AHC EMPLOYEE STOCK OWNERSHIP PLAN

SUMMARY OF MATERIAL MODIFICATIONS TO SUMMARY PLAN DESCRIPTION

This Summary of Material Modifications ("SMM") sets forth certain changes to the AHC Employee Stock Ownership Plan (the "Plan"). It supplements the Plan's Summary Plan Description ("SPD"), and you should retain it with your copy of the SPD. Capitalized terms that are not defined in this document have the meanings ascribed to them in the Plan.

Summary of Changes.

The Plan is being terminated effective as of April 6, 2021. The following changes are being made in connection with the termination of the Plan and are effective as April 6, 2021.

1. The following is added to the end of Article II:

   Notwithstanding the foregoing, no Eligible Employees shall become Members after April 6, 2021.

2. The following is added to the end of Article IV:

   Notwithstanding the foregoing, no Employer contributions shall be made after April 6, 2021. Any forfeitures remaining after such date shall be allocated to the ESOP Account of each Member (i) who is an Eligible Employee on such date, or (ii) whose death or Retirement Date occurred during the Plan Year. The allocation shall be made in the proportion that the Member's Annual Compensation bears to the aggregate Annual Compensation of all such Members. A Member on FMLA Leave on such date shall be deemed to be employed on such date.

3. The following is added to the end of the "Form and Time of Payment of Employer Contribution Account, Rollover Account, and Transfer Account" section of Article VII:

   Notwithstanding the foregoing, effective as of April 6, 2021, all distributions shall be in the form of a lump sum payment in cash.

4. The following is added to the end of the "Form of Payment of ESOP Account" section of Article VII:

   Notwithstanding the foregoing, effective as of April 6, 2021, all distributions shall be in the form of a lump sum payment in cash. Furthermore, to the extent a payment with respect to the 2020 Plan Year for your shares of Company Stock is less than the proceeds from the Transaction allocable to such shares, you will receive a payment for the difference.

5. The following is added to immediately follow the vesting schedule in Article VIII:

   Notwithstanding the above vesting schedule, effective as of April 6, 2021, all amounts credited to a Member's Account as of such date will become 100% vested and will not be subject to forfeiture.

6. The following is added to the end of the "Form and Time of Payment of Vested Employer Contribution Account, Rollover Account, and Transfer Account" section of Article VIII:

   Notwithstanding the foregoing, effective as of April 6, 2021, all distributions shall be in the form of a lump sum payment in cash.

7. The following is added to the end of the "Form and Time of Payment of Vested ESOP Account" section of Article VIII:

   Notwithstanding the foregoing, effective as of April 6, 2021, all distributions will be in the form of a lump sum payment in cash. Furthermore, to the extent a payment with respect to the 2020 Plan Year for your shares of Company Stock is less than the proceeds from the Transaction allocable to such shares, you will receive a payment for the difference.

8. The following is added to the end of the "Forfeitures of Nonvested Accounts" section of Article VIII:

   Notwithstanding the foregoing, effective as of April 6, 2021, all amounts credited to a Member's Account as of such date will become 100% vested and will not be subject to forfeiture.

9. The following is added to the end of Article IX:

   Notwithstanding the foregoing, effective as of April 6, 2021, no elections under this Section will be permitted.

10. The following is added to the end of Article X:

    Following the complete termination of the Plan and notice from the Plan Administrator, you may make a one-time election to receive a distribution of up to 75% of your Account (excluding any amounts held in escrow under the terms of the Transaction). Any remaining balance of your Account will be distributed in a lump sum upon the liquidation of the Trust.

11. Article XI is revised to read as follows:

CLAIMS AND ARBITRATION

Claims

Benefits will be paid to you and your beneficiaries without the necessity for formal claims. Subject to the foregoing, any claim, dispute or controversy of any kind asserted by or through a current or former Employee, current or former Member, current or former Beneficiary, or the Plan (to the extent a claim is brought on the Plan's behalf) (a "Claimant") that arises out of or relates to the Plan or the Trust including, without limitation, any (a) claim for benefits under the Plan or the Trust; or (b) claim asserting a breach of, or failure to follow, the terms of the Plan or the Trust or any provision of the Code or ERISA (including, without limitation, claims for breach of fiduciary duty and the failure to timely provide notices or information required by ERISA or the Code) (collectively, the "Claims"), will be resolved exclusively pursuant to the procedures set

forth in this Article XI of the SPD, including the claims procedure set forth in the Section titled "Claims Procedure" (the "Claims Procedure") and the mandatory arbitration procedure described in the Section titled "Mandatory Arbitration Procedure" (the "Arbitration Procedure").

For the avoidance of doubt, the Claims Procedure and Arbitration Procedure represent the sole and exclusive means for adjudicating any Claim asserted by a Claimant, whether such Claim is asserted against (x) any fiduciary under the Plan including, but not limited to, the Plan Administrator, the Employer, and/or Trustee; and/or (y) any other individual or entity acting as Plan sponsor or providing services to the Plan in a non-fiduciary capacity (e.g., a service provider).

Claims Procedure

A Claimant must submit any necessary forms and information when making a Claim under the Plan. Claims must be filed in writing with the Plan Administrator and will be subject to a full and fair review. If a Claim is wholly or partially denied, the Plan Administrator shall provide adequate written notice to the Claimant whose Claim has been denied. The notice will be furnished within 90 days of the date that the Claim is received by the Plan without regard to whether all of the information necessary to make a Claim determination is received. The Claimant will be notified in writing within this initial 90-day period if special circumstances require an extension of the time needed to process the Claim. The notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator's decision is expected to be rendered. In no event will such extension exceed a period of 90 days from the end of the initial 90-day period.

The Plan Administrator's notice to the Claimant will: (i) specify the reason or reasons for the denial; (ii) reference the specific Plan provisions on which the denial is based; (iii) describe any additional material and information needed for the Claimant to perfect his or her Claim; (iv) explain why the material and information is needed; and (v) inform the Claimant of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to, pursuant to the Arbitration Procedure, bring an action in arbitration under ERISA Section 502(a) following an adverse Claim determination on appeal.

Any appeal made by a Claimant must be made in writing to the Plan Administrator within 60 days after receipt of the Plan Administrator's notice of denial of the Claim. If the Claimant appeals to the Plan Administrator, the Claimant may submit written comments, documents, records, and other information relating to the Claim. The Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim. The Plan Administrator shall review the Claim taking into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Claim determination.

The Plan Administrator shall provide adequate written notice to the Claimant of the Plan's Claim determination on review. The notice will be furnished within 60 days of the

date that the request for review is received by the Plan without regard to whether all of the information necessary to make a Claim determination on review is received. The Claimant will be notified in writing within this initial 60-day period if special circumstances require an extension of the time needed to process the Claim. The notice will indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review. In no event will such extension exceed a period of 60 days from the end of the initial 60-day period.

In the event the Claim determination is being made by a committee that holds regularly scheduled meetings at least quarterly, the above paragraph will not apply. The Claim determination will be made by the date of the meeting of the committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, the Claim determination will be made by the date of the second meeting following the Plan's receipt of the request for review. The date of the receipt of the request for review will be determined without regard to whether all of the information necessary to make a Claim determination on review is received. The Claimant will be notified in writing within this initial period if special circumstances require an extension of the time needed to process the Claim. The notice will indicate the special circumstances requiring an extension of time and the date by which the committee expects to render the determination on review. In no event will such Claim determination be made later than the third meeting of the committee following the Plan's receipt of the request for review. The Plan Administrator will provide adequate written notice to the Claimant of the Plan's Claim determination on review as soon as possible, but not later than five days after the Claim determination is made.

If the Claim is wholly or partially denied on review, the Plan Administrator's notice to the Claimant will: (i) specify the reason or reasons for the denial; (ii) reference the specific Plan provisions on which the denial is based; (iii) include a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of, all documents, records, and other information relevant to the Claimant's Claim; and (iv) include a statement of the Claimant's right to, pursuant to the Arbitration Procedure, bring an action in arbitration under ERISA Section 502(a). Any further action regarding the Claim must be brought in arbitration in accordance with the Arbitration Procedure and the time limits set forth therein. A Claimant may authorize a representative to act on the Claimant's behalf with respect to a Claim or appeal of an adverse Claim determination. Such authorization will be made by completion of a form furnished for that purpose by the Plan Administrator or otherwise approved by the Plan Administrator. In the absence of any contrary direction from the Claimant, all information and notifications to which the Claimant is entitled will be directed to the authorized representative.

Any actions required to be taken by the Plan Administrator under this Claims Procedure may be taken by an authorized representative of the Plan Administrator.

The Claims Procedure will be administered in accordance with Department of Labor Regulation Section 2560.503-1, as amended from time to time, and will not be construed to provide, and will not provide, the Claimant with rights greater than those provided for under the regulation.

Mandatory Arbitration Procedure

Subject to and without waiver of full compliance with the Claims Procedure that a Claimant must exhaust with respect to any Claim before initiating arbitration under this Section, all Claims must be resolved exclusively pursuant to the provisions of this Arbitration Procedure. To the fullest extent permitted by law, no application or appeal to any court may be made in connection with any question of law arising in the course of arbitration pursuant to this Arbitration Procedure or with respect to any award, except as to (i) the Class Action Waiver (described below), (ii) actions relating to enforcement of this Arbitration Procedure; (iii) any award seeking interim or other provisional relief or remedies in aid of arbitration; or (iv) any action permitted under the Federal Arbitration Act, U.S.C. § 1, et. seq. ("FAA"). For those issues permitted in the preceding sentence, such an application or appeal may be made solely to the Nashville Division of the United States District Court for the Middle District of Tennessee. Any actions required to be taken by the Plan Administrator under this Arbitration Procedure may be taken by an authorized representative of the Plan Administrator.

(a) Request for Arbitration / No Split Claims. A Claimant may initiate arbitration by serving a demand for arbitration on the Plan Administrator and, if applicable, the Trustee, or any other respondent, and by filing such demand for arbitration with the appropriate office of the American Arbitration Association ("AAA"). In order to save time and expenses, the parties may agree to have the arbitrator(s), and not the AAA, administer the arbitration. In the absence of such an agreement, however, the AAA will administer the arbitration. Any Claim must be submitted to arbitration within the earlier of the applicable statutory period of limitations or three years following the date on which the Claim accrued or it will be barred as untimely; provided, however, any Claim under ERISA Section 502(a)(1)(B) for a denial of benefits will be deemed to have accrued on the date the Plan Administrator's final denial is issued under the Claims Procedure, and any demand for arbitration involving such Claim will be served on the Plan Administrator and, if applicable, the Trustee, and filed with the AAA within 12 months following the date on which the denial of the Claim is issued by the Plan Administrator.

A Claimant must assert all Claims in the same arbitration and will not split Claims. If, for example, a Claimant wishes to pursue both a claim for benefits under ERISA Section 502(a)(1)(B) and a claim for breach of fiduciary duty under ERISA Section 502(a)(2) and/or ERISA Section 502(a)(3), the Claimant shall first exhaust the Plan's Claims Procedure and then assert such Claims in one demand for arbitration.

(b) No Class Arbitration or Class Relief. Each Claimant, or any party claiming for or through such Claimant, agrees that any Claim will be arbitrated individually and will not be brought in a representative capacity or on a purported class, collective, or group basis (the "Class Action Waiver"). Each arbitration will be limited solely to all Claims asserted by a single Claimant, and Claimant may not seek or receive any remedy that has the purpose or effect of providing additional benefits or monetary or other relief to any person other than the Claimant. For instance, with respect to any Claim brought under ERISA Section 502(a)(2) to seek

appropriate relief under ERISA Section 409, the Claimant's remedy, if any, will be limited to (i) the alleged losses to the Claimant's individual Account resulting from the alleged breach of fiduciary duty, (ii) a pro-rated portion of any profits allegedly made by a fiduciary through the use of Plan assets where such pro-rated amount is intended to provide a remedy solely to Claimant's individual Account, and/or (iii) such other remedial or equitable relief as the arbitrator(s) deems proper so long as such remedial or equitable relief does not include or result in the provision of additional benefits or monetary relief to any person, including without limitation, any Employee, Member, or Beneficiary other than the Claimant, and is not binding on the Plan Administrator or the Trustee with respect to any person other than the Claimant. Arbitrator(s) will consequently have no jurisdiction or authority to compel or permit any class, collective, group, or representative action in arbitration, to consolidate different arbitration proceedings, or to join any other party to any arbitration.

This Class Action Waiver requirement will govern irrespective of the Rules (as defined below) or decision to the contrary and is a material and non-severable term of the Arbitration Procedure. Except as to the validity and enforceability of the Class Action Waiver, the arbitrator(s) will have exclusive authority to resolve any and all disputes or issues relating to the scope, validity, or enforceability of any provision of the Arbitration Procedure. Any dispute or issue relating to the validity or enforceability of the Class Action Waiver will be determined exclusively by the Nashville Division of the United States District Court for the Middle District of Tennessee. In the event the Class Action Waiver is determined to be invalid or unenforceable by such court and there is no right of appeal or such right has expired, any and all rights created by this Arbitration Procedure will be rendered null and void.

(c) AAA Rules. The arbitration of any Claim will be administered in accordance with the National Rules for the Resolution of Employment Disputes of the AAA ("Rules") then in effect, except to the extent such Rules are modified by this Arbitration Procedure. Under no circumstances will the AAA Supplementary Rules for Class Arbitrations govern the arbitration of any Claim. Any Claimant may obtain a copy of the Rules at any time upon written request to the Plan Administrator or by reviewing the Rules at www.adr.org, and will be provided a current copy of such Rules if a Claim is denied in whole or in part upon review in accordance with the Claims Procedure.

(d) Arbitration Venue; Standard of Review; Discovery. Any arbitration proceeding will be held in Nashville, Tennessee, or such other venue as may be selected by mutual agreement of the parties; provided, however, that (i) the same standards of review will apply to the review of any Claim hereunder as would apply had such Claim been filed in the Nashville Division of the United States District Court for the Middle District of Tennessee (e.g., any discretionary decision or action will be reviewed under an "abuse of discretion" standard); and (ii) the arbitration of any Claim under ERISA Section 502(a)(1)(B) will be premised solely upon the provisions set forth under the Plan and the record developed in connection with the Claims Procedure. Any party to an arbitration hereunder may request that the arbitrator(s) grant discovery to the extent permitted by Rules if it is

demonstrated such discovery is necessary for a fair arbitration. All disputes regarding discovery will be decided by the arbitrator(s).

(e) Selection of Arbitrator(s). The arbitrator(s) will be mutually acceptable to all parties and must be licensed attorney(s) with prior experience with ERISA claims. The parties intend that the arbitrator(s) be independent and impartial. To that end, the arbitrator(s) shall disclose to the parties, both before and during the proceedings, any professional, family or social relationships, past or present, with any party or counsel.

Arbitrator(s) need not be selected from the panel of arbitrators designated under the AAA if the parties can reach agreement on the selection of the arbitrator(s). If Claims raised by a Claimant solely involve (i) a Claim to recover benefits due Claimant under ERISA Section 502(a)(1)(B), or to enforce or clarify the Claimant's rights under the terms of the Plan, and/or (ii) a Claim for penalties under ERISA Section 502(c), the Claims will be submitted to and decided by a single arbitrator. For all other disputes, the Claims will be submitted to and decided by a panel of three arbitrators, all meeting the experience requirements set forth above. If the parties cannot mutually agree on the selection of the arbitrator(s) within 21 days of the demand for arbitration, then the arbitrator(s) will be selected pursuant to the Rules; provided, however, that (x) the list of potential arbitrators provided by the AAA will be limited to attorneys with prior experience with ERISA claims; (y) for an arbitration to be heard by one arbitrator, the AAA shall provide the names of seven potential arbitrators from which the two sides (Claimant on one side and all respondents on the other side) shall alternatively strike names until only one name remains, with the Claimant striking first; and (z) for an arbitration to be heard by three arbitrators, the AAA shall provide the names of 11 potential arbitrators from which the two sides shall alternatively strike names until only three names remain, with the Claimant striking first.

(f) Arbitration Award. The award of the arbitrator(s) will be in writing. In rendering the award, the arbitrator(s) shall determine the respective rights and obligations of the parties under federal law, or, if federal law is not applicable, the laws of the State of Tennessee. The judgment on the final award rendered by the arbitrator(s) may be entered in any court having jurisdiction thereof and will be *res judicata* as to all Claims that the Claimant asserted or could have asserted in the demand for arbitration.

(g) Fees and Expenses. Except as may be awarded by the arbitrator(s) in a final award, the fees and expenses of the arbitrator(s) and arbitration will be advanced by the Employer, and each party will bear the expense of his, her, or its own counsel, experts, witnesses, and preparation and presentation of evidence. The final award issued by the arbitrator(s) may include an award of arbitration fees and expenses and/or attorneys' fees and expenses to the extent permitted under ERISA. However, if any party prevails on a statutory claim that entitles the prevailing party to attorneys' fees and costs, or if there is a written agreement between the parties providing for attorneys' fees and costs, the arbitrator(s) may award reasonable attorneys' fees and costs in accordance with the applicable statute or written

agreement. In that event, the arbitrator(s) shall resolve any dispute as to the reasonableness of any fee or cost that may be awarded.

(h) Confidentiality. Neither the Claimant nor arbitrator(s) may disclose any information relating to an arbitration proceeding without the prior written consent of the Plan Administrator. This confidentiality provision will apply to all aspects of the arbitration proceeding including, without limitation, discovery, testimony, other evidence, briefs, and the award. In the event of a breach or threatened breach of this confidentiality provision, the Plan Administrator or, if applicable, the Trustee or other respondent, may seek temporary, preliminary, and/or permanent injunctive relief to prevent such breach or threatened breach, as well as any damages suffered by the Plan Administrator, Employer, Trustee or other respondent. In the event the Plan Administrator or, if applicable, the Trustee or other respondent brings an action to enforce this confidentiality provision and receives any remedy (whether temporary or permanent), the Claimant or arbitrator(s) responsible for such breach or threatened breach shall pay the attorneys' fees and expenses incurred in connection with such enforcement action. In any action to confirm or set aside an arbitration award, the parties will cooperatively seek to file the arbitration award under seal or for an *in camera* inspection by the court without the award being filed in the public record.

(i) Enforcement. This Arbitration Procedure will be governed and enforced under ERISA, the FAA, and, to the extent that it does not conflict with or is not preempted by ERISA or the FAA, the laws of the State of Tennessee. The final award rendered by the arbitrator(s) will be final and binding on the parties to the arbitration with respect to the Claimant's individual claims only.

12. Article XII is revised to read as follows:

YOUR RIGHTS UNDER ERISA

As a Member of the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Members shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all Plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) the Plan filed 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 copies of the latest annual report (Form 5500 Series) and 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 Member with a copy of this summary annual report.

- Obtain a statement telling you whether you have a right to receive a benefit at normal retirement age (the later of age 65 or your fifth anniversary as a Member) and if so, what your benefits would be at normal retirement age if you stop working under the Plan now. If you do not have a right to a benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

In addition to creating rights for Plan Members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Members and beneficiaries. 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 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 a Claim and initiate arbitration if your Claim is denied on review. In such a case, the arbitrator(s) 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 that is denied or ignored, in whole or in part, you may file a Claim and initiate arbitration if your Claim is denied on review. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file a Claim and initiate arbitration if your Claim is denied on review. 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 a Claim and initiate arbitration if your Claim is denied on review. The arbitrator(s) will decide who should pay arbitration costs and legal fees. If you are successful, the arbitrator(s) may order the person you have sued to pay the costs and fees. If you lose, the arbitrator(s) may order you to pay the costs and fees, for example, if the arbitrator(s) 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.

KEEP THIS SUMMARY OF MATERIAL MODIFICATIONS WITH YOUR SPD FOR FUTURE REFERENCE.