American Senior Communities, L.L.C.
Prescription Drug Plan

Plan Document and Summary Plan Description

Effective Date: January 1, 2026

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This document constitutes both the formal Plan Document and also constitutes the Summary Plan Description for the American Senior Communities, L.L.C. Prescription Drug Plan (referred to as the "Rx Plan" or the "Prescription Drug Plan" in this document). The benefit plans and programs provided under the Rx Plan are provided for employees of American Senior Communities, L.L.C. (referred to herein as the "Employer" or "Plan Sponsor" in this booklet) and its controlled group members and/or affiliates as defined and stated in this document. This is a Rx Plan that provides coverage for prescription drug and related pharmaceuticals to Employees and Eligible Dependents as defined herein. Prescription Drug Benefits are offered hereunder on a self-insured basis, but if subject to insurance, this is stated in Exhibit A. The Rx Plan may be subject to required Employee contributions.

The intent of this Prescription Drug Plan document is to satisfy the Employee Retirement Income Security Act of 1974 (ERISA) requirement for both a Plan Document under ERISA Section 402(a)(1) and the requirements of a Summary Plan Description ("SPD"), pursuant to ERISA Section 102. This entire document, including all of the Exhibits and any other attachments are incorporated as part of this Rx Plan. All of the terms in this document and all determination of facts related to benefits hereunder, are subject to the discretion and interpretation of the Plan Administrator, except as specifically reserved for any Pharmacy Benefit Manager which acts as a Claims Administrator, as stated in this document. All matters pertaining to rights and obligations with respect to the Rx Plan, are subject to the Plan Administrator, except as may otherwise be specifically reserved or determined by the Pharmacy Benefit Manager Claims Administrator, as referenced in this document and Exhibit A.

Although the Plan Sponsor's present intent is to continue this Prescription Drug Plan indefinitely, please be advised and aware that the Plan Sponsor retains the absolute right to eliminate this Rx Plan, or substitute other coverage, initiate and change employee contribution amounts as permitted by law, and amend, change, modify, and/or completely terminate some or all of the benefits, plans, or programs under this Prescription Drug Plan, at any time. Neither this document nor any other writing regarding the Rx Plan will grant or confer any vested or other rights to any employee, former employee or any other person for future benefits beyond amounts payable for periods of time while the Rx Plan is in effect and that are not specifically provided for in the Rx Plan terms.

The effective date of this restatement of the Rx Plan is the Effective Date stated in Section 2.

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SECTION 1: RX PLAN INTRODUCTION

The Plan Sponsor has adopted and established this American Senior Communities, L.L.C. Prescription Drug Plan (which we will refer to as the "Rx Plan" or the "Prescription Drug Plan") for the purpose of providing prescription drug and pharmaceutical health and welfare benefits to eligible Employees under the terms stated herein.

This document, along with its Exhibits establish the Rx Plan for the Plan Sponsor. This Rx Plan is intended to satisfy the Employee Retirement Income Security Act of 1974 (ERISA) requirements for both a Plan Document under ERISA Section 402 and a Summary Plan Description ("SPD"), pursuant to ERISA Section 102.

SECTION 2: BASIC INFORMATION

Description	Plan Information
Employer and Plan Sponsor:	American Senior Communities, L.L.C.
Address:	6900 S. Gray Road, Indianapolis, IN 46237
Telephone Number:	317-788-2500
Plan Administrator and Named Fiduciary:	American Senior Communities, L.L.C. at Address Stated Above
Other Participating Employers:	See Exhibit B
Plan Name:	American Senior Communities, L.L.C. Prescription Drug Plan
Plan Type and Funding:	The Rx Plan is Funded by the Employer including Employee contributions, if any, and is Self-Funded or Self-Insured, unless the purchase of insurance funds all or a portion of the Rx Plan benefits, as stated in Exhibit A.
Schedule(s) of Benefits Offered:	Schedule(s) of Benefits offered under the Rx Plan, as described in Section 4.2 and as shown in Exhibit A
Plan Number:	501
Agent for Service of Legal Process:	American Senior Communities, L.L.C. at Address Stated Above
Employer Identification Number:	35-2077389
Type of Administration:	See Section 3.2. A Pharmacy Benefit Manager provides administrative services to the Rx Plan. See Section 4 and the PBM Data Sheet at page 37
Agent for Service of Process:	The Employer Listed Above, at the Address Above
Effective Date:	January 1, 2026
Plan Year:	Twelve Month Period Beginning: January 1
"Eligible Employee":	See Exhibit A
Spouse Restrictions:	See Exhibit A
Grandfathered Status:	See the group health plan of the Employer

SECTION 3: ADMINISTRATION AND RELATED INFORMATION

3.1 Plan Funding and Constituent Benefit Programs

Funding. The Rx Plan is funded by contributions from the Employer and Employees may be required to contribute toward the coverage under this Rx Plan. The Rx Plan is self-funded or self-insured, unless the purchase of insurance funds all or a portion of the Rx Plan benefits, as stated in Exhibit A. Employees may be required to pay for a portion of the premium for coverage, as determined from time to time by the Employer. Continued eligibility is conditional upon the Employee authorizing and paying the required Employee contribution amount either from the Employee's pay or otherwise. Employee contribution amounts for the Rx Plan may in part come from contributions made for coverage under the main group health plan of the employer. The Employer will provide reasonable notice of the Employee contribution amounts, which may change from time to time, as determined by the Employer. If any rebates, credits, refunds or other amounts are paid back, or made available from insurers, administrators, or others, such amounts are paid to the Employer to offset the Employer's cost to provide and/or administer benefits under the Plan.

"Rx Benefit Programs." The plan and program of Rx Plan benefits, which may include several options, are referenced in Exhibit A to this Rx Plan document. Exhibit A will include details of eligibility, deductibles, Co-Payments, Co-Insurance, Out-of-Pocket Maximums, coordination with group health plan coverage, spousal and dependent coverage information, and other details of the plan and program of Rx Plan benefits under this Prescription Drug Plan. The Rx Benefit Program or Programs stated in Exhibit A to this Rx Plan are an integral part of and incorporated into this Rx Plan document and SPD by reference. Additional documentation is often provided to Employees and covered Dependents by the Employer and Pharmacy Benefit Manager (PBM) (See Section 4.1). If there is any conflict between any documentation provided by the Employer or PBM the Plan Administrator will reconcile such inconsistency and has full rights to do so, as further provided under this Plan and SPD.

3.2 Plan Administrator, Claims Administrator and Discretionary Authority

The Rx Plan is administered by the Pharmacy Benefit Manager ("PBM") that acts as the Claims Administrator, and by the Plan Administrator, in accordance with the provisions of this Rx Plan. Information on the PBM is in Section 4.1.

Routine Rx Plan claims under the Rx Plan are processed by the Pharmacy Benefit Manager ("PBM") which is the Claims Administrator and is directly responsible as the fiduciary for claims and claim determinations, unless specified otherwise. In addition, the Formulary or Drug List or lists and other related determinations in this Rx Plan, including those in Section 4, when made by the PBM are subject to the full discretionary authority of the PBM as noted in this Section. When a claim determination is delegated to or is the responsibility of the PBM as Claims Administrator under the Rx Plan, the Plan Administrator is not the responsible fiduciary. When a determination on a claim, or eligibility, or other term, or of fact, law or interpretation under the Rx Plan is not specifically reserved to the PBM as the Claims Administrator, the Plan Administrator is the responsible fiduciary for such determinations under the Rx Plan. If there is any question as to whether the Claims Administrator or Plan Administrator is the responsible fiduciary, the Plan Administrator makes such determination in its sole and absolute discretion. The Rx Plan is self-funded, which means there is no insurance that funds the Rx Plan. If any part of the Rx Plan is insured, the insurance provider is the Claims Administrator and is directly responsible as the fiduciary for claims and claim determinations under the Rx Plan. If any part of the Rx Plan is insured, this is stated in Exhibit A.

When the Claims Administrator acts, or when the Plan Administrator is the responsible fiduciary, such responsible fiduciary has full discretionary authority with respect to all of its determinations under this Plan, the determination of facts, the interpretation of the Rx Plan or its terms and all decisions and determinations under this Rx Plan made by such fiduciary. This discretionary authority is to be interpreted in the broadest sense permitted under law.

3.3 Plan Amendment and Termination

Amendment. The Plan Sponsor may amend or alter the provisions of the Rx Plan, or any information in the Schedule of Benefits in Exhibit A, at any time, by any action of the Plan Sponsor taken in the normal course of its business. This includes, without limitation, any action by an officer or employee of the Plan Sponsor or any individual designated in writing by such an officer as authorized to take such action. Any such amendment will be effective at the time designated in the amendment.

Termination. The Plan Sponsor may discontinue or terminate the Rx Plan, in whole or in part, at any time whatsoever, by any action in the normal course of business, including without limitation, by written action of the Plan Sponsor in accordance with its operating documents and/or applicable state law. Any such termination will be effective at the time designated in such documentation.

SECTION 4: PROGRAMS OF BENEFITS

4.1 Pharmacy Benefit Manager ("PBM")

The Name and Basic Information on the Pharmacy Benefit Manager ("PBM") is below and important additional information on the PBM is on the PBM Data Sheet at page 37.

Name of Pharmacy Benefit Manager ("PBM"):	True Rx Health Strategists
Main PBM Mailing Address:	7 Williams Bros. Dr., Washington, IN 46501
Website Access:	www.TrueRx.com
PBM Telephone Number:	(866) 921-4047

SEE THE PBM DATA SHEET AT PAGE 37 FOR MORE INFORMATION ON THE PBM

4.2 Schedule(s) of Benefits - Exhibit A

The Rx Plan includes a Schedule or Schedules of Benefits to state the Rx Plan's rules on a number of specific items. These include Eligibility, Spouse and Dependent Benefits, Deductibles, whether those Deductibles coordinate with any group health plan of the employer, the Co-Payments and/or Co-Insurance amounts, Out-of-Pocket Maximums amounts for covered Prescription Medicine and related supplies and more. The Deductibles, Co-Payment and/or Co-Insurance amounts may also depend upon which Schedule of Benefits applies to you and your Dependents and also on the type of Prescription Medicine that you purchase; sometimes, this is referred to as a "Tier" of a covered Prescription Medicine. These details are stated in Exhibit A, and are incorporated into this Rx Plan by reference.

Other materials regarding the Rx Plan, the Schedule of Benefits and how Covered Persons should use the Rx Plan are provided by the PBM and your Employer. Covered Persons should review those materials as well. If the PBM or the Employer mark any document with the name of the Plan and as "Included in the Rx Plan," then such document becomes part of this Rx Plan.

Defined terms are generally noted with an initial Capital letter. See defined terms below in Section 4.6, and otherwise throughout this Rx Plan document.

4.3 Rx Plan Benefit Information

Coverage – General Conditions - The Plan provides coverage for Prescription Medicine under the Rx Plan, if all of these conditions are met:

1. you are an eligible Employee or Dependent covered under the Rx Plan;
2. it is Medically Necessary;
3. it is obtained through an authorized source, including a Retail, Network, or Non-Network Pharmacy;
4. you have met any Utilization requirements such as Pre-Authorization or Step Therapy;

5. the Prescription Medicine is not subject to an Exclusion or limit under this Rx Plan or Exhibits A or C;
6. the Prescription Medicine is in the Formulary specified by the PBM;
7. you pay the required Deductible, Co-Payment and/or Co-Insurance amount; and
8. you have otherwise complied with the terms of the Rx Plan.

What the Rx Plan Covers - The Rx Plan provides benefits to Covered Persons for Prescription Medicines (or Drugs):

1. prescribed by a Prescriber;
2. listed as a Medication on the then applicable Formulary and otherwise payable under this Rx Plan, subject to the rules and requirements of this Rx Plan and the PBM;
3. in an amount not to exceed the day's supply stated in the applicable Schedule of Benefits (if any);
4. Medically Necessary for the care and treatment of an Illness or Injury;
5. subject to the payment of any required Deductible, Co-Payment, and/or Co-Insurance amount;
6. not excluded in the Exclusions and Limitations Section, or otherwise;
7. not Experimental, Investigative, or Unproven;
8. with certain limited exceptions, may only be obtained by Prescription and are dispensed in a container labeled "Rx only;"
9. dispensed by a Pharmacy or a Participating Pharmacy that is both legally permitted to dispense the Medication and is a permitted dispensing Pharmacy, either Network, or Non-Network permitted under this Rx Plan and by the PBM; and
10. certain non-prescription products prescribed by a duly licensed medical professional as provided in the Formulary of the PBM. See below.

Deductibles, Co-Payments, Co-Insurance and Out-of-Pocket Maximums

Coverage is subject to the payment of any required Deductible, Co-Payment, or Co-Insurance, subject to any Out-of-Pocket Maximums and the provisions of this Rx Plan, and the Schedule(s) of Benefits at Exhibit A.

Deductible. A Deductible, if any, is the amount you must pay each year before the Rx Plan pays for benefits under the Rx Plan. The applicable "year" that applies is defined in the Schedule(s) of Benefits at Exhibit A. This is a payment that is required in order for you to receive benefits under the Rx Plan. Deductible amounts are subject to and count toward the Out-of-Pocket Maximum, as stated in Exhibit A. The Deductible will be waived for certain preventive Drugs.

Co-Payments. A Co-Payment (or Copay) is the amount you pay each time you receive Drugs or Supplies under the Rx Plan, and if applicable, it is stated in the Schedule(s) of Benefits at Exhibit A. The Co-Payment is usually a fixed dollar amount and is paid at the time of service when receiving a Drug or supply. If the cost of the Drug or supply is less than the Co-Payment, you are only responsible for paying the cost of the Covered Drug or supply. Network Prescription Drug Co-Payments are subject to and count toward the Out-of-Pocket Maximum, as stated in Exhibit A.

Co-Insurance. A Co-Insurance is the amount you pay each time you receive Drugs or Supplies under the Rx Plan, and if applicable, it is stated in the Schedule(s) of Benefits at Exhibit A. The Co-Insurance is usually a percentage of the cost of the Drug payable by the Rx Plan or as otherwise negotiated between the PBM and the Pharmacy and is paid at the time of service when receiving a Drug or supply. Drug Co-Insurance amounts are subject to and count toward the Out-of-Pocket Maximum, as stated in Exhibit A.

Out-of-Pocket Maximum. The Out-of-Pocket Maximum is your overall limit for the out-of-pocket amounts you will pay during the applicable year for Drugs or Supplies, and this amount is stated in the Schedule(s) of Benefits at Exhibit A. The Out-of-Pocket Maximum that applies to Network Pharmacies may be different than that applicable to Non-Network Pharmacies, as stated in Exhibit A. Also, the Out-of-Pocket Maximum amount may coordinate with another group health plan or other plan or program of the Employer, as stated in Exhibit A. Once the Covered Person reaches the applicable Out-of-Pocket Maximum, the Covered Person will not be required to pay additional out-of-pocket expenses for benefits under the Rx Plan for the remainder of the Plan Year. Special rules regarding the applicability of Out-of-Pocket Maximums are stated in the Schedule(s) of Benefits at Exhibit A, or under the Special Rules at Exhibit C.

About the Formulary - The Drug List

The PBM will establish a "Formulary" or "Formulary Medication" list or "Drug List" of the Medications covered by the Rx Plan. Formulary Lists may be compiled by Drug categories, such as "Generic" or "Preferred," or even by Tiers, or otherwise, and the Formulary list or lists are available to Covered Persons as stated in this Rx Plan.

The establishment of the Formulary or Drug List is the responsibility of the PBM and its determinations of what is on any Formulary is subject to its full and complete discretion. The Formulary or Drug List is also subject to the terms of the Plan and any specific parameters developed by the Plan Sponsor in the design of the Rx Plan.

The Formulary list or lists are subject to change at any time. Covered Persons will be reasonably notified of any changes or updates, including any additions or deletions to the Formulary, consistent with the terms of the Rx Plan and applicable law.

The Formulary lists serve also as a guide for Covered Persons and their Prescribers and Physicians. See Section 4.2 and the Schedule(s) of Benefits at Exhibit A for additional information regarding the Formulary or Drug List.

Certain Restrictions and Limitations.

Some Medications may be subject to quantity limits. These limits help your doctor and pharmacist check to ensure that the Medication that you are taking is being used correctly and safely for an appropriate duration. The PBM may employ various tools to assist it in determining quantity limits, which may include medical guidelines, FDA-approved recommendations, and recommendations from Drug manufacturers. The quantity limits determined by the PBM are done so at its discretion and all Covered Persons are bound by such determinations.

Medications lost as a direct result of a natural disaster, or other circumstance may be replaced under rules and guidelines established by the PBM in its sole discretion. Covered Persons will be given the opportunity to prove that the Medications were lost due to a legitimate reason, including a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claim of loss or other writing.

Information About Generic Medications. Generic Medications contain the same active ingredients in the same amount as Brand Medications, but may not otherwise resemble the Brand Medication in name or packaging. Generic Medications are widely seen as one of the best ways to save money on Prescriptions and are as safe and effective as Brand Medications, but on average Generic Medications can cost about 30 percent to 80 percent less.

All Generic Medications that have been approved for substitution have been reviewed by the FDA and found to be as safe and effective as the equivalent Brand Medication. The companies that manufacture Generic Medications must meet the same FDA manufacturing and quality standards as those that make Brand Medications. Only your Physician can decide what's best for you, but be sure to ask about your generic options. Ask your Physician or other Prescriber to approve Generic substitution whenever appropriate. You can use these FDA-approved products with confidence and the knowledge that you are saving money.

Some Plans have requirements regarding the use of Generics when one is available. See the Schedule(s) of Benefits at Exhibit A and the Section "Generic Drug Limitation" below.

Information About Preferred or Brand Medications. "Preferred" or "Brand" Medications are safe and effective choices that the PBM identifies in the Formulary or Drug List. They are often more expensive than Generic Medications, when a Generic is available, and Covered Persons should always consider whether a Generic version of the Medication is available.

Coverage of Preventive Care Medications. Certain preventive care Medications, specifically, evidence-based items that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force are normally covered under the Rx Plan without any cost sharing. That means the Covered Person will not be required to pay a Deductible, Co-Payment or Co-Insurance when obtaining such preventive care medications from a Network Pharmacy. The PBM will determine what Medications are to be treated as preventive care Medications subject to this provision of the Rx Plan consistent with the terms of this Rx Plan and applicable law.

Compound Medication. Compound Medications may need to be purchased at a Pharmacy that is a Network Pharmacy. Contact the PBM to be sure that you are obtaining any Compound Medication from an authorized source, and at the best price. Prior Authorizations may be required, so Covered Persons should check with the PBM or Pharmacist before obtaining any Compound Medication that is prescribed. The PBM has the right to review all Compound Medication claims and exclude any excessive charges, which may include charges for bases and bulk compounding powders or other substances.

Chronic Care Drugs. The Rx Plan with the PBM may have special rules for any Medications that address chronic conditions, such as asthma and diabetes. The PBM may undertake efforts to promote adherence to Medication regimens to help with the Covered Person's self-management of the chronic condition. The Rx Plan retains the final discretionary authority on what constitutes a Medication subject to Chronic Care rules. See Exhibits A and C for any specific rules, or consult with the PBM regarding any Chronic Care Drugs.

Injectable Medications. Coverage for injectable Drugs is found on the Injectable Drug List or is contained in the Formulary or Drug List or lists provided by the PBM. Some Injectable Medications may be available through a specialty Pharmacy and/or a program for home delivery. For those Injectable items that require a medical professional to administer the drug, the cost for that injection is not covered under this Rx Plan. Any administration costs should be submitted under the Covered Person's group health plan.

Opioids. Any Prescription for an Opioid Medication may require additional authorizations or pre-authorizations and may be subject to limitations, including quantity limits. The Covered Person or their treating Prescriber should contact the PBM for more information.

Specialty Drugs – If Covered (See Exhibit A). If Specialty Drugs are Covered Drugs under the Rx Plan, this will be indicated in the Schedule(s) of Benefits at Exhibit A. Specialty Drugs include Orphan Drugs, which are a subset of Specialty Drugs. See the Definitions for more information. The Rx Plan is not required to cover Specialty Drugs or Orphan Drugs and if the Rx Plan excludes Specialty and Orphan Drugs, such exclusion will be stated in Exhibit A and/or Exhibit C.

Certain Specialty Drugs may not be included in the Formulary or Drug List or lists and may be subject to different Deductibles, Co-Payment or Co-Insurance amounts as stated in the Schedule(s) of Benefits at Exhibit A.

Certain Specialty Drugs require special clinical monitoring and if so, they are not dispersed through a traditional retail Pharmacy. Instead, some of these medications have to be dispensed through specialty Pharmacies or hospital providers. The PBM has the right to direct where Covered Persons are to obtain any Specialty or Orphan Covered Drug. If you obtain a Specialty or Orphan Drug from a source that is not approved by the PBM, your claim for such Drug to be a Covered Drug may be denied in whole or in part and any amounts that you pay toward such Drug that is not approved, will not count for purposes of any Out-of-Pocket Maximum, Deductible, Co-Payment or Co-Insurance.

IMPORTANT: Specialty Drugs and Orphan Drugs, when deemed Covered Drugs, may be subject to the Prior Authorization process that is described below. You should read the Prior Authorization section carefully before obtaining a Specialty or Orphan Drug and contact the PBM regarding the process for obtaining such Medication, when it is a Covered Drug under the Rx Plan.

Generic Drug Limitation

If indicated in the Schedule(s) of Benefits at Exhibit A, this Generic Drug Limitation may apply. This Generic Drug Limitation provides that when a Covered Person is prescribed and/or requests a Preferred or Brand Medication, instead of a Generic Drug, or when the Prescriber provides a "dispense as written instruction" even though a Generic Drug is available to that Covered Person, then the Covered Person may be responsible for the difference in cost between a Generic Drug and applicable Brand Medication, in addition to any applicable Deductible, Co-Payment or Co-Insurance amount. If this limitation applies, it will be stated in Exhibit A. Any difference in cost paid by the Covered Person will not be included in the applicable Out-of-Pocket Maximum amount. In the event that a treating Physician certifies that a Generic Drug is not available, or the available Generic Drugs are not suitable to the Covered Person, subject to evaluation of this certification by the PBM, this Generic Drug Limitation may be Waived.

Drug Utilization Review and Step Therapy Procedures

The PBM may establish Step Therapy and/or certain other Drug Utilization Review procedures and protocols in connection with benefits payable under the Rx Plan.

Step Therapy, or a similarly described therapy process, is a process that may be applied by the PBM under the Rx Plan. Step Therapy applies to certain Medications, Drugs or supplies under the Rx Plan to ensure the most appropriate use of Drugs for the treatment of your condition and to manage costs and expenses. For Covered Drugs or supplies that are subject to Step Therapy requirements, you must follow the Step Therapy process established by the PBM in accordance with its then prevailing rules in order to have your Medication covered under the Rx Plan. If you do not follow the Step Therapy process, then your Medication may be denied for coverage under the Rx Plan. The Step Therapy process will generally have you try the most cost-effective drug therapy first before the PBM will authorize and the Rx Plan will cover the more costly Medication, in connection with the treatment of your condition. Undertaking the Step Therapy process in effect with the PBM is a condition to having a Medication deemed a Covered Drug, Medicine or supply covered under the Rx Plan.

To learn if your medication is subject to Step Therapy requirements, visit the PBM's website or contact the PBM.

Your PBM may also establish a Drug or Medication Utilization Review or similar program. This program may include creating certain on-screen alerts for the dispensing pharmacists when a claim is checked for completeness and accuracy and utilization in general. Under such a program, before a claim is processed and paid, the PBM can check for potential errors or problems with the Prescription, or similar issues. The Covered Person will be reasonably notified if such a Utilization Review or similar program applies. Covered Persons may contact the PBM in order to establish whether a Utilization Review or similar program applies.

Prior Authorization

Prior Authorization ensures that high quality, cost effective and Medically Necessary Prescription Drugs are made available to Covered Persons related to the Covered Person's Illness or Injury. In most cases, Prior Authorization occurs before a Medication is prescribed and dispensed. Certain services and Medication preparations and/or Medications for certain diseases or illness as well as for Specialty and Orphan Medications when covered by the Rx Plan will require Prior Authorization as determined by the PBM in its absolute discretion from time to time. Any time this Rx Plan, the PBM rules or the PBM otherwise determines that Prior Authorization is required, the Covered Person must obtain Prior Authorization in accordance with the procedures established by the PBM.

To obtain Prior Authorization, the Covered Person or the Prescriber must contact the PBM and provide to the PBM medical information regarding the Covered Person prior to obtaining the Medication subject to the Prior Authorization requirement. Even though a Prescriber may directly request a Prior Authorization on behalf of a Covered Person, it remains the ultimate responsibility of the Covered Person to ensure necessary Prior Authorization is obtained. The PBM may establish reasonable time periods for receipt of information regarding Prior Authorization and the Covered Persons should follow such time periods in order to obtain Prior Authorization.

When Prior Authorization is obtained, Covered Expenses will be reimbursed for the Covered Person. If Prior Authorization is not obtained, the Covered Person may be subject to a rejection of a claim for benefits and the Covered Person may be financially responsible for the full cost of the Medication and no amounts paid will count toward cost sharing Deductibles, Co-Payment or Co-Insurance amounts. Or, if determined otherwise by the PBM and under the Rx Plan, the Medication may be subject to a reduced payment as determined in the discretion of the PBM under the circumstances. If Prior Authorization is approved, Covered Expenses are paid according to the Rx Plan provisions listed in the Schedule(s) of Benefits in Exhibit A.

Important Note: Prior Authorization does not guarantee either payment of benefits or the amount of benefits. Eligibility for, and payment of, benefits are subject to all of the terms of the Prescription Drug Plan.

4.4 Accessing Your Benefits

How to Get Your Prescription Filled

Using a PBM Participating Pharmacy, rather than a non-Participating Pharmacy, is generally more convenient and less expensive for you. Participating Pharmacies can easily access information about the Prescription Drug Plan and the appropriate payment. You will not need to file any additional paperwork when you use a PBM Participating Pharmacy.

How to Fill or Refill Your Prescription at a Retail Pharmacy

To locate a participating pharmacy, you should refer to the PBM information above. You may access the PBM's website, or you may obtain additional information on participating pharmacies from your Employer.

At the retail pharmacy, present your Prescription from your Prescriber along with your Prescription Benefit Card. If your Prescriber has ordered refills, let the Pharmacist know when you are ready to reorder. Make sure that the Pharmacist has accurate information about you and your Dependents who are covered under the Prescription Drug Plan, including dates of birth and gender and any Drug allergies.

The Pharmacist will look up your Prescription Drug Plan benefit information on the computer to verify coverage and dispense the Prescription. If you do not present your Prescription Benefit Card at the time your Prescription is filled, or if you are having your Prescription filled at a non-Participating Pharmacy, you will be asked to pay 100% of the Prescription price. Then, you will need to submit a manual claim to the PBM, along with the original Prescription receipt(s), for reimbursement of your Prescription expenses (to the extent those expenses are covered by this Prescription Drug Plan). You should refer to the PBM Data Sheet at Page 37 to obtain information on how to submit a manual claim. Also, importantly, in most cases, if you use a Pharmacy that is a Non-Network Pharmacy, you will pay more for your Prescription than if you use a Pharmacy that is a Participating Pharmacy.

How to Fill or Refill Your Mail Order Prescription

In most instances, when you are on a medication for a longer period of time, or you take a Maintenance Medication, it is less expensive and more convenient to use any available Mail Order Pharmacy to fill your Prescription. If this Rx Plan mandates that you use Mail Order for Prescriptions over a certain number of days for a fill or refill, that will be indicated in Exhibit A. You and your Dependents should check with the PBM on this requirement and overall whether Mail Order is required or would be better in any event.

How to File an Initial Claim for Benefits

If you present your Prescription Benefit Card to the Pharmacist or provide information from your Card for a Mail Order fill or refill, a claim will be submitted by the Pharmacist to the PBM for processing.

If for any reason your claim is denied in whole or in part, you should first check with your retail Pharmacist or the Mail Order Pharmacist to see if there is some way in which your claim can be corrected. There are many different reasons why a claim for Prescription Medication may be denied under this Rx Plan and you should find out as much information about the denial as you can. If the Retail Pharmacist or Mail Order Pharmacist cannot give you information about any denial you should contact the PBM using the information in Section 4.1 above and investigate why your claim was denied.

If you are submitting a claim manually, follow the manual submission process established by the PBM. Be sure to have the original prescription from the Prescriber along with your receipt for the Medications, and complete all of the information requested.

4.5 Exclusions and Limitations

This Section lists certain Medications, services, supplies, charges, and other items that are excluded from coverage under the Prescription Drug Plan. This is provided merely as an aid to identify certain common Medications, supplies, services, charges, or other items, that may be misconstrued as Covered Services, but is in no way a limitation upon, or a complete listing of, such Medications, services, supplies, charges, and other items that are not considered to be covered under the Prescription Drug Plan. Exclusions, including complications from excluded items, are not considered benefits under this Prescription Drug Plan and will not be considered for payment.

Unless covered under the applicable formularies, the Prescription Drug Plan does not pay costs or expenses for the following Medications, services, supplies, charges, or other items, or for Medications prescribed for the following, even if deemed to be Medically Necessary, unless otherwise expressly stated below:

1. International Claims for Drugs covered under the Plan will generally be reimbursed; however, all claims are subject to review, and reimbursement is not guaranteed.
2. Durable Medical Equipment: These excluded devices include, but are not limited to, therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Except as provided under the Clinical Trial coverage, Experimental, Investigational, or Unproven Medicines, or any charges related to them, even though a charge is made to a Covered Person, and whether or not incurred prior to, in connection with, or subsequent to an Experimental, Investigational, or Unproven service or supply, all as determined by the PBM; Medications or other substances used for other than FDA-approved indications; or Medications labeled: "Caution – limited by Federal law to investigational use."
4. Any Medication not approved by the FDA, or any that is approved for purposes other than for which the Medication is prescribed.
5. Except as provided under the Clinical Trial coverage, new FDA-approved drug product or technology (including but not limited to Medications, medical supplies, or devices) available in the marketplace for dispensing by the appropriate source for the product or technology, including but not limited to pharmacies, for the first six months after the date the product or technology received FDA new drug approval or other applicable FDA approval. The Rx Plan may, in its sole discretion, waive this exclusion in whole in part for a specific new FDA-approved drug product or technology.
6. Medications that are prescribed for, and related to, procedures, treatments, and/or services that are otherwise excluded or not covered under the Rx Plan, or are excluded under the group health plan.
7. Any Prescription Medications that may be properly received without charge under local, state, or federal Plans.
8. Any Medications, treatments, supplies, charges, or items for which the Covered Person has no legal obligation to pay in the absence of coverage under the Rx Plan or other such prescription drug coverage.
9. Except as described elsewhere within this document, over-the-counter Medications and Medications that can legally be bought without a written Prescription or a pharmaceutical alternative to an over-the-counter Medication other than insulin.
10. Cosmetic surgery and care primarily intended to improve the Covered Person's appearance. However, benefits are provided under the Rx Plan if necessary to improve a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from accident or trauma, or a disfiguring disease.
11. Chemical face peels or abrasion of the skin.
12. Cosmetic products (other than certain acne Medications such as retinoids).
13. Comfort, luxury, personal hygiene, or convenience items that are not Medically Necessary.
14. Completion of Claim forms or charges for medical records or reports, unless otherwise required by law.
15. Conditions resulting from a riot, war (declared or undeclared), civil disobedience, nuclear explosion, nuclear accident, or terrorist act.
16. Court-ordered testing or care unless Medically Necessary.
17. Custodial care, domiciliary care, or convalescent care.
18. Medical supplies stocked in the home for general use, like adhesive bandages, thermometers, and petroleum jelly, or any delivery charges associated with any Medication.
19. Medications, services, supplies, charges, or items that are not Medically Necessary.

20. Medications consumed at the time and place where dispensed or where the Prescription is issued, including but not limited to samples provided by a Physician or Prescriber.
21. Medications dispensed prior to the effective date of the Rx Plan.
22. Medications received from other than a licensed pharmacy.
23. Vitamins and other nutritional diet supplements, unless prescribed and Medically Necessary.
24. Drugs used for cosmetic purposes.
25. Drugs used to treat erectile dysfunction.
26. Abortifacients.
27. Off-label use and any use prohibited by law.
28. Quantities that exceed limits established by the Rx Plan, or replacement Medications due to being lost, stolen.
29. Quantities that exceed the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription order.
30. Specialty Drugs, including but not limited to gene and cellular therapies, if excluded under Exhibit A or C. If not excluded, Specialty Drugs obtained from pharmacies that are not approved by the PBM.
31. Orphan Drugs, if excluded under Exhibit A or C. If not excluded, Orphan Drugs obtained from pharmacies or other providers that are not approved by the PBM.
32. Any Medication or category of Medication that the PBM publishes as excluded or that is not contained in the PBM's Formulary.
33. Any Medications which are prescribed, dispensed, or intended for use while the Covered Person is an inpatient in a hospital or other facility.
34. Any other Medication, product, service or supply not specifically authorized and payable under the Rx Plan or otherwise payable under any separate program of benefits of the Employer.
35. Any other Medication, product, service or supply that is specifically excluded under Exhibit C to the Rx Plan.
36. Drugs used for weight loss.

4.6 Definitions – Rx Plan Benefits

The following are definitions and related terms regarding the Rx Plan benefits.

ALLOWED CHARGE OR AMOUNT

The maximum amount the Rx Plan determines is payable for a covered expense for pharmacy benefits. The Allowable Charge under the Rx Plan is generally the lower of following amounts:

A. The Customary and Reasonable charge;
B. Any price specified on a PBM maximum allowable cost list plus Dispensing Fee; or
C. The Average Wholesale Price less a contractually determined discount amount plus Dispensing Fee.

When this Rx Plan is secondary to other coverage, the Allowed Charge will be the amount allowed but not covered by the other plan subject to the coverage provisions of this Rx Plan.

APPROVED CLINICAL TRIAL

The term "Approved Clinical Trial" means a phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other Life Threatening Condition and is one of the following:

A. A federally funded trial that is approved or funded, including in-kind contributions, by one or more of the following entities:

1. the Centers for Disease Control and Prevention;
2. the Agency for Health Care Research and Quality;
3. the Centers for Medicare & Medicaid Services;
4. the National Institutes of Health;
5. the United States Department of Defense;
6. the United States Department of Veterans Affairs;
7. cooperative group or center of any of the above entities;
8. the United States Department of Energy; or
9. a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

B. A clinical trial conducted under an FDA investigational new drug application; or

C. A drug trial that is exempt from the requirement of an FDA investigational new drug application.

AVERAGE WHOLESALE PRICE

Average Wholesale Price ("AWP") is a nationally tracked pricing index provided to the PBM by Medi-Span, or such other nationally available reporting service of pharmaceutical prices as recommended by the PBM. AWP is the list price charged by wholesalers in the United States for the drug products they sell to a Pharmacy.

BRAND (BRAND-NAME) MEDICATION

The term "Brand Medication" or "Brand-name Medication" means a Prescription Medicine identified by the PBM based on criteria provided by nationally recognized source(s) of prescription drug pricing information, as appropriate as a non-generic product, that is also not a Specialty or Orphan Drug. Designations by a manufacturer are not binding on the PBM as to its determination of whether a medication is a Brand Medication.

CLEAN CLAIM

The term "Clean Claim" means a billing for a service and/or supply that is submitted to the Rx Plan by a Covered Person or a Provider that has no defect, impropriety, or special circumstance, including incomplete documentation that delays timely payment. It must clearly identify the Covered Person receiving the services or supplies and the Rx Plan to which it is being submitted and be submitted on an appropriate form that has been properly and entirely completed, including all data elements required by the applicable form. If a claim that has been submitted to this Rx Plan is determined by the Claims Administrator or Plan Administrator to not constitute a Clean Claim, the Covered Person and/or the Provider will be notified of the defects, and it will not be considered to have been received by the Rx Plan until all required information is received.

COMPOUND MEDICATION

Compound Medication is a medication mixed for a specific patient and not available commercially. To be eligible for reimbursement, claims for compounds must meet the PBM's requirements, including without limitation, they must list the 11-digit National Drug Code for each ingredient used in the compound.

CO-INSURANCE

The term "Co-Insurance" means a percentage of the Covered Expenses that the Covered Person must pay before the Prescription Drug Plan pays benefits for a particular service or supply.

CO-PAYMENT

The term "Co-Payment" (or "Copay") means a specific dollar amount, of the Covered Expenses that the Covered Person must pay before the Prescription Drug Plan pays benefits for a particular service or supply.

COVERED DRUG, MEDICINE OR SUPPLY

A Covered Drug, Medicine or Supply is any Prescription Drug or Prescription Medicine, related supplies, other pharmaceutical products, services or supplies dispensed by a Pharmacy to a Participant for which coverage is provided in accordance with this Program and which are Covered and payable under the terms of this Rx Plan. See Section 4.3, Rx Plan Benefit Information.

COVERED EXPENSES

The term "Covered Expenses" means expenses incurred by a Covered Person for any Medically Necessary Drugs or Medications that are not specifically excluded from coverage elsewhere in this Plan, or other charges which are specifically listed as covered under this Rx Plan.

COVERED PERSON

A Covered Person is an eligible Employee who is participating in the Rx Plan and their Spouse and/or eligible Dependents also covered by the Rx Plan, in accordance with the terms of the Rx Plan. Covered Persons are also referred to as "you" or "Participant" within this document.

CUSTOMARY

See "Usual, Customary and Reasonable" below.

DEDUCTIBLE

The term "Deductible" means the amount a Covered Person must pay before any benefits will be paid by the Prescription Drug Plan, unless the Deductible is specifically waived. The Deductible applies to the Out-of-Pocket Maximum under the Prescription Drug Plan.

DENIAL

The term "Denial" means the adverse determination of a Prior Authorization request or a submitted Claim.

DISPENSE AS WRITTEN

Dispense As Written is an order by the Prescriber that is to be followed and generally involves dispensing a Brand-name Drug when a Generic Drug is available. If you or your Prescriber chooses not to substitute a Generic Drug for the Brand-name Drug, you may have to pay an additional amount, and/or you may be charged the Brand-name Co-Insurance or Co-Payment amount, but only receive credit on the deductible for the generic Co-Insurance or Co-Payment amount. Any special rules for Dispense as Written are stated in Exhibit A.

DISPENSING FEE

Dispensing Fee is a fee charged by a Pharmacy to cover costs associated with dispensing a medication.

DRUG

"Drug" refers to a prescription drug or medication. See "Medication" below.

DRUG LIST

A "Drug List" or "Formulary" or "Formulary Medication" all mean a Medication or Drug or other pharmaceutical product, service or supply set forth on a Formulary Drug List (or just "Drug List") provided by the PBM. This list is updated and revised by the PBM from time to time under the terms of this Rx Plan to include new drugs, generic equivalents and drugs removed from the market or made available over the counter. A current version of the Drug List or Formulary may be found at the PBM's website as indicated in the PBM Data Sheet and is the listing of Drugs and Medications and related services that are generally covered.

EMPLOYEE

"Employee" refers to an eligible Employee of the Plan Sponsor or a participating Employer under the Rx Plan and such status is determined by the Plan Administrator in its sole and absolute discretion.

EXPERIMENTAL OR INVESTIGATIVE

Medications, Drugs, supplies or therapies that are determined by the Rx Plan to be: (1) not approved by the U.S. Food and Drug Administration ("FDA") to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopeia Dispensing Information as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase I, II, or III Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

FDA

The term "FDA" means the United States Food and Drug Administration.

FORMULARY OR FORMULARY MEDICATION

The Term "Formulary" or "Formulary Medication" or "Drug List" all mean a Medication or Drug or other pharmaceutical product, service or supply set forth on a Formulary Drug List (or just "Drug List") provided by the PBM. This list is updated and revised by the PBM from time to time under the terms of this Rx Plan to include new drugs, generic equivalents and drugs removed from the market or made available over the counter. A current version of the Formulary may be found at the PBM's website as indicated in the PBM Data Sheet.

GENERIC

The term "Generic" refers to a Drug or Medication that is not a Brand-name Medication, is a non-Specialty Medication and is chemically equivalent to a Brand or Brand-name Medication on which a patent has expired. Generic drugs are identified by the PBM based on criteria provided by nationally recognized source(s) of prescription drug pricing information, as deemed appropriate by the PBM.

ILLNESS

The term "Illness" means Sickness, disease, or pregnancy. Sickness refers to any physical illness, disease or Pregnancy. Sickness also includes mental illness and substance-related and addictive disorder, regardless of the cause or origin of the mental illness or substance-related and addictive disorder.

INJECTABLE DRUG LIST

An Injectable Drug List may be provided by a PBM and includes injectable medications covered under this Rx Plan that are intended to be self-administered by the Covered Employee or Dependent and/or a family member as well as some injectable drugs that may need to be administered by a medical professional. The cost to inject these Prescription Drugs is not covered under this Rx Plan. Coverage is limited to those medications that have been designated by the Rx Plan. This list is subject to periodic review and modification.

INJURY

The term "Injury" means bodily damage or loss sustained by a Covered Person which requires treatment by a Physician, and is incurred by a Covered Person on or after the date of coverage under this Prescription Drug Plan, excluding any condition arising from an occupational Injury.

LIFE THREATENING CONDITION

The term "Life Threatening Condition" means any disease or condition from which the likelihood of death is probable, unless the course of the disease or condition is interrupted.

LIFETIME

The term "Lifetime" is a word used in the Plan in reference to benefit maximums and limitations. The term "Lifetime" means the total time period of a Covered Person's coverage under this Plan, regardless of the number of breaks in that coverage. Under no circumstances does the term "Lifetime" mean the duration of a Covered Person's life.

MAIL ORDER PHARMACY

Mail Order Pharmacy is a Pharmacy related to the PBM that dispenses longer term supplies of certain Maintenance Medications to you.

MAINTENANCE MEDICATION

A "Maintenance Medication" is a medication used for long periods of time to treat chronic conditions, for example, insulin or hypertension medications.

MAXIMUM ALLOWABLE COST

Maximum Allowable Cost List – a list of Prescription Drugs that will be covered at a price level that the PBM has established as a maximum amount that it will pay for such Prescription Drug.

MEDICALLY NECESSARY

All Prescription Medications paid for under the Rx Plan must be Medically Necessary, which means that they are provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, Injury, mental illness, substance-related and addictive disorder, or disease (and symptoms), that meet the following requirements:

A. provided in accordance with Generally Accepted Standards of Medical Practice in the United States (see definition below);
B. clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, Injury, mental illness, substance-related and addictive disorder, or disease (and symptoms);
C. not primarily for the convenience, personal preference, or appearance of the Participant or their Physician or Other Provider; and
D. not Experimental or Investigative Services in nature at the time the Drugs are provided.

For this purpose, the term "Generally Accepted Standards of Medical Practice" are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled Clinical Trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the health care services and positive health outcomes. If the PBM determines in its discretion that no credible scientific evidence is available, then standards based on Physician specialty society recommendations or professional standards of care may be considered. The PBM may consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the PBM's sole discretion. In addition, the PBM may develop and maintain clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines or the PBM's own standards to support its determinations regarding specific covered Prescription Drugs or related services.

MEDICINE or MEDICATION

The term "Medicine or Medication" (or "Drug") means a substance or preparation that alleviates or treats an Illness or Injury and may be available by Prescription only, or over-the-counter (OTC). Medicines and Medications include only substances and preparations that qualify as medical care under Section 213 of the Internal Revenue Code. In general, medical care means care for the diagnosis, cure, mitigation, treatment, or prevention of disease or for the purpose of affecting any structure or function of the body.

NETWORK PHARMACY

A Network Pharmacy is a Pharmacy that has entered into an agreement with the PBM, or an organization contracting on its behalf, to provide Prescription Drugs to Participants, which has agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and has been designated by your PBM as a Network Pharmacy. Some PBMs may not apply a Network or have open Networks. See the PBM's information and website for more information.

NON-NETWORK PHARMACY

Any Pharmacy that is not in any designated Network is a Non-Network Pharmacy and the PBM will provide any rules and restrictions on the use of a Non-Network Pharmacy. When a Pharmacy is a Non-Network Pharmacy, there may be no reimbursement, or the PBM will pay out at a UCR or predominant reimbursement rate as the PBM determines in its sole and absolute discretion. The PBM may reimburse you after you have fully paid the amount. See also Exhibits A and C for any rules.

NON-PREFERRED MEDICATION

The Term "Non-Preferred Medication" means medication not included on any Formulary or list of preferred prescriptions under this Prescription Drug Plan. Non-Preferred Medications often have higher Co-Payments or Co-Insurance than preferred Medications.

NON-PRESCRIPTION MEDICATION

The term "Non-prescription Medication" means an over-the-counter (OTC) Medication or supply, normally purchased without a prescription and which is pre-packaged for use by the consumer and labeled in accordance with the requirement, statutes, and regulations of federal and applicable state governmental authorities.

ORPHAN DISEASE

The term "Orphan Disease" means a condition that affects fewer than 200,000 people nationwide. This includes diseases as familiar as cystic fibrosis, Lou Gehrig's disease, and Tourette's syndrome, and as unfamiliar as Hamburger disease, Job syndrome, and acromegaly, or "gigantism."

ORPHAN DRUG

The term "Orphan Drug" means a pharmaceutical agent that has been developed specifically to treat an Orphan Disease or other rare medical condition, and for purposes of this definition, the drug must also be included on the PBM Specialty Drug List. There are some drugs that are designated as an "Orphan Drug" but are not included on the PBM Specialty Drug List and are therefore excluded from the Plan.

OUT-OF-POCKET

The term "Out-of-Pocket" means the amount of expenses, including Deductibles, Co-Payment and Co-Insurances that are the responsibility of the Covered Person and that accumulate towards the Rx Plan's Out-of-Pocket Maximum, which is the amount listed in Exhibit A, not including amounts for:

A. expenses that are not covered under this Plan;
B. in excess of the UCR for a Prescription Medication, service or supply;
C. in excess of any maximum benefit listed in the Plan; or
D. attributable to any penalty, including any Dispense as Written penalty.

PATIENT ADVOCACY AND PATIENT ASSISTANCE PROGRAMS

Patient Advocacy and Patient Assistance Programs may be part of the Rx Plan or separate from the Rx Plan as indicated in the Exhibits. Patient Advocacy involves a third party that assists individuals in obtaining Prescription Drugs that are often excluded from the Rx Plan and in such case, the Patient Advocacy Program is not part of the Rx Plan. Patient Advocacy and Patient Assistance Programs may also work to obtain financial assistance for individuals to augment the coverages provided under the Rx Plan. In such case, amounts paid through any Patient Advocacy or Patient Assistance Programs may or may not count toward meeting Plan Deductibles or Out-Of-Pocket Maximums. This will also be indicated in Exhibit A. Patient Assistance Programs may include copay cards, coupons and other such manufacturer sponsored assistance programs. Again see, Exhibit A for the indicator of whether or not such program exists under the Rx Plan, and its impact.

PHARMACIST

The term "Pharmacist" means a professional who is licensed under the applicable state and federal law to fill and dispense Prescriptions.

PHARMACY AND PARTICIPATING PHARMACY

A Pharmacy is a licensed provider authorized to prepare and dispense Drugs and Medications. A Pharmacy must have a National Association of Boards of Pharmacy identification number. A "Participating Pharmacy" is another term that describes a Network Pharmacy that contracts with the PBM. Participating or Network Pharmacies may be found through the PBM's pharmacy locator information at the PBM's website. See Section 4.1 and Exhibit A for more information.

PHYSICIAN

The term "Physician" means A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Acupuncturist, Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.O.), Pharmacist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist, Nutritionist/Dietician and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of their license.

POST-SERVICE CLAIM

The term "Post-Service Claim" means a Claim with respect to which the Covered Person has received the Medication and is requesting reimbursement, and which is not a Pre-Service Claim or an Urgent Care Claim.

PREFERRED DRUG

The PBM's Preferred Drug List is a list of Generic and Brand Medications that your Prescription Drug Plan covers as amended by the PBM from time to time. This list excludes Specialty Drugs. This may generally be referred to or be part of an approved Formulary, or may be the entire listing or entire Formulary. See information on the Preferred Drug Lists and Formularies that apply in Exhibit A. Such Preferred Drug list is subject to periodic review and modification. The Preferred Drug List is available at the PBM's website, see Section 4.1 and Exhibit A.

PRESCRIBER

The term "Prescriber" means a Physician or other health care practitioner licensed or authorized by law to issue an order for a Prescription Medicine. Prescribers may include other professionals who are licensed to prescribe Prescription Medicines, and the PBM will determine in its discretion which Prescribers have rights to be Prescribers and the scope of that capacity.

PRESCRIPTION

Any order authorized by a Prescriber for a Prescription Medicine or a Non-Prescription Medicine that could be a Medication or supply for the Covered Person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the Prescriber prescribing and the name of the Covered Person for whom prescribed. It must also identify the name, strength, quantity, and directions for use of the Medication or supply prescribed.

PRESCRIPTION BENEFIT CARD

The identification card issued by the PBM to Covered Persons who participate in the Prescription Drug Plan.

PRESCRIPTION DRUG

"Prescription Drug" (or "Prescription Medicine") is a Licensed Medicine that is regulated by legislation to require a Prescription before it can be obtained by a Covered Person.

PRESCRIPTION DRUG CHARGE

The "Prescription Drug Charge" is the rate that the PBM has agreed to pay its Network Pharmacies, including the applicable Dispensing Fee and any applicable sales tax, for a Prescription Medicine dispensed at a Network Pharmacy under the terms of this Rx Plan. The Eligible Employee or Dependent is responsible for paying the lowest of the:

- Applicable Co-Payment or Co-Insurance amount;
- Network Pharmacy's Usual and Customary Charge for the Prescription Drug; or
- Prescription Drug Charge that the PBM agreed to pay the Network Pharmacy.

PRESCRIPTION MEDICINE

"Prescription Medicine" (or "Prescription Drug") is a Licensed Medicine that is regulated by legislation to require a Prescription before it can be obtained by a Covered Person.

PRESCRIPTION ORDER OR REFILL

A Prescription Order or Refill is the written or verbal order from a Prescriber to a Pharmacist for a drug to be dispensed.

PRE-SERVICE CLAIM

A Claim with respect to which receipt of the benefit requires approval in advance of obtaining medical care. Prior Authorization requests are usually Pre-Service.

PRIOR AUTHORIZATION

Prior authorization or pre-authorization, is a requirement that a Covered Person's Physician obtain approval from the PBM of the Rx Plan to prescribe a specific medication or for a Quantity Limit for Prescription Medications for a Covered Person. Prior authorization is based on current medical findings, FDA-approved manufacturer labeling information, and cost and manufacturer rebate arrangements. Without this prior approval, the Rx Plan may not provide coverage, or pay for, the Covered Person's medication.

QUALIFIED INDIVIDUAL

The term "Qualified Individual" means an individual who is properly enrolled in the Rx Plan and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another Life Threatening Condition or disease. To be a Qualified Individual, there is an additional requirement that a determination be made that the individual's participation in the Approved Clinical Trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual.

QUANTITY LIMIT

The PBM and/or Provider may apply limits to the number of units of Prescription Drugs dispensed under their discretion or in accordance with nationally recognized guidelines. If a Prescription Medicine may be dispensed above the Quantity Limit, the Covered Person may be responsible for the entire cost of the Prescription Medication that exceeds the Quantity Limit.

REASONABLE

See Usual, Customary and Reasonable below.

ROUTINE PATIENT COSTS

The term "Routine Patient Costs" means all items and services consistent with the coverage provided under the Plan that is typically covered for a Qualified Individual for treatment of cancer or another Life Threatening Condition or disease who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition, and the Plan is not required under federal law to pay for the following: a) the cost of the investigational item, device or service; b) the cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management; or c) the cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

ROUTINE VACCINES

Routine Vaccines refers to certain scheduled immunizations, and payment for such Vaccines may be subject to guidelines based on age, risk factors, dosage, and frequency determined by the PBM. In general, these include Hepatitis A and Hepatitis B, Herpes Zoster, Human Papilloma Virus (HPV), Influenza (Flu), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis (Tdap), Tetanus, Diphtheria, Varicella. Certain of these Routine Vaccines may be preventive care and if they are, they are covered under the Rx Plan without cost sharing.

SPECIALTY DRUG

The term "Specialty Drug" means certain pharmaceuticals and/or biotech or biological drugs that are high-cost/high technology and are used in the management of chronic or genetic disease, including, but not limited to, injectable, infused or oral Medications, or that otherwise require special handling, dispensing conditions or monitoring, delivered by any means including by purchase at a pharmacy and processed for payment by the pharmacy benefit manager or an Outpatient basis from a provider or facility or purchased directly by the Covered Person. For this purpose, the term "Specialty Drug" means any injectable or non-injectable drug that is on the PBM's list of Specialty Drugs as it determines such list from time to time. Specialty drugs may be found by selecting the appropriate formulary at the PBM's website. See Section 4.1 and Exhibit A.

THERAPEUTICALLY EQUIVALENT

"Therapeutically Equivalent" describes a circumstance in which two or more Prescription Medicines have essentially the same clinical effectiveness and safety characteristics.

TIER

If a Tier structure applies to this Rx Plan, it will be so indicated in Exhibit A. A Tier refers to a level of Co-Payment or Co-Insurance that applies for certain categories of Prescription Medicines or supplies. The Tiers (in some cases there may only be one) are stated in Exhibit A.

UNPROVEN DRUG OR SERVICE

A Drug or other therapy, medication or device that has not been determined to be effective for treatment of a particular Sickness, Injury or other medical condition and/or that has not been shown to have a beneficial effect on health outcomes due to insufficient and/or inadequate clinical evidence, including those from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

USUAL, CUSTOMARY AND REASONABLE

The term "Usual, Customary and Reasonable" or "Reasonable" or "Customary and Reasonable" ("UCR") refers to the designation of a charge in amount and frequency as being appropriate based on the medications, drugs or supplies actually supplied to the Covered Person, but considering other factors. Such factors include industry billing practices for similar items, the true circumstances of a charge that may warrant a lesser or higher charge than the customary charge for the services, supplies or prescription drugs that were, in fact, provided to the Covered Person, geography, and/or fair market value and other factors determined in the sole discretion of the PBM and the Plan Administrator. The PBM and the Plan Administrator, and each of them, have the right to review a provider's records and shall determine, in their absolute discretion, whether or not the charge made by the provider is a UCR charge. Taken into consideration will be additional charges that were attributable to the errors, negligence or inefficiency of the provider, and the PBM or Plan Administrator may consult with medical experts in the related fields to determine whether such charges would be considered UCR within the context in which they were provided. Finally, this Rx Plan never has to pay for anything at a price that is not a fair and market-based price, as determined in the sole and absolute discretion of the PBM and Plan Administrator. UCR is sometimes referred to as "Customary" or "Reasonable" or Usual Customary and Reasonable, which for purposes of this Rx Plan are the same.

SECTION 5: ELIGIBILITY AND EFFECTIVE DATE

5.1 Who Is Eligible for Coverage

In General. The coverage described in this Rx Plan is provided to the Employees of the Employer as detailed in the attached Exhibit A, along with their designated Spouses and their Dependents, as may be applicable. Each of these individuals, the Employee, the Spouse and Dependents (as applicable) is a Covered Person. Existing Employees may be subject to certain open enrollment periods for eligibility or changes in coverages, as determined by the Employer. Other eligibility periods may apply as required by law. Certain Employees or certain Dependents may not be eligible under the Rx Plan and this is reflected in Exhibit A. Employees subject to collective bargaining are only Eligible if the terms of such bargaining agreement provides for their inclusion in the Rx Plan. Leased employees are not covered by the Rx Plan, unless the Employer specifically grants coverage for leased employees through its agreement with any employee leasing company. Independent contractors are not Employees eligible under the Rx Plan.

Requirements. Employees may be required to satisfy certain requirements for eligibility under the Rx Plan. Eligibility for Employees are specified in Exhibit A. In addition, as a condition for coverage to apply, Employees are required to pay the Employee contribution amounts that may be required by the Employer, from time to time, with respect to each of the constituent benefit programs, and must authorize such payments to be made. Also, coverage is conditional upon the Employee providing any required information or completing any required forms. For certain dates and times prior to the effective date of this Rx Plan, Employees and former Employees may be subject to entry dates and eligibility terms that are different and that apply to such prior periods of employment.

Reasonable Determination Periods – Variable Hour, Seasonal and Temporary Employees. When the Rx Plan is tied to a group health plan, as determined by the Plan Administrator, the eligibility rules and regulations for the group health plan will apply to the Rx Plan, including the determination of eligibility for variable hour, part-time, seasonal or temporary Employees. If special rules apply in this regard for the Rx Plan, they are stated in Exhibit C. Similarly, the Plan Administrator will apply reasonable determination periods to determine if Employees and the Employer will apply the measurement period or periods and the stability period or periods as provided for under the group health plan. If special periods apply to the Rx Plan, they will be reflected in Exhibit C. The Employer has discretion to determine the eligibility rules that apply to the Rx Plan consistent with applicable law.

"Spousal Exclusion." If the Spousal Exclusion is indicated in Exhibit A, special rules apply to Spousal coverage under this Plan as stated in this section. When the Spousal Exclusion applies, the Plan generally excludes Spouses of Employees altogether, or excludes Spouses who have Prescription Drug coverage available to them from some other source. If the Spousal Exclusion applies to the Rx Plan, it will be so indicated in Exhibit A. If indicated and the Employee's otherwise eligible Spouse has Other Coverage (as defined below), the Spouse must be enrolled in those other plans and they cannot participate in the Rx Plan.

Available Other Coverage for the Spouse may be determined and confirmed by means of a written statement in a form determined by the Plan Administrator.

If your Spouse's coverage eligibility or participation status changes, you must notify the Plan Administrator, in writing, of this change as soon as possible, but not later than the time period stated in the group health plan, or if not stated there, within five (5) business days after its occurrence, unless the five (5) business days are waived or extended by the Plan Administrator.

"Spousal Limitation." If the Spousal Limitation is indicated in Exhibit A, special rules apply to Spousal coverage under the Rx Plan, as stated in this section. When a Spousal Limitation applies, the Rx Plan generally limits coverage of the Spouse of any Employee, or limits coverage when the Spouse has Prescription Drug coverage available to them from some other source. If the Spousal Limitation applies to the Rx Plan, it will be so indicated in Exhibit A. Under the terms of the Spousal Limitation, if your Spouse has "Other Rx Coverage" (as defined below), your Spouse must be enrolled in such Other Rx Coverage and they cannot be covered by the Rx Plan, unless you pay a Covered Spouse Premium. The Covered Spouse Premium amount is an additional premium or required Employee contribution amount that applies to Spouses who have Other Rx Coverage. Such Covered Spouse Premium amount is periodically determined by the Employer. Such Spousal Coverage may also only be secondary coverage, if this is indicated in Exhibit A.

If the Employee's Spouse has no Other Rx Coverage available, then the Spouse is eligible under the Rx Plan when the Covered Spouse Limitation applies. Available coverage for the Spouse will be determined and confirmed by means of a written statement in a form determined by the Plan Administrator.

If your Spouse's coverage eligibility or participation status changes, you must notify the Plan Administrator, in writing, of this change as soon as possible, but not later than the time period stated in the group health plan, or if not stated there, within five (5) business days after its occurrence, unless the five (5) business days are waived or extended by the Plan Administrator.

Other Definitions: As used herein, the following terms are defined as stated below:

"Dependent" Defined: Except as otherwise specified in Exhibit A, or Exhibit C, "Eligible Dependents" under the Rx Plan include each: (i) Spouse of a Participant; (ii) Eligible Child of a Participant; (iii) other Dependent of a Participant within the meaning of Section 152 of the Internal Revenue Code; and (iv) any other individual who is eligible for coverage as stated in Exhibit A or Exhibit C.

"Spouse" Defined: Except as otherwise specified in Exhibit A, or Exhibit C, a "Spouse" is the legal Spouse of an Eligible Employee as defined by applicable state law, except that such term does not include: (i) a common law spouse unless any and all documentation or registration of the common law marriage required by the Plan Administrator, in its discretion, has been filed with the Plan Administrator; or (ii) a Spouse who is an Employee. In the event that the Spouse is an Employee, the Employer will determine a policy to determine how coverage will apply with respect to the Rx Plan. If common law spouses or domestic partners are covered under the Rx Plan, that will be indicated in Exhibit C. Note that there may be tax consequences for the Employee if common law spouses or domestic partners are covered.

"Child" Defined: Except as otherwise specified in Exhibit A, or Exhibit C, a "Child" is defined as the legally recognized offspring of a Participant, as recognized by the state law where the Employee or other covered person resides. A "child" includes those recognized through a legal adoption process. A "Child" under the Plan does not include a Child who is an Employee. The final determination of a child is subject to the discretion of the Plan Administrator.

"Other Rx Coverage" Defined: "Other Rx Coverage" is coverage that is available to the Spouse from some other source, such as the Spouse's employer, a retiree benefit program, certain governmental benefits, veterans benefits, or otherwise.

5.2 Effective Date of Coverage

Your coverage will become effective as provided in Exhibit A. No benefits are payable unless you are an eligible Employee and have met the requirement to be eligible. Eligibility Entry dates also apply to changes in status. Please note that you must have submitted any required enrollment form, or any other required documentation as determined by the Plan Administrator, in order to obtain coverage under the Rx Plan and such forms must be completed fully and accurately.

SECTION 6: WHEN YOUR COVERAGE WILL END

Subject to your continuation of coverage rights under COBRA (see below for a full explanation of COBRA rights, if it applies to the Employer and the Rx Plan), and subject to any other policy or rule of the Employer or the PBM, your coverage under the Rx Plan will end under the terms of this Section. Unless specified in Exhibit C for special rules on the cessation of your coverage under the Rx Plan, **the coverage of the Employee (and the Employee's Dependents) ends on the termination date of coverage under the group medical plan of the Plan Sponsor**. See Exhibit A for any additional terms.

Common **examples** of events that may result in termination of coverage include, but are not limited to:

- the last day of the calendar month you cease active work;
- your last day of active work;
- your last day of active work immediately preceding the day you are considered as laid off from the Employer;
- your last day of active work immediately preceding the day you are considered as retired from the Employer;
- the day you have a change in employment status that results in your ceasing to meet the then applicable eligibility requirements of the Rx Plan, unless specific terms of leave provided by the Employer otherwise provide for continued eligibility;
- your last day of active work immediately preceding your transfer to an ineligible status;
- any day upon which you fail to authorize or make any employee contribution or other payments required for coverage;
- the day of your death; or
- the day the Plan terminates.

Except as provided in Exhibit A otherwise, there is no severance or retiree coverage under the Plan, whatsoever.

SECTION 7: CLAIMS FOR BENEFITS, BENEFIT DETERMINATION AND CLAIM APPEALS

7.1 Claims for Benefits and Benefit Determinations

Each Covered Person claiming a benefit under the Rx Plan must follow the terms of the Rx Plan and any rules, requirements or guidelines issued by the PBM or the Plan Administrator. Certain PBMs may publish a separate claims and appeals procedure and if so, all Covered Persons must follow that procedure. Details on how and where and when claims and appeals may be filed are provided in the Rx Plan, the PBM Data Sheet or are made available by the PBM on its website. Regardless of any claim procedure otherwise provided, no claim for benefits under this Rx Plan may be made after one (1) year from the date the Claim was incurred. In the event that the PBM does not have or publish a claim and appeal procedure, or if the PBM has a procedure that for purposes of a particular claim or appeal is determined by the Plan Administrator in its sole discretion to be incomplete or not in compliance with current law, or there are any questions or inconsistencies that exist in any PBM procedure, then this claims procedure and procedure for appeals - or a "Review of Denial" will apply.

When the PBM provides a different claim and/or appeal procedure that is not determined by the Plan Administrator to be incomplete or not in compliance with current law, the PBM, not the Plan Administrator, will process and decide such a claim and appeal. On matters that do not directly involve the PBM, the Plan Administrator will process and decide such claim and appeal. When there is a question as to whether the PBM or the Plan Administrator will process and decide a claim and/or appeal, the Plan Administrator in its sole and absolute discretion will determine who will process and decide the claim and/or appeal. This claim and appeal procedure may be applied whenever there does not otherwise exist a PBM established claim and/or appeal procedure.

7.2 Important Terms

Adverse Benefit Determination. An "Adverse Benefit Determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigative or not Medically Necessary or appropriate; and in the case of a plan providing disability benefits, the term "Adverse Benefit Determination" also means any rescission of disability coverage with respect to a Participant or beneficiary (whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or a denial, reduction, or termination of, or a failure to provide or make payment for (in whole or in part), a benefit.

Claim. A "Claim" under the Plan is a request for benefits under the Rx Plan made by a Claimant in accordance with the procedure for filing benefit claims. All Claims must be filed as specified in this Rx Plan. Claim appeals on Adverse Benefit Determinations must be in writing.

Claimant. A "Claimant" is the Rx Plan Covered Person who files a Claim or an Appeal. A personal representative may be authorized to act on behalf of a Claimant. This authorization must be in writing and signed by the Claimant.

Claim File. A "Claim File" means the file or other compilation of "Relevant" information, which includes information that: 1) was relied upon in making the benefit determination; 2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; 3) demonstrates compliance with the administrative processes and safeguards as provided in this procedure, or 4) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Claims Administrator. The "Claims Administrator" for the Rx Plan is the PBM, unless the Plan Administrator has determined that it will handle the claim and/or appeal.

Plan Administrator. The "Plan Administrator" for the Plan is the Employer.

7.3 Claim and Appeal Procedures

In the event that this Claims Procedure applies to a Claim or Appeal, as stated in Section 7.1 above, the following claim and appeal process is to be followed.

a) Initial Claim for Benefits

Filing of Claim. A Claim for benefits under the Rx Plan will be filed, in writing, with the PBM with a copy to the Plan Administrator.

Notice of Denial. If a Claim is for post service, or certain concurrent non-urgent service claims for benefits under the Rx Plan is wholly or partially denied, except as otherwise provided herein, the Plan Administrator or the PBM will, within 30 days after receipt of the Claim, notify the Claimant of the denial of the Claim. Such 30-day period may be extended for no more than an additional 15 days if the Plan Administrator or the PBM determines that an extension of time for processing the Claim is necessary due to matters beyond the control of the Rx Plan, in which case the Plan Administrator or PBM will notify the Claimant of the extension in writing within the initial 30-day period, and such notice of extension will indicate the circumstances requiring the extension and the date by which the Plan Administrator or PBM expects to render its decision.

Urgent Health Claims. Urgent health claims, if applicable, will be decided as soon as possible within 72 hours rather than within 30 days. The 72-hour deadline may not be extended. An urgent health claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Pre-Service Health Claims. Pre-service Health Claims, if applicable, will be decided within 15 days rather than 30 days. The 15-day deadline may be extended by an additional 15 days. A Pre-Service Health Claim is any claim for a benefit with respect to which Plan terms condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

If an extension of time is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded 45 days from receipt of the notice within which to provide the specified information. If the request for information is made after the initial period, then the Plan Administrator or PBM, as applicable, may toll the deadlines stated, until the Claimant submits the requested material.

b) Notice of Denial

A notice of denial will be (a) in writing (or in electronic form); (b) written in a way to be understood by the Claimant; and (c) contain:

- the specific reason or reasons for denial of the claim;
- references to the specific Rx Plan provisions, or PBM rules or programs upon which the denial is based;
- a description of any additional material or information necessary to perfect the Claim and an explanation of why such material or information is necessary;
- an explanation of the claim review procedures and the time limits applicable to such procedures, in accordance with the provisions of this Claim and Appeal Procedures; and
- a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA if the claim is denied upon review.

Special Group Health Plan Rules. In the case of an Adverse Benefit Determination that refers or relates to a group health plan, which depending upon the structure of the Rx Plan, may include the Rx Plan (as determined in the sole and absolute discretion of the Plan Administrator), the determination will include free of charge to the Claimant upon request:

- A copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination.
- If the Adverse Benefit Determination is based on a Medical Necessity or Experimental or Investigative 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 Claimant's medical circumstances.
- In the case of an Adverse Benefit Determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims. All information required to be provided may be done so orally within the time frames stated herein, provided that a written or electronic notice including the required information is furnished to the Claimant not later than 3 days after the oral notification.

c) Appeal of Decision

Request for Review of Denial. The Claimant may, within 180 days after receiving a written notice of denial of the Claim, file a written request with the Plan Administrator or PBM (whichever issued the denial) that it conduct a full and fair review of the denial of the Claim. The Plan Administrator or PBM will:

- provide the Claimant with the opportunity to submit written comments, documents, records and other information relating to the Claim;
- provide the Claimant, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claim;
- effect a review of the denial that takes 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 benefit determination;
- provide a review that (a) does not afford deference to the initial Adverse Benefit Determination, (b) is conducted by a Plan fiduciary (the "reviewing fiduciary") who did not make the Adverse Benefit Determination and who is not the subordinate of the individual who made the Adverse Benefit Determination;
- provide that the reviewing fiduciary will, before deciding an appeal based in whole or in part on a medical judgment, consult with a health care professional having appropriate training and experience, who was not involved with the Adverse Benefit Determination and is not the subordinate of any such individual; and
- provide for the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination (regardless of whether the advice was relied upon).

Decision on Appeal. The Plan Administrator or PBM will deliver to the Claimant a decision in writing (or in electronic form) on the appeal within 60 days after the receipt of the Claimant's request for review, unless the claim category and type is described below.

- Urgent health appeals will be decided within 72 hours rather than 60 days and shall be transmitted by an expeditious method such as telephone or facsimile.
- Pre-service Health Appeals will be decided within 30 days rather than 60 days.
- Disability and other appeals will be decided within 45 days rather than 60 days.

Extensions and Tolling. The 60-day appeal deadline for non-urgent claims and the 45-day deadline for disability claims may be extended by an additional 45 days. In the event that information is requested from the Claimant, and if such a request is made or is pending after the initial deadline period, then the Plan Administrator or PBM may toll the applicable time periods relative to the claim, while waiting for information from the Claimant. Any extension of time sought hereunder is deemed reasonable under the Rx Plan, but the Plan Administrator or PBM will provide a reasonable explanation to the Claimant as to why the extension of time is sought.

d) Final Determination

The Plan Administrator's written decision will:

- be written in a manner calculated to be understood by the Claimant;
- include the specific reason or reasons for the decision and contain references to the specific Plan provisions upon which the decision is based;
- state 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 for benefits; and

- state the Claimant may have a right to bring a civil action under Section 502(a) of ERISA;
- include any internal rule, guideline, protocol, or other similar criterion that was relied upon in an Adverse Benefit Determination, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
- include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request when an Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit; and
- include 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."

Authorized Representative. The Plan Administrator or PBM will permit an authorized representative of the Claimant to act on behalf of the Claimant under this claim and appeal procedure. The Plan Administrator or PBM may establish reasonable procedures for determining whether an individual who purports to be an authorized representative of a Claimant has in fact been authorized to act on behalf of such Claimant.

Culturally and Linguistically Appropriate Notices. Whenever the phrase: "culturally and linguistically appropriate" appears in this claims procedure, the following requirements apply:

- The plan will provide oral language services (such as a telephone customer assistance hotline) that include answering questions in any applicable non-English language and providing assistance with filing claims and appeals in any applicable non-English language.
- The plan will provide, upon request, a notice in any applicable non-English language.
- The plan will include in the English versions of all notices, a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the plan.
- For purposes of these rules, with respect to an address in any United States county to which a notice is sent, a non-English language is an applicable non-English language if ten percent or more of the population residing in the county is literate only in the same non-English language, as determined in guidance published by the Secretary.

Administrative Processes and Safeguards. The Plan Administrator will develop such administrative processes and safeguards as it deems necessary to ensure and verify that claim determinations are made in accordance with the Rx Plan and other governing documents, if any, and that where appropriate, the provisions of the Rx Plan have been applied consistently with respect to similarly situated Claimants.

7.4 External Review (Only Applies to Non-Grandfathered Health Plans)

Voluntary External Review. This is a special default language for a procedure that applies only if the Rx Plan has "non-grandfathered" status, or if it loses grandfathered status. In such a case, a voluntary external review process applies if the Claimant has exhausted the two levels of appeal (when required), and the Claimant is still not satisfied with the final determination. Voluntary external review only applies to the denial of medical, mental health/substance abuse, prescription drug, certain dental, or vision claim denials if the denial is based on one of the following:

1. Clinical reasons based upon medical judgment, including medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or if a treatment is experimental or investigational; or
2. Rescission (retroactive termination) of care.

External review does not apply with respect to claims based upon the eligibility of an Employee, Spouse or Dependent, or with respect to whether a particular claim involves a covered product or service. If you have any questions regarding the external review, you may contact the Plan Administrator or the PBM for more information about whether or not the voluntary external review program is available to you.

Request for External Review. A request for an external review generally must be made within four months following the day that you receive notice of the denial on appeal. Also, you can request an expedited external review as described in Expedited External Review below.

Preliminary Review. Within five business days of receiving your request for external review, the Plan Administrator will complete a preliminary review, which determines:

1. if you were covered under the Rx Plan at the time of service;
2. that the review does not relate to your eligibility to participate in the Rx Plan;
3. that your review meets the criteria for external review stated above; and
4. that you completed the Rx Plan's internal appeals process to the extent required, and that you have provided all necessary information and forms for processing an external review.

You are not eligible for an external review if the Claims Administrator determines that you have not met all of the above requirements. Within one business day after the initial review of your request, the Rx Plan or Claims Administrator may provide you with a notice that includes the reasons your request does not meet the requirements for an external review and contact information for the Employee Benefits Security Administration of the U.S. Department of Labor. The notice will describe information or materials needed to complete your request, if applicable.

Your deadline to complete the request is the end of the four-month period described above or, if later, 48 hours after you receive the notice that the request was not complete. If your request is expedited, the Plan Administrator or PBM will immediately consider the above criteria and notify you of the determination as described in Expedited External Review below.

External Review by an Independent Review Organization (IRO). If your request qualifies for external review, it will be assigned to one of the qualified Independent Reviewer Organizations (IRO) with which the Plan Administrator or PBM has a contract. Within five business days after assigning the request to the IRO, the Plan Administrator or PBM will provide the IRO with the documents and information that were considered in the denial. If the Plan Administrator or PBM does not provide this information, the IRO may end the external review and reverse the Plan Administrator's or PBM's decision. If this occurs, the IRO will notify you and the Plan Administrator or PBM within one business day of this action.

The IRO will give you written notice of the request's acceptance for external review. The notice will include a statement that you have 10 business days to submit additional written information. The IRO will consider this information in its review. The IRO also may agree to consider additional information submitted after 10 business days. Within one business day after receiving additional information from you, the IRO will forward the information to the Plan Administrator or PBM, which may reconsider the denial on appeal based on this additional information. If the Plan Administrator or PBM decides to reverse the denial on appeal and provide coverage or payment, written notice will be provided to you and to the IRO within one business day of the decision. The IRO's external review will end if this notice is received.

If the Plan Administrator or PBM does not provide any notice of reversal of the decision, the IRO will review all information and documents submitted by the deadline. The IRO must review each claim without being bound by or subordinate to any decisions or conclusions reached during the entire prior claims and appeals process.

In addition to the documents and information provided by you and the Plan Administrator or PBM, the IRO will consider the following information or documents if they are available and the IRO considers them appropriate:

1. Your medical records;
2. Your attending health care professional's recommendation, reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider;
3. Plan terms, unless the terms are inconsistent with applicable law;
4. Appropriate practice guidelines, which include applicable evidence-based standards;
5. Any applicable clinical review criteria developed and used by the Administrator involved, unless the criteria are inconsistent with Rx Plan terms or applicable law; and
6. The opinion of the IRO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The IRO will provide written notice of the decision to you and the Plan Administrator or PBM involved within 45 days after the IRO receives your request. This notice may contain, if relevant:

1. A general description of the reason for the request and information that identifies the claim such as the date(s) of service, health care provider, and claim amount (if applicable);
2. A statement describing the availability, upon request, of the diagnosis code and/or treatment code (and their corresponding meanings);
3. The reason for the prior denial;
4. The date the IRO received the request and the date of the decision;
5. References to the evidence or documents (including the specific coverage provisions and evidence-based standards) considered in reaching the decision;
6. A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
7. A statement that the IRO's determination is binding, unless other remedies are available under state or federal law;
8. A statement that judicial review may be available to you; and
9. The phone number and other current contact information for any applicable office of health insurance consumer assistance or ombudsmen.

If the Plan Administrator or PBM receives notice from the IRO that reverses a denial, the Plan Administrator or PBM, as applicable, will immediately provide or authorize coverage for or payment of the claim. The IRO will maintain records of all claims and notices associated with the outside review process for six years and make these records available for examination by you, the Plan Administrator or PBM, or a state or federal oversight agency upon request (except where disclosure would violate state or federal privacy laws).

Expedited External Review. An urgent care claim or urgent health appeal is determined as such by the attending provider. In such case, for notification of the Rx Plan's benefit determination (whether adverse or not) must be completed as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

7.5 Time Limit to Appeal Denial of a Claim Will Be Strictly Enforced

The time limits for a Claimant to file an appeal after an initial denial of a Claim for benefits and to file a final appeal will be strictly enforced. If a Claim is initially denied and the Claimant does not request a review within the time limit after receipt of that determination, the Claimant will forever forfeit their right to request a review of this determination.

If a Claimant does not make an appeal within the time limit after receipt of the initial denial, the Claimant will forever forfeit their right to final appeal.

The Plan Administrator or PBM, as applicable, may at all times, consistent with the applicable regulations, toll the timing of any claim or appeal, or may extend the deadlines of such claim or appeal process, if the Plan Administrator or PBM (as applicable) determines in their sole discretion that such toll or extension is reasonable under the circumstances.

If a Claimant does not make a final appeal within the time limit after a determination, the Claimant will lose their right to file an action in federal or state court, because the Claimant will not have exhausted their administrative remedies.

7.6 Exhaustion, Process and Correction of De Minimis Process Matters

In the event that during the claim or appeal process, either the Rx Plan or the Claimant fails to strictly follow the requirements of the claim or appeal procedure, the affected party shall notify the other in writing and provide for a reasonable opportunity to cure the failure. Any failure of process deemed de minimis, or not, that may be corrected so that there is no prejudice or harm to the Claimant, determined to have occurred by good cause, or beyond the control of the Rx Plan or the Claimant where such violation occurred in the context of an ongoing good faith exchange of information, will be corrected and such correction will be deemed a complete correction of any process defect and not an exhaustion of remedies.

In the event that the Plan or Claimant believes that a defect in process has occurred, the affected party shall notify the other in writing. A response to such assertion shall be provided in 10 days from the date of receipt and such response shall include a specific description of its bases, if any, for asserting that the violation should not cause the administrative remedies available under the Rx Plan to be deemed exhausted, and may include the corrective actions taken.

7.7 One Year Limit to File a Legal Action, Assignment

If the Plan Administrator or PBM denies a Claim on appeal, the Claimant has the right to file suit in federal court under ERISA Section 502(a). However, no legal action for recovery of benefits allegedly due under the Rx Plan may be commenced by or on behalf of a Claimant against the Rx Plan, the Plan Administrator or any other Plan fiduciary, PBM or other Third Party Administrator unless it is filed within one year after the date of the final determination by the Plan Administrator or the PBM, as applicable, under the Claims Appeal Procedure described herein.

No rights under this Plan may be assigned, unless such assignment is specifically permitted.

SECTION 8: RIGHTS OF REIMBURSEMENT AND SUBROGATION

If the Employer pays benefits under the Rx Plan which are the result of an event: (a) caused by the act or omission of another party; or (b) sustained on the property of a third party which has premises or other liability insurance available, the Employer, or the PBM on behalf of the Employer, has the right to recover benefit payments made under the Rx Plan. Reimbursement means that the Employee must repay the Employer at the time the Employee makes any recovery. "Recovery" means all amounts received by the Employee from any persons, organizations, or insurers by way of settlement, judgment, award or otherwise on account of such injury or illness. The right of subrogation means that the Employer, or the PBM or other third party acting on behalf of the Employer, may make a claim in the name of the Employee or in the name of the Employer or Plan Administrator, as applicable, against any persons, organizations or insurers on account of such injury or illness.

The rights of reimbursement and subrogation apply whether or not the Employee has been fully compensated for the Employee's losses or damages by any recovery of payments. In the event the Employee settles a claim against a third party, the Employee is deemed to have been made whole by such settlement and the Employer, or the PBM or other third party acting on behalf of the Employer, will be entitled to immediately collect the present value of its subrogation rights as the first priority claim from said settlement or judgment. The Employer and the Rx Plan and each of them are entitled to the first dollars recovered. No attorney's fees will be payable from any subrogation recovery unless the Plan Administrator has been notified of the attorney's proposed representation in advance and the Plan Administrator has agreed in writing to the representation of the Employer's interests by that attorney. Under certain circumstances, the Employee will be required to hold the Employer, the Rx Plan and the Plan Administrator harmless against future benefit payments due to the injury or illness for which a settlement is reached.

This right of reimbursement and subrogation applies to any type of recovery from any third party, including but not limited to recoveries from tortfeasors, underinsured motorist coverage, uninsured motorist coverage, other substitute coverage or any other right of recovery, whether based on tort, contract, equity or any other theory of recovery. Any amounts the Employee or the Employee's attorney receives from such a recovery must be held in trust for the benefit of the Employer, the Rx Plan and/or the Plan Administrator to the extent of the subrogation claim. Any amounts received in this regard, even if maintained in an attorney's trust account, or otherwise, shall be deemed held in trust or in a constructive trust for the benefit of the Rx Plan, and the Employer that funds the benefits under the Rx Plan, and the Plan Administrator in regard to the recovery of benefits under this Rx Plan.

By filing a Claim for benefits under the Plan, the Employee must cooperate fully in every effort by the Plan Administrator (or the Employer) and/or the PBM, or any other third party acting on behalf of the Rx Plan or the Plan Administrator or the PBM, to enforce the rights of reimbursement and subrogation under this Rx Plan in favor of the Employer, Plan Administrator and/or the PBM. The Employee must not do anything to interfere with those rights and must support such rights of reimbursement and subrogation. The Rx Plan, Plan Administrator and the PBM, and each of them, have the right to discontinue the payment of benefits under the Rx Plan in the event that the Employee fails to cooperate and to seek reimbursement from the Employee for the amount of benefits paid due to that injury or illness, and to seek all legal and equitable remedies to recover amounts owed. The Employee agrees to promptly inform the Plan Administrator, in writing, of any situation or circumstance which may allow it to invoke the rights of reimbursement and subrogation under this section.

SECTION 9: ACCESS TO RECORDS

By filing a Claim for benefits under the Rx Plan, each Eligible Employee, Spouse and Dependent authorizes the Plan Administrator and the PBM, and their representatives (collectively the "Administrators") to access any records, health records or medical information held by any health care provider and employment information held by any employer. Authorization applies to the Administrators' use and disclosure of health records, medical information and employment information for claims evaluation and processing including, without limitation, claims by the Rx Plan, the Employer or the PBM for reimbursement or subrogation under the Rx Plan; evaluation of potential or actual claims against the Administrators, and any other matter in respect of payment of claims under the Rx Plan.

Any person filing a claim under the Rx Plan may be asked to complete an authorization under HIPAA for such purpose and the payment of claims may only be made if authorization is permitted. Such authorization is deemed part of the claim process. See Section 14.2 below.

SECTION 10: RECOVERY OF BENEFITS

If any benefit payments are made in excess of the amount any Covered Person receives under the Rx Plan, the Rx Plan, the Plan Administrator and the PBM, and each of them, have a right to recover such payments. Such instances of overpayment may include erroneous payments; any payments made for any periods or events for which the Covered Person fails to satisfy the Rx Plan or PBM rules or requirements; or any payments that are not reduced by amounts as specified in the Rx Plan or under PBM rules or requirements. When any circumstance arises where payments are made under the Rx Plan in excess of the amount that the Covered Person is entitled to receive, the Rx Plan, the Plan Administrator and the PBM, and each of them, have the right to recover all excess payments of any amounts, from any source, regardless of whether it is related to the Employee, Spouse or Dependent. All excess payments will be recovered directly from the recipient, or if necessary, from future benefit payments, or from the estate or other assets of the Covered Person who received the overpayment, to the extent permitted by law. In this regard, the Covered Person who received an overpaid benefit agrees to cooperate fully with the collection and return of any excess benefit payments, and the location where any excess payments were deposited or held is deemed a trust or constructive trust for purposes of the recovery of overpaid amounts. This includes any bank account, trust account, investment account or otherwise and the Rx Plan has an interest in such amounts for purposes of such recovery.

SECTION 11: COBRA

11.1 Introduction, Default Language and Use

Section 11 provides for continuing, extended health coverage, to the extent that the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") applies with respect to this Rx Plan sponsored by the Employer.

In general, COBRA coverage only applies to extend health coverage for employer sponsored group health plans, which may include this Rx Plan, when such Employer generally employs more than 20 Employees during the relevant testing period. If the Employer is a smaller company, it may not be subject to COBRA, and this Section 11 only applies if the Employer is legally required to provide COBRA coverage.

COBRA coverage applies if a "Qualified Beneficiary" (as defined below) loses their coverage under this Rx Plan as a group health plan or part of a group health plan and coverage is lost as a result of a "Qualifying Event" (as defined below). In such case the Qualified Beneficiary has the opportunity to continue health coverage for up to 18, 29, or 36 months (the time limit depends on the reason coverage ended as described below). The benefit programs under the Plan that are "group health plans" for purposes of COBRA coverage are any group health or medical plans providing inpatient and outpatient hospital care, physician care, surgery and other major medical benefits, prescription drug coverage, dental and vision care, and would include health savings or health reimbursement accounts that provide for the reimbursement of such items.

11.2 Qualified Beneficiaries

You and any of your Eligible Dependents who are covered by the Rx Plan on the day before coverage would otherwise end are known as "Qualified Beneficiaries." A "Qualified Beneficiary" also includes (1) any child who is born to or placed for adoption with you during your COBRA coverage period and (2) any individual who is not covered by the Rx Plan on the day before coverage would otherwise end if such individual's lack of coverage is solely the result of a violation of applicable law.

11.3 Qualifying Events

If your Eligible Dependent is a Qualified Beneficiary and loses coverage as a result of any of the following events, those events are considered "Qualifying Events" entitling that Qualified Beneficiary to COBRA coverage:

- Termination of your employment (other than by reason of gross misconduct, as determined by the Employer), including retirement;
- Reduction in your scheduled work hours;

- Your death while covered under the group health plan;
- Your divorce or legal separation from your Spouse while covered under the group health plan;
- Your Eligible Child's termination of "Eligible Dependent" status under the terms of the group health plan (because of, for example, attainment of age); or
- Your becoming entitled to Medicare.

COBRA coverage may also be available if the Employer files for bankruptcy and you and your Eligible Dependents lose coverage under a retiree medical program maintained by the Employer. In the event of such a "Qualifying Event," the Plan Administrator (or its designee) will notify you of your election rights.

11.4 Required Notice of Qualifying Event

If the Qualifying Event is divorce, legal separation, or loss of dependent status, you or your Eligible Dependent must notify the Plan Administrator, in writing, within 60 days of the later of (1) such Qualifying Event or (2) the resulting loss of health coverage. ***If you or your Eligible Dependent fail to notify the Plan Administrator within this 60-day period, the right to COBRA coverage will be lost.***

If the Qualifying Event is your termination of employment, reduction in hours, death, or entitlement to Medicare, or if the Plan Administrator is notified of a Qualifying Event described in the previous paragraph, the Plan Administrator will notify each Qualified Beneficiary of the right to continue coverage. Your duty to elect COBRA coverage, if you desire such coverage, does not arise until the Plan Administrator sends such notice.

11.5 Election of COBRA Coverage

Once the Plan Administrator is notified regarding the Qualifying Event, an event notification letter and a COBRA enrollment form will be sent to the last known address of each Qualified Beneficiary. *Please notify the Plan Administrator (or COBRA Administrator, if applicable) of all address changes.* If you desire COBRA coverage, you must return the properly completed enrollment form to the Plan Administrator no later than 60 days from the later of: (1) the date coverage is lost due to the Qualifying Event; or (2) the date you received notification (the "60-day COBRA Election Period"). Each Qualified Beneficiary has a separate election right and may choose to continue single coverage for himself or herself. The Plan Administrator will not be responsible for the receipt of COBRA forms sent by regular U.S. mail. ***If you do not elect COBRA coverage within this 60-day period, your right to elect COBRA coverage will be lost.***

11.6 Rights and Obligations of COBRA-Covered Qualified Beneficiaries

A Qualified Beneficiary who elects COBRA coverage has the same rights and obligations under the terms of the Rx Plan as those provided to Participants, including the right to enroll family members who would qualify as Eligible Dependents.

11.7 Cost of COBRA Coverage

You will be charged a COBRA premium equal to the full cost (as determined by the Plan Administrator) of your COBRA coverage, plus a 2% administration fee. Since coverage is retroactive to the date of the Qualifying Event, you will be required to pay for coverage that is retroactive to the date of the Qualifying Event. This premium must be paid within 45 days after your COBRA enrollment form is received. Additionally, in accordance with normal insurance billing procedures, you will be required to pay the next month's premium. This initial payment and all subsequent monthly premium payments must be paid in a timely manner. ***If any COBRA premiums are not paid within the required time periods, coverage will be terminated. Once terminated, COBRA coverage cannot be reinstated.***

11.8 Maximum Length of COBRA Coverage

If the Qualifying Event is termination of your employment or reduction in your scheduled work hours, the maximum length of COBRA coverage for you and your Dependent Qualified Beneficiaries is 18 months.

If the Qualifying Event is your death, divorce from your Spouse, termination of an Eligible Child's Eligible Dependent status, or your becoming entitled to Medicare, the maximum length of COBRA coverage for your Dependent Qualified Beneficiaries is 36 months.

If you become entitled to Medicare before your termination of employment or reduction of hours, and you elect Medicare coverage, your Eligible Dependents who are Qualified Beneficiaries, if any, may elect to continue coverage for the greater of 36 months from the date you become entitled to Medicare or 18 months from the date of your termination or reduction in hours.

Special Length of Coverage Rule for Disabled Qualified Beneficiaries

The maximum period of COBRA coverage available at termination of employment or reduction of work hours is increased from 18 months to 29 months with respect to individuals who are disabled at the time of such a Qualifying Event. The extended coverage period is available if the disabled Qualified Beneficiary:

- Is determined to have been disabled under Title II or XVI of the Social Security Act, for Social Security purposes, at any time during the first 60 days of COBRA coverage; and
- Gives the Plan Administrator notice of such determination, in writing, no later than 60 days after the date of the notice by Social Security of its determination of disability and before the end of the 18-month COBRA continuation period.

Family members who are Qualified Beneficiaries and are not disabled during the first 60 days of COBRA coverage, but who elect COBRA coverage along with the disabled Qualified Beneficiary, may also extend their periods of coverage from 18 months to 29 months.

Extension of Period of Coverage for Secondary Qualifying Events

If your Eligible Dependent is covered under COBRA due to your termination of employment or reduction in hours and a second Qualifying Event occurs that is a death, divorce or legal separation, loss of dependent status, or entitlement to Medicare, that Eligible Dependent may receive up to an additional 18 months of coverage (for a total of 36 months). You or your Eligible Dependent must notify the Plan Administrator within 60 days of the second event. ***If you or your Eligible Dependent fail to notify the Plan Administrator within this 60-day period, the right to extend coverage for an additional 18 months will be lost.***

11.9 Termination of COBRA Coverage

The COBRA coverage period ends when the first of the following events occurs:

- The last day of the 18-, 29-, or 36-month maximum period (described above), as applicable;
- The Qualified Beneficiary's COBRA premium is not paid in a timely manner (and note that COBRA coverage ends the last day of the month for which a timely payment is made);
- After electing COBRA coverage, the Qualified Beneficiary becomes covered under another group health plan, which does not contain an exclusion or limitation for any pre-existing condition that affects the Qualified Beneficiary or their Dependent(s) after taking into account any creditable coverage of the Qualified Beneficiary;
- The Qualified Beneficiary becomes entitled to Medicare benefits after electing COBRA coverage; or
- If coverage was extended due to disability, a determination that the disabled Qualified Beneficiary is no longer disabled (such disabled Qualified Beneficiary must notify the Plan Administrator within 30 days of such determination, and COBRA coverage ends as of the later of (1) the month that begins more than 30 days after a final determination is made, or (2) the end of the original 18-month COBRA coverage period).

As soon as administratively practicable after a Qualified Beneficiary's COBRA coverage terminates, the Plan Administrator will provide such Qualified Beneficiary with notice of such termination and the effective date thereof.

SECTION 12: QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

If you must provide health care coverage to a Dependent child under a QMCSO from a court, then you must request coverage for the child in writing within 31 days of the date of the order. Other court orders may be covered by this Rx Plan as well. The Plan Administrator has sole and absolute discretion to determine whether any QMCSO is valid and binding upon the Rx Plan and how such QMCSO applies to benefits under the Rx Plan. If any eligible person has questions, they should contact the Plan Administrator.

SECTION 13: NOTICE INFORMATION

13.1 General Notices

Notices in General. There are a number of related and additional notices that apply to the Rx Plan and any related health and welfare and or group health plan that is offered along with the Rx Plan. Such notices may be contained in other notices and information provided to the Employee and Covered Persons. These notices are incorporated by reference. If you do not have, or do not have access to notices and other information you should see the Plan Administrator, or Human Resources representative to obtain a copy.

Medicaid and Children's Health Insurance Program - ("CHIP"). (Free or Low-Cost Health Coverage for Children and Families that may apply). For Eligible Employees who are Participants and are eligible for health coverage under the Rx Plan, but are unable to afford the Employee portion of the total cost (sometimes referred to as the employee premium), some states have premium assistance programs that Participants may access to help pay for coverage. Certain states use funds from their Medicaid or CHIP programs to help people who are eligible for health coverage provided by employers, but need assistance in paying their health premiums.

For those Employees who are already enrolled in Medicaid or CHIP, or have Dependents so enrolled, they can contact the applicable State Medicaid or CHIP office to find out if premium assistance is available. If covered Dependents are not currently enrolled in Medicaid or CHIP, they can contact the State Medicaid or CHIP office, or dial 1-877- KIDS-NOW, or go to www.insurekidsnow.gov to find out how to apply for this premium assistance. If one qualifies, the program in the state where the individual resides will provide information as to whether it has a program that might help pay the premiums toward the Employee portion payable for coverage under the Rx Plan. Once it is determined that the Eligible Employee or Dependent is eligible for premium assistance under Medicaid or CHIP, this Rx Plan will permit such Eligible Employee or Dependent to enroll, as long as such persons are eligible, and not already enrolled. This is a special enrollment period for such individuals. Such individuals must request coverage within 60 days of being determined eligible for premium assistance.

SECTION 14: GENERAL COMPLIANCE AND OTHER INFORMATION

14.1 No Vesting

Benefits Are Not Subject to Vesting and Are Not Vested. As stated above, the Rx Plan may be amended or terminated at any time. Any amendment may at the determination of the Employer, change, reduce, eliminate or otherwise affect benefits provided for under the Rx Plan and no Eligible Spouse, Dependent or beneficiary has any vested right, whatsoever, to benefits under the Rx Plan.

14.2 HIPAA Rules, Policies and Procedures

Health Insurance Portability and Accountability Act.

It is intended that this Plan comply with the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act of 2009, Title XIII of division A and Title IV of division B of the American Recovery and Reinvestment Act ("ARRA"), and the regulations issued under HIPAA, HITECH and ARRA (together we refer to HIPAA, HITECH and ARRA as "HIPAA"). Any Rules and/or Policy adopted by the Employer that addresses HIPAA are automatically incorporated in this Plan by reference and become part of the Plan.

HIPAA requires certain entities called "Covered Entities," which include the Rx Plan, to safeguard and protect the privacy of individuals' health information, to limit how individuals' health information may be used and disclosed, to grant certain rights to individuals with respect to their health information, and to maintain certain administrative processes that address these rules.

The Rx Plan and Plan Administrator may not generally have regular access to any Protected Health Information ("PHI"), as that term is described under HIPAA. In the event that any PHI is provided to the Plan Administrator, it will be disclosed or obtained consistent with HIPAA, in order to assist you in your access to benefits, or some other function under the Rx Plan. Any such information obtained will be protected from dissemination and will be used only for purposes under the Rx Plan.

14.3 USERRA Leave

Leave Under the Uniformed Services Employment and Re-employment Rights Act ("USERRA"). If you leave your job to perform military service, you have the right to elect to continue any existing group health plan, including Rx Plan coverage for up to 24 months while in the military. Coverage is at your cost and works like the COBRA coverage stated above.

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan, and this Rx Plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre- existing condition exclusions) except for service-connected illnesses or injuries.

14.4 FMLA Leave

Family and Medical Leave Act ("FMLA"). The FMLA entitles eligible employees to take up to 12 weeks of unpaid, job protected leave each year for specified family and medical reasons. For a medical leave, any period for which you are paid short-term disability or workers' compensation benefits will count against any period of available FMLA leave. See your Human Resources Department for additional information on the FMLA and how FMLA leave is addressed with respect to coverage under this Rx Plan. The Employer's leave policies apply.

14.5 No Employment Rights

No Right of Employment. This Plan does not confer upon anyone a right or contract of employment in any way.

14.6 Fraud or Concealment

Fraud or Concealment. By participating in this Rx Plan, you agree to provide accurate and truthful information concerning any of your benefits or any subject matter for which you need to provide information in connection with your participation in the Rx Plan. This applies to your Spouse, Dependents and beneficiaries as well. In the event of any fraud, or concealment or any untruthful information provided by any person related to any benefit under this Rx Plan, any of the rights and remedies under law shall apply, and the Plan Administrator and the PBM may undertake any act or remedy available to it in this regard, in their sole and absolute discretion.

14.7 Compromise of Claims

Compromise of Claims. The Plan Administrator and the PBM may compromise any Claim filed under the Rx Plan, in accordance with the terms of the Rx Plan, or otherwise, as long as they satisfy obligations to the Covered Persons.

14.8 References and Inconsistencies

References and Inconsistencies. Any references to the Rx Plan include each of the Constituent Benefit Programs, unless the context specifically suggests otherwise. In the event that any term, provision or statement in this Rx Plan conflicts with or creates ambiguity with any other document, including documents from the Employer, broker, PBM, or other administrators, or other plan documents or plans of the Employer, this document shall control the terms of the Rx Plan, and the Plan Administrator has full and complete discretionary authority to interpret the terms, determine facts and reconcile any inconsistency, or determine the meaning of any provision.

14.9 Applicable Law

Applicable Law. The Rx Plan is subject to ERISA, which pre-empts state law. To the extent that federal law does not apply for any reason, any claim brought with respect to the Rx Plan must be brought in the courts where the Plan Sponsor is headquartered.

SECTION 15: STATEMENT OF ERISA RIGHTS

As a Participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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 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 Group Health Plan Coverage

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.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit 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 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 a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare 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 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 domestic relations order or 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.

Assistance with Your Questions

If you have any questions about your 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.

SECTION 16: PLAN INTERPRETATION

The Plan Administrator has discretionary authority to determine eligibility for benefits and to construe any and all terms of the Rx Plan, including, but not limited to, any disputed or doubtful terms, to the extent that this right is not specifically reserved to the PBM or any other administrator. The Plan Administrator also has the power and full and complete discretion to determine all questions of fact and law arising in connection with the administration, interpretation and application of the Rx Plan, unless such right is specifically reserved to the PBM or other administrator, as determined by the Plan Administrator. Any and all determinations by the Plan Administrator with respect to any aspect of the Rx Plan, not otherwise reserved, is and will be conclusive and binding on all persons with respect to this Rx Plan.

SECTION 17: ADOPTION

The Rx Plan is hereby adopted by the Employer, effective as of the date indicated herein, as a Formal Rx Plan Document and also the Summary Plan Description for the Rx Plan, incorporating by reference the PBM Data Sheet, and the Exhibits to this Rx Plan.

The Rx Plan is hereby adopted and approved by the Employer and is effective as stated herein.

American Senior Communities, L.L.C.

By: Mary Hedlund

Print Name: Mary Hedlund

Title: VP Employee Benefits

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PBM DATA SHEET

The Following is important information regarding the Pharmacy Benefit Manager (the "PBM") and how you can access information and benefits under the Rx Plan.

Pharmacy Benefit Manager ("PBM"):	True Rx Health Strategists
PBM Main Telephone Number:	(866) 921-4047
PBM Main Website:	www.TrueRx.com
PBM Paper Claim Submission Address:	True Rx Health Strategists, Attn: Claims, PO Box 431, Washington, IN 47501
PBM Mail Order Address:	True Rx Health Strategists, 7 Williams Bros. Dr., Washington, IN 46501
PBM Mail Order Telephone Number:	(866) 921- 4047
PBM Appeals Mailing Address:	True Rx Health Strategists, Attn: Appeals, PO Box 431, Washington, IN 47501
PBM Appeals Fax Number:	866-921-4047
PBM Appeals Electronic Mail Address:	N/A
PBM Urgent Appeals (contact):	Call 866-921-4047
PBM Formulary Website Link:	Exclusive Formulary: www.truerx.com/formularies
PBM Other Important Links:	Forms: www.truerx.com/forms
PBM Other Information:	There are three easy ways to contact True Rx: 1. By accessing the True Rx website at True Rx.com and click on the "Members" tab. There you will find helpful information such as locating Participating Pharmacies, generic equivalents, prior authorization forms, Formulary, Member Access, claim forms, and patient assistance programs. 2. By utilizing the Member Access site (https://True Rx.com/member-portal/registration/) or the True Rx Mobile App (available for Android and Iphone) which allows covered individuals to identify the cost for any prescription medication, retrieve drug information, identify pharmacy locations, etc. 3. By calling the Customer Service Team, where you can speak to a True Rx Customer Care representative. The Customer Service Team may be reached at (866) 921-4047.

Exhibit A - Schedule of Benefits Traditional Plan			
Eligible Employees:	Employees of American Senior Communities, L.L.C. who are covered under the Traditional Plan option under the American Senior Communities, L.L.C. Group Medical Plan		
Eligible Entry Date:	Employee Enters as of the Date the Employee of American Senior Communities, L.L.C. enters the Traditional Plan under the American Senior Communities, L.L.C. Group Medical Plan		
Who Pays for the Coverage	Combination of Employer and Employee contributions		
Any Restrictions on Spouse Participation?	Only Spouses who are covered under the Traditional Plan option under the Group Medical Plan		
Is Spousal Coverage Subject to a Limitation Secondary Coverage Only?	See Medical Plan Document		
Deductible:	No		
Is the Deductible for Individual Embedded in the Family Deductible?	N/A		
Does the Deductible Accumulate with the Group Medical Plan of the Employer?	N/A		
Maximum Out-of-Pocket "MOOP"	Individual: $6,000 Family: $12,000		
Is MOOP for Individual Embedded in the Family MOOP?	Yes		
Does the MOOP Accumulate with the Group Medical Plan of the Employer?	Yes		
Special Rules?	• Dispense As Written Penalty (DAW 2) - If the participant fills a prescription with a brand name medication when there is a generic equivalent available, then the Plan participant will pay the difference between the brand cost and the generic cost, and the member will be charged the highest tier cost share. This does not apply if your physician indicates the brand name medication must be dispensed. • Diabetic Medications and Supplies - Must be filled through Northwind Pharmaceuticals. Phone Number: 800-722-0772		
Supply Method:	**Preferred Pharmacy Network**	**Retail CVS/Walgreens/Rite-Aid**	**WB Rx Express Mail Order**
Supply Limits	**30 Day**	**30 Day**	**90 Day**
Generic	$15 Copay	$30 Copay	$30 Copay
Preferred Brand	$30 + 30% Coinsurance (Max $65)	$60 + 30% Coinsurance (Max $130)	$70 Copay
Non-Preferred Brand	$50 + 30% Coinsurance (Max $85)	$100 + 30% Coinsurance (Max $170)	$130 Copay
Specialty/Orphan	Not Covered	Not Covered	Not Covered
Other Rules	N/A	N/A	N/A

Exhibit A - Schedule of Benefits Blended Plan			
Eligible Employees:	Employees of American Senior Communities, L.L.C. who are covered under the Blended Plan option under the American Senior Communities, L.L.C. Group Medical Plan		
Eligible Entry Date:	Employee Enters as of the Date the Employee of American Senior Communities, L.L.C. enters the Blended Plan under the American Senior Communities, L.L.C. Group Medical Plan		
Who Pays for the Coverage	Combination of Employer and Employee contributions		
Any Restrictions on Spouse Participation?	Only Spouses who are covered under the Blended Plan option under the Group Medical Plan		
Is Spousal Coverage Subject to a Limitation Secondary Coverage Only?	See Medical Plan Document		
Deductible:	No		
Is the Deductible for Individual Embedded in the Family Deductible?	N/A		
Does the Deductible Accumulate with the Group Medical Plan of the Employer?	N/A		
Maximum Out-of-Pocket "MOOP"	Individual: $6,000 Family: $12,000		
Is MOOP for Individual Embedded in the Family MOOP?	Yes		
Does the MOOP Accumulate with the Group Medical Plan of the Employer?	Yes		
Special Rules?	• Dispense As Written Penalty (DAW 2) - If the participant fills a prescription with a brand name medication when there is a generic equivalent available, then the Plan participant will pay the difference between the brand cost and the generic cost, and the member will be charged the highest tier cost share. This does not apply if your physician indicates the brand name medication must be dispensed. • Diabetic Medication and Supplies - Must be filled through Northwind Pharmaceuticals. Phone Number: 800-722-0772		
Supply Method:	**Preferred Pharmacy Network**	**Retail CVS/Walgreens/Rite-Aid**	**WB Express Mail Order**
Supply Limits	**30 Day**	**30 Day**	**90 Day**
Generic	$15 Copay	$30 Copay	$30 Copay
Preferred Brand	$30 + 30% Coinsurance (Max $65)	$60 + 30% Coinsurance (Max $130)	$70 Copay
Non-Preferred Brand	$30 + 30% Coinsurance (Max $85)	$100 + 30% Coinsurance (Max $170)	$130 Copay
Specialty/Orphan	Not Covered	Not Covered	Not Covered
Other Rules	N/A	N/A	N/A

Exhibit B - Participating Employers

The following are Participating Employers in the Plan:

No other companies participate

Exhibit C - Addendums / Amendments

Addendum or Amendment Name:	Mark Cuban Cost Plus Program
Effective Date:	January 1, 2026

The Mark Cuban Cost Plus Program is an in-network pharmacy benefit offering, additional that allow mail order pharmacies, as part of their standard benefits. The program offers lower costs option for Members on select drugs that are available through Mark Cuban Cost Plus. Members must enroll into the program through the True Rx member portal.

Exhibit C - Addendums / Amendments

Addendum or Amendment Name:	Maximum Dollar Per Rx
Effective Date:	January 1, 2026

Maximum Dollar Per Rx (Mandatory Prior Authorization for High Cost Medication):

Max Threshold Amount: $2000

Exhibit C - Addendums / Amendments

Addendum or Amendment Name:	Coverage (Inclusion/Exclusion List)
Effective Date:	January 1, 2026

Section 4.5 and the Formulary are modified to include, exclude, or include as required by the ACA mandates certain medications as described below:

Include:

- Acne Medications (Prior Authorization required for ages 30 and older)
- ADD/ADHD Medications (Prior Authorization required for ages 18 and older)
- Anabolic Steroids and Testosterone
- Compound Medications
- Devices: Inhaler Spacers
- Emergency Injectables
- Federal Legend Drugs
- Gender Dysphoria
- Migraine Medications
- Nail Anti-Fungal, Topical (Onyxhomycosis medications excluded)
- Nutrition Supplements and Medical Food (with Prior Authorization)
- Sexual Health
- Substance Abuse Treatment

Exclude:

- Abortifacient
- Allergy Sera
- Anti-Obesity/Appetite Suppressants
- Cosmetics (non-acne)
- Diabetic Insulin (Fill through Northwood)
- Diabetic Supplies (Fill through Northwood)
- Diabetic Devices (Fill through Northwood)
- Diabetic GLP1 and GIP/GLP1 (Fill through Northwood)
- Durable Medical Equipment
- Fertility Agents
- Gene and Cellular Therapy
- Orphan Drugs
- Repackaged Products
- True Rx Specialty List (Except for certain low-cost generic specialty medications)
- Vitamins

Include Per ACA Mandate:

- Bowel Prep
- Breast Cancer
- Female Contraceptives
- Fluoride Supplements - Pediatric
- Folic Acid
- Pre-Exposure Prophylaxis of HIV
- Smoking Cessation
- Statin Medications
- Vaccines

Exhibit C - Addendums / Amendments

Addendum or Amendment Name:	Formulary Modifications
Effective Date:	January 1, 2026

Please note that our pharmacy formulary is subject to periodic review and modification; as a result, a drug that appears on the current formulary may subsequently be excluded from the formulary and thus, excluded from coverage under the plan. Coverage of any medication is always determined at the time of dispensing, based on the most up-to-date formulary, utilization-management edits, and benefit design in effect.

Exhibit C - Addendums / Amendments

Addendum or Amendment Name:	Exclusion – Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists
Effective Date:	January 1, 2026
All GLP-1 receptor agonist medications (including but not limited to semaglutide, tirzepatide, liraglutide, dulaglutide, exenatide, and any biosimilars or future FDA-approved GLP-1 agents) are excluded from coverage under this Plan. This exclusion applies to all current and future FDA-approved indications, including but not limited to treatment of weight management, type 2 diabetes, obstructive sleep apnea, cardiovascular disease, liver disease, or any other condition.	