# FIVE STAR SENIOR LIVING INC. BENEFITS PLAN

# SUMMARY PLAN DESCRIPTION

December, 2021

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Effective as of January 1, 2021, Five Star Senior Living Inc. (the "Company") has amended and restated its welfare benefit plan, maintained on its behalf and on behalf of its affiliated participating employers and known as the Five Star Senior Living Inc. Benefits Plan (the "Benefits Plan"). The Benefits Plan provides medical, vision and dental benefits as well as life insurance, accidental death and dismemberment insurance, short-term disability insurance, long-term disability insurance and the opportunity to pay for certain health and dependent care expenses on a pre-tax basis. Explanations of each of the benefit options available under the Benefits Plan and the administrative rules of the Benefits Plan are explained in this Summary Plan Description and in the comprehensive benefit booklets that are available from the Plan Administrator.

The Benefits Plan consists of several distinct programs, each of which covers a specific category of benefits. This summary together with booklets provided by the designated insurance companies or other providers describe benefits available under the Benefits Plan.

Although the Company intends to maintain this Plan indefinitely, it reserves the right, at its sole discretion, to amend or terminate the Benefits Plan in whole or in part at any time. If the Benefits Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

In the event you or a member of your family receive any benefits under the Benefits Plan at a time when you or they are ineligible to receive benefits, you or they will be required to reimburse the Benefits Plan for the benefits.

*Special Note: This document is a Summary Plan Description only. Your specific rights to benefits under the Benefits Plan are governed solely, and in every respect, by the Five Star Senior Living Inc. Benefits Plan. This Summary Plan Description is not intended to give you any substantive rights to benefits not provided under the Benefits Plan. Copies of the documents that make up the Benefits Plan and/or this Summary Plan Description are available from the Plan Administrator at Five Star Senior Living Inc. upon your request. You may examine copies at the offices of the Company at any time during regular working hours. If there is any discrepancy between the description of the Benefits Plan as contained in this summary and the official documents, the language of the official documents will govern.*

## OVERVIEW

The Benefits Plan includes the following benefit options: medical benefits provided under a self-insured arrangement (the "Medical Plan"); dental benefits provided through a self-insured (fully-insured, effective October 1, 2021) contract (the "Dental Plan"); vision benefits provided through a fully-insured contract (the "Vision Plan"); life and accidental death and dismemberment insurance provided through a fully-insured contract (the "Insurance Plan"); self-insured short-term disability and fully-insured long-term disability benefits (the "Disability Plan"); a health care flexible spending account pursuant to the Five Star Senior Living Inc. Health Care Flexible Spending Account (the "Health FSA"); and a dependent care reimbursement account pursuant to the Five Star Senior Living Inc. Dependent Care Reimbursement Plan (the "Dependent Care FSA"). The Benefits Plan also includes the Five Star Senior Living Inc. Cafeteria Plan (the "Cafeteria Plan"), cafeteria plans that permit you to use pre-tax dollars to pay for your share of the cost of certain benefit options under the Benefits Plan.

The Benefits Plan operates on a October 1 through September 30 fiscal year (the "Plan Year"). Re-enrollment in one or more benefit options may be necessary each year or, in the case of certain benefit options and as described below, a prior enrollment election may be carried over from year to year. This will be communicated at the time of the annual open enrollment period.

## ELIGIBILITY AND PARTICIPATION

### Eligibility

You are eligible to participate in the Benefits Plan as of the first of the month following satisfaction of the waiting periods described in Schedule B of the Benefits Plan as long as you are an employee of a Participating Company who is scheduled to work at least 30 hours per week (or, in the case of the Medical Plan, are otherwise determined to be a "full-time employee" by the Plan Administrator). Temporary or irregular or per diem employees or contractors, members of a union, independent contractors and leased employees are not eligible to participate in the Benefits Plan. In the case of the Health FSA and the Dependent Care FSA, in addition to the hourly service requirement stated above, you must also be employed for one year, and upon completion of the year, you will be immediately eligible to participate in the Health FSA. If an independent contractor or a leased employee is recharacterized as or determined to be an employee for any federal, state or local law purpose, that individual will remain ineligible to participate in the Benefits Plan. As of the date of this Summary Plan Description, the Participating Companies include the Company and FSQ, Inc.

Eligible employees may also elect to cover their dependents (including adult children until they attain age 26) under our Medical Plan, Dental Plan, and/or Vision Plan.

In general, your eligibility to participate in the Benefits Plan will terminate as of the earliest of: (i) the date your employment terminates; (ii) the date you no longer meet the eligibility requirements of the Benefits Plan, as summarized above; or (iii) the date the Benefits Plan is terminated. Coverage under the Benefits Plan or a benefit option may terminate earlier if you fail to pay your share of the costs of coverage or submit false claims. Note that you may be entitled under federal law to continue coverage at your own expense in the Medical Plan, the Dental Plan, the Vision Plan and/or the Health FSA if you cease to be eligible to participate in

the Benefits Plan. See the section below entitled "Continuation of Coverage Rights" for additional information. Other circumstances can result in the termination, reduction or denial of benefits.

You may be required to reimburse the Benefits Plan for benefits you receive if you recover on a claim against a third party for damages arising from an injury or condition that triggered the payment of benefits. This right of the Benefits Plan, referred to as a "subrogation" right, is provided for in the Benefits Plan and is explained further in the Medical Plan, Dental Plan or Vision Plan, as applicable, comprehensive benefit description booklets. The Benefits Plan also has the right to recover overpaid benefits in certain circumstances. If you have any questions about subrogation or the Benefits Plan's reimbursement rights, please contact the Plan Administrator.

If you terminate employment and are rehired in the same Plan Year, you may begin to participate in the Benefits Plan after you again satisfy any applicable eligibility requirements. However, you may not be able to pay for your share of the cost of any benefits under the Benefits Plan with pre-tax income until the start of the next Plan Year.

Medical Plan coverage generally may not be rescinded except where a participant has engaged in fraud or intentionally misrepresented a material fact. Enrolling an ineligible individual or otherwise failing to comply with the Medical Plan's requirements for eligibility will constitute fraud or an intentional misrepresentation of a material fact that will trigger rescission. In the event Medical Plan coverage is rescinded, liability for benefits already paid may be asserted against you.

**Enrollment**

If you are an eligible employee you may enroll yourself (and your spouse and dependents, including children until they attain age 26) in some or all of the benefit options under the Benefits Plan effective as of the first of the month following satisfaction of the waiting periods described in Schedule B of the Benefits Plan. An eligible employee may be automatically enrolled in some benefits. If you are not initially an eligible employee but later become an eligible employee, you may enroll (or be automatically enrolled) in some or all of the benefit options under the Benefits Plan effective as of the first of the month following satisfaction of the waiting period described in Schedule B of the Benefits Plan. The Plan Administrator will provide you with any appropriate enrollment forms.

If you do not elect to enroll when you are first eligible to do so, you may enroll in certain benefit options during any future open enrollment period, effective as of the beginning of any subsequent Plan Year, provided you remain eligible to participate and satisfy any enrollment requirements then applicable.

**Special Enrollment Rights for Certain Benefit Options**

If you, your spouse or your dependents are not enrolled in the Medical Plan, the Dental Plan, the Vision Plan, and/or the Health FSA because you or they have other medical coverage, and at the time you are first eligible for coverage you notified the Plan Administrator in writing of your other coverage, you may be able to enroll yourself and them in these options on a date

other than the first day of the Plan Year if you request enrollment within 30 days after the other coverage ends upon submission of appropriate supporting documentation.

In addition, if you have a new spouse or dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and them in the Medical Plan, the Dental Plan, the Vision Plan, and/or the Health FSA on a date other than the first day of the Plan Year if you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption and you submit appropriate supporting documentation. Coverage will be retroactive to the date of the event, although you may not be able to use pre-tax dollars to pay for your share of the cost of the retroactive benefit.

Finally, you or your dependents may be able to enroll in the Medical Plan on a date other than the first day of the Plan Year if you request enrollment within 60 days after becoming eligible for Medicaid or the State Children's Health Insurance Program ("SCHIP"), or losing coverage under either program. These programs may provide you or your dependents with assistance with paying the premium under the Medical Plan.

The 30- and 60-day periods referenced above may be extended per applicable law. Please contact the Plan Administrator for details.

## MEDICAL PLAN, DENTAL PLAN AND VISION PLAN BENEFITS

Comprehensive benefit description booklets, which are a part of this Summary Plan Description, for the Medical Plan, the Dental Plan and the Vision Plan are available from the Plan Administrator. You should refer to these booklets for an explanation of the medical, dental and vision benefits available to you under the Benefits Plan. Circumstances that can result in the reduction, loss or denial of benefits under the Medical Plan, the Dental Plan or the Vision Plan, the circumstances in which you can change your benefits and the procedures for filing claims for medical, dental and vision benefits are also described in these booklets. Please read the applicable comprehensive benefit description booklets carefully.

Unless the Plan Administrator announces otherwise, you will not need to re-enroll in the Medical Plan, the Dental Plan and the Vision Plan each Plan Year, although you may decide to change your benefit options during the annual open enrollment period prior to the first day of the Plan Year.

Under the Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA"), the Benefits Plan generally may not 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, the Benefits Plan may pay for a shorter stay if the attending physician (that is, your physician, nurse, midwife or a physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under NMHPA, the Benefits Plan may not set the level of benefits or out-of-pocket costs so that the latter portion of the 48 or, if applicable, 96 hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. Finally, NMHPA provides that the Benefits Plan may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or, if applicable, 96 hours. However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be

required to obtain precertification. Information on precertification can be found in the Medical Plan's comprehensive benefit description booklet and can also be obtained from the Plan Administrator.

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; and
- 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 the Medical Plan. If you would like more information on WHCRA benefits, please contact the Plan Administrator.

In accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, if applicable, the Medical Plan will not impose any financial requirement or treatment limitations on mental health and substance use disorder benefits that are more restrictive than the limits that apply to medical and surgical benefits under the Medical Plan.

In accordance with the Genetic Information Nondiscrimination Act of 2008 ("GINA"), if applicable, the Medical Plan will not deny, limit or cancel health care coverage for you or your dependents based on genetic information and premiums or contributions will not be adjusted on the basis of genetic information. The arrangements will not request, require or purchase genetic information for underwriting purposes or in advance of or in connection with any individual's enrollment to the extent prohibited by GINA.

One or more of the contracts offered under the Medical Plan may require designation of a primary care provider. For information on how to select a primary care provider and a list of participating primary care providers, please review the applicable comprehensive benefits booklet or contact the Plan Administrator. For children, you may designate a pediatrician as a primary care provider. You do not need prior authorization or from any other person in order to obtain access to obstetrical or gynecological care. Your health care professional may, however, be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or procedures for making referrals.

## INSURANCE PLAN BENEFITS

A comprehensive benefit description booklet, which is a part of this Summary Plan Description, of the Insurance Plan, which includes both life insurance and accidental death and dismemberment insurance, is available from the Plan Administrator. You should refer to this booklet for an explanation of the life and accidental death and dismemberment insurance benefits available to you under the Benefits Plan. Circumstances that can result in the reduction, loss or denial of benefits under the Insurance Plan, the circumstances in which you can change your

benefits and the procedures for filing claims for insurance benefits, are described in this booklet. Please read the applicable comprehensive benefit description booklet carefully.

Unless the Plan Administrator announces otherwise, you will not need to re-enroll in the Insurance Plan each Plan Year, although you may decide to change your supplemental life benefits during the annual open enrollment period prior to the beginning of the Plan Year. Evidence of insurability may be required to make a change.

## DISABILITY PLAN BENEFITS

A comprehensive benefit description booklet, which is a part of this Summary Plan Description, of the Disability Plan, is available from the Plan Administrator. You should refer to this booklet for an explanation of the short-term and long-term disability benefits available to you under the Welfare Plan. Circumstances that can result in the reduction, loss or denial of benefits under the Disability Plan, the circumstances in which you can change your benefits and the procedures for filing claims for disability benefits, are described in this booklet. Please read the applicable comprehensive benefit description booklet carefully.

Unless the Plan Administrator announces otherwise, you will not need to re-enroll in the Disability Plan each Plan Year.

## PAYING FOR CERTAIN BENEFITS PLAN BENEFITS

### Overview

If you elect to participate in the Medical Plan, Dental Plan or Vision Plan, you may be required to contribute toward the cost of coverage. The Participating Companies will announce each year during the open enrollment period your share of the cost of coverage, which may vary depending on the number of persons covered. The Participating Companies will pay the entire cost of Insurance Plan (other than supplemental life insurance) and Disability Plan (other than supplemental long term disability insurance) benefits on your behalf. The entire cost of coverage under the Health FSA, the Dependent Care FSA and the entire cost of coverage for any optional life insurance or optional long-term disability benefits, is paid for by you, and whether you purchase one or more of these benefits is at your complete discretion.

Your contributions for Medical Plan, Dental Plan and Vision Plan coverage can be withheld from your pay on a pre-tax or after-tax basis through the Cafeteria Plan. If you decide to make your contributions using pre-tax income, the amount withheld from your pay will not be subject to federal income or Social Security and Medicare ("F.I.C.A.") taxes. This could result in a reduction in the Social Security benefits you receive at retirement if you earn less (after taking the contributions into account) than the "taxable wage base." The taxable wage base for 2021 is $142,800 and is adjusted annually. The tax advantages you gain by paying for benefits with pre-tax income may, however, offset any possible reduction in Social Security benefits and you should consult a tax advisor to determine whether in your situation the benefits achieved outweigh any potential reduction of Social Security benefits.

The premiums paid by the Participating Companies toward the cost of long-term disability coverage are included in your income as taxable wages. By paying tax on the premiums, any benefits you receive under the long-term disability policy should not be taxable when received.

**Enrollment Form**

Each year during the open enrollment period that precedes the year for which the election will be in effect, the Plan Administrator will provide you with an election form that will enable you to elect to use pre-tax income to pay for benefits. If you become eligible to participate in the Benefits Plan during the year, the Plan Administrator will provide you with an election form and your election will be effective for the remainder of the year.

You will need to make a new election each year with respect to participation in the Health FSA and the Dependent Care FSA. If you have a change in status, as described below, you may change your payroll election, in a manner consistent with the change in status, if you give notice to the Plan Administrator. Certain other changes to your payroll election are automatic.

The Plan Administrator will determine whether a change can be made and whether it satisfies the requirements of applicable law.

**Changing Elections**

Only when a "change in status," as defined in the Benefits Plan, occurs can you elect to increase or decrease your payroll contribution election or change your payroll contribution election for the Medical Plan, Dental Plan, Vision Plan, Health FSA or Dependent Care FSA from pre-tax to after-tax, or vice versa. The term change in status generally means for purposes of the Medical Plan, Dental Plan and Vision Plan: your marriage, divorce, legal separation or annulment; the death of your child or spouse; the birth, adoption or placement for adoption of a child; the satisfaction or cessation of satisfaction of any health coverage requirements by your spouse or child because of age, student status, marriage or similar circumstances; and certain changes in employment status that affect eligibility to participate in the Plans or underlying benefit options, including the termination or commencement of your, your spouse's or dependent's employment; an increase or decrease in hours of employment by you, your spouse or your dependent; a change between part-time and full-time employment; a strike or lockout or commencement of or a return from an unpaid leave of absence; or a change in the place of residence or work of you, your spouse or dependent. Effective September 18, 2014, certain changes in employment status that correspond to an enrollment in another group health plan providing minimum essential coverage or a qualified health plan offered through a public exchange (a "Marketplace") will constitute a "change in status" even if the change does not affect eligibility to participate in the Medical Plan, Dental Plan or Vision Plan or underlying benefit options. In addition, a "change in status" includes certain events affecting children under age 27 who are not otherwise considered dependents for federal income tax purposes. You may also be able to change your payroll contribution election if you are subject to a judicial order, including a qualified medical child support order, or you or your spouse or child become enrolled in, or lose eligibility under, Medicare or Medicaid. A change may also be permitted if there is a significant increase or decrease in the cost of coverage or a significant curtailment or improvement in coverage, including certain changes provided under a plan provided by your spouse's or child's employer.

In the case of the Health FSA, a change in status generally means: your marriage, divorce, legal separation or annulment; the death of your child or spouse; the birth, adoption or placement for adoption of a child; the satisfaction or cessation of satisfaction of any health

coverage requirements by your spouse or child because of age, student status, marriage or similar circumstances; and certain changes in employment status that affect eligibility to participate in the Health FSA, including the termination or commencement of your, your spouse's or dependent's employment; an increase or decrease in hours of employment by you, your spouse or your dependent; a change between part-time and full-time employment; a strike or lockout or commencement of or a return from an unpaid leave of absence. You may also be able to change your payroll contribution election if you are subject to a judicial order, including a qualified medical child support order, or you or your spouse or child become enrolled in, or lose eligibility under, Medicare or Medicaid.

In the case of the Dependent Care FSA, a change in status generally means: your marriage, divorce or legal separation; the death of your child or spouse; the birth or adoption of a child or the child attaining age 13 (and therefore ceasing to be a qualifying individual under the Dependent Care FSA); the termination or commencement of your spouse's employment; a change between part-time and full-time employment by you or your spouse; or the commencement of an unpaid leave of absence by you or your spouse. In addition, a change in status can include certain changes in qualified dependent care expenses, an increase or decrease in cost of qualified dependent care expenses or changes in the residence of the qualifying child.

Other than in the case of special enrollments (discussed earlier in the "Special Enrollment Rights for Certain Benefit Options" section), in order to make a change to your election, the requested change must also be on account of, and consistent with, the change in status. For example, the birth of child will permit you to switch to family coverage, but would not permit you to switch to employee only coverage (since that change would not be consistent with the change in status).

Whether or not an election change is permitted is determined in the sole discretion of the Plan Administrator. If the Plan Administrator determines that your benefit election and your payroll contribution election can be changed due to a change in status, the change will be effective as soon as administratively possible after the date of the event and after the change is approved by the Plan Administrator. (The effective date of the change in coverage generally will be the date of the event that caused the change in status.)

**Elections During Certain Leaves**

If you take an unpaid leave under the Family and Medical Leave Act ("FMLA") or under a state statute similar to FMLA, you may revoke an existing payroll election and Benefits Plan benefit election for the remainder of the year. If your medical, dental and/or vision coverage terminates while you are on an FMLA (or state equivalent) leave, you may elect to have your pre-tax payroll contribution election reinstated upon your return, but you will not have coverage during the intervening period. If you continue your medical, dental and/or vision coverage while on an unpaid FMLA (or state equivalent) leave, contributions due during the FMLA (or state equivalent) leave period may be paid in full prior to commencement of the FMLA (or state equivalent) leave on a pre-tax basis from your compensation or you may continue to pay contributions due during the FMLA (or state equivalent) leave period on the same schedule as payments would be made if you were not on leave, generally on an after-tax basis (unless you continue to receive compensation from which pre-tax contributions can be made during the leave). You may also make, upon your return, a pre-tax catch-up payment from compensation equal to the amounts due during the FMLA (or state equivalent) leave period if you agree with

the Participating Company in advance that you will continue coverage while on an unpaid FMLA (or state equivalent) leave and that any amounts advanced by a Participating Company to continue your coverage will be repaid (on a pre-tax or after-tax basis) upon your return from the FMLA (or state equivalent) leave.

If you leave to perform military service and you return within certain time limits, the Uniformed Services Employment and Re-employment Rights Act ("USERRA") may provide you certain rights under the Benefits Plan. If your employment is interrupted because of military service, you should contact the Plan Administrator to learn more about your rights.

**Automatic Changes**

A change in your share of the cost of coverage under the Benefits Plan will generally result in an automatic change in your payroll election. If your employment terminates, your payroll election will automatically be modified to provide that your share of the cost of Benefits Plan coverage is paid on an after-tax basis, effective upon the date your employment terminates. (To the extent that you continue to receive compensation following termination of employment, you may elect to pay for this coverage on a pre-tax basis.)

If your compensation is insufficient to support your pre-tax payroll contribution, your election will automatically be changed to provide that you will pay your share of the cost of coverage directly to the Plan Administrator on an after-tax basis, effective as of the date that you cease to have sufficient compensation.

If you fail to pay your share of the coverage, your participation in the Benefits Plan will be terminated, and your entitlement to benefits will cease, as of the date you fail to pay. In the event of nonpayment, you will be unable to make a new pre-tax payroll contribution election for the remainder of the Plan Year in which your benefits cease, unless you were on an FMLA (or state equivalent) leave.

## FLEXIBLE SPENDING ACCOUNTS

**In General**

There are some expenses you know you will have to pay for in the coming year, such as prescription co-payments that are not covered by the Medical Plan or perhaps care for a child or an incapacitated dependent adult while you are at work. Normally you would have to pay for expenses like these with after-tax dollars. And, because taxes reduce your income, you would have to earn considerably more than $100 to pay for $100 of expenses.

If you are eligible to participate, the Benefits Plan allows you to set aside pre-tax dollars in flexible spending accounts that may be used to reimburse yourself on a pre-tax basis for certain medical, dental, vision and dependent care expenses. You may choose to participate in either the Health FSA or the Dependent Care FSA, or both, and you must re-enroll for either or both each Plan Year. If you do not re-enroll, you will be treated as having elected to receive as taxable compensation the pay that you would otherwise have contributed.

There are limits on the maximum amount that you may contribute under each flexible spending account, and contributions that are not used to pay appropriate expenses will be

forfeited. The contributions you make to these accounts are not subject to federal income or F.I.C.A. taxes.

Keep in mind that your elections must remain in effect for the entire Plan Year. You may change your payroll contribution election only in the event of a change in status. You should think carefully about your needs because contributions you make that exceed your eligible health care or dependent care expenses cannot be converted to cash or (other than up to the indexed maximum annual amount permitted by the IRS, which is $550 in 2021, of Health FSA contributions) rolled over from year to year.

This is the comprehensive benefit booklet that describes the benefits available from flexible spending accounts and the procedures for filing claims for flexible spending account benefits. Please read the following provisions carefully. Each flexible spending account has separate benefits and administration rules. These rules are explained in more detail in the Benefits Plan documents, copies of which can be obtained from the Plan Administrator.

**Health FSAs: participation**

In order to participate in the Health FSA, you must:

- Complete the appropriate portion of the Open Enrollment Form or New Hire Enrollment Form;
- Observe all rules and regulations of the Health FSA; and
- Agree to inquiries by the Plan Administrator with respect to any health care expenses for which you seek reimbursement.

**Health FSAs: annual election**

If you are an eligible employee, you may enroll in the Health FSA during the open enrollment period by completing the appropriate portions of the applicable Enrollment Form. In the form, you will specify the amount you wish to have withheld on a pre-tax basis from your pay, with a minimum of $250 and a maximum amount determined and communicated to you by the Administrator. Employees who become eligible during the Plan Year can also elect to participate and have the full amount up to the maximum annual limit withheld on a pre-tax basis from pay. A pro rata portion of the elected amount will be withheld each pay period during the year.

As you incur eligible health care expenses, you become entitled to be reimbursed for the expenses on a pre-tax basis from the amount you elected to withhold. Under the Health FSA, you are entitled to be reimbursed up to the maximum amount you elected to have withheld, even if that amount has not yet been withheld. However, you will only be reimbursed for expenses incurred while you are a participant in the Health FSA and before the end of the Plan Year (the "Coverage Period"). Expenses are incurred when health care is provided and not when you are formally billed, charged or pay for the care. The Plan Administrator may establish a minimum reimbursable amount.

If you have a change in status, as described earlier, you may change your pre-tax election in a manner consistent with and on account of the change in status, if you timely notify the Plan Administrator.

If for any reason you cease to make contributions to the Health FSA, your participation will end at that time and expenses incurred after that date cannot be reimbursed. Further, you will not be able to resume contributions on a pre-tax basis until the next Plan Year. You may, however, be eligible to continue to participate in the Health FSA on an after-tax basis, which would enable you to continue to use your Health FSA.

**Health FSAs: eligible health care expenses**

Determining how much to set-aside is an important decision. One way to predict your reimbursable expenses is to look at your out-of-pocket health care expenses over the past several years. It is important, however, not to overestimate your needs, because the tax law permits only $550 (indexed amount for 2021) of unused amounts in your Health FSA to carry over to and be used in the next Plan Year; the remainder is forfeited at the end of each Plan Year. Stated differently, if the health care expenses you incur during a Plan Year are less than the amount you elected to contribute to your Health FSA, you will only be able to carry over $550 (indexed amount for 2021) of the excess. Therefore, you should contribute to your Health FSA only enough money to cover expenses you are likely to incur during the Plan Year.

In general, expenses that are deductible under Internal Revenue Code Section 213(d), such as deductibles and co-payments, uninsured medical and dental expenses, vision care and hearing care, and expenses incurred after December 31, 2019 for over-the-counter medications may be reimbursed from your Health FSA. Generally, the expense must be "medically necessary" or prescribed by a licensed physician. Covered expenses do not include premiums paid for other medical or dental plan coverage, including plans maintained by the employer of your spouse or dependents, or expenses for non-reconstructive cosmetic surgery.

Health FSA benefits are intended to reimburse medical expenses not reimbursed elsewhere. Accordingly, the Health FSA is not considered a group health plan for coordination of benefit purposes.

**Health FSAs: participating after termination of employment**

Employees who terminate employment during the Plan Year may be eligible to elect COBRA continuation coverage to continue participation in the Health FSA through the end of the Plan Year. The Plan Administrator will inform you if you have a COBRA election right with respect to your Health FSA. If COBRA continuation coverage is elected, contributions must continue to be made after termination, generally from after-tax dollars, up to the amount that was specified in your original election from the Plan Year. If COBRA continuation coverage is not elected, your existing payroll contribution will cease, no expenses incurred after termination will be eligible for reimbursement, and you will have 60 days after termination to submit claims for expenses incurred prior to your termination of employment. See the section below entitled "Continuation of Coverage Rights" for additional information.

**Dependent Care FSAs: participation**

In order to participate in the Dependent Care FSA, you must:

- Complete the appropriate portion of the Open Enrollment Form or New Hire Enrollment Form;
- Observe all rules and regulations of the Dependent Care FSA; and

- Agree to inquiries by the Plan Administrator with respect to any dependent care services for which you seek reimbursement.

Note that if you participate in the Dependent Care FSA, you must file Form 2441, Child and Dependent Care Expenses, with your federal income tax return.

**Dependent Care FSAs: annual election**

If you are an eligible employee, you may enroll in the Dependent Care FSA during the open enrollment period by completing the appropriate portions of the applicable Enrollment Form. The forms will indicate the amount of income you wish to contribute, on a pre-tax basis, to a dependent care flexible spending account established for you.

If you are single, you cannot elect to contribute more than the smaller of $5,000 ($10,500 only for the 2021 Plan Year) or your earned income for the Plan Year. If you are married and you and your spouse file separate income tax returns, your contributions generally cannot exceed the smaller of $2,500 ($5,250 only for the 2021 Plan Year) or your earned income. If you are married and filing a joint federal income tax return with your spouse, the maximum amount of pre-tax contributions you may make to the Dependent Care FSA and any similar plan in which your spouse participates cannot exceed in the aggregate the smaller of: (1) $5,000 ($10,500 only for the 2021 Plan Year); (2) your earned income for the year; or (3) your spouse's earned income for the year. (Thus, if your spouse elects to contribute $5,000 (or $10,500 for the 2021 Plan Year) to a dependent care flexible spending account under his or her employer's plan, you cannot contribute anything to the Dependent Care FSA.) If your spouse is a full-time student or is physically or mentally incapable of caring for himself or herself during the year, your spouse will be considered to have earned income of $250 per month if you have dependent care expenses for one dependent, or $500 per month if you have expenses for two or more dependents.

Employees who become eligible during the Plan Year can also elect to participate for the remainder of the year and contribute up to the maximum amount allowable. A pro rata portion of the elected amount will be withheld each pay period during the year.

As you incur eligible dependent care expenses, you become entitled to be reimbursed for the expenses on a pre-tax basis from the amount you have had withheld to date. Under the Dependent Care FSA, you are only entitled to be reimbursed up to the maximum amount that has been withheld, less prior reimbursement. You will only be reimbursed for expenses incurred while you are a participant in the Dependent Care FSA and before the end of the Plan Year (plus a two and one-half month period following the end of the Plan Year) (the "Coverage Period"). Expenses are incurred when dependent care is provided and not when you are formally billed, charged or pay for the care. The Plan Administrator may establish a minimum reimbursable amount.

If you have a change in status, as described below, you may change your pre-tax election in a manner consistent with and on account of the change in status, if you timely notify the Plan Administrator.

If for any reason you cease to make contributions to the Dependent Care FSA, your participation will end at that time and expenses incurred after that date cannot be reimbursed. Further, you may not be able to resume contributions on a pre-tax basis until the next Plan Year.

**Dependent Care FSAs: eligible dependent care expenses**

You may be reimbursed from the Dependent Care FSA for certain dependent care expenses if (1) you and your spouse both work, (2) you work and your spouse is a full-time student or disabled or (3) you are single and dependent care services are necessary to enable you to work. Dependent care expenses incurred to permit you or your spouse to perform volunteer work are not eligible for reimbursement.

The Dependent Care FSA covers costs for the care of certain persons for whom you can claim a personal exemption on your federal income tax return. Generally, the person must be either (1) your child under age 13 for whom a personal exemption may be claimed on your federal income tax return or (2) an individual who is physically or mentally incapable of caring for themselves and who has the same principal place of abode as you for more than half of the year who is (i) your dependent (child or relative) for whom a personal exemption may be claimed on your federal tax return (subject to special rules) or (ii) a spouse. The term "child" for this purpose means your child, a stepchild, grandchild, legally adopted child or foster child who is a member of your household. The individual must have the same principal place of abode as you for more than half the year (special rules apply for parents that are divorced or separated) and may not provide more than half of his own support. For more detailed information concerning the federal income tax rules for personal exemptions for dependents, consult your tax advisor or Internal Revenue Service Publication 501, available at www.irs.gov.

If dependent care is required to enable you (and your spouse if you are married) to work, the following expenses are generally eligible for reimbursement: payment for licensed day care facilities providing care to more than six persons; payment for certain approved family day care homes providing care to six or fewer persons; payment for an individual who is neither your child under age 19, nor your spouse, the parent of the child under age 13 for whom you are claiming reimbursement or your dependent for tax purposes; and payment for certain schools for children up to but not including kindergarten. Eligible expenses may also include payment for summer day camps, after-school care and elderly care.

Expenses for the care of a dependent who has reached his or her 13th birthday and who is incapable of caring for himself outside your home may be reimbursed only if the dependent regularly spends at least eight hours a day in your home. (Therefore, nursing home care of a dependent parent is not eligible for reimbursement.)

For more detailed information concerning eligible dependent care expenses, consult your tax advisor.

**Dependent Care FSAs: federal tax credit**

Depending on your annual family income, you could save more taxes under the Dependent Care FSA than by claiming the dependent care credit on your federal income tax return. The effect the Dependent Care FSA will have on your tax bill will depend on the amount of your pre-tax contributions for dependent care and the rate of federal income tax that applies to you. Because every person's tax situation is different, it is impossible to generalize about whether you will be best off making pre-tax payroll contributions to the Dependent Care FSA, claiming the available tax credit for expenses you pay outside the Dependent Care FSA or some combination thereof.

You cannot claim a tax credit and use the Dependent Care FSA to get double tax benefits, but you can pay a portion of your dependent care expenses using the Dependent Care FSA and claim a tax credit for the balance. For example, if your total dependent care expenses for one child are $2,400, you might pay $1,000 through the Dependent Care FSA and claim the $1,400 difference on your tax return as "qualified expenses" for purposes of the credit. However, the maximum "qualified expenses" you can claim for purposes of the tax credit in any year is reduced, dollar for dollar, by the dependent care expenses paid through the Dependent Care FSA. For example, if your maximum "qualified expenses" for the tax credit are $2,400, your total child care expenses are $6,000, and $3,000 of those expenses are paid through the Dependent Care FSA, you cannot claim any tax credit on your return. You may wish to consult a tax advisor to determine whether using the tax credit would be more advantageous than participating in the Dependent Care FSA.

**Dependent Care FSAs: participating after termination of employment**

Employees who terminate employment during the Plan Year will have their existing elections revoked, will not be able to resume participating on a pre-tax basis during the same Plan Year, and will have 60 days after termination to submit claims for expenses incurred prior to your termination of employment.

**Flexible Spending Account Claim Procedures**

To be reimbursed, you must fill out an appropriate claim form, attach a bill or receipt for the expense, and submit it to the Plan Administrator or the Plan Administrator's designee. At the present time, all claims for reimbursement should be submitted online at myuhc.com. (Alternatively, you may use a specially issued "debit" card to pay for eligible expenses. Some expenses paid with a debit card will be validated at the time the expense is incurred. For other expenses, the reimbursement is conditional, and you will still need to submit supporting documents. For more information on the use of debit cards, please contact the Plan Administrator.)

Upon submission, claims will be paid monthly. Health FSA claims will be paid up to your annual election amount less reimbursements already received. Dependent Care FSA claims will be paid up to the balance of your Dependent Care FSA account. Portions of your approved but unreimbursed dependent care expenses will be paid monthly as your account rebuilds. For the Health FSA, you will have three months after the Plan Year ends to submit claims for expenses incurred in that Plan Year. For the Dependent Care FSA, you will have three months after the Plan Year ends to submit claims for expenses incurred in that Coverage Period. However, the time periods described in the preceding two sentences may be extended per applicable law.

The Plan Administrator may set a minimum reimbursable amount for claims made other than at the end of the period of time for submitting claims.

## COVID-19 RELATED INFORMATION AND CHANGES

The Plan Administrator has implemented certain temporary relief permitted by Congress in connection with the COVID-19 pandemic, including permitting amounts remaining in your Health FSA and Dependent Care FSA at the end of the 2020 plan year to be carried over into the

2021 plan year. Expenses incurred in the 2021 plan year will first be reimbursed from amounts elected for the 2021 plan year.

## CLAIMS PROCEDURES FOR ALL BENEFIT OPTIONS

The procedures for filing claims for benefits are located in the comprehensive benefit booklets for each benefit option. If, however, you believe that you have not received the benefits to which you are entitled under the Benefits Plan, you should write to the Plan Administrator describing your claim and requesting payment. Unless specifically provided by a benefit option or pursuant to applicable law, you must file a claim for benefits within one year after the date the expense was incurred that gives rise to the claim.

If your claim for benefits is denied in whole or in part, the Plan Administrator must notify you in writing of (1) the specific reasons for the denial, (2) the specific provision of the Benefits Plan on which the denial is based, (3) a description of any additional information or material necessary for you to perfect your claim (and an explanation of why such information or material is necessary) and (4) an explanation of the Benefits Plan's claims review procedure.

You may have any claim that has been denied in whole or in part reviewed by the Plan Administrator by filing a petition for review within 180 days (for the Medical Plan, Dental Plan, Vision Plan or Disability Plan; 60 days for other benefits) after you receive the written notice referred to above. This petition is required to state the specific reasons you believe you are entitled to benefits or to greater or different benefits. The Plan Administrator must give you (and your counsel, if any) an opportunity to present your position orally or in writing. You (or your counsel, if any) also have the right to review the pertinent documents. The Plan Administrator will notify you in writing of its decision, stating specifically the basis of and the provisions of the Benefits Plan on which the decision is based. The 60- and 180-day period described above may be extended per applicable law. Please contact the Plan Administrator for details.

If after review of any appeal of an adverse benefit determination with respect to a claim made under the Medical Plan, Dental Plan or Vision Plan your claim is again denied in whole or in part, you may have the right under certain circumstances to obtain an external review (that is, review outside of the Medical Plan, Dental Plan or Vision Plan) of that decision. Unless specifically provided by a benefit option or pursuant to applicable law, a suit for benefits under the Benefits Plan must be brought within one year after the date of a final decision on the claim in accordance with applicable claims procedures.

The Plan Administrator has discretionary authority to interpret the rules of the Benefits Plan, and to make factual determinations with respect to Benefits Plan matters, and its decision on appeal is final. Certain benefit options under the Benefits Plan are fully-insured. Claims for benefits under these benefit options are submitted to the insurance company, which is responsible for determining and paying your claim and, to the fullest extent permitted by law and as delegated by the Plan Administrator, has the discretionary authority to interpret the Benefits Plan in order to make benefit determinations. The claims and claims review procedures are set forth in full in the Benefits Plan.

## CONTINUATION OF COVERAGE RIGHTS

### Federal Continuation of Coverage Rights

***Introduction***

This Section contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical Plan, Dental Plan, Vision Plan and, in certain circumstances, the Health FSA. **This Section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Medical Plan, Dental Plan, Vision Plan and, in certain circumstances, the Health FSA (collectively, the "COBRA Eligible Plans"), when you would otherwise lose your group health coverage. For additional information about your rights and obligations under the Medical Plan, Dental Plan, Vision Plan and Health FSA and under federal law, you should contact the Plan Administrator.

**You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through a Marketplace. By enrolling in coverage through a Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a generally 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally does not accept late enrollees.

***What is COBRA Continuation Coverage?***

COBRA continuation coverage is a continuation of group medical, vision, dental, and, in limited situations, health care flexible spending account coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under a COBRA Eligible Plan is lost because of a qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay the full cost of COBRA continuation coverage (and in some cases an additional 2% administrative fee or a 50% fee in certain disability situations).

If you are an employee, you will become a qualified beneficiary if you lose your coverage under a COBRA Eligible Plan as a result of either of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under a COBRA Eligible Plan as a result of any of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under a COBRA Eligible Plan as a result of any of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the COBRA Eligible Plan as a "dependent child."

***When Is COBRA Continuation Coverage Available?***

The COBRA Eligible Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee or the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the Company must notify the Plan Administrator of the qualifying event.

In the case of the Health FSA, whether you are entitled to COBRA continuation coverage will depend on the amount of your contributions and reimbursements to date. The Plan Administrator will notify you if COBRA continuation coverage is available with respect to the Health FSA.

***You Must Give Notice Of Some Qualifying Events***

**For the other qualifying events (divorce or legal separation of the employee and his or her spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator.** This 60-day period may be extended per applicable law. Please contact the Plan Administrator for details.

***How Is COBRA Continuation Coverage Provided?***

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

A child who is born to or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Plan Administrator of the birth or adoption.

You must elect COBRA continuation coverage within 60 days of the later of (1) the date you are notified of your COBRA continuation rights or (2) the date you would lose coverage because of one of the above-described events. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage would otherwise have been lost.

If you elect COBRA continuation coverage, the COBRA Eligible Plan is required to allow you to purchase coverage that is identical to the coverage being provided under the COBRA Eligible Plan to similarly-situated active employees or family members. If coverage under the COBRA Eligible Plan is modified for such similarly-situated individuals, your coverage will also be modified.

If you do not choose COBRA continuation coverage within the timeframe stated above, your right to continue coverage under the COBRA Eligible Plan will end.

The 60-day timeframe for electing COBRA continuation coverage may be extended per applicable law. Please contact the Plan Administrator for details.

***How Long Can I Maintain COBRA Continuation Coverage?***

In general. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for up to 18 months. (See discussion below for two circumstances in which the 18-month period can be extended.)

When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B or both), the employee's divorce or legal separation or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Disability extension of 18-month period of continuation coverage. If you or anyone in your family covered under the COBRA Eligible Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total of up to 29 months. The disability would have to have started

at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

The disabled individual must also notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage. If your family experiences another qualifying event during the 18-month period of COBRA continuation coverage resulting from termination of employment or a reduction in hours, your spouse and dependent children may continue coverage for up to an additional 18 months (a maximum of 36 months) if notice of the second qualifying event is properly provided to the Plan Administrator. This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B or both), get divorced or legally separated or if the dependent child stops being eligible under the COBRA Eligible Plan as a dependent child, but only if the event would have caused your spouse or dependent child to lose coverage under the COBRA Eligible Plan had the first qualifying event not occurred.

***Under What Circumstances Can COBRA Continuation Coverage Be Terminated By The COBRA Eligible Plan?***

The law provides that COBRA continuation coverage may automatically end sooner than 18 months (or sooner than 29 or 36 months, if an additional period described above applies) for any of the following reasons:

- The Company and its affiliates no longer provides group health coverage to any of their employees;
- The cost for continuation coverage is not paid on time;
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition he or she may have;
- After electing COBRA continuation coverage, the qualified beneficiary becomes entitled to Medicare; or
- The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

***Are There Other Coverage Options Besides COBRA Continuation Coverage?***

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through a Marketplace, Medicare, Medicaid, SCHIP or other group health plan coverage options (such as a spouse's plan) through a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

***Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?***

In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Benefits Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

***Additional Information About COBRA Continuation Coverage***

You do not have to show that you are insurable to obtain COBRA continuation coverage. However, COBRA continuation coverage is provided subject to your eligibility for coverage and the Plan Administrator reserves the right to terminate your COBRA continuation coverage retroactively if you are determined to be ineligible.

You must pay all or part of the premium for your COBRA continuation coverage in addition to a 2% administrative fee. The cost of COBRA continuation coverage may increase by 50% for all individuals who extend coverage beyond the initial 18 months due to a disability, unless the only individuals who extend coverage are not disabled. There is a grace period of 30 days for payment of the regularly scheduled premium. (This 30-day period may be extended per applicable law. Please contact the Plan Administrator for details.) At the end of the 18, 29 or 36 month continuation coverage period, qualified beneficiaries must be allowed to enroll in an individual conversion health plan if conversion is generally otherwise available under the COBRA Eligible Plan.

Finally, if you lose group health coverage under the COBRA Eligible Plan as a result of a termination or reduction of hours and you qualify for assistance under a federal law called the Trade Act of 1974, you are entitled to a second opportunity to elect COBRA continuation coverage for yourself and certain family members (if they did not already elect COBRA continuation coverage). If you qualify or think you may qualify for assistance under the Trade Act of 1974, you must contact the Plan Administrator promptly or you may lose these special COBRA election rights.

***If You Have Questions***

Questions concerning the COBRA Eligible Plans or your COBRA continuation coverage rights should be addressed to the Company's Benefits Manager. For more information about your rights under the Employee Retirement Income Security Act of 1974 ("ERISA"), COBRA, the Patient Protection and Affordable Care Act and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about a public Marketplace, visit www.healthcare.gov.

**Keep Your Plan Informed Of Address Changes**

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Children's Continuation Coverage**

The Welfare Plan will comply with the terms of any "medical child support order" to the extent the order is qualified by the Plan Administrator. You may request a copy of the procedures to qualify an order from the Plan Administrator.

**Michelle's Law**

The Medical Plan generally may not terminate a dependent college student's coverage simply because the child takes a leave of absence from school or changes to part-time status due to a medical necessity. If your dependent child loses his or her status as a student as a result of a medically necessary leave of absence, such child generally will be eligible to continue coverage as a dependent for up to 12 months from the commencement of the leave or until coverage would otherwise terminate. For more information on Michelle's Law, please contact the Plan Administrator.

## ERISA RIGHTS

As a participant in the Benefits Plan you are guaranteed certain rights and protections under ERISA, other than with respect to the Dependent Care FSA (which is not subject to ERISA). ERISA provides that all Benefits Plan participants will be entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Benefits Plan documents, and copies of all documents filed by the Benefits Plan with the U.S. Department of Labor (such as detailed annual reports and Benefits Plan descriptions). However, you may not inspect materials containing confidential information about other Benefits Plan participants;

2. Obtain copies of all non-confidential Benefits Plan documents and other Benefits Plan information upon written request to the Plan Administrator. The Plan Administrator may make reasonable charges for the copies;

3. File a suit in a federal court if any materials requested are not received within 30 days of your written request, unless the materials were not sent due to matters

beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $110 a day until the materials are received;

4. Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Benefits Plan on the rules governing your COBRA continuation coverage rights; and

5. For Plan Years beginning prior to January 1, 2014, reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. Prior to December 31, 2014, you should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Prior to January 1, 2014, without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Benefits Plan participants, ERISA also imposes obligations upon the persons responsible for the operation of the employee benefit plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of Benefits Plan participants and they must exercise prudence in the performance of their Benefits Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Benefits Plan. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit under the Benefits Plan or exercising your rights under ERISA.

If you have a claim for benefits that is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Benefits Plan, you may file suit in a state or federal court. If it should happen that Benefits Plan fiduciaries misuse the Benefits Plan's money or you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, in certain circumstances the court may order you to pay these costs and fees, for example, if it finds that your claim was frivolous.

If you have any questions about the Benefits Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

## ADDITIONAL INFORMATION ABOUT THE BENEFITS PLAN

**Name of Plan and Plan Identification Number**

The Five Star Senior Living Inc. Benefits Planincludes the Five Star Senior Living Inc. Cafeteria Plan, the Five Star Senior Living Inc. Health Care Flexible Spending Account and the Five Star Senior Living Inc. Dependent Care Reimbursement Plan.

Plan Number: 501

**Type of Plan**

The Five Star Senior Living Inc. Benefits Plan is an accident and health benefits and disability plan under Internal Revenue Code Sections 105 and 106, a dependent care plan under Internal Revenue Code Section 129, a group life insurance plan under Internal Revenue Code Section 79 and a cafeteria plan under Internal Revenue Code Section 125.

**Source of Contributions**

Benefits under the Benefits Plan are provided by the Participating Companies and amounts withheld on a pre-tax or after-tax basis from your compensation or contributed on an after-tax basis by you. All benefits are paid either through insurance contracts or, in the case of the Medical Plan, Dental Plan (prior to October 1, 2021), the Health FSA and the Dependent Care FSA, out of the general assets of the Participating Companies. No special trust or fund has been set up to provide benefits under the Benefits Plan.

**Type of Plan Administration**

The Benefits Plan is administered by the Plan Administrator. United Healthcare processes benefits under the medical and dental options of the Benefits Plan pursuant to one or more administrative contracts. United Healthcare provides benefits under the Benefits Plan pursuant to medical insurance contracts. United Healthcare provides benefits under the Dental Plan. VSP provides benefits under the Vision Plan. Cigna and the Standard provide benefits under the Insurance Plan and the Disability Plan.

**Identification of Plan Administrator**

Five Star Senior Living Inc.
400 Centre Street
Newton, MA 02458-2076

**Identification of Plan Sponsor**

Five Star Senior Living Inc.
400 Centre Street
Newton, MA 02458-2076

Taxpayer Identification Number: 04-3516029

**Agent for Service of Legal Process**

Five Star Senior Living Inc.
400 Centre Street
Newton, MA 02458-2076

Service can also be made upon the Plan Administrator.

**Plan Year**

October 1 through September 30

**No Contract for Employment**

No provision of the Benefits Plan is to be considered a contract of employment between you and Five Star Senior Living Inc. or any other affiliated company. The rights of the Participating Companies to discipline and/or terminate an employee, if necessary, are not changed by any provision of the Benefits Plan.

**No Guarantee of Income Tax Consequences**

Federal income tax rules govern cafeteria plans (Internal Revenue Code Section 125), dependent care flexible spending accounts (Internal Revenue Code Section 129) and medical, dental and vision plans and health flexible spending accounts (Internal Revenue Code Section 105 and 106). The Benefits Plan is based on the Company's understanding of the current provisions of the Internal Revenue Code. Payment of your share of the cost of the Medical, Dental and Vision Plan benefit options and the reimbursement of eligible expenses through the flexible spending accounts are tax-free only if the Benefits Plan and your participation in it comply with the relevant rules. Further, the Benefits Plan and the benefits provided under it are subject to numerous nondiscrimination rules. If the Plan Administrator should determine that the Benefits Plan or any benefit provided under it does not satisfy the applicable nondiscrimination tests, certain highly paid employees and employees who own a portion of the Participating Companies may not receive some or all of the tax benefits described in this document. Even if the Benefits Plan or any benefit provided under it fails one or more nondiscrimination tests, you generally will not be adversely affected if you are not a member of one of these groups.

If you receive one or more reimbursements from the Health FSA or the Dependent Care FSA that are not for eligible health or dependent care expenses, as defined in the Benefits Plan, you agree to indemnify and reimburse the Participating Companies for any liability it may incur for failure to withhold federal or state income tax or F.I.C.A. tax from the reimbursements.

The material in this document is not intended to constitute tax advice and you are urged to consult your tax advisor before electing to participate in the Benefits Plan.

SUMMARY PLAN DESCRIPTION

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