Your Benefits Guide

Alerislife | FIVE STAR SENIOR LIVING

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Your 2025 Benefits

Here's where to find ...

We understand the important role that benefits play in the lives of you and your family. As a new hire and then annually during open enrollment, you have an opportunity to make changes to your benefits package to ensure you and your family have the right coverage.

This benefits guide can help familiarize you with AlerisLife's benefit options. It also provides useful tips, tools and resources to help you think through your options and make wise decisions. As you prepare to enroll:

- Consider your benefit coverage needs for the upcoming year. For example, is your family financially protected if you can't work due to an accident or illness?
- Consider other available coverage.
- Gather information you'll need. If you are covering dependents, you will need their dates of birth and Social Security numbers. **In addition, you may need to provide legal documentation verifying their eligibility — such as a marriage license or birth certificate.**

Getting the most value from your benefits depends on how well you understand your plans and how you choose to use them. Be sure to read this entire guide for important information about your benefit options.

Your Eligibility

Employee Eligibility

You are eligible to participate in the medical, dental and vision plans if you are a full-time team member working 30 or more hours per week. You are eligible to participate in the Health Care FSA and Dependent Care FSA if you are a full-time team member working 30 or more hours per week and have been employed with AlerisLife for at least 180 days of continuous service. Most benefits are effective on the day you become eligible as long as you enroll within 30 days of your date of hire or during the open enrollment period.

Dependent Eligibility

The following dependents are also eligible:

- Your legal spouse (note: your spouse is only eligible for the medical plan if they don't have access to coverage through their own employer)
- Your children up to age 26

Changes to your Benefits

Generally, you may only make or change your existing benefit elections as a new hire or during the annual open enrollment period. However, you may change your benefit elections during the year if you experience an event such as:

- Marriage, divorce or legal separation
- Birth or adoption of a child
- Loss or gain of other coverage by the employee or dependent
- Eligibility for Medicare or Medicaid

You have 30 days from the qualified life event to make changes to your coverage. Depending on the type of event, you may need to provide proof of the event, such as a marriage license. **If you do not make the changes within 30 days of the qualified event, you will have to wait until the next open enrollment period to make changes (unless you experience another qualifying event).**

Enrolling in your Benefits

Review your Benefits at flimp.live/AlerisLife-Benefits

Begin the benefits enrollment process in workday myworkday.com/wday/authgwy/5ssl/login.htmld

Elect the benefits you want

Save or submit your elections

Print a copy of your elections for your records

Your Medical and Pharmacy Overview

We offer the choice of two medical plans through UnitedHealthcare (UHC). Both of the medical options include coverage for prescription drugs through Express Scripts. To select the plan that best suits your family, you should consider the key differences between the plans, the cost of coverage (including payroll deductions) and how the plan covers services throughout the year.

Understanding How Your Plan Works

Your Deductible

You pay out-of-pocket for most medical and pharmacy expenses, except those with a copay, until you reach the deductible.

Your Coverage

Once your deductible is met, you and the plan share the cost of covered medical and pharmacy expenses. You will pay a copay for most services and the plan will pay the rest.

Your Out of Pocket Maximum

When you reach your out-of-pocket maximum, the plan pays 100% of covered medical and pharmacy expenses for the rest of the plan year.

Embedded Deductibles and Out-of-Pocket Maximums

Under an embedded approach, each person only needs to meet the individual deductible and out-of-pocket maximum before the plan begins paying its share for that individual. (And, once two or more family members meet the family limits, the plan begins paying its share for all covered family members.)

Making the Most of Your Plan

Getting the most out of your plan also depends on how well you understand it. Keep these important tips in mind when you use your plan.

- **In-network providers and pharmacies:** You will always pay less if you see a provider within the medical and pharmacy network.
- **Preventive care:** In-network preventive care is covered at 100% (no cost to you). Preventive care is often received during an annual physical exam and includes immunizations, lab tests, screenings and other services intended to prevent illness or detect problems before you notice any symptoms.
- **Preventive drugs:** Many preventive drugs and those used to treat chronic conditions like diabetes, high blood pressure, high cholesterol and asthma are on the Preventive Condition Drug List. These prescriptions are covered at 100% (no cost to you) when you use an in-network pharmacy.
- **Mail Order Pharmacy:** If you take a maintenance medication on an ongoing basis for a condition like high cholesterol or high blood pressure, you can use the Mail Order Pharmacy to save on a 90-day supply.
- **Pharmacy coverage:** Medications are placed in categories based on drug cost, safety and effectiveness. These tiers also affect your coverage.
  - Generic – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.
  - Brand preferred – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.
  - Brand non-preferred – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.
  - Specialty – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Medical and prescription plan comparison

Medical Plan Provisions Group #: 717168	CHOICE PLUS $2,500		CHOICE PLUS $1,000	
	In-network	Out-of-network	In-network	Out-of-network
Annual Deductible Indivdual Family	 $2,500 $5,000	 $3,000 $6,000	 $1,000 $2,000	 $1,500 $3,000
Out-of-pocket maximum (includes deductible) Employee only Family	 $4,000 $8,000	 $5,000 $10,000	 $4,000 $8,000	 $5,000 $10,000
Preventive Care	Covered at 100%	40%*	Covered at 100%	40%*
Primary Care Office Visit	$40 Copay	40%*	$25 Copay	40%*
Specalist Office Visit	$80 Copay	40%	$50 Copay	40%
Telemedicine	$30 Copay	40%*	$15 Copay	40%*
X-Ray and Lab	20%*	40%*	20%*	40%*
Inpatient Hospital Services	$500 Copay	40%*	$250 Copay	40%*
Outpatient Hospital Services	$250 Copay	40%*	$100 Copay	40%*
Urgent Care	$80 Copay	40%*	$50 Copay	40%*
Emergency Room	$250 Copay	$250 Copay	$250 Copay	$250 Copay
Prescription drugs	Employee pays			
Retail (30-day supply) Tier 1 — generics Tier 2 — preferred Tier 3 — nonpreferred Tier 4 — specialty	 $15 $25 $50 $100	 Not Covered	 $15 $25 $50 $100	 Not Covered
Mail order (90-day supply) Tier 1 — generics Tier 2 — preferred Tier 3 — nonpreferred Tier 4 — specialty	 $37.50 $62.50 $125 $250	 Not Covered	 $37.50 $62.50 $125 $250	 Not Covered

**After Deductible*

Medical and prescription biweekly employee payroll contributions

Coverage level	Choice Plus $2,500	Choice Plus $1,000
Employee	$52.25	$123.08
Employee + Spouse	$189.63	$322.71
Employee + Child(ren)	$156.52	$265.41
Family	$255.86	$437.35

Employees can elect the medical and prescription drug plan without enrolling in the dental or vision plan.

Your Medical Plan Resources

Livongo

AlerisLife is proud to provide Livongo, a health benefit that helps team members manage their diabetes and hypertension through personalized coaching paired with the latest technology. Livongo is available at no cost to AlerisLife team members with diabetes or hypertension enrolled in AlerisLife medical plans. The confidential services provided for both diabetes and hypertension care are:

- Real-time support from coaches when you need it
- Personalized tips and articles picked just for you
- Summary reports you can send to your doctor
- Optional family alerts to update your loved ones

Livongo for Diabetes

Millions of Americans have diabetes or are at risk for diabetes. If you or a dependent is enrolled in an AlerisLife medical plan and has Type 1 or Type 2 diabetes, you are eligible for Livongo. This program provides you with the resources you need to manage your condition. In addition to the services provided above, team members enrolled in the diabetes program will receive blood glucose monitors and unlimited strips and lancets.

Livongo for Hypertension

Hypertension, or high blood pressure, is another medical condition millions of people face each year. If you or a dependent is enrolled in an AlerisLife medical plan and has hypertension, you are eligible for Livongo. When you enroll, you will receive help through the Livongo services listed above as well as a blood pressure monitor. If you or a dependent has diabetes or hypertension, enroll today at livongo.com.

Rx Savings Solutions

Through Rx Savings Solutions, you can:

- Locate better prices for your prescription drugs at pharmacies near you.
- Identify different medications that perform the same as your current or prescribed medication, but with a lower out-of-pocket price.
- Search drugs and compare prices.
- Learn how to speak with your doctor or prescriber about making any changes to your prescriptions, or Rx Savings Solutions can do the work for you.

Register at myrxss.com or call 800-268-4476.

"Quit for Life" Smoking Cessation Program

Have you been thinking about quitting smoking? Enroll in UHC's "Quit for Life" program and receive a free 8-week supply of nicotine patches or gum mailed directly to your home. Visit myuhc.com or call 800-362-9054 to enroll.

Your Flexible Spending Accounts

A Flexible Spending Account (FSA) helps you set aside pre-tax dollars to pay for certain health care or dependent care costs. This lowers your taxable income and increases your spendable income. Your contribution to your FSA is deducted from your paycheck on a pre-tax basis and put into the FSA. When you incur eligible expenses, you can access the funds in your account to pay for those expenses.

This chart shows the eligible expenses for each FSA and how much you can contribute each year.

Account Type	Eligible Expenses	Annual Contribution Limits
Health Care FSA	Most medical, dental and vision care expenses that are not covered by your health plan (such as copays, coinsurance, deductibles, eyeglasses and prescriptions).	Maximum contribution is $3,300 per year. AlerisLife will pre-fund your FSA with your full contribution amount on October 1, 2025, making the entire balance available to you right away. That amount will then be recovered through pre-tax deductions from each paycheck throughout the plan year.
Dependent Care FSA	Dependent care expenses (such as day care, after school programs or elder care programs) for children under age 13 or dependents of any age who are physically or mentally incapable of self-care.	Maximum contribution is $5,000 per year ($2,500 if married and filing separate tax returns). AlerisLife will pre-fund your FSA with your full contribution amount on October 1, 2025, making the entire balance available to you right away. That amount will then be recovered through pre-tax deductions from each paycheck throughout the plan year.

Important Information About FSAs

Your FSA elections are effective from October 1, 2025 through September 30, 2026. Claims for reimbursement must be submitted by December 31, 2026. You can carry over up to $660 of unused Health Care FSA funds into the following plan year. However, funds over this amount will be forfeited. Note that FSA elections do not automatically continue from year to year; you must **actively enroll each year**.

Your Dental Plan

We offer a dental plan through MetLife. It's important to have regular dental exams and cleanings so problems are detected before they become painful — and expensive. Keeping your teeth and gums clean and healthy will help prevent most tooth decay and is an important part of maintaining your overall health.

Using In-Network Dental Providers

While you have the option of choosing any provider, you will save money when you use in-network dentists. When using an out-of-network dental provider, you will pay more because the provider has not agreed to charge you a negotiated rate.

Dental Plan Provisions Group #: 235283	In-Network Coverage
Annual Deductible Indivdual Family	 $50 $150
Calendar Year Maximum	$2,000 per individual
Orthodontia Lifetime Maximum	$1,500 per individual
Diagnostic and Preventive Services (e.g., X-rays, cleanings, exams)	Covered at 100%
Basic and Restorative Services (e.g.,fillings)	20%*
Major Services (e.g., dentures, crowns, bridges)	50%*
Orthodontia	Covered for children under age 19 at 50%*

**For out-of-network coverage, the plan pays a percentage of reasonable and customary (R&C) charges, so you may be balance-billed for any amounts over the R&C amount.*

Your bi-weekly payroll contributions for dental benefits are shown here.

Coverage level	Dental Pro
Employee	$9.36
Employee + Spouse	$24.39
Employee + Child(ren)	$16.29
Family	$29.07

Your Vision Plan

The vision plan through Vision Service Plan (VSP) covers routine eye exams and pays for all or a portion of the cost for glasses or contact lenses. You can choose any provider; however, you always save money if you see in-network providers.

Vision Plan Provisions Group #: 12314233	In-Network	Out-of-Network Non-VSP Provider Allowances
Exam	$20 Copay	$45
Frames	**Standard**: $180 allowance and 20% off remaining balance* **Featured Brands**: $230 allowance and 20% off remaining balance	$70
Lenses with prescription glasses Single vision lenses Bifocal lenses Trifocal lenses	$20 copay Included with prescription glasses	$30 $50 $65
Contact Lenses (in lieu of glasses)	$180 allowance; 15% savings on a contact lens exam	Elective $105 Necessary $210
Frequency Exam Lenses Frames Contact lenses	12 Months 12 Months 24 Months 12 Months	12 Months 12 Months 24 Months 12 Months

**$100 frame allowance at Walmart, Sam's Club and Costco.*

Extra Savings

Glasses and Sunglasses

- Extra $50 to spend on featured frame brands. Go to vsp.com/specialoffers for details.
- 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision exam.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price; discounts available only from contracted facilities.

Your bi-weekly payroll contributions for dental benefits are shown here.

Coverage level	VSP Choice
Employee	$2.90
Employee + Spouse	$5.81
Employee + Child(ren)	$6.22
Family	$9.93

Your Life Insurance and Disability

Life Insurance: FLX-966800 | Disability Insurance: LK-751842

Basic Life and AD&D Insurance

Life and Accidental Death & Dismemberment (AD&D) insurance protects your family's financial security if you pass away. AlerisLife provides basic life and AD&D insurance at no cost to you equal to 1x your base annual earnings, up to a maximum of $500,000. Coverage is automatic; you do not need to enroll.

Supplemental Life and AD&D Insurance

You may choose to purchase additional life and AD&D coverage for yourself and your dependents at affordable group rates. Rates are based on age and the coverage level chosen. You must purchase supplemental coverage for yourself in order to buy coverage for your spouse or child.

Disability Insurance

You may be eligible for disability coverage. Please check with your benefits department for details.

Family Medical Leave Act (FMLA)

If you have been with the company for 12 months, you may be eligible for up to 12 work weeks of unpaid leave per year under the Family and Medical Leave Act (FMLA). FMLA can be used for an illness of your own, care needed for a family member, care for a newborn and certain other medical needs. Other state-specific paid leave benefits may apply.

Supplemental Life and AD&D Insurance for You
Employee
• 1 to 5 times annual compensation salary/wage rounded to the next higher $1,000 • Up to a $1,000,000 maximum • Guaranteed issue up to $300,000 (new hires only)

Supplemental Life and AD&D Insurance for Your Dependents	
Spouse	Child(ren)
• Units of $5,000 to the lesser of $50,000 or 100% of your voluntary life and AD&D amount • Up to a $50,000 maximum • Guaranteed issue up to $25,000 (new hires only)	• Birth to 6 months: $1,000 • 6 months to 26 years: Units of $1,000 to $10,000 • All Guaranteed Issue • Must be added within 31 days of birth

Your 401(k) Retirement Plan

Group #: 385087-01

Whether retirement is way down the road or just around the corner, it's important to have savings goals and specific investment objectives. To help you meet your goals and objectives, we offer a 401(k) Retirement Savings Plan, administered by Empower Retirement, with multiple investment options and a company match. Key details and features of our plan are listed below.

Vesting

Vesting refers to your ownership of the money in your 401(k). All contributions to the plan are immediately vested.

Employee Contributions

You can contribute up to $23,500 in 2025, and if you are age 50 or older, you may contribute up to an additional $7,500 as a "catch-up" contribution. Contributions may be made on a pre-tax or Roth after-tax basis.

Employer Contributions

AlerisLife matches 100% of the first 3% you contribute to your 401(k), and 50% of the next 2%.

More Information

- Once eligible, you can enroll in the plan and make changes to your contributions and investment allocations at any time.
- Empower Retirement has many different investment options for you to choose from, along with tools and resources you can use to determine which options best meet your investment objectives.

For additional details about the 401(k) Retirement Savings Plan or to enroll or change your contribution rates or investment elections, visit empowermyretirement.com or call 800-338-4015.

Your Wellbeing Benefits

AlerisLife is dedicated to investing in whole person health and wellness, including your physical, mental and financial health. AlerisLife has continued to build upon more targeted offerings to engage and support team members throughout their wellness journey.

Employee Assistance Program

Because personal issues can affect every aspect of your life, we automatically provide you and your family with an Employee Assistance Program (EAP) through ComPsych, at **no cost** to you. Call the EAP 24/7 for unlimited confidential assistance with nearly any personal matter you may be experiencing. You and your family have access to **three** free consultations with a licensed clinician per need, per individual, per calendar year.

Services include:

- **Legal Services:** Consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more.
- **Financial Services:** Budgeting, credit and financial guidance, retirement planning and assistance with tax issues.
- **Childcare and Eldercare Assistance:** Needs assessment along with referrals to childcare and eldercare providers.
- **Identity Theft Recovery Services:** Information on identity theft prevention, an identity theft emergency response kit and help if you are victimized.
- **Grief and Caregiver Support Counseling:** There is no right or wrong way to grieve the death of a family member, resident or other loved one. We can help.

Confidential assistance is available any time by calling 800-344-9752 or online at guidanceresources.com (Web ID: NYLGBS).

Payactiv Flexible Paycheck

Because sometimes you can't wait 'til payday! With Payactiv, get paid on your terms – daily, weekly, when you need it!

PayActiv is available to our hourly team members. It provides Earned Wage Access as well as a variety of financial counseling services. Payactiv gives you access to the money you worked for but haven't been paid yet. The money that you access is then deducted from your next paycheck, giving you the flexibility to pay for things on your own schedule.

Access up to 50% of your earned wages before your scheduled payday.

- Transfer earned wages to your bank account or a Payactiv Visa® debit card
- Trusted vendor of AlerisLife
- Not a loan
- Free or minimal fees depending on transaction type
- No credit cards or credit check
- All hourly team members are eligible – no waiting period
- No recurring fees

Go to get.payactiv.com to learn more and enroll.

What you'll need to enroll:

- Company name
- Employee ID: [last 4 of social + employee ID]

Your Wellbeing Benefits

Voluntary Benefits

We partner with UHC and Chubb to offer voluntary benefits that pay a lump-sum if you have a health event or accident, need long-term care or pass away.

These are 100% employee paid and include:

- Accident
- Hospital Indemnity
- Critical Illness
- Disability Insurance
- Supplemental Life Insurance with a Long-Term Care Rider

Most plans pay cash to the employee, over and above any other coverage you may have.

To enroll in the Voluntary Benefits through US Enrollments, call 877-231-8423 or go to alerislife.mybenefitsinfo.com to book an appointment.

Paid Time Off

Team members are eligible for Paid Time Off. This program combines traditional vacation, sick time and holidays into one program.

Home Office team members are eligible for the traditional vacation and sick time plan. For more information, contact your manager.

Parental Leave

One week of paid parental leave is available to you after one year of employment. This is to support you after the birth or adoption of a child.

Your Wellbeing Benefits

PTO Cashout Benefit

The company offers the Very Important Payout (VIP) Program for Ageility and AlerisLife team members who are PTO-eligible.

During a special enrollment time in December, you have the option to cash out up to one week of PTO in June and up to one week of PTO in November of the following year to contribute to your family's summer or winter vacation.

With our Hardship PTO Cash Out Plan, you can also cash out PTO to help cover a catastrophic life event, such as eviction or foreclosure, major injury or illness, or a natural disaster.

You must maintain a minimal balance of at least one week of PTO after cashing out.

TicketsAtWork

TicketsAtWork is the leading Corporate Entertainment Benefits provider, offering exclusive discounts, special offers and access to preferred seating and tickets to top attractions, theme parks, shows, sporting events, movie tickets, hotels and much more.

Commuter Benefits

Now you can reduce your commuter expenses with commuter benefits plan. You can set aside up to $650 pre-tax total for both transit and parking costs, but keep in mind that the funds are considered two separate buckets of money and cannot be mixed and mingled. So be sure to calculate both your transit and parking expenses related to your daily commute, and elect contributions accordingly.

Eligible Commuter Options:

- Parking
  - You can use pre-tax dollars to pay for parking at or near your workplace, or at a location where you connect to other transit options.
- Buses
- Trains & subways
- Ferries
- Van pools

How to spend transit funds?

- Rechargeable payment card
- Transit vouchers
- Direct fare media
- Van pool vouchers

How to spend parking funds?

- Rechargeable payment card
- Parking cash reimbursement
- Parking vouchers
- Direct pool to garages

Your Wellbeing Benefits

Future You Educational Reimbursement Program

To encourage you to build your professional knowledge and skills, AlerisLife offers a tuition reimbursement program. Through this program, you may be reimbursed for expenses for courses related to your job or to progress toward your career goals. Under this program, tuition costs for courses may be covered up to $3,000 per calendar year, as long as they contribute to your career advancement at AlerisLife.

PersonalSAGE Financial Planning

PersonalSAGE provides financial tools, technology and one-on-one coaching to help you understand your financial situation and plan for the future. You can schedule meetings with a financial coach to discuss retirement planning, investments, debt management and more. The platform also offers monthly Financial Wellness Workshops and a library of educational articles and videos. To get started, visit mypersonalsage.com and enter the code **AlerisLife00134** to access the Financial Education and Coaching Center.

Nourish You

With our Nourish You program, you can enjoy a free, balanced meal during every shift – including nights and weekends! Save on out-of-pocket meal expenses, eliminate the stress of prepping and packing lunch, and relax and recharge during your breaks.

Pet Insurance

We offer discounted pet insurance through MetLife to help support your furry family members following an accident or illness. With flexible plans, you can choose coverage levels, deductibles and reimbursement rates up to 90%. You're free to visit any licensed U.S. vet, and optional preventive care and 24/7 Telehealth Concierge Services are also available. To enroll, visit metlife.com/getpetquote or call 1-800-GET-MET8.

Home/Auto Insurance

We offer discounted auto, home and renter's insurance through Farmers Insurance Choice®, a platform that lets you compare quotes from top-rated carriers in minutes. You'll benefit from convenient payment options and personalized coverage. To get your free, no-obligation quote, call 866-586-6048 or visit farmersinsurancechoice.com/alerislife.

Glossary

Brand preferred drugs – A drug with a patent and trademark name that is considered "preferred" because it is appropriate to use for medical purposes and is usually less expensive than other brand-name options.

Brand non-preferred drugs – A drug with a patent and trademark name. This type of drug is "not preferred" and is usually more expensive than alternative generic and brand preferred drugs.

Calendar Year Maximum – The maximum benefit amount paid each year for each family member enrolled in the dental plan.

Coinsurance – The sharing of cost between you and the plan. For example, 80% coinsurance means the plan covers 80% of the cost of service after a deductible is met. You will be responsible for the remaining 20% of the cost.

Copay – A fixed amount (for example $25) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible – The amount you have to pay for covered services before your health plan begins to pay.

Flexible Spending Accounts (FSAs) – FSAs allow you to pay for eligible health care and dependent care expenses using tax-free dollars. The money in the account is subject to the "use it or lose it" rule which means you must spend the money in the account before the end of the plan year.

Generic drugs – A drug that offers equivalent uses, doses, strength, quality and performance as a brand-name drug, but is not trademarked.

In-network – A designated list of health care providers (doctors, dentists, etc.) with whom the insurance provider has negotiated special rates. Using in-network providers lowers the cost of services for you and the company.

Inpatient – Services provided to an individual during an overnight hospital stay.

Mail Order Pharmacy – Mail order pharmacies generally provide a 90-day supply of a prescription medication at a discounted rate. Plus, mail order pharmacies offer the convenience of shipping directly to your door.

Out-of-network – Providers that are not in the plan's network and who have not negotiated discounted rates. The cost of services provided by out-of network providers is much higher for you and the company. Higher deductibles and coinsurance will apply.

Out-of-pocket maximum – The maximum amount you and your family must pay for eligible expenses each plan year. Once your expenses reach the out-of-pocket maximum, the plan pays benefits at 100% of eligible expenses for the remainder of the year. Your annual deductible is included in your out-of-pocket maximum.

Outpatient – Services provided to an individual at a hospital facility without an overnight hospital stay.

Primary Care Provider (PCP) – A doctor (generally a family practitioner, internist or pediatrician) who provides ongoing medical care. A primary care physician treats a wide variety of health-related conditions.

Reasonable & Customary Charges (R&C) – Prevailing market rates for services provided by health care professionals within a certain area for certain procedures. Reasonable and Customary rates may apply to out-of-network charges.

Specialist – A provider who has specialized training in a particular branch of medicine (e.g., a surgeon, cardiologist or neurologist).

Specialty drugs – A drug that requires special handling, administration or monitoring. Most can only be filled by a specialty pharmacy and have additional required approvals.

Contacts

	Carrier	Contact Information
Medical Plan	United Healthcare	myuhc.com 800.362.9054
Pharmacy	Express Scripts	express-scripts.com 800.375.0685
Pharmacy Discounts	Rx Savings Solutions	myrxss.com 800.268.4476
Diabetes and Hypertension	Support Livongo	get.livongo.com 800.945.4355
Dental	MetLife	metlife.com/mybenefits 800.438.6388
Vision	VSP	vsp.com 800.877.7195
Flexible Spending Accounts	UnitedHealthCare	myuhc.com 877.311.7849
Life and AD&D Insurance	NYLife	mynylgbs.com 800.644.5567
Voluntary Benefits	US Enrollment Services	alerislife.mybenefitsinfo.com 877.231.8423
Employee Assistance Program	ComPsych	guidanceresources.com Web ID: NYGLabs 800.344.9752
401(k) Retirement	Plan Empower Retirement	participant.empower-retirement.com 855.756.4738
Flexible Paycheck	Payactiv	payactiv.com 877.937.6966
Benefits Team	AlerisLife	benefitsquestions@5ssl.com

The AlerisLife Benefits Portal keeps all of your benefit contacts and information in one place. For easy access to your benefit carriers' group numbers, phone numbers and websites from your smartphone, tablet or computer, bookmark flimp.live/AlerisLife-Benefits

Required Notices

AlerisLife, Inc.

HEALTH PLAN NOTICES

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IMPORTANT NOTICE

This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From AlerisLife, Inc. About Your Prescription Drug Coverage and Medicare."

IMPORTANT NOTICE FROM ALERISLIFE, INC. 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 AlerisLife, Inc. 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.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

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. AlerisLife, Inc. has determined that the prescription drug coverage offered by the AlerisLife, Inc. Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare—General Rules

As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty

If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15 through December 7. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1 percent of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go 19 months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the AlerisLife, Inc. Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the AlerisLife, Inc. Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the AlerisLife, Inc. Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your AlerisLife, Inc. prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call (617) 796-8387. **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 AlerisLife, Inc. changes. You also may request a copy.

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).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium (a penalty).

Date:	October 1, 2025
Name of Entity/Sender:	Lauren Duffy
Contact—Position/Office:	Senior Director, Human Resources
Address:	255 Washington St. Suite 230 Newton, MA 02458
Phone Number:	(617) 796-8387

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

ALERISLIFE, INC.
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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.

This notice is provided to you on behalf of:

AlerisLife Inc. Benefits Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, AlerisLife, Inc. is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities;
- When required for judicial or administrative proceedings;
- When required for law enforcement purposes;
- When required to be given to a coroner or medical examiner or funeral director;
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its

representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to

the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).

21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Lauren Duffy
Senior Director, Human Resources
(617) 796-8387

Effective Date

The effective date of this notice is: October 1, 2025.

NOTICE OF SPECIAL ENROLLMENT RIGHTS

ALERISLIFE, INC. EMPLOYEE HEALTH CARE PLAN

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later 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).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (e.g., divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy toward this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *30 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Lauren Duffy
Senior Director, Human Resources
(617) 796-8387

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

AlerisLife, Inc. Employee Health Care Plan is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections 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; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

The AlerisLife, Inc. Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

Choice Plus $2,500	In-Network	Out-of-Network
Individual Deductible	$2,500	$3,000
Family Deductible	$5,000	$6,000
Coinsurance	0	0
Choice Plus $1,000	In-Network	Out-of-Network
Individual Deductible	$1,000	$1,500
Family Deductible	$2,000	$3,000
Coinsurance	0	0

If you would like more information on WHCRA benefits, please refer to your or contact your Plan Administrator at:

Lauren Duffy
Senior Director, Human Resources
(617) 796-8387

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately preceding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Lauren Duffy, Senior Director, Human Resources, (617) 796-8387.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) NOTICE

https://lockton.seismic.com/Link/Content/DC4V9B4MQ37XV8HXV37g3GDcVjBP

ILLINOIS DOL EMPLOYER EHB LIST MODEL NOTICE

https://lockton.seismic.com/Link/Content/DC2f3jQcCddcmGc23qCVbd4pC8BG

Alerislife

FIVE STAR SENIOR LIVING

This benefit summary provides selected highlights of the AlerisLife benefits program. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at the company. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. AlerisLife reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Plan Administrator.