MRM RESIDENTIAL MANAGEMENT DBA MERION RESIDENTIAL EMPLOYEE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

Covering Employees of MRM Residential Management dba Merion Residential, MainLine Investment Partners LLC and Merion Realty Advisers, LLC

July 1, 2024

MRM RESIDENTIAL MANAGEMENT DBA MERION RESIDENTIAL EMPLOYEE BENEFIT PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION 2
OTHER SUMMARY PLAN DESCRIPTIONS 2
CLAIMS 4
Refunds/Indemnification 4
Third Party Recovery 4
Claim Procedures - In General 5
CONTINUATION RIGHTS 14
Military Service 14
COBRA 14
FMLA 14
YOUR RIGHTS UNDER ERISA 14
MISCELLANEOUS 16
Qualified Medical Child Support Orders 16
HIPAA Special Enrollment Rights 16
Women's Health and Cancer Rights Act 16
Newborns' and Mothers' Health Protection 17
Michelle's Law 17
Mental Health Parity and Addition Equity Act 18
Loss of Benefit 18
Amendment and Termination 18
Administrator Discretion 18
Taxation 18
Privacy 19
Funding Medium 19
Insurer Refunds 19
Plan Provisions 19
ADMINISTRATIVE INFORMATION 21
COBRA NOTICE 22

WELFARE BENEFITS CHART APPENDIX..... 27

INTRODUCTION

WHEREAS, MRM Residential Management dba Merion Residential (the "Company") maintains Medical/Prescription Drug, Dental, Vision, Health Reimbursement Account, Flexible Spending Accounts, Employee Assistance Program, Life/Accidental Death & Dismemberment, Short-Term Disability, Long-Term Disability, Long-Term Care and various Voluntary Worksite benefits benefits under this Plan. The Company maintains Medical/Prescription Drug, Dental, Vision and Flexible Spending Accounts through a Cafeteria Plan for the exclusive benefit of its employees and certain individuals related to its employees, such as employees' spouses and dependents. The document, along with the Attachments, summarizes the terms of the Plan as of the Effective Date.

WHEREAS, the Company desired to consolidate these benefits into one plan;

WHEREAS, by virtue and exercise of the power reserved to the Company, MRM Residential Management dba Merion Residential Employee Benefit Plan (the "Plan") effective May 1, 2009 is hereby amended and restated effective July 1, 2024.

NOW, THEREFORE, this revised Summary Plan Description supplements all previous relevant documents for the Component Benefit Programs such as insurance contracts, certificates, booklets, and/or notices prepared by insurance carriers and/or vendors or by the Company otherwise referenced here within as "governing documents".

OTHER SUMMARY PLAN DESCRIPTIONS

This Plan incorporates the terms of all welfare benefits (or Component Benefit Programs) subject to ERISA sponsored by MRM Residential Management dba Merion Residential or any affiliate who has adopted the Plan. See the Appendix "WELFARE BENEFITS CHART APPENDIX" for a list of these plans.

You should receive separate governing documents from each of the welfare benefits described above. In the separate governing documents, you should find information about eligibility, benefits and employee/employer contributions for each of the separate welfare benefits. You are eligible to participate in this Plan if you are eligible to participate in one of the welfare benefits described above. In addition, in general, all benefits of this Plan are provided by the welfare benefits described above. When combined with this document, these documents create the Summary Plan Description (or "SPD") for MRM Residential Management dba Merion Residential benefits.

This Summary Plan Description incorporates the terms of the other Summary Plan Descriptions for each of the welfare benefits described above.

You can find a summary of the eligibility requirements for the welfare benefits mentioned above in the "WELFARE BENEFITS CHART APPENDIX" at the end of the document.

The purpose of this Summary Plan Description (SPD) is to give you an overview of the Plan and to address certain information that may not be addressed in the Attachments. This document, together with the Attachments, is the SPD required by ERISA section 102. This document is not intended to give you any substantive rights to benefits that are not already provided by the Attachments. If you have not received a copy of the Attachments, contact the Human Resource Manager of the Company. You must read the SPD and all attachments to understand your benefits.

The benefit programs summarized apply for MRM Residential Management dba Merion Residential, EIN 47-2271359, MainLine Investment Partners LLC, EIN 45-2845118 and Merion Realty Advisers, LLC, EIN 45-2835814.

CLAIMS

Refunds/Indemnification

You must immediately repay any excess payments/reimbursements. You must reimburse the Company for any liability the Company may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (1) to the extent permitted by applicable law, offset your salary or wages, and/or (2) offset other benefits payable under this Plan.

In certain circumstances under the Medical Loss Ratio Standards in section 2718 of the Patient Protection and Affordable Care Act of 2010 (PPACA), rebates may be paid to this Plan. The federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the Company and Plan costs paid by participants. The participant portion of the rebate will be used for the benefit of the Plan participants. This can be done by a number of actions, including but not limited to lowering the Plan costs for the participants for the next Plan Year, applied towards the cost of administering the Plan, paid as taxable income to the participants, or in any manner that allocates the rebate to Participants based on each Participant's actual contributions, or to apportion it on any other reasonable basis.

All refunds from fully-insured plans paid to the Plan will be disbursed within 90 days of receipt by the Plan Administrator. When the Plan Administrator determines that the Medical Loss Ratio Rebates will be paid to participants, these payments will be disbursed within 90 days of receipt.

Third Party Recovery

If you are paid benefits from another Component Benefit Program, the Plan may be entitled to reimbursement. In particular, the Plan may be entitled to reimbursement for benefits which are related to medical expenses that are also payable under Workers' Compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason.

By participating in the Plan, you and your covered dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance, you and your covered dependents agree to cooperate with the Plan in reimbursing it for Plan costs and expenses. If you or your covered dependents have any reason to believe that the Plan may be entitled to recovery from any third party, you must notify the Plan. And, at that time, you (and your attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from

circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

You and your covered dependent consent and agree that you will not assign your rights to settlement or recovery against a third person or party to any other party, including your attorneys, without the Plan's consent, which shall not be unreasonably withheld or delayed. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Claim Procedures - In General

This section applies for any claim for benefits under a Component Benefit Program that is covered by ERISA unless the Component Benefit Program has a claims procedure that is compliant with ERISA section 503. If the Component Benefit Program has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Component Benefit Program will apply. In general, this means that if the claims procedure of the Component Benefit Program has timeframes and procedures that are at least as favorable to you or more favorable than the deadlines provided below, the claims procedure of the Component Benefit Program will apply. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures are described in the relevant SPD for that plan and incorporated herein.

You or any other person entitled to benefits from the Component Benefit Program (a "Claimant") may apply for such benefits by completing and filing a claim with the applicable Component Benefit Program provider in accordance with the provider's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Component Benefit Program provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. Any claim must include all information and evidence that the Component Benefit Program provider or Plan Administrator (the "Claim Reviewer") deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. If a claim is received, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined that your inquiry is an attempt to file a claim.

If you want to bring a claim for benefits under the Plan, you may designate an authorized representative to act on your behalf so long as you provide written notice of such designation to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of your medical condition may act as your authorized representative with or without prior notice.

Timing of Notice of Claim

The Claim Reviewer will notify the Claimant of any benefit determination within a reasonable period of time but not later than the timeframe specified below depending on the type of claim.

Group Health Plan Claims

Group health plan claims may involve urgent care, concurrent care claims, pre-service care claims or post-service claims. Each has different time frames that may apply and is described below.

Urgent Care Claims

An "urgent care" claim is any claim for medical care or treatment where the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If you fail to follow the Plan's procedures for filing an urgent care claim, the Claim Reviewer will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 24 hours following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Claim Reviewer will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the Claim Reviewer will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Claim Reviewer will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period given to you to provide the specified additional information.

Pre-Service Claims

A "pre-service" claim is any claim where the Plan conditions receipt of the benefit on approval in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, the Claim Reviewer will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication by you that is received by a person or organizational unit customarily

responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Claim Reviewer will notify you if its determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Claim Reviewer for up to an additional 15 days. The Claim Reviewer may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

Post-Service Claims

A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Claim Reviewer will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Claim Reviewer for up to an additional 15 days. The Claim Reviewer may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

Concurrent Care Claims

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute claim denial. The Claim Reviewer will notify you of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a review of that denial before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Claim Reviewer will notify you of the denial, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Disability Benefit Claims

The Claim Reviewer will provide you with notice of an adverse benefits determination within 45 days after receipt of the claim. This period may be extended for up to 30 days, provided that the Claim Reviewer determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if the Claim Reviewer notifies you prior to the expiration of the first 30-day extension period of the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice of extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and you will be afforded at least 45 days within which to provide the specified information.

Non-Group Health Plan and Non-Disability Benefit Claims

For all other claims not described above, the Claim Reviewer will provide you with a notice of claim denial within 90 days after receipt of the claim. This period may be extended one time by the Claim Reviewer for up to an additional 90 days. The Claim Reviewer may only extend the deadline if they determine that such an extension is necessary due to matters beyond the control of the Plan and they notify you of the extension prior to the expiration of the initial 90-day period.

Content of Notice of Adverse Benefit Determination

If your claim is denied, the Claim Reviewer will provide you with a written notice identifying:

1. the reason(s) for the denial;
2. the Plan provisions on which the denial is based;
3. any material or information needed to grant the claim and an explanation of why the additional information is necessary; and
4. an explanation of the steps that you must take if you wish to appeal the denial, including a statement that you may bring a civil action under ERISA.

In addition, if the denied claim is for a group health plan or disability benefit under the Plan, the following information will also be included in the written notice:

1. the specific rule, guideline, protocol, or other similar criterion, if any, that was relied upon in the denial; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you upon request.

If the denied claim is for a disability benefit under the Plan, the following information will also be included in the written notice:

1. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding you presented by you to the Plan.
2. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
3. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.
4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for disability benefits.

In the case of a denied urgent care claim where the Included Benefit is a group health plan, the notice will include a description of the expedited review process applicable to such claims. This information may be provided orally provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

Appeal of Adverse Benefit Determination

You may appeal the denial of a claim (including a rescission of coverage) by filing a written appeal with the Claim Reviewer on or before the 60th day after you receive the Claim Reviewer's written notice that the claim has been denied. If the denial involves a claim under an Included Benefit that is a group health plan or disability plan, you may file a written appeal on or before the 180th day after you receive written notice of the denial. If the denial involves a claim for disability benefits, a denial includes a cancellation or discontinuance of coverage that has retroactive effect (unless it is due to your failure to pay required premiums).

Your written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based. You will lose the right to appeal if your appeal is not timely made.
The Plan will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit. You may submit written comments, documents, records, and other information relating to the claim for benefits.

The Plan will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or

considered in the initial claim. The Claim Reviewer will consider the merits of your written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Claim Reviewer may deem relevant.

If the claim is for group health plan or disability plan benefits the following will apply:

1. The review will not afford deference to the initial claim denial. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. In deciding an appeal of any denial that is based on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the claim denial that is the subject of the appeal, nor the subordinate of any such individual.
3. The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in the denial.
4. In the case of an urgent care claim, the Plan will expedite review of the claim and you may submit a request for an expedited appeal of a denial orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.

If the claim is for disability benefits under the Plan, the following will apply:

1. Before the Plan issues any adverse benefit determination, the Claim Reviewer will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.
2. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had reasonable opportunity to respond. After you respond or had a reasonable opportunity to respond but failed to do so, the Claim Reviewer will notify you of the Plan's benefit determination as soon as a Claim Reviewer acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The Claim Reviewer will ordinarily rule on an appeal of a claim denial within 60 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Claim Reviewer furnishes you with a written extension notice during the initial period, the Claim Reviewer may extend this period of time by 60 days if written notice of the extension is furnished to you prior to the termination of the initial 60-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.
If the claim is for group health plan benefits, the Claim Reviewer will notify you of the Plan's benefit determination on review as follows:

1. Urgent Care Claims. The Claim Reviewer will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.
2. Pre-Service Claims. The Claim Reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.
3. Post-Service Claims. The Claim Reviewer will notify you of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of your request for review of an adverse benefit determination.

If the claim is for disability benefits, the Claim Reviewer will ordinarily rule on an appeal of a claim denial within 45 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the Claim Reviewer furnishes you with a written extension notice during the initial period, the Claim Reviewer may extend this period of time by 45 days if written notice of the extension is furnished to you prior to the termination of the initial 45-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

All claims and appeals involving group health plan benefits and disability benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

Denial of Appeal

If an appeal is wholly or partially denied, the Claim Reviewer will provide you with a notice

identifying:

1. the reason or reasons for such denial;
2. the Plan provisions on which the denial is based;
3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. a statement describing your right to bring an action under section 502(a) of ERISA. The determination rendered by the Claim Reviewer will be binding upon all parties.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

1. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
3. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

In the case of a claim involving disability benefits, the notice will also include:

1. Any applicable contractual limitations period that applies to your right to bring an action under section 502(a) of ERISA, including the calendar date that the contractual limitations period expires for the claim.
2. A discussion of the decision, including an explanation of the basis for disagreeing with or not following (a) the views presented by health care professionals treating the covered person and vocational professionals who evaluated the covered person; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination made by the Social Security Administration regarding you presented by you to the Plan.
3. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the medical circumstances, or a statement that such explanation will be provided free of charge upon request.
4. Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively,

a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

You must exhaust all internal remedies before you may file a claim or lawsuit in court.

CONTINUATION RIGHTS

Military Service

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

COBRA

Under Federal law, you, your spouse, and your dependents may be entitled to COBRA continuation coverage in certain circumstances. Please see the "COBRA NOTICE" that is attached to the end of this Summary Plan Description for important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The COBRA NOTICE generally explains COBRA continuation coverage and when it may become available to you. If this Plan is subject to state continuation laws, please contact your Plan Administrator for information. The Plan Administrator will inform you of these rights, if any, when you terminate employment.

FMLA

If you go on leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits.

YOUR RIGHTS UNDER ERISA

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This federal law provides that you have the right to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 plan on the rules governing your COBRA continuation coverage rights.

In addition, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining your benefits or exercising your rights under ERISA.

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MISCELLANEOUS

Qualified Medical Child Support Orders

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a Qualified Medical Child Support Order (QMCSO). You may obtain a copy of the QMCSO procedures from the Plan Administrator, free of charge.

HIPAA Special Enrollment Rights

If you decline enrollment for health insurance benefits for yourself or your eligible dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and your eligible dependents (including domestic partners and civil union partners) in the health insurance benefits provided under this Plan if you or your eligible dependents lose eligibility for that other coverage (or if the other employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your eligible dependents' other coverage ends (or after the other employer stops contributing toward the other coverage).

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, your spouse and your new eligible dependent children. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The plan is not required to extend all of the HIPAA special rules for a newly acquired domestic partner, however, you may still be able to add them to the health plan coverage as described in your Component Benefit Programs attached here within.

The Plan must allow a HIPAA special enrollment for employees and dependents (including domestic partners and civil union partners) who are eligible but not enrolled if they lose Medicaid or CHIP coverage because they are no longer eligible, or they become eligible for a state's premium assistance program. Employees have 60 days from the date of the Medicaid/CHIP event to request enrollment under the Plan. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Women's Health and Cancer Rights Act

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 lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information

on WHCRA benefits, call your Plan Administrator at the number provided at the end of this Summary Plan Description.

Newborns' and Mothers' Health Protection

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Michelle's Law

Health coverage under the Plan includes dependent coverage for the children of its participants until a child has attained age 26, regardless of the child's status as a student. For children covered under the Plan after attaining age 26, Michelle's Law provides continued health coverage under the Plan for dependent children who are covered as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child has attained age 26 and is no longer a student because he/she is on a medically necessary leave of absence, your child may continue to be covered by the health benefits under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the Plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at the institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the plan.

The coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the plan would otherwise terminate, and
2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the health coverage under the Plan is changed during this one-year period, the Plan must provide the changed coverage for the dependent child for the remainder of the medically

necessary leave of absence unless, as a result of the change, the health coverage under the Plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the Plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Mental Health Parity and Addition Equity Act

Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA Section 712 (where applicable).

Loss of Benefit

In general, your coverage under this Plan terminates on the date your employment with the Company ends. However, some of the Component Benefit Plans may terminate on the last day of the month in which your employment ends. Coverage also terminates if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, or you submit false claims, and for certain other reasons described in the Component Benefit Plan Documents. Additionally, coverage under the Plan or under a Component Benefit Plan will terminate upon the termination of the Plan or such Component Benefit Plan.

Coverage for your spouse or domestic partner, children, and dependents stops when your coverage stops and for other reasons specified in the Component Benefit Plan Documents (for example, divorce or reaching an age limit).

Note that termination of coverage under a Component Benefit Plan does not necessarily mean your coverage under the Plan in general terminates. You may still have coverage under another Component Benefit Plan.

Amendment and Termination

The Company may amend, terminate or merge the Plan at any time.

Administrator Discretion

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding.

Taxation

The Company intends that certain benefits provided under the Plan may not be taxable to you under federal tax law. However, the Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result

from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

Privacy

The Plan is required under federal law to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential. The Plan Administrator will provide you with more information about the Plan's privacy practices.

Funding Medium

Benefits under this Plan are funded by one or more of the following methods: insured benefits and self-funded benefits (these are benefits funded by general assets of the Plan). For specifics on the funding status of Component Benefit Programs, see the subsidiary documents attached.

Insurer Refunds

Whenever a payment has been made under any benefit plan in a total amount, at any time, in excess of the maximum amount payable under the plan's provisions ("Overpayment"), you or any other person for whom the payment was made must refund the applicable Overpayment to the plan and/or help the plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In case of a recovery from a source other than the plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the plan that should have been made under another group plan. In that case, the plan may recover the payment from one or more of the following: any other insurance company, any other organization, or any person to or for whom payment was made.

The Plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to you and/or your family members; stopping future benefit payments that would otherwise be due under the plan (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from you or any other person for whom the payment was made.

Plan Provisions

This document contains a summary in English of your plan rights and benefits under this Company's Plan. If you have difficulty understanding any part of this document, contact:

MRM Residential Management dba Merion Residential
308 E Lancaster Avenue, Suite 310
Wynnewood, PA 19096
610-896-7500

The actual terms and conditions of the Component Benefit Programs offered under this Plan: Medical/Prescription Drug, Dental, Vision, Health Reimbursement Account, Flexible Spending Accounts, Employee Assistance Program, Life/Accidental Death & Dismemberment, Short-Term Disability, Long-Term Disability, Long-Term Care and various Voluntary Worksite benefits are contained in separate, written documents governing each respective benefit, and shall govern in the event of a conflict between the individual plan document and this Plan. To that end, each such separate Component Benefit Program, as amended or subsequently replaced, is hereby incorporated by reference and should be attached herein.

ADMINISTRATIVE INFORMATION

1. The Plan Sponsor and Plan Administrator is MRM Residential Management dba Merion Residential.

   Its address is 308 E Lancaster Avenue, Suite 310, Wynnewood, PA 19096.

   Its telephone number is 610-896-7500.

   Its Employer Identification Number is 47-2271359.

2. The Plan is a welfare benefit plan which has been designated by the sponsor, its plan number is 510, and its plan name is MRM Residential Management dba Merion Residential Employee Benefit Plan.

3. The Plan's designated agent for service of legal process is the chief officer of the entity named in number 1. Any legal papers should be delivered to him or her at the address listed in number 1. However, service may also be made upon the Plan Administrator.

4. The Company's plan year ends on June 30.

5. Certain benefits under the Plan may be funded by insurance contracts except for the Flexible Spending Accounts and Health Reimbursement Account, which are funded through the general assets of the Plan Sponsor.

COBRA NOTICE

Introduction

You're getting this notice because you recently gained coverage under the group health benefits offered through the MRM Residential Management dba Merion Residential Employee Benefit Plan. The group health plan benefits are referred to collectively as the "Plan" in this notice. This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or 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 the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 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 doesn't accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. 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 the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because 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're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because 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 the Plan because 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 plan as a "dependent child."

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

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).

For all other qualifying events (divorce or legal separation of the employee and 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 Company at 308 E Lancaster Avenue, Suite 310, Wynnewood, PA 19096. The Company's telephone number is 610-896-7500.

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.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 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 COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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 the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP) or other group health plan coverage options (such as a spouse's plan) through what is called 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 don't 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 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 don't 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 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.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including 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 the 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.

Plan Contact Information

If you have additional questions about COBRA continuation coverage, please contact the Company:

Human Resources Director
MRM Residential Management dba Merion Residential
308 E Lancaster Avenue, Suite 310
Wynnewood, PA 19096
610-896-7500

WELFARE BENEFITS CHART APPENDIX

Doc#	Coverage	Funding	Administrator /Insurer	Who is Eligible
1	Medical/Rx - PPO $1500 $20-$40/100%, PPO HSA $3000 $30-$60/$500	Fully-Insured, Employee & Employer Funded	Independence BlueCross*	Mainline Investment Partners, Merion Realty Partners Employees, Spouses, and Dependents, Qualified Domestic Partner/Children
2	Medical/Rx - PPO HSA $3000 $30-$60/$500	Fully-Insured, Employee & Employer Funded	Independence BlueCross*	Merion Residential Employees, Spouses, and Dependents, Qualified Domestic Partner/Children
3	Health Reimbursement Account	Self-Insured, Employer Funded	Ameriflex	Merion Residential Employees
4	Medical, Dependent Care, Commuter Flexible Spending Accounts	Self-Insured, Employee Funded	Ameriflex	All Employees
5	Dental	Fully-Insured, Employee & Employer Funded	Guardian	All Employees, Spouses, Dependents, Qualified Domestic Partner/Children
6	Vision	Fully-Insured, Employee & Employer Funded	Guardian (VSP)	All Employees, Spouses, Dependents, Qualified Domestic Partner/Children

Doc#	Coverage	Funding	Administrator /Insurer	Who is Eligible
N/A	Employee Assistance Program	Fully-Insured, Value-Add Program	Mutual of Omaha	All Employees, Spouses, and Dependents, Qualified Domestic Partners/Children
7	Basic Life/AD&D	Fully-Insured, Employer Funded	Mutual of Omaha	All Employees
8	Voluntary Life/AD&D	Fully-Insured, Employee Funded	Mutual of Omaha	All Employees, Spouses, and Dependents, Qualified Domestic Partners/Children
9	Short-Term Disability	Fully-Insured, Employer Funded	Mutual of Omaha	All Employees
10	Long-Term Disability	Fully-Insured, Employer Funded	Mutual of Omaha	All Employees
11 and 12	Accident and Critical Illness	Fully-Insured, Employee Funded	UNUM	Mainline Investment Partners and Merion Realty Partners Employees, Spouse, Dependents, Qualified Domestic Partner/Children
13	Long-Term Care	Fully-Insured, Employee and Employer Funded	UNUM	Employee, Spouse, Dependents, Qualified Domestic Partner/Children
N/A	Life/Disability/ Accident, Hospital Confinement, Cancer, Critical Illness	Fully-Insured, Employee Funded	Colonial Life	Merion Residential Employee, Spouse, Dependents, Qualified Domestic Partner/Children

- Effective July 1, 2025, the medical/prescription drug coverage changed carrier to Highmark BlueCross BlueShield.

The vendors listed above for coverages that are self-funded (not insured) provide certain administrative services for the relevant Component Benefit Program. These vendors provide claims payment and other administrative services under an administrative services contract with the Company, but they do not assume any financial risk or obligation with respect to claims or benefits under the relevant plans. The vendors listed above for coverages that are fully insured provide benefits under one or more insurance policies or contracts issued to the Company. These vendors are solely responsible for financing and providing the benefits under the insurance policies and contracts. The Company has no liability for any benefits due or alleged to be due, under any such insurance policies or contracts.

Note: Not all of the benefit programs summarized above may be subject to ERISA. They are described as part of the Plan for purposes of convenience and because there may be other applicable state or federal laws that require a written document.

Note: Employees who work 30 hours or more per week are eligible to participate. Participation begins 1st of the month following date of hire for Mainline Investment Partners and Merion Realty Partners employees. Participation begins 1st of the month following 60 days of employment for Merion Residential employees. Participation begins immediately for Long-Term Care benefits.

Note: The following Participating Employers have adopted the Plan:

MRM Residential Management dba Merion Residential, EIN 47-2271359
MainLine Investment Partners LLC, EIN 45-2845118
Merion Realty Advisers, LLC, EIN 45-2835814

ELECTRONIC MEANS DISCLAIMER

To facilitate efficient operation of the Plan, the Plan may allow these, along with other forms and notices, whether required or permissive, to be maintained, sent and/or made available by electronic means within approved ERISA guidelines.