Care Reimbursement Plan in accordance with the provisions of this Health Care Reimbursement Plan.

3.4 Payroll Contributions. Subject to the following rules, a Form will provide for a reduction in the amount of Compensation on a before-tax basis that otherwise would be paid to the Participant by the Employer on each payday equal to a pro rata portion of the dollar amount designated by the Participant, which may not be greater than the maximum annual benefit amount determined by the Administrator and communicated to Participants; provided, however, that the maximum annual benefit amount may not exceed the limit determined under Section 125(i) of the Code. The Administrator may also establish a minimum annual benefit amount that a Participant may elect under the Plan.

If the Participant's participation is effective on any date other than the Anniversary Date, the maximum dollar limitation will not be prorated to reflect that the application will be in effect for less than a full Plan Year. The reduction in Compensation agreed to by the Participant will be made by the Employer on and after the effective date of the election in accordance with uniform procedures established by the Administrator.

3.5 Election to Participate.

(a) In General. Approximately 30 days before the commencement of each Plan Year, the Administrator will provide a Form to each Participant and to each other individual who is or will be eligible to become a Participant at the beginning of the Plan Year. The Administrator will similarly provide such Forms to Employees who become

eligible to participate in the Health Care Reimbursement Plan during a Plan Year. Each eligible Employee who desires to participate in the Health Care Reimbursement Plan for the Plan Year (or in the case of a new Employee, the remainder of the Plan Year) must so specify on the appropriate Form or Forms and must agree to a reduction in Compensation equal to the amount of Payroll Contributions elected by the Participant.

(b) Effective Date of Elections. Elections pursuant to Forms that are timely submitted to the Administrator will be effective as of the first day of the following Plan Year. In the case of a newly eligible Employee who timely submits Forms to the Administrator, elections will be effective as soon as practicable following delivery.

(c) Deemed Elections. Until a Participant returns completed Forms to the Administrator for the initial Plan Year of participation, or for the Plan Year in which the Employee becomes a Participant, the Participant will be deemed to have elected to receive all Compensation in cash and not to participate in the Health Care Reimbursement Plan. Unless otherwise announced by the Administrator, a Participant who fails to return completed Forms to the Administrator on or before the due date specified by the Administrator for any subsequent Plan Year will be deemed to have elected to receive all Compensation in cash and to not participate in the Health Care Reimbursement Plan.

3.6 Nondiscrimination Requirement of Health Care Rules. If the Administrator determines before or during any Plan Year that the Health Care Reimbursement Plan may fail to satisfy for the Plan Year any nondiscrimination requirement imposed by the Health Care Rules, or any limitation imposed by the Health Care Rules on benefits provided to persons who are key employees within the meaning of Section 416(i) of the Code, the Administrator will take such action as the Administrator deems appropriate, under rules uniformly applicable to similarly situated Participants, to ensure compliance with the requirement or limitation in question. Such action may include, without limitation, a modification of elections by Participants who are highly compensated individuals or participants or key employees, each within the meaning of the Health Care Rules, with or without the consent of the Participants.

3.7 Cessation of Participation. An individual will cease to be a Participant in the Health Care Reimbursement Plan as of the earlier of: (a) the date the Health Care Reimbursement Plan terminates; (b) the date the Participant revokes an election pursuant to the terms of the Benefits Plan; (c) the date the Participant fails to pay the cost of benefits pursuant to the terms of the Benefits Plan; or (d) the date the Participant's right to receive benefits pursuant to any applicable state or federal law expires.

3.8 Statutory Continuation Rights. Notwithstanding any conflicting provision in the Health Care Reimbursement Plan, an eligible Employee who is a Participant will have the right to continue coverage under the following statutory provisions, to the extent that the statutory provision relied upon is applicable.

(a) FMLA Continuation Coverage. Coverage for a Participant on FMLA Leave will be administered pursuant to the rules set forth in the Benefits Plan.

(b) USERRA Continuation Coverage. Coverage for a Participant on a leave of absence for qualified military service, and upon the Participant's return to employment following the leave, will be administered pursuant to the rules set out in USERRA.

(c) COBRA Continuation Coverage. Upon the loss of eligibility for benefits under the Health Care Reimbursement Plan, continuation coverage, if any, will be administered pursuant to the COBRA Continuation Coverage rules; provided, however, that in no event will COBRA Continuation Coverage be available beyond the Plan Year during which the Participant loses eligibility to participate in the Health Care Reimbursement Plan; and provided, further, that if upon the loss of eligibility to participate in the Health Care Reimbursement Plan the Participant's Health Care Reimbursement Account is zero or less, then the Participant will not be eligible for COBRA Continuation Coverage.

ARTICLE 4

HEALTH CARE BENEFITS

4.1 Health Care Benefits. The Administrator will establish for each Participant a Health Care Reimbursement Account for recordkeeping purposes only, to which there will be credited the Payroll Contributions made in accordance with the Participant's election under Article 3 of the Health Care Reimbursement Plan. Cash reimbursements from the Employer's general assets will from time to time be provided to the Participant to reimburse the amounts paid by the Participant for Health Care Expenses as reported to the Administrator in accordance with Section 4.3.

4.2 Amount Available for Reimbursement. The amount of reimbursement available to a Participant will be the aggregate amount of Payroll Contributions the Participant has elected for the Plan Year, reduced by the cumulative amount previously reimbursed to the Participant with respect to the Plan Year plus, at the election of the Administrator, an additional two and one-half month period (the "Grace Period") following the close of the Plan Year (the entire period being the "Coverage Period"). In addition, in lieu of establishing a Grace Period, the Administrator may permit an amount not in excess of $500 (or such different amount as may be permitted in accordance with the Cafeteria Plan Rules and Health Care Rules) that remains unused at the end of the Plan Year (the "Carryover Amount") to be used to pay or reimburse Health Care Expenses incurred during the subsequent Plan Year (or any future Plan Year to which such Carryover Amount continues to be available). The Carryover Amount does not reduce the salary reduction limit (as specified in Section 3.4) for the subsequent Plan Year.

Reimbursement will be made only for Health Care Expenses incurred (a) during the Participant's participation in the Health Care Reimbursement Plan and (b) during the Coverage Period. If the Administrator adopts a Grace Period, to the extent the amount available for reimbursement during the final two and one-half months of the Coverage Period is insufficient, Health Care Expenses incurred during such period will be reimbursed from amounts available for the current Plan Year. If there is a Carryover Amount from a prior Plan Year, expenses incurred during the current Plan Year will be reimbursed first from Payroll Contributions the Participant has elected for the Plan Year. No reimbursement will be made for Health Care Expenses incurred after the termination of the Participant's employment with the Employer unless the Participant is entitled thereto in accordance with COBRA Continuation Coverage.

Health Care Expenses will be treated as having been incurred when the services are provided and not when the Participant is formally billed, charged or pays for the services.

No reimbursement will be made if the Participant's Claim is for an amount less than the minimum reimbursable amount established by the Administrator. The amount of any expense not reimbursed as a result of the preceding sentence will be carried over and reimbursed only if and when the Participant's Claim equals or exceeds the minimum amount; provided, however, that in no event will a Claim for an expense be carried beyond the Plan Year. Claims for expenses incurred during a Plan Year that are submitted for reimbursement during the last month of the Plan Year or within three months of the close of the Plan Year will be paid regardless of whether they equal or exceed the minimum reimbursable amount. No reimbursements will be made for expenses incurred during a Plan Year and submitted more than three months after the end of the Plan Year. If a Participant terminates employment with the Employer during the Plan Year, Claims for reimbursement of expenses incurred through the date of termination must be submitted within 60 days of termination.

4.3 Requests for Reimbursement. In order to receive benefits under the Health Care Reimbursement Plan, a Participant must submit a request for reimbursement to the Administrator stating:

(a) The amount of Health Care Expense for which reimbursement is requested;

(b) The date or dates of treatment or other service for which the Health Care Expense was incurred;

(c) The name of the person for whom the Health Care Expense was incurred, the relationship of the person to the Participant and whether the person is a Dependent; and

(d) The name of the person, organization or entity to whom the Health Care Expense was paid.

All such requests must be accompanied by a receipt from the payee, a canceled check or other proof of payment acceptable to the Administrator. The Administrator will establish and announce to Participants reasonable rules and regulations concerning the times at which requests will be accepted and reimbursements will be made, the minimum reimbursable amount, the method by which reimbursements are made and other matters in connection with the reimbursement procedure. Notwithstanding anything to the contrary, reimbursements will be permitted at least monthly.

The Plan may pay benefits solely for Health Care Expenses that have not been previously reimbursed and for which the Participant will not seek reimbursement elsewhere. The Health Care Reimbursement Plan will not be considered a group health plan for coordination of benefits purposes. In the event an expense is eligible for reimbursement under both this Plan and an HSA, the Participant may not seek reimbursement from both this Plan and the HSA.

4.4 Use of Credit or Debit Cards.

(a) The procedures outlined in Section 4.3 will be deemed to have been satisfied where a Participant uses a credit or debit card to pay for Health Care Expenses at locations authorized under Treasury Regulations finalized under Section 125 of the Code or, prior to the effective date of such regulations, Notice 2006-69, Notice 2007-2 and/or other guidance issued by the Internal Revenue Service, provided that the following substantiation procedures are followed.

(i) If the dollar amount of the reimbursement equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service provided as a Health Benefit, the charge is treated as fully substantiated.

(ii) If the reimbursement is for a recurring expense that matches expenses previously approved as to amount, provider and time period in accordance with Section 4.3, the charge is treated as fully substantiated.

(iii) If the merchant, service provider or other independent third-party at the time and point of sale provides information (whether by e-mail, the internet, intranet or telephone) to verify to the Administrator that the reimbursement is for a Health Care Expense, the charge is treated as fully substantiated.

(iv) All other reimbursements for charges to the credit or debit card will be treated as conditionally approved pending confirmation of the charge upon submission of the documentation described in Section 4.3.

Notwithstanding the foregoing provisions of this Section 4.4(a), any payment made using a credit or debit card from a merchant that has established an inventory information approval system that meets the requirements of Treasury Regulations finalized under Section 125 of the Code or, prior to the effective date of such regulations, Notice 2006-69 and/or other guidance issued by the Internal Revenue Service, will be deemed to be fully substantiated in accordance with Section 4.4.

(b) If a Claim for reimbursement is subsequently identified as not qualifying for reimbursement, the following correction procedures will, as determined by the Administrator, be followed with respect to the improper payment:

(i) Upon identifying an improper payment, the Participant will be required to pay back to the Health Care Reimbursement Plan an amount equal to the improper payment;

(ii) If the amount equal to the improper payment cannot be obtained in accordance with Section 4.4(b)(i), the amount of the improper payment will be withheld from the Participant's wages or other compensation to the extent consistent with applicable law;

(iii) If the improper payment remains outstanding after application of the correction procedures set forth in Sections 4.4(b)(i) and (ii), the

Administrator will substitute or offset the improper payment amount against another substantiated Claim(s) incurred during the same Coverage Period; and

(iv) If the improper payment remains outstanding after application of the correction procedures outlined in Sections 4.4(b)(i), (ii) and (iii), the Administrator will report the amount of the improper payment to the Employer, and the Employer will treat the payment as it would any other business indebtedness.

The Administrator will deny access to the credit or debit card during any period in which the Participant remains indebted to the Health Care Reimbursement Plan.

(c) In the event a Coverage Period is greater than 12 months in duration, the Administrator may require that any expenses incurred during the portion exceeding 12 months may not be submitted using any credit or debit card system otherwise available.

(d) The substantiation and correction procedures outlined in this Section 4.4 may be supplemented or modified in accordance with Treasury Regulations and/or guidance issued by the Internal Revenue Service including, without limitation, Revenue Ruling 2003-43 and Notices 2006-69 and 2007-2.

4.5 Forfeitures. Any unused amount credited to a Health Care Reimbursement Account as of the end of a Coverage Period may not be redeemed for cash by the Participant or applied to Health Care Expenses incurred in any subsequent Coverage Period, except as otherwise provided in Section 4.2. Except as otherwise provided pursuant to Section 4.2, such unused amount will be forfeited and applied by the Administrator to the reasonable expenses of administering the Health Care Reimbursement Plan, or in such other manner as the Administrator considers, upon advice of counsel, appropriate.

4.6 Benefits Limited to Reimbursement. The Employer will have no liability to any Participant in connection with the Health Care Reimbursement Plan apart from the provision of reimbursements equal in amount to the lesser of: (a) the aggregate amount of Payroll Contributions the Participant has elected for the Plan Year, plus any Carryover Amount; and (b) the amount of Health Care Expenses documented by the Participant in accordance with Section 4.3.

4.7 Annual Statement of Benefits. Approximately one month following the close of the Coverage Period, the Administrator will furnish to each Participant who received reimbursements under the Health Care Reimbursement Plan with respect to a Coverage Period a statement of all such reimbursements paid for such period.

4.8 Indemnification of Employer by Participants. If any Participant receives one or more reimbursements under the Health Care Reimbursement Plan that are not for Health Care Expenses, the Participant will indemnify and reimburse the Employer for any liability it may incur for failure to withhold federal, state or local income tax or Social Security tax from such reimbursements. However, such indemnification and reimbursement will not exceed the amount of additional federal, state and local income tax that the Participant would have owed if the reimbursements had been made to the Participant as regular Compensation plus the Participant's

share of any Social Security tax that would have been paid on such Compensation, less any such additional income and Social Security tax actually paid by the Participant.

4.9 COVID-19 Related Provisions. For the Plan Year ended on September 30, 2021, the Administrator may permit an amount that remains unused at the end of such Plan Year (the "Special Carryover Amount") to be used to pay or reimburse Health Care Expenses incurred during the subsequent Plan Year. The Special Carryover Amount does not reduce the salary reduction limit (as specified in Section 3.4) for the subsequent Plan Year. If there is a Special Carryover Amount from a prior Plan Year, expenses incurred during the current Plan Year will be reimbursed first from Payroll Contributions the Participant has elected for the Plan Year. The deadlines specified in this Article 4 for submitting reimbursement claims shall be extended to the extent required under ERISA and the Employee Benefits Security Administration Disaster Relief Notices 2020-01 and 2021-01.

ARTICLE 5

FUNDING

Funding for the Health Care Reimbursement Plan will be from the general assets of the Employer. Nothing herein will be construed to require the Employer to create or maintain any separate fund, account or reserve with respect to obligations hereunder.

FIVE STAR SENIOR LIVING INC., on its behalf and on behalf of participating employers

By: _____

Date: 12-22-21

Rev. 9/2014

FIVE STAR SENIOR LIVING INC.

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