PRESCRIPTION BENEFIT LANGUAGE

American Senior Communities Master Welfare Plan
Prescription Drug Plan

This sample plan document including the specialty/orphan drug exclusion and the override program language involves multiple federal laws that have been unaddressed/undefined. Before utilizing this language, you should consult with your own legal counsel to determine the legal risks involved and the appropriateness of this program and language for you and your members.

This sample language includes exclusion language that could be included in the plan document. A sample amendment for potential override of this exclusion is also included.

American Senior Communities Master Welfare Plan
Prescription Drug Plan

Rx Prescription Drug Plan

January 2022

THIS DOCUMENT CONTAINS ALL PROVISIONS OF THE PLAN. ANY CONFLICT OR AMBIGUITY ARISING BETWEEN THIS DOCUMENT AND ANY OTHER DOCUMENT OR COMMUNICATION, INCLUDING, BUT NOT LIMITED TO, ANY SUMMARY PLAN DESCRIPTION, BROCHURE, OR ORAL OR VIDEO PRESENTATION, DESCRIBING THE RIGHTS, BENEFITS, OR OBLIGATIONS OF THE COMPANY AND PARTICIPANTS UNDER THE PLAN SHALL BE RESOLVED IN FAVOR OF THIS PLAN DOCUMENT.

American Senior Communities Master Welfare Plan Prescription Drug Plan
PRESCRIPTION DRUG PLAN
DOCUMENT AND SUMMARY PLAN DESCRIPTION

This **American Senior Communities Master Welfare Plan Prescription Drug Plan** (the "Prescription Drug Plan") is effective as of January 1, 2022. This document is designed to be a plan document under ERISA §402 and a summary plan description under ERISA §102, to provide Covered Employees and their eligible Dependents with information about the American Senior Communities Master Welfare Plan Prescription Drug Plan. This American Senior Communities Master Welfare Plan Prescription Drug Plan is integrated within the American Senior Communities Master Welfare Plan Prescription Drug Plan (the “Client Welfare Plan”) and in particular with the group health plan sponsored by American Senior Communities, LLC (“Client”) to provide to those who are Eligible, prescription drug coverage as provided under this American Senior Communities Master Welfare Plan Prescription Drug Plan.

This Prescription Drug Plan is part of, and incorporated by reference into, the **American Senior Communities Master Welfare Plan** Health Care Plan (the "Health Care Plan"). Certain provisions of the Health Care Plan (such as, for example, provisions regarding eligibility, termination of benefits, plan administration, and Claims procedures) are incorporated herein by reference, unless specifically stated otherwise.

\

1 SCHEDULE OF BENEFITS UNDER THE PRESCRIPTION DRUG PLAN

Schedule of Benefits

This Schedule of Benefits ("Schedule of Benefits") provides you with information about your benefits under the American Senior Communities Master Welfare Prescription Drug Plan, including information about certain Co-payments. More specific information about the Prescription Drug Plan is found throughout this document.

You will be responsible for paying Co-payments on the medications covered under the American Senior Communities Master Welfare Prescription Drug Plan. A Co-payment is the amount a Covered Person is required to pay for a Prescription in accordance with the Prescription Drug Plan, which may be a percentage of the Prescription price, a fixed amount, or other charge, with the balance (if any) paid by the American Senior Communities Master Welfare Prescription Drug Plan. The Co-payments for this American Senior Communities Master Welfare Prescription Drug Plan are:

Standard Plan				
	Individual	Family		
Deductible	N/A	N/A		
Out of Pocket Max	$5,500	$11,000		
	Retail (30-day supply)	CVS/Walgreen/Rite-Aid (30-day supply)	Mail Order (90-day supply)	CVS/Walgreens/Rite-Aid (90-Day Supply)
Generic	$15 Co-Pay	$30 Co-Pay	$30 Co-Pay	$60 Co-Pay
Preferred Brand	$30 Co-Pay + 30% (max $65)	$60 Co-Pay + 30% (max $130)	$70 Co-Pay	$140 Co-Pay
Non-Preferred Brand	$50 Co-Pay + 30% (max $85)	$100 Co-Pay + 30% (max $170)	$130 Co-Pay	$260 Co-Pay
Specialty	Not Covered	Not Covered	Not Covered	Not Covered

The American Senior Communities Master Welfare Prescription Drug Plan includes certain limits as stated below. This includes certain exclusions regarding Specialty and related types of pharmacy benefits. See Below.

The American Senior Communities Master Welfare Prescription Drug Plan offers maximum out of pocket amounts as well. The out of pocket maximums are integrated under the Standard Plan and include your out of pocket amounts expended under the group health plan and under this American Senior Communities Master Welfare Plan Prescription Drug Plan. The American Senior Communities Master Welfare Plan Prescription Drug Plan has an "embedded" OOP max. This means each covered family member only needs to satisfy his or her individual accumulator, not the entire family accumulator. These amounts include medical dollars as well as prescription dollars.

\

Pay Saver Plan				
	Individual	Family		
Deductible	N/A	N/A		
Out of Pocket Max	$6,450	$12,900		
	Retail (30 day supply)	CVS/Walgreens/Rite-Aid (30 day supply)	Mail Order (90 Day Supply)	CVS/Walgreens/Rite-Aid (90 day supply)
Generic	$15 Co-Pay	$30 Co-Pay	$30 Co-Pay	$60 Co-Pay
Preferred Brand	$30 Co-Pay + 30% (max $85)	$60 Co-Pay + 30% (max $130)	$110 Co-Pay	$220 Co-Pay
Non-Preferred Brand	$50 Co-Pay + 30% (max $110)	$100 Co-Pay + 30% (max $170)	$160 Co-Pay	$320 Co-Pay
Specialty	Not Covered	Not Covered	Not Covered	Not Covered

The American Senior Communities Master Welfare Plan Prescription Drug Plan includes certain limits as stated below. This includes certain exclusions regarding Specialty and related types of pharmacy benefits. See Below.

The American Senior Communities Master Welfare Plan Prescription Drug Plan offers maximum out of pocket amounts as well. The out of pocket maximums are integrated under the Pay Saver Plan and include your out of pocket amounts expended under the group health plan and under this American Senior Communities Master Welfare Plan Prescription Drug Plan. The American Senior Communities Master Welfare Plan Prescription Drug Plan has an "embedded" OOP max. This means each covered family member only needs to satisfy his or her individual accumulator, not the entire family accumulator. These amounts include medical dollars as well as prescription dollars.

2. GENERAL AND PRESCRIPTION PLAN DEFINITIONS

APPEAL.
The term "Appeal" means written request made by a Covered Person or a Covered Person's authorized representative for reconsideration of an adverse determination regarding a Covered Person's Claim.

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 investigation new drug application.

BENEFIT MANAGER.
The term "Benefit Manager" means the individual or business entity, if any, appointed and retained by the Plan Administrator to supervise the management, consideration, investigation and settlement of claims, maintain records, submit reports and other such duties as may be set forth in a written agreement. If no Benefit Manager is appointed or retained (as a result of the termination or expiration of such agreement or other reason) or if the term is used in connection with a duty not expressly assigned to and assumed by the Benefit Manager in writing, the term will mean the Plan Administrator.

BRAND MEDICATION,
The term "Brand Medication' means a Prescription Medicine identified by True Rx based on criteria provided by nationally-recognized source(s) of prescription drug pricing information, as appropriate as a non-generic product.

CALENDAR YEAR.
The term "Calendar Year" means the period of time from January 1st, at 12:00 A.M. midnight, through the next December 31st.

CLAIMS ADMINISTRATOR

The Claims Administrator under the ASC Pharmacy Benefit Plan is True Rx, to the extent and only to the extent that True Rx processes and approve or deny a claim for payment under the ASC Pharmacy Benefit Plan. The Claims Administrator will only have the authorities stated herein.

CLEAN CLAIM.
The term "Clean Claim" means a billing for a service and/or supply that is submitted to the Plan by a Covered Person or 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 Plan to which it is being submitted and be submitted on an appropriate form that has been properly and entirely completed, as described in

Section 4.1 and Section 4.2, including all data elements required by the applicable form. If a claim that has been submitted to this Plan is determined by the Plan Administrator to not constitute a Clean Claim within this definition, 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 Plan until all required information is received.

COBRA.
The term "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COMPANY.
The term "Company" means True Rx Health Strategists the Plan sponsor.

COPAYMENT or CO-PAY.
The term "Copayment or Co-Pay" means a specific dollar amount, or percentage, of the Covered Expenses that the Covered Person must pay before the Plan pays benefits for a particular service or supply.

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 Plan.

COVERED PERSON.
The term "Covered Person" means any person meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

CUSTOMARY.
The term "Customary" refers to the designation of a charge as being the usual charge made by a Physician or other provider of supplies, medication or equipment that does not exceed the general level of charges made by other providers rendering or furnishing such care or treatment within the same general geographic area, taking into consideration differences in demographics of specific locations and using generally accepted standards of medical practice. The term "area" in this definition means a county or such other area as is necessary to obtain a representative cross section of such charges. Due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual circumstances that require additional time, skill or expertise. In regards to services or supplies provided by preferred providers, this term refers to the contracted rate for the service or supply in question, as determined by the agreement between the Plan and the network to which the provider belongs.

Customer Service Team

The term "Customer Service Team means the True Rx Customer Service Team, which may be contacted (toll free) at (866) 921-4047.

DEPENDENT.
The term "Dependent" means any individual who is enrolled as a Dependent of the Participant under the American Senior Communities Master Welfare Plan Prescription Drug Plan.

DEPENDENT COVERAGE.
The term "Dependent Coverage" means coverage under the Plan for benefits payable as a consequence of an illness or injury of a Dependent.

DEDUCTABLE.
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 Expense Maximum under the Prescription Drug Plan.

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

EMPLOYER.
The term "Employer" means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Internal Revenue Code of 1986, as

amended, that adopts this Plan for the benefit of its employees, whose participation in the Plan is approved by the President (or any duly authorized officer) of the Company. An Employer may withdraw from the Plan by delivering to the Plan Administrator written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

ERISA.
The term "ERISA" refers to the Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL or INVESTIGATIVE.
The terms "Experimental" or "Investigative" mean a substance that has been tested in a laboratory and has
received approval from the U.S. Food and Drug Administration (FDA) to be tested in people. An experimental drug may be approved by the FDA for use in one disease or condition but be considered investigational in other diseases or conditions. Also called investigational agent and investigational drug.

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

FAMILY.
The term "Family" means a covered Participant and his or her covered Dependents.

FORMULARY MEDICATION.
The Term Formulary Medication means a Medication set forth on the Formulary Drug List. This list is updated and revised by True Rx from time to time to include new drugs, generic equivalents and drugs removed from the market or made available over the counter. A current version of the Preferred Drug List may be found at: http://truerx.com/formulary/.

GENERIC MEDICATION.
The term "Generic Medication" means a generic (*i.e.*, non-Brand Medication) as identified by True Rx based on criteria provided by nationally-recognized source(s) of prescription drug pricing information, as appropriate.

HEALTH INFORMATION.
The term "Health Information" means any information, whether oral or recorded in any form or medium that:

A. is created or received by this Plan, or a Plan designee; and
B. relates to any of the following:
1. The past, present or future physical or mental health or condition of an individual;
2. the provision of health care to an individual; or
3. the past, present or future payment for the provision of health care to an individual.

HIPAA.
The term "HIPPA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

ILLNESS.
The term "Illness" means Sickness, disease, or pregnancy.

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.

MEDICALLY NECESSARY or MEDICAL NECESSITY.
The terms "Medically Necessary" or "Medical Necessity" mean The fact that a Physician has prescribed, ordered, recommended or approved a medication or drug does not, of itself, make such medication or drug Medically Necessary under the Plan, nor does it make the charge a Covered Expense. The Plan reserves the right to make the final determination of Medical Necessity on the basis of final diagnosis and supporting medical data.

MEDICINE or MEDICATION.
The term "Medicine or Medication 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). Medicine 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.

MEDICARE.
The term "Medicare" means the programs established by Title I of Public Law 89-98, as amended, entitled "Health Insurance for the Aged Act," and which includes parts A, B and D of Subchapter XVIII of the Social Security Act, as amended from time to time.

NAMED FIDUCIARY.
The term "Named Fiduciary" means the individual or entity which has the ultimate authority to control and manage the overall operation of the Plan.

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 have a higher Co-payment than preferred Medications. You pay more if you use Non-Preferred Medications than if you opt for generics or 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 a rare medical condition, the condition itself being referred to as an orphan disease, and for purposes of this definition, the drug must also be included on the True Rx Specialty Drug List. There are some drugs that may be designated as an "Orphan Drug" but are not included on the True Rx Specialty Drug List and are therefore not excluded from the Plan.

OUT-OF-POCKET.
The term "Out-of-Pocket" means the amount of Covered Expenses that are the responsibility of the Covered Person and that accumulate towards the Plan's Out-of-Pocket maximum, not including amounts for:

A. expenses that are not covered under this Plan;

B. in excess of the Reasonable and Customary charge for a service or supply;

C. in excess of any maximum benefit listed in the Plan; or

D. attributable to any penalty.

PARTICIPANT.
The term "Participant" means a person who meets the eligibility requirements listed in Section 5.2 and who is properly enrolled in the Plan.

PARTICIPANT CONTRIBUTION.
The term "Participant Contribution" means that amount which is due from an eligible employee in order for that employee to obtain Participant and/or Dependent coverage(s) under the Plan. The Company shall determine the amount of the Participant Contribution which may vary depending upon the type of coverage an eligible employee desires to obtain. Eligible Participants will be advised of any required Participant Contributions at the time each applies for Participant and/or Dependent coverage. Participants in the Plan will be notified by the Plan Administrator prior to an increase in the required Participant Contribution amount. Participants in the Plan that are not required to make Participant Contributions at the time of enrollment will be notified by the Plan Administrator prior to the date a Participant Contribution requirement is made effective.

PARTICIPATING PHARMACY.
A retail pharmacy that contracts with True Rx. Participating Pharmacies may be found through the True Rx Pharmacy Locator at http://truerx.com/pharmacy-locator/ or by calling the True Rx Customer Service Team at (866) 921-4047. Benefits under the Prescription Drug Plan are generally more favorable when Medications are obtained through a Participating Pharmacy.

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

PHYSICIAN.
The term "Physician" means A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (DD.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.), 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 his or her license.

PLAN.
The term "Plan" means the sickness and accident plan, as described in and administered by the American Senior Communities Master Welfare Plan Prescription Drug Plan for Prescription Benefits.

PLAN ADMINISTRATOR.
The entity responsible for the day-to-day functions and management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan related services. True Rx Health Strategists is the Plan Administrator as of the Plan Effective Date.

PLAN EFFECTIVE DATE.
The Plan Effective Date of this Plan January 1, 2022.

PLAN YEAR.
The term "Plan Year" means a period of time used for certain reporting and disclosure requirements of the Plan. The Plan Year will begin on January 1, 2022 and end on December 31, 2022 of the same year.

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.

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.

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 True Rx to Covered Persons who participate in the Prescription Drug Plan.

Prescription Medicine
Licensed Medicine that is regulated by legislation to require a Prescription before it can be obtained by a Covered Person.

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.

Preferred Drug List or Formulary
The True Rx Preferred Drug List is a list of Generic and Brand Medications that your Prescription Drug Plan covers as amended by True Rx from time to time. This list excludes Specialty Drugs. A current copy of the Preferred Drug List may also be obtained at: https://truerx.com/formulary/, or by calling the Customer Service Team at (866) 921-4047.

Prior Authorization
Prior authorization is a requirement that a Covered Person's physician obtain approval from the Prescription Drug Plan to prescribe a specific medication 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 Prescription Drug Plan may not provide coverage, or pay for, the Covered Person's medication.

PROTECTED HEALTH INFORMATION.
The term "Protected Health Information" means Health Information that either identifies an individual, or for which there is a reasonable basis to believe it can be used to identify an individual, and which is one (1) of the following: A. transmitted by electronic media, including:

1. the internet;
2. an extranet;
3. leased lines;
4. dial-up lines;
5. private networks; and
6. those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media; B. maintained in any electronic media; or C. transmitted or maintained in any other form or medium.

QUALIFIED INDIVIDUAL.
The term "Qualified Individual" means an individual who is properly enrolled in the Plan and who is eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to 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.

REASONABLE.
The term "Reasonable" refers to the designation of a charge as being appropriate based on the medications, drugs or supplies actually supplied by a provider to a Covered Person. While the charge made for such items may be considered to be Customary within the general context of billing practices for similar items, the true circumstances of the case may warrant a lesser or higher charge than the Customary charge for the supplies that were, in fact, provided to the Covered Person. The Plan Administrator shall have the right to review provider's records relative to the supply, and shall determine, in its absolute discretion, whether or not the charge made by the provider for the supply is Reasonable. In making this determination, the Plan Administrator will take into consideration additional charges that were attributable to the errors, negligence or inefficiency of the provider, and may consult with medical experts in the related fields to determine whether such charges

would be considered Reasonable within the context in which they were provided.

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.

SERVICE IN THE UNIFORMED SERVICES.
The term “Service in the Uniformed Services” means performance of duty in the Armed Forces or Uniformed Services for a period of five (5) years or less, on a voluntary or involuntary basis, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty in the Armed Forces, the Army National Guard, Air National Guard, the commissioned corps of the Public Health Service, or any other category of persons designated by the President of the United States in time of war or emergency. Service in the Uniformed Services also includes a period for which an individual is absent from a position of employment for the purpose of an examination to determine the fitness of the person for duty in the Armed Forces or the commissioned corps of the Public Health Service.

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 Pharmacy Benefit Manager’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 following website https://truerx.com/formulary/ , or by calling the Customer Service Team at (866) 921-4047.

SUMMARY HEALTH INFORMATION.
The term “Summary Health Information” means information that may be individually identifiable Health Information that:
A. summarizes the claims history, claims expenses or type of claims experienced by Covered Persons under this Plan; and
B. from which the following information has been removed:

1. names;
2. geographic subdivisions smaller than the level of a five (5) digit zip code, including, but not limited to, street addresses;
3. all elements of dates (except year) for dates directly related to an individual, including, but not limited to, birth dates and dates of admission and discharge; 4. telephone numbers; 5. fax numbers; 6. electronic mail addresses; 7. social security numbers; 8. medical record numbers; 9. Plan identification numbers; and 10. Other identifiers as listed in 45 C.F.R. § 164.514(b)(2)(i).

.

URGENT CARE CLAIM.
The term “Urgent Care Claim” means a Claim which the Physician specifies as urgent or True Rx, using judgment of a prudent layperson, determines is urgent.

3 ADDITIONAL INFORMATION REGARDING PLAN BENEFITS

GENERAL INFORMATION

True Rx is the company that has been selected by American Senior Communities, LLC to administer your American Senior Communities Master Welfare Plan Prescription Drug Plan benefits. True Rx will do everything it can to help you with your prescription drugs so you can focus on the other important things in your life. Keep this document as it contains important information pertaining to your Prescription Drug Plan benefits.

Through True Rx, you will experience convenience through access to over 65,000 Participating Pharmacies. True Rx will provide you with safety and cost-savings by monitoring your prescriptions and suggesting generic substitutes that will reduce costs for you and **American Senior Communities, LLC.**

True Rx provides several services in connection with the Prescription Drug Plan such as:

- ***A Broad Pharmacy Network:*** There are more than 65,000 pharmacies nationwide (retail and independent) that are contracted with True Rx. You will find our Pharmacy Locator at http://www.true-rx.com/pharmacy-locator.html so that you can find pharmacies in your area. You can also contact True Rx at (866) 921-4047 and let a Customer Service Representative assist you with your search. If your pharmacy is not listed in the Pharmacy Network, a representative at True Rx can contact that pharmacy to inquire about joining our network.

- ***Generic Enforcement:*** If Covered Person elects not to purchase a generic drug when available and approved by the physician, the employee will be responsible for the brand copay plus the difference in the cost of the generic and the brand name drug purchased.

- ***Step Therapy Plan:*** The Step Therapy Plan encourages the use of generic medicines. Generic Medications will be required in certain drug classes before Brand Medications will be approved. In other drug classes, only Generic Medications will be covered. You may contact the Customer Service Team at (866) 921-4047 for more information about the Step Therapy Plan and when the use of a Generic Medication is required.

- ***Additional Programs:*** Additional programs may be introduced to improve the Prescription Drug Plan, and these additional benefits will be communicated to covered individuals when available.

- ***Answering Your Questions:*** If you have questions about your Prescription Drug Plan, you can always contact the True Rx Customer Service Team at (866) 921-4047.

WHAT THE PRESCRIPTION DRUG PLAN COVERS

The Prescription Drug Plan provides benefits to Covered Persons for the following:

- Certain Prescription Medicines:
  - prescribed by a Prescriber; ***and***
  - In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits; ***and***
  - Medically Necessary for the care and treatment of an Illness or Injury; ***and***
  - Not excluded in the Exclusions and Limitations Section; ***and***

- Not Experimental, Investigative, or Unproven; ***and***
- With certain limited exceptions, may only be obtained by Prescription and are dispensed in a container labeled "Rx only."
- The following non-prescription product prescribed by a duly licensed medical professional:
  - Compounded medications of which at least one ingredient is a Prescription Drug.

- **Prescription Drugs lost as a direct result of a natural disaster**. Covered Persons will be given the opportunity to prove that the Prescription Drugs otherwise considered Covered Expenses under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claim of loss (homeowner's, property, etc.).
- Diabetic Medicines and supplies (including insulin syringes, lancets, and test strips), if prescribed by a Prescriber
- Devices; Inhaler Spacers
- Acne medications; Retin-A, Differin, Avita, Tazorac with a prior authorization above age 30
- All other Prescription Medicines and supplies required to be covered by a prescription drug plan by the Patient Protection and Affordable Care Act of 2010 and that is covered under Attachment 3 (subject to reasonable medical management techniques to determine the frequency, method, treatment, or setting for an item or service to the extent not specified in a recommendation or guideline adopted under the Patient Protection and Affordable Care Act of 2010).
- Generic and Brand medications as determined from time to time by True Rx.

Coverage is subject to any Co-pays, maximums, limits, exclusions, or other provisions of this Prescription Drug Plan. The Schedule of Benefits provides some additional information you may find helpful regarding coverage, exclusions, and limitations under the American Senior Communities Master Welfare Plan Prescription Drug Plan.

Some Medications, including Specialty Drugs, may be subject to quantity limits. These limits help your doctor and pharmacist check that your prescribed drugs are used correctly and safely. Medical guidelines and FDA-approved recommendations from drug makers are used to set coverage limits.

Any Prescriptions or other items covered under the Prescription Drug Plan will be limited based on Medical Necessity and quantity limits established by the Prescription Drug Plan (see the Schedule of Benefits). The Prescription Drug Plan may, in its sole discretion, establish quantity guidelines for specific Prescription Medications or other items. You should ask your Prescriber or Pharmacist to verify Medications that are covered by the Prescription Drug Plan, any quantity limits, and appropriate Brand Medications or Generic Medications recognized under the Prescription Drug Plan. Prior Authorization may be required for certain Medications.

About the Formulary Drug List:

The Formulary Drug List is a guide for Covered Persons and their Physicians. Generic Medications should be considered the first line of prescribing. If there is no Generic Medication available, there may be more than one Brand Medication to treat a condition. These preferred Brand Medications are listed on the Formulary Drug List to help identify products that are clinically-appropriate and cost-effective. The Formulary Drug List identifies drugs in three tiers with Tier 1 medicines requiring the lowest Co-payments. The amount you pay depends on the drug your doctor prescribes. Higher tier Medicines require greater Co-payments. **Make sure your doctor knows that you pay more for Tier 2 and 3 drugs.**

- **Tier 1: Generics** – You pay the lowest cost for drugs in this level.

- **Tier 2: Preferred Brands** – You pay a slightly higher cost for drugs in this level.

- **Tier 3: Non-Preferred Brands** – You pay the highest cost for drugs in this level.

The Formulary Drug List is not an all-inclusive list. The Formulary Drug List represents:

- Brand Medications (Tier 2 and 3)
- Generic Medications (Tier 1)

Any Brand Medication for which a Generic Medication becomes available may be designated as a non-preferred Brand Medication. You may obtain a current version of the Formulary Drug List at: https://truerx.com/formulary/, or by calling the Customer Service Team at (866) 921-4047.

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, name or packaging. Generic Medications are widely seen as one of the best ways to save money on Prescription Medicines and are as safe and effective as Brand Medications, but on average cost about 30 percent to 80 percent less. Here are some important facts about Generic Medications:

- 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 who make Generic Medications must meet the same FDA manufacturing and quality standards as those that make Brand Medications.

- Generic Medications usually cost much less because their manufacturers do little advertising and did not have to invest in the original research, development, and testing of them.

- A Generic Medication will be a different color or shape but is the same as the Brand Medication in:

  - strength (number of milligrams, etc.)
  - dosage form (pill, liquid, cream, etc.)
  - quality
  - active ingredient
  - effectiveness (how it works in the body)

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.

INFORMATION ABOUT PREFERRED BRAND MEDICATIONS

Preferred Brand Medications are safe and effective choices that the Prescription Drug Plan identifies for consideration. They usually are available at a lower cost than non-preferred Brand Medications. If there is no Generic Medication equivalent available for your Prescription Medicine, ask your Prescriber to consider prescribing a Brand Medication from the Preferred Drug List. Preferred Brand Medications and Generic Medications are identified as such on the applicable portion of the Preferred Drug List (see page of Preferred Drug List captioned "Preferred Brand Medications/Generic Medications List").

SPECIALTY DRUGS – EXCLUDED

The American Senior Communities Master Welfare Plan Prescription Drug Plan does not pay for any Medicine or Medication that is a Specialty Drug or an Orphan Specialty Drug. See Exclusion below.

CLINICAL TRIAL COVERAGE – EXCLUDED

The American Senior Communities Master Welfare Plan Prescription Drug Plan does not pay for any Medicine or Medication that is the subject of a Clinical Trial, provided in connection with data collection and analysis in a Clinical Trial, or not consistent with widely accepted and established standards of care for a particular diagnosis in connection with a Clinical Trial. See Exclusions below.

PRIOR AUTHORIZATION

Prior Authorization ensures that a high quality, cost effective and Medically Necessary method of treatment has been selected for 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 disease states as well as specialty medications will require Prior Authorization as determined by True Rx in its absolute discretion from time to time.

To obtain Prior Authorization, the Covered Person or the Physician must provide True Rx's Customer Service Team, (866) 921-4047, with the appropriate medical information prior to obtaining the proposed medicines, supplies, or services. Even though a physician 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 Authorizations are obtained**. The information must be received by True Rx at least one (1) working day before the medicines, supplies, or services are dispensed or provided.

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 benefit reduction if the benefit is covered at all. Covered Expenses remaining after this reduction will be paid according to the Prescription Drug Plan provisions listed in the Schedule of Benefits.

If a Covered Person fails to obtain Prior Authorization for care which requires Prior Authorization, the Covered Person will be financially responsible for the full cost of the medication. The Covered Person will be financially responsible for the entire bill(s) and the cost of the medication will not be applied to the Covered Person's Coinsurance Stop Loss Amount or Deductible.

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.

HELPFUL TIPS

When you visit your Physician or other Prescriber:

- Bring this guide or a copy of the Preferred Drug List with you to appointments to discuss coverage limitations or alternatives to Brand Medications.

- Let your Physician or other Prescriber know that you are interested in using Prescription Medicines that are appropriate for you and cost-effective.

- If you need a Prescription, ask for a Generic Medication and ask your Physician or other Prescriber to authorize generic substitution, when medically appropriate.

- Make sure your Physician or other Prescriber indicates the number of refills on the Prescription, if appropriate.

- If your Physician or other Prescriber tells you that you will be taking certain Medicine for a long time, ask for both a short-term Prescription and a long-term Prescription.

Other ways to save on prescription costs:

If you have Prescriptions at a non-Participating Pharmacy, you will probably save money by having your Prescription transferred to a True Rx Participating Pharmacy. To do this, contact a True Rx Participating Pharmacy or the Customer Service Team and tell the Pharmacist where your Prescription is currently on file. If possible, have your Prescription bottle with you when you make the call so you can answer any questions. The Pharmacist will contact the non-Participating Pharmacy and make the transfer for you. When you pick up the Prescription, bring along your benefit information so that the Pharmacist can verify your Prescription Drug Plan coverage. You may also ask your prescriber to write a new prescription for you to take to the Participating Pharmacy, or your prescriber can call the prescription in for you.

Rx Help Centers

For those employees with prescription drugs that may no longer be covered under the Plan, we have retained Rx Help Centers prescription drug advocate services, Rx Help Centers, that will work with our employees to assist them in obtaining the prescription drugs that they need.

HOW TO FIND OUT MORE INFORMATION ABOUT YOUR BENEFITS

There are three easy ways to contact True Rx:

1. By accessing the True Rx website at truerx.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://truerx.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.

4 ACCESSING YOUR BENEFITS

HOW TO GET YOUR PRESCRIPTION FILLED OR REFILLED

Using a True Rx 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 True Rx Participating Pharmacy.

How to fill or refill your Prescription at a retail pharmacy:

- To locate a True Rx Participating Pharmacy near you, visit http://www.true-rx.com/pharmacy-locator.html, or call the True Rx Customer Service Team at (866) 921-4047.

- At the retail pharmacy, present your Prescription along with your Prescription Benefit Card. If your Prescriber has ordered refills, let the Pharmacist know 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.

- 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 paper Claim form to True Rx, 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). In most cases, you will pay more for your Prescription if you use a pharmacy that is a non-Participating Pharmacy. You can obtain a paper Claim form at http://truerx.com/true-rx-drug-claim-form/ or by calling the True Rx Customer Service Team at (866) 921-4047.

HOW TO FILE A CLAIM FOR BENEFITS

Claims may be submitted to True Rx by submitting a completed Claim form and related documentation by mail to True Rx at the address printed on the Claim form. You can obtain a paper Claim form at http://truerx.com/true-rx-drug-claim-form/, or by calling the True Rx Customer Service Team at (866) 921-4047.

To submit a Claim, fill out the Claim form completely and attach copies of receipts for any Medications listed on the Claim form, then mail the completed form to True Rx at the address specified on the Claim form. Claims must be received by True Rx within one year after the Prescription is filled. Once True Rx receives the Claim form, the Claim will be processed within six weeks thereafter.

5 CLAIM APPEAL PROCESS

CLAIM APPEAL PROCESS OVERVIEW

True Rx acts as the Claims Administrator under the Client Prescription Drug Plan and conducts day-to-day processing of claims and appeals under the American Senior Communities Master Welfare Plan Prescription Drug Plan. With respect to any claim determination, the Claims Administrator full and absolute discretionary authority with respect to all determinations under the American Senior Communities Master Welfare Plan Prescription Drug Plan, including the determination of facts, the interpretation of the American Senior Communities Master Welfare Plan Prescription Drug Plan and/or its terms, and with respect to all factual and legal decisions and determinations under this American Senior Communities Master Welfare Plan Prescription Drug Plan. This discretionary authority is to be interpreted in the broadest sense permitted under the law. Under the American Senior Communities Master Welfare Plan Prescription Drug Plan, the Plan Administrator has the right to notify the Claims Administrator that it is exercising its role as named fiduciary and that the Plan Administrator is taking over a claim determination from the Claims Administrator. Such determination will be made in writing and in such case, the Claims Administrator is no longer responsible for any such claim determination and will follow the direction of the Plan Administrator. In the event that the Plan Administrator takes over a claim determination, the Plan Administrator shall have full and absolute discretionary authority with respect to all determinations under the American Senior Communities Master Welfare Plan Prescription Drug Plan, including the determination of facts, the interpretation of the American Senior Communities Master Welfare Plan Prescription Drug Plan and/or its terms, and with respect to all factual and legal decisions and determinations under this American Senior Communities Master Welfare Plan Prescription Drug Plan. This discretionary authority is to be interpreted in the broadest sense permitted under law. In the event that an External Review is involved in such a determination, the Claims Administrator and/or Plan Administrator shall defer to the External Review, consistent with the law.

Initial Claim for Benefits. For the initial claim, the following shall apply:

- Filing of Claim. A claim for benefits under the Plan will be filed in writing with the Acting Administrator, which is the Claims Administrator, unless the Acting Administrator has taken over a claim as referenced above. The reference herein to the Acting Administrator refers to the Claims Administrator, unless the Plan Administrator has taken over a claim determination, as referenced above.

- Notice of Denial. If a claim for benefits under the Plan is wholly or partially denied, the Acting Administrator 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 Acting Administrator determines that an extension of time for processing the claim is necessary due to matters beyond the control of the Plan, in which case Acting Administrator 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 Acting Administrator expects to render its decision.

- Special Rules for Urgent Medical Plan Claims. Urgent health claims 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.

- Special Rules for Pre-Service Health Claims. Pre-service health claims 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.

- Disability and Other Claims. Disability claims will be decided within 45 days rather than 30 days. The 45 day deadline may be extended twice, each extension adding no more than 30 days to the prior deadline.

- Extension. If an extension 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.

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 Plan provisions 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 procedure and the time limits applicable to such procedures, in accordance with the provisions of this Claim and Appeal Procedure; 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.

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 Acting Administrator that it conduct a full and fair review of the denial of the claim. The Acting Administrator 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 Acting Administrator 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. The initial deadline may be extended by an additional period of sixty (60) days, upon written notice to the claimant. Decision on Appeal deadlines for the following categories of claims are subject to special timing considerations below.

- Urgent health appeals will be decided within 72 hours rather than 60 days.

- 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 of time for response on any appeal may be granted upon notice to the claimant in writing and the deadline is an additional period of the same number of days for the initial period.

Final Determination. The Acting 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 Section 502(a) of ERISA.

External Review (Only applies to Non-Grandfathered Plans.)

Voluntary External Review. This is a special default language for a procedure that applies only if the medical plans referenced in the Constituent Benefit Programs are non-grandfathered plans, or if they lose such status. In such a case, there is a voluntary external review process that applies, if after exhausting the two levels of appeal (when required), you are 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 a Participant or a 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 Acting Administrator 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 Expedited External Review below.

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

1. if you were covered under the Plan at the time of service;
2. that the review does not relate to your eligibility to participate in the Plan;
3. that your review meets the criteria for external review stated above;
4. that you completed the Plan's internal appeals process to the extent required; and
5. 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 Acting 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. 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 Acting Administrator 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 Acting Administrator has a contract. Within five business days after assigning the request to the IRO, the Acting Administrator will provide the IRO with the documents and information that were considered in the denial. If the Acting Administrator does not provide this information, the IRO may end the external review and reverse the Acting Administrator's decision. If this occurs, the IRO will notify you and the Acting Administrator 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 Acting Administrator. The Acting Administrator may reconsider the denial on appeal based on this additional information. If the Acting Administrator 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 Acting Administrator 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 Claims Administrator, 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;
3. Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider;
4. Plan terms unless the terms are inconsistent with applicable law;
5. Appropriate practice guidelines, which include applicable evidence-based standards;
6. Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with Plan terms or applicable law; and
7. 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 Claims Administrator 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, 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 of 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 of 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 Acting Administrator receives notice from the IRO that reverses a denial, the Acting Administrator 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 Claims Administrator 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 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.

Authorized Representative. The Acting Administrator will permit an authorized representative of the Claimant to act on behalf of the Claimant under this claim and appeal procedure. The Acting Administrator 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.

Administrative Processes and Safeguards. The Acting 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 Plan and other governing documents, if any, and that where appropriate, the provisions of the Plan have been applied consistently with respect to similarly situated Claimants.

Time Limit to Appeal Denial of a Claim Will Be Strictly Enforced. The 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 forfeit his or her right to request a review of this determination.

- If a Claimant does not make an appeal within the time limit after receipt of the determination on the initial determination, the Claimant will forfeit his or her right to final appeal.

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

One Year Limit to File a Legal Action. If the Acting Administrator 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 Plan may be commenced by or on behalf of a Claimant against the Plan, the Acting Administrator or any other Plan fiduciary, Claims Administrator or other Third Party Administrator unless it is filed within one year after the date of the final determination by the Acting Administrator under the Claims Appeal Procedure described herein.

True Rx conducts First Level Appeals and, if applicable, Second Level Appeals relating to eligibility and coverage of the American Senior Communities Master Welfare Plan Prescription Drug Plan benefit determinations. For more details about the Claim review process, please see the claims and appeals section of the American Senior Communities Master Welfare Plan Prescription Drug Plan. Such reviews are with respect to coverage of American Senior Communities Master Welfare Plan Prescription Drug Plan benefits only. With respect to such reviews, True Rx has the sole and absolute discretion to interpret the provisions of the American Senior Communities Master Welfare Plan Prescription Drug Plan and to make factual findings. The decision of True Rx is final, subject to judicial review only for abuse of discretion. True Rx may, in its sole discretion, consider the opinions of additional medical and/or legal experts with respect to interpretation of the provisions of this American Senior Communities Master Welfare Plan Prescription Drug Plan. True Rx is a fiduciary solely for the purpose of reviewing Appeals relating to the coverage of Prescription Medication benefits. True Rx will review Appeals in accordance with the rules and procedures established by True Rx to govern Appeals from the Denial of Claims, as may be amended from time to time.

If you are informed that a Claim is wholly or partially denied, you have the right to Appeal in accordance with the procedures described below and all of the requirements for Appeals under ERISA (please refer to the American Senior Communities Master Welfare Plan Prescription Drug Plan). If a request for Prior Authorization is wholly or partially denied, you will receive a letter notifying you of the Denial, which will set forth information regarding how to contact True Rx to submit an Appeal (the "Denial Letter"). Otherwise, you will be informed of the Denial at the pharmacy, and you may contact the Customer Service Team at (866) 921-4047 for more information regarding how to contact True Rx to submit an Appeal.

First Level Appeals (Initial Benefit Reconsideration):

- The internal Appeal process begins in the True Rx Medical Affairs Department. Once you contact the True Rx Medical Affairs Department with a request to Appeal, you will be instructed regarding how to submit a First Level Appeal.

- The True Rx Medical Affairs Department will mail you the appropriate First Level Appeal form to complete. You may submit the First Level Appeal either on the designated First Level Appeal form or in other written form acceptable to True Rx. You may submit the First Level Appeal form to True Rx for processing either via facsimile or mail or, in the case of Urgent Care Claim Appeals, your Physician may submit information regarding the First Level Appeal to True Rx by telephone. For Denials of Prior Authorization requests, the address, facsimile number, and telephone number of the True Rx Medical Services Department, to which you must send all First Level Appeal forms and related information, will be specified in the Denial Letter.

- *You must submit the First Level Appeal to True Rx, if at all, no later than 180 days after your Claim has been Denied.*

- The True Rx Medical Affairs Department will process a First Level Appeal within the following time frames from the date on which the True Rx Medical Affairs Department receives complete information:

  Pre-Service Claims: 15 days
  Post-Service Claims: 30 days
  Urgent Care Claims: 72 hours

- The True Rx Medical Affairs Department will review First Level Appeals based upon the American Senior Communities Master Welfare Plan Prescription Drug Plan and Prior Authorization criteria.

- The First Level Appeal process includes the consideration of relevant and supporting documentation submitted by and for you, as the Covered Person. Supporting documentation may include, for example, a letter written by your Physician in support of the First Level Appeal, a copy of the Denial Letter sent by True Rx, a copy of your payment receipt for the Prescription that is the subject of the First Level Appeal, and your relevant medical records.

- A True Rx Appeals Analyst reviews and determines First Level Appeals relating to non-clinical benefits (*e.g*., eligibility determinations, Co-Pay issues, and explicit exclusions under the Prescription Benefit Prescription Drug Plan). First Level Appeal determinations regarding clinical knowledge (*e.g.,* Prior Authorization Denials) are reviewed by a True Rx Appeals Pharmacist.

- After reviewing the First Level Appeal, the True Rx Medical Affairs Department will send a letter to you and your Physician notifying of the First Level Appeal decision. If the First Level Appeal overturns the original True Rx Claim Denial, this communication will explain the basic steps or process that either True Rx or you would need to follow. If the First Level Appeal upholds the original True Rx Claim Denial, the communication will provide the specific reason that the Denial was upheld and will reference the section of this Prescription Drug Plan upon which the Denial was based.

- For all Claims other than Claims for Denials of Prior Authorization, the First Level Appeal is the only level of internal Appeal available to you under the Prescription Drug Plan.

Second Level Appeals (Medical Necessity/Prior Authorization Denials):

True Rx has contracted with independent external review organizations ("IROs") to conduct independent specialist Physician reviews of the Medical Necessity of Denials of Prior Authorizations when you are entitled to obtain such a review. These reviews will only be performed for Denials of Prior Authorization requests upheld by a First Level Appeal and for which you requests a Second Level Appeal. Subject to the foregoing, the process steps for a Second Level Appeal are as follows:

- After you have received notice from True Rx that your First Level Appeal with respect to a Prior Authorization request has been Denied, you must request a Second Level Appeal. The Denial Letter will provide you with more information regarding the Second Level Appeal process, including how to request a Second Level Appeal and within what timeframe you must submit the Second Level Appeal. You may submit the Second Level Appeal form to True Rx for processing either via facsimile or mail.

- True Rx will forward or cause to be forwarded to the IRO applicable medical records, documentation, Prescription Drug Plan language and your applicable diagnosis, and the type of review needed.

- The IRO will select an independent specialist Physician to conduct the review for the Second Level Appeal.

- The IRO may contact you or your provider for additional information, if such information is deemed by the independent specialist Physician to be necessary or potentially useful in his or her review.

- The independent specialist Physician will review available medical records, any additional information obtained from the provider, and current medical literature, and will write an independent rationale in support of his or her final decision.

- The letter containing the rationale will be forwarded to True Rx for communication to you or your representative.

CONFIDENTIALITY

- All Appeal documentation of the Covered Person and the Company is handled in a confidential manner and in accordance with applicable statutes and regulations, including without limitation HIPAA, to protect the Covered Person's identity and his or her Prescription history.

- To promote confidentiality of the Covered Person's information, all Appeal information becomes part of a permanent case file.

6 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.

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

1. International Claims submitted by paper Claim will be reimbursed; however, the following Prescription Drug Plan parameters will be waived for such International paper Claims: Generic Drug Rules, Pharmacy Pricing, Days Supply, Refill Restrictions.

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 True Rx; 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.

5. Except as provided under the Clinical Trial coverage, new FDA-approved drug product or technology (including but 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 Prescription Drug 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 Prescription Drug Plan or the Health Care Prescription Drug 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 Prescription Drug Plan or other such prescription drug coverage.

9. Except as described elsewhere within this document, over-the-counter Medications and Medication that can legally be bought without a written Prescription.

10. Cosmetic surgery and care primarily intended to improve the Covered Person's appearance. However, benefits are provided under the American Senior Communities Master Welfare Plan Prescription Drug 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 and authorized by True Rx.

17. Custodial care, domiciliary care, or convalescent care.

18. Medical supplies stocked in the home for general use, like Band-aids, thermometers, and petroleum jelly.

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 Prescription Drug Plan.

22. Medications received from other than a pharmacy.

23. Vitamins and other nutritional diet supplements, unless prescribed.

24. Drugs used for Cosmetic purposed and for Weight Loss

25. Drugs used to treat Infertility

26. Off-label use, except as otherwise prohibited by law.

27. Quantities that exceed limits established by the Prescription Drug Plan.

28. Quantities that exceed the quantity prescribed, or for any refill dispensed later than one year after the date of the original Prescription order.

29. Specialty Drugs obtained from pharmacies that are not approved by True Rx.

30. Specialty Drug, as defined within this document, delivered by any means including by purchase at a pharmacy and processed for payment by the pharmacy benefit manager on an Outpatient basis from a provider or facility or purchased directly by the Covered Person are excluded. For this purpose, the term “Specialty Drug” means any injectable or non- injectable drug that is on the Pharmacy Benefit Manager’s list of Specialty Drugs as it determines such list from time to time.

    Notwithstanding the foregoing limitation: Specialty Drugs provided in an outpatient setting are covered if the Plan Administrator determines in its sole and absolute discretion and under the facts and legal interpretation that it deems appropriate under the circumstances (in consultation with the third party administrator and/or pharmacy benefit manager as it deems appropriate including a prior authorization requirement), that the Specialty Drug: is not being provided on a clinical or inpatient basis primarily for the convenience of the

patient or the any health care provider; and such Specialty Drug cannot otherwise be provided safely and effectively in a non-clinical setting.

The following items are covered, even if they are deemed Specialty Drugs:

- Anti-coagulants (such as Lovenox for post-surgery blood clots);
- Anti-rejection drugs prescribed in generic form;
- The following generic oral cancer therapies: Letrozole, Anastrozole, Mercaptopurine & Tamoxifen

31. Orphan Drugs, as defined here are excluded. “Orphan Drug ”means a pharmaceutical agent that has been developed specifically to treat a rear medical condition, the condition itself being referred to as an orphan disease. “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”.

7 CONTINUATION COVERAGE UNDER COBRA

CONTINUATION COVERAGE UNDER COBRA

8.1 RIGHT TO ELECT CONTINUATION COVERAGE

If a Qualified Beneficiary loses coverage under the Group Health Plan due to a Qualifying Event, he or she may elect to continue coverage under the Group Health Plan in accordance with COBRA upon payment of the monthly contribution specified from time to time by the Company. A Qualified Beneficiary must elect the coverage within the sixty (60) day period beginning on the later of:

A. the date of the Qualifying Event; or

B. the date the Qualified Beneficiary was notified of his or her right to continue coverage.

If a Covered Employee has been determined to be an Eligible TAA Recipient or an Eligible Alternative TAA Recipient, as those terms are defined in the Trade Act of 2002, and his or her petition for certification for trade adjustment assistance (TAA) under the Trade Act of 1974 was submitted on or after November 4, 2002, such Covered Employee and his or her Dependents who lost coverage under the Plan due to a job loss which qualified such employee for TAA assistance shall be entitled to a second sixty (60) day election period (if continuation coverage was not elected during the period described above) beginning on the first day of the month in which the Covered Employee is determined to be TAA eligible, provided such election is made within six (6) months of the original loss of coverage. If elected under this provision, coverage shall begin on the first day of the month in which the Covered Employee is determined to be TAA eligible. The period of time between the original termination of coverage, and the coverage which is elected pursuant to this paragraph will not be regarded for purposes of determining whether the individual has experienced more than a sixty-two (62) day break in coverage under the Creditable Coverage provisions of this Plan.

8.2 NOTIFICATION OF QUALIFYING EVENT

If the Qualifying Event is divorce, legal separation or a Dependent child's ineligibility under a Group Health Plan, the Qualified Beneficiary must notify the Company, in writing addressed to the Plan Administrator, of the Qualifying Event within sixty (60) days of the event, or within sixty (60) days of the date the Qualified Beneficiary would lose coverage because of the event, in order for coverage to continue. Appropriate documentation of the Qualifying Event must be submitted, including, as appropriate, final divorce and legal separation decrees issued and properly signed by the court. In addition, a Totally Disabled Qualified Beneficiary must notify the Company in accordance with the section below entitled “Total Disability” in order for coverage to continue.

8.3 LENGTH OF CONTINUATION COVERAGE

A Qualified Beneficiary who loses coverage may continue coverage under the Group Health Plan for:

A. a Qualified Beneficiary who loses coverage due to the reduction in hours or termination of employment (other than for gross misconduct) of a Covered Employee:

1. for up to eighteen (18) months from the date of the Qualifying Event; or
2. if a Qualified Beneficiary is Totally Disabled at any time during the first sixty (60) days of Continuation Coverage, he or she may continue coverage for up to twenty-nine (29) months from the date of the Qualifying Event, provided the Qualified Beneficiary notifies the Company of the determination of his or her Total Disability under the Social Security Act:
   a. before the end of the original eighteen (18) month continuation period; and
   b. within sixty (60) days following the date of such determination; or

B. a Qualified Beneficiary who loses coverage due to the Covered Employee's death, divorce, or Medicare eligibility and Dependent children who have become ineligible for coverage may continue under the Group Health Plan for up to thirty-six (36) months from the date of the Qualifying Event.

8.4 TERMINATION OF CONTINUATION COVERAGE

Continuation Coverage will automatically end earlier than the applicable eighteen (18) or thirty six (36) month period for a Qualified Beneficiary if:

A. the required monthly contribution for coverage is not received by the Company within thirty (30) days following the date it is due;

B. the Qualified Beneficiary becomes covered under any other Group Health Plan containing an exclusion or limitation relating to a Pre-Existing Condition, and such exclusion or limitation applies to the Qualified Beneficiary, then the Qualified Beneficiary shall be eligible for Continuation Coverage as long as the exclusion or limitation relating to the Pre-Existing Condition applies to the Qualified Beneficiary;

C. for Totally Disabled Qualified Beneficiaries continuing coverage for up to twenty-nine (29) months, the last day of the month coincident with or following thirty (30) days from the date of a final determination by the Social Security Administration that such Qualified Beneficiary is no longer Totally Disabled;

D. the Qualified Beneficiary becomes entitled to Medicare benefits; or

E. the Company ceases to offer any Group Health Plans.

8.5 MULTIPLE QUALIFYING EVENTS

If a Qualified Beneficiary is continuing coverage due to a Qualifying Event for which the maximum Continuation Coverage is eighteen (18) months, and a second Qualifying Event occurs during the eighteen (18) month period, the Qualified Beneficiary may elect, in accordance with the section entitled "Right to Elect Continuation Coverage," to continue coverage under the Group Health Plan for up to thirty-six (36) months from the date of the first Qualifying Event.

8.6 TOTAL DISABILITY

In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act (hereinafter the "Act") to have been Totally Disabled at the time of a Qualifying Event or at any time during the first sixty (60) days of the Qualified Beneficiary's Continuation Coverage (if the Qualifying Event is termination of employment or reduction in hours), that Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the Continuation Coverage) for a total of twenty-nine (29) months as long as the Qualified Beneficiary notifies the Employer, in writing addressed to the Plan Administrator:

A. prior to the end of eighteen (18) months of Continuation Coverage that he or she was disabled as of the date of the Qualifying Event; and

B. within sixty (60) days of the determination of Total Disability under the Act.

A copy of the determination letter from Social Security must be submitted with the notification. The Employer will charge the Qualified Beneficiary an increased contribution for Continuation Coverage extended beyond eighteen (18) months pursuant to this Section. If during the period of extended coverage for Total Disability (Continuation Coverage months nineteen (19) through twenty-nine (29)) a Qualified Beneficiary is determined to be no longer Totally Disabled under the Act:

A. the Qualified Beneficiary shall notify the Employer of this determination within thirty (30) days; and

B. Continuation Coverage shall terminate the last day of the month following thirty (30) days from the date of the final determination under the Act that the Qualified Beneficiary is no longer Totally Disabled.

8.7 CARRYOVER OF DEDUCTIBLES AND PLAN MAXIMUMS

If Continuation Coverage under the Group Health Plan is elected by a Qualified Beneficiary under COBRA, expenses already credited to the Plan's applicable Deductible, Copayment and/or Coinsurance features for the year will be carried forward into the Continuation Coverage elected for that year. Similarly, amounts applied toward any maximum payments under the Plan will also be carried forward into the Continuation Coverage. Coverage will not be continued for any benefits for which Plan maximums have been reached.

8.8 PAYMENTS OF PREMIUM

The Group Health Plan will determine the amount of premium to be charged for Continuation Coverage for any period, which will be a reasonable estimate of the cost of providing coverage for such period for similarly situated individuals, determined on an actuarial basis and considering such factors as the Secretary of Labor may prescribe.

A. The Group Health Plan may require a Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred two percent (102%) of the applicable premium for that period.
B. For Qualified Beneficiaries whose coverage is continued pursuant to the Section entitled "Total Disability" of this provision, the Group Health Plan may require the Qualified Beneficiary to pay a contribution for coverage that does not exceed one hundred fifty percent (150%) of the applicable premium for continuation coverage months nineteen (19) through twenty-nine (29).
C. Contributions for coverage may, at the election of the payer, be paid in monthly installments.
D. If Continuation Coverage is elected, the first monthly contribution for coverage must be made within forty-five (45) days of the date of election.

Without further notice from the Company, the Qualified Beneficiary must pay the monthly contribution for coverage by the first day of the month for which coverage is to be effective. If payment is not received by the Company within thirty (30) days of the payment's due date, Continuation Coverage will terminate in accordance with the section entitled "Termination of Continuation Coverage," Subsection A. No claim will be payable under this provision for any period for which the contribution for coverage is not received from or on behalf of the Qualified Beneficiary.

8.9 DEFINITIONS

For purposes of this Article VI, unless specifically stated otherwise, the following definitions apply:

A. "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
B. "Code" means the Internal Revenue Code of 1986, as amended.
C. "Company" means the Employer, as defined in Article III.
D. "Continuation Coverage" means the Group Health Plan coverage elected by a Qualified Beneficiary under COBRA.
E. "Covered Employee" has the same meaning as that term is defined in COBRA and the regulations thereunder.
F. "Group Health Plan" has the same meaning as that term is defined in COBRA and the regulations thereunder.
G. "Qualified Beneficiary" means: for Prescription Benefits
   1. a Covered Employee whose employment terminates (other than for gross misconduct) or whose hours are reduced, rendering the Covered Employee ineligible for coverage under the Plan; and
   2. a covered spouse or Dependent who becomes eligible for coverage under the Plan due to a Qualifying Event, as defined below. Qualified Beneficiary also includes any child who is born to or Placed for Adoption with the Covered Employee during the period of Continuation Coverage.
H. "Qualifying Event" means the following events which, but for Continuation Coverage, would result in the loss of coverage of a Qualified Beneficiary:
   1. termination of a Covered Employee's employment (other than gross misconduct) or reduction in the Covered Employee's hours of employment;
   2. the death of the Covered Employee;
   3. the divorce or legal separation of the Covered Employee from his or her spouse;
   4. the Covered Employee becoming entitled to Medicare coverage; or
   5. a child ceasing to be eligible as a Dependent child under the terms of the Group Health Plan.
I. "Totally Disabled" or "Total Disability" means totally disabled as determined under Title II or Title XVI of the Social Security Act.

8.10 COBRA BANKRUPTCY PROVISIONS UNDER TITLE XI

For purposes of this subsection only:

A. "Qualified Beneficiary" means:
   1. a Covered Employee who retired on or before the date of the Qualifying Event and who was covered as a retiree under the Group Health Plan;
   2. an individual who was covered under the Group Health Plan as a surviving spouse of a deceased retiree on the day before the date of the Qualifying Event; and

3. a Dependent of either of the above described individuals who was covered under the Group Health Plan on the day before the date of the Qualifying Event.

B. "Qualifying Event" means the substantial elimination of coverage under the Group Health Plan within one (1) year before or after the Company files a petition in bankruptcy under Title XI of the United States Code.

If a Qualified Beneficiary experiences a Qualifying Event, as defined in this provision, he or she may elect to continue coverage under the Group Health Plan if he or she pays the monthly contribution specified from time to time by the Company and makes his or her election in accordance with the provision above entitled “Right to Elect Continuation Coverage.” Continuation Coverage for a Qualified Beneficiary who is a retiree and his or her Dependents who are Qualified Beneficiaries will continue for the life of the retiree. When the retiree dies, his or her Qualified Beneficiaries may elect to continue coverage for up to thirty-six (36) additional months. If a surviving spouse and Dependent children are covered as beneficiaries of a deceased retiree when the loss of coverage due to bankruptcy occurs, they may elect to continue coverage until the death of the surviving spouse. Upon the death of the surviving spouse, the Continuation Coverage terminates. Continuation Coverage elected under this provision will automatically end earlier than the periods specified above if the required contribution for coverage is not paid on a timely basis or if the Company ceases to offer any Group Health Plans.

GENERAL INFORMATION

9.1 COORDINATION OF BENEFITS

Coordination of benefits (COB) is a feature that prevents duplicate payment under this Plan and other health insurance or prepayment plans, including Medicare Part A or Part B or other types of insurance. A Covered Person may have coverage under this Plan, some other health plan of coverage or other kind of insurance policy at the same time. Other health plans of coverage include a group sickness and accident insurance policy or program, a group contract of a health maintenance organization, an individual sickness and accident insurance policy and an individual contract of a health maintenance organization. Other kinds of insurance policies include your automobile insurance policy's medical payments and uninsured motorist's coverage. For example, a person may be covered by an employer's group insurance program and also by the group program provided by a spouse's employer. Or a person may be covered by an employer's group insurance and also have coverage under a parent's group plan. If a Covered Person files a claim under this Plan for services or supplies that are also covered under another plan or insurance policy, for instance, one of the plans or policies listed in the first paragraph, payments will be "coordinated." This means that this Plan will adjust its benefit payments so that combined payments under this and any other health plan(s) or insurance policy will be no more than the usual, Customary, and Reasonable fee payments. Once a Covered Person has provided this Plan with information about other health benefit plans and health benefits under other insurance policies under which he or she has coverage, the Plan will handle the coordination. This will be done according to the "Order of Benefit Determination." The Order of Benefit Determination works as follows:

A. The plan that pays first is called the primary plan. Any other plan that covers the Covered Person is called the secondary plan. A group or individual plan or policy that does not contain a COB feature is always primary.

B. A plan that covers a person as the certificate holder or the contract holder is primary. In the two examples given, the coverage the person has through his or her employer would be primary. The coverage through a spouse's or parent's employer would be secondary. The exception to this would be when the laws and regulations governing Medicare require that the plan covering the person as a Dependent pay its benefits as primary to Medicare, but such laws and regulations also provide that the plan covering them as the certificate holder/contract holder should pay its benefits as secondary to Medicare. In such a case, the plan which is required to pay as primary to Medicare shall also pay as primary to the other coverage. C. If a person is covered as a Dependent child of two working parents, the plan of the parent whose birthday falls earliest in the year has primary responsibility for paying the claim. The plan of the parent with the later birthday becomes the secondary plan. If both parents have the same birthday, the parent whose coverage has been in effect the longest is primary. The ages of the respective parents are not relevant. This method of coordinating benefits is commonly referred to as the "birthday rule." If divorced or separated parents (and/or their current spouses) each have group health care coverage that includes a Dependent, the order of benefit determination will be determined, as follows:

1. the plan of the custodial parent, if any, shall pay its benefits first;
2. the plan of the spouse of the custodial parent, if any, will pay next;
3. the plan of the non-custodial parent, if any, will pay after the prior listed plans; and
4. the plan of the spouse of the non-custodial parent, if any, shall pay it benefits last.

However, if a court order establishes responsibility for payment of health care benefits with the parent who does not have custody of the Dependent and the entity that would be for Prescription Benefits 27 obligated to pay the benefits has actual knowledge of the court order's terms, the plan of such non-custodial parent shall pay its benefits before any of the other plans listed above. If the non-custodial parent named in the court order as responsible for the health care benefits does not have any health coverage, the plan of the non-custodial parent's spouse, if any, shall pay its benefits before any of the other plans listed above. If the

court order specifies that the parents have joint custody, and neither parent is named as the primary residential custodian, or the court order requires both parents to provide health care coverage, the "birthday rule" specified above shall apply.

D. A plan that covers a person as an active employee or as a Dependent of an active employee is primary to a plan that covers a person as an inactive employee, such as a laid-off or retired employee or as a Dependent of a laid-off or retired employee.

E. There are some situations in which none of these rules apply. Here the program that has been in effect longer is primary. An example would be when a person who works two jobs has health coverage through both employers.

F. A plan or policy that covers a specific event may be primary to a plan that provides general coverage. For example, if a person is injured in an automobile accident with an uninsured motorist, his or her automobile policy's uninsured motorist's coverage would be primary to a group health plan if both policies had similar provisions regarding other insurance.

If coverage under this Plan is primary, benefits will be paid as if the Covered Person had no other coverage. But if this coverage is secondary, this Plan's payments will be calculated by subtracting the primary plan's benefits for the services and supplies covered under this Plan from the usual, customary and reasonable allowance for the services and supplies. Of course, the Plan will not pay more when secondary than it would if primary. By accepting coverage under this Plan, a Covered Person agrees to do two things to enable the Plan to coordinate benefits. First, the Covered Person will supply the Plan with information about other coverage he or she has when asked. Second, if the Plan makes a payment and later finds out that the coverage under this Plan should not have been primary, the Covered Person will return the excess amount to the Plan. The Plan has the right to obtain information needed to coordinate benefits from others as well, i.e., insurance companies and other persons, for instance.

9.2 THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one (1) or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one (1) party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one (1) or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan. If the Participant(s) fails to file a claim or pursue damages against:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;
D. workers' compensation or other liability insurance company; or
E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The

Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).
This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he/she is required to:

A. notify the Plan or it authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
B. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
C. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and
D. hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved. No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of injury, sickness, disease or disability there is available, or potentially available, any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to any of the following:

A. the responsible party, its insurer, or any other source on behalf of that party;
B. any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
C. any policy of insurance from any insurance company or guarantor of a third party;

D. workers' compensation or other liability insurance company; or

E. any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

A. to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

B. to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

C. to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

D. to do nothing to prejudice the Plan's rights of subrogation and reimbursement;

E. to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

F. to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

G. to not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or coverage;

H. to instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

I. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

J. to make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s). The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical

benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or courtappointed guardian. Language Interpretation The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

9.3 MEDICARE BENEFITS

This provision prevents duplication of benefits for Covered Expenses when Medical Care benefits are available from Medicare. Benefits under this Plan will be reduced to the extent that the Participant or his or her Dependents are reimbursed or entitled to reimbursement for those expenses by Medicare. Any individual at any time entitled to enroll in Medicare will be considered enrolled in Part A and Part B even if the individual did not enroll. Under the Tax Equity and Fiscal Responsibility Act of 1982, as amended (TEFRA), active employees and/or their spouses who are sixty-five (65) or over may choose to have the Company program as primary coverage, in which case Medicare may pay benefits on a secondary basis. Otherwise, an employee may elect to drop out of the company program and choose Medicare as primary coverage. Employees in this category who are enrolled under this Plan will remain so enrolled with this Plan as primary coverage unless an option form is on file indicating otherwise. The Plan may also pay its benefits as primary to Medicare's in other situations, as prescribed by applicable laws and regulations. The Plan intends to comply with the federal Social Security Act, as amended, and other applicable laws, as such apply to Medicare benefits.

9.4 ADDITIONAL RIGHTS OF RECOVERY

If payments are made under the Plan that should not have been made, the Plan may recover that incorrect payment. The Plan may recover this payment from the person to whom it was made or from any other appropriate party. If any such incorrect payment is made to the Participant, the Plan may deduct it when making future payments directly to the Participant. Once the Plan Administrator determines that a previous benefit payment should be reimbursed, in whole or in part, either due to the provisions described in Section 8.2 or because such benefit payment should not have been made in accordance with the provisions of this Plan, the Participant and/or the applicable Provider will be notified of such overpayment, and a request will be made for such Participant/Provider to reimburse the Plan. If the reimbursement is not made as requested, such amount will constitute a lien against future claim payments that would otherwise be paid on the Participant or the Covered Person's behalf. The Plan Administrator retains the right to reduce or withhold such future claim payments until the lien is satisfied. This Plan will comply with Sections 609(b)(1), (2) and (3) of the Employee Retirement Income Security Act with regard to Covered Persons eligible for Medicaid. An Employee's or Dependent's eligibility for, or participation in, Medicaid will not affect determination of whether or not payments should be made. Under state and federal law, should a

Covered Person be entitled to payment of a claim under this Plan, and all or part of that claim has been paid by Medicaid, then the state is subrogated to the Covered Person's right to payment under this Plan to the extent of the amount paid by Medicaid, and reimbursement under this Plan will be made in that amount directly to the state.

9.5 FACILITY OF PAYMENT

Whenever a Covered Person or provider to whom payments are directed to be made is mentally, physically, or legally incapable of receiving or acknowledging receipt of such payments, neither the Plan Administrator nor the Benefit Manager shall be under any obligation to see that a legal representative is appointed or to make payments to such legal representative, if appointed. A determination of payment made in good faith shall be conclusive on all persons. The Plan Administrator, Benefit Manager or any fiduciary shall not be liable to any person as a result of a payment made and shall be fully discharged from all future liability with respect to a payment made.

9.6 ADMINISTRATION OF THE PLAN

Except as otherwise specifically provided for in the Plan, the Plan Administrator shall have the exclusive authority to control and manage the operation and administration of the Plan and shall be Named Fiduciary of the Plan for purposes of ERISA. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions thereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have the full discretion, power, and the duty to take all action necessary or proper to carry out the duties required under ERISA and all other applicable law.

The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient; provided however, that both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Employer shall indemnify any employee to whom duties are delegated by the Plan Administrator pursuant to this section from and against any liability that such employee may incur in the administration of the Plan, except for liabilities arising from the recklessness or willful misconduct of such employee.

The Plan Administrator shall be responsible for controlling and managing the operation and administration of this Plan, including, but not limited to, the power:

A. to employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;

B. to construe and interpret this Plan;

C. to adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;

D. to decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;

E. to prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;

F. to authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;

G. to prepare and to distribute, in such manner as it deems appropriate, information explaining the Plan;

H. to apply consistently and uniformly to all Covered Persons in similar circumstances its rules, regulations, determinations and decisions;

I. to prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of ERISA and all other applicable laws, and all regulations promulgated thereunder; and

J. to retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of the Plan.

The Plan Administrator shall be the sole judge of the standards of proof required in any case. In the application and interpretation of this Plan document, the decision of the Plan Administrator shall be final and binding on the Participants, Dependents, and all other persons. The Plan Administrator shall have the full power and authority, in its sole discretion, to construe and interpret the provisions and terms of this Plan document and all other written documents. Any such determination and any such construction adopted by the Plan Administrator in good faith shall be binding upon all of the parties hereto and the beneficiaries thereof and may not be reversed by a court of competent jurisdiction unless the court finds the determination to be arbitrary and capricious.

9.7 NON-ALIENATION AND ASSIGNMENT

The Plan shall not be liable for any debt, liability, contract or tort of any employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Expenses directly to the Covered Person who incurred the Covered Expenses, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service provider; provided further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service provider shall be binding on the Plan only if:

A. the Plan Administrator or Benefit Manager is notified of such assignment prior to payment of benefits;

B. the assignment is made on a form provided by, or approved by, the Plan Administrator or the Benefit Manager; and

C. the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or Benefit Manager.

9.8 FAILURE TO ENFORCE

Failure to enforce any provision of this Plan does not constitute a waiver or otherwise affect the Plan Administrator's right to enforce such a provision at another time, nor will such failure affect the right to enforce any other provision.

9.9 FIDUCIARY RESPONSIBILITIES

No fiduciary of the Plan shall be liable for any acts or omission in carrying out his, her or its responsibilities under the Plan, except as may be provided under ERISA and other applicable laws. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to such fiduciary under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in ERISA and other applicable laws.

9.10 DISCLAIMER OF LIABILITY

The Plan is not responsible for the efficiency or integrity of any health care provider delivering services or supplies utilized by the Participant. The Plan is not liable in any way for the effect of delivery of such services or supplies, the results of actions taken as a result of such services or supplies being limited or not covered by the Plan, nor any limitations imposed on the cost sharing responsibility of the Plan. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, Benefit Manager, or any Employer for the acts or omissions of any health care provider from whom a Covered Person receives care, or for the acts or omission of any Physician from whom the Covered Person receives care under the Plan, or for any acts or omissions of any provider of services or supplies under this Plan. Neither the Plan,

nor the Plan Administrator, nor the Benefit Manager have any responsibility for or control over the actions of any Preferred Provider networks offering services and/or supplies under the Plan.

9.11 ADMINISTRATIVE AND CLERICAL ERRORS

The benefits payable to or on behalf of a Participant or Dependent under this Plan will not be decreased nor increased due to administrative or clerical errors made by the Employer, the Plan Administrator, the Utilization Review Service or the Benefit Manager. If written application for coverage for an eligible employee or Dependent is submitted by the employee/Participant within the applicable time frame specified in Article V, any subsequent administrative or clerical error made by the Employer, the Plan Administrator or the Benefit Manager shall not act to delay the effective date of such person's coverage beyond the date such coverage would otherwise become effective if such application was processed in a timely manner. In addition, any such error made in claims processing, utilization review or other administrative functions shall not affect the benefits payable to or on behalf of a Covered Person under this Plan. The Plan Administrator may require proof of an error described in this provision. The Plan Administrator shall have the sole responsibility to determine when an error is an "administrative or clerical" error and will be the sole judge of any proof required.

9.12 RESCISSION OF COVERAGE

A rescission of coverage means that the coverage may be legally voided all the way back to the day the Plan began to provide an individual with coverage, just as if he or she never had coverage under the Plan. Such coverage can only be rescinded if the individual (or a person seeking coverage on an individual's behalf) perform an act, practice, or omission that constitutes fraud; or unless the individual (or a person seeking coverage on the individual's behalf) make an intentional misrepresentation of material fact, as prohibited by the terms of this Plan. Coverage can also be rescinded due to such an act, practice, omission or intentional misrepresentation by an employer. Such individual will be provided with thirty (30) calendar days' advance notice before coverage is rescinded. Such individual has the right to request an internal appeal of a rescission of his or her coverage. Once the internal appeal process is exhausted, such person has the additional right to request an independent external review.

9 PRIVACY

PRIVACY

10.1 PRIVACY OF HEALTH INFORMATION

This provision is intended to bring this Plan into compliance with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder. Health Information transmitted or maintained by the Plan will be subject to the provisions described in this article.

10.2 USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Protected Health Information will only be disclosed or used by the Plan under one (1) of the following conditions:

A. with the specific consent of the individual who is the subject of the Protected Health Information, provided that the Plan obtains any required authorization;

B. for payment of claims submitted to the Plan, or for utilization review activities as described in Article VI, including, but not limited to, the review of any grievances or appeals involved in such activities which are generated by the Covered Person or his or her authorized representatives; or

C. for other reasonable purposes necessary to operate the Plan, to the extent that such Protected Health Information is required for such purposes, including:

1. quality assessment and improvement activities;
2. evaluation of Plan performance;
3. underwriting and premium rating and other activities relating to the procuring, renewal or replacement of stop loss or excess loss insurance;
4. conducting or arranging for medical review, legal services and auditing functions, including f raud and abuse detection and compliance programs;
5. business planning and development of the Plan;
6. business management and general administrative activities of the Plan, including, but not limited to, enrollments, billing, customer service and the resolution of internal grievances; and
7. other health care operations listed under 45 C.F.R. § 164.501. No other use or disclosure of Protected Health Information is permitted by this Plan.

10.3 DISCLOSURES OF HEALTH INFORMATION TO THE COMPANY

The Plan Administrator will disclose, or permit the disclosure of, Health Information to the Company only as described below:

A. for any of the purposes and under the conditions described in Section 9.2;

B. as Summary Health Information, if requested by the Company for the following purposes:

1. obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. modifying, amending or terminating the Plan; or

C. for informational purposes regarding whether an individual is participating in the Plan, provided such information is only used by the Company for the purpose of performing Plan administrative functions.

Prior to any disclosure of Health Information to the Company, such entity must agree:

A. not to use or further disclose the information other than as permitted or required by this section, or as required by law;

B. that it will ensure that any agents, including subcontractors, employed by the Company or Plan Administrator for Plan administration or other Plan purposes to whom it provides Protected Health Information, including, but not limited to, the Benefit Manager, any Utilization Review Service or

Pharmacy benefit manager, agree to the same restrictions and conditions that apply to the Company with respect to such information;

C. not to use or disclose the Protected Health Information for employment-related actions and decisions, or in connection with any other benefit or employee benefit plan sponsored by the Company;

D. that it will report to the Plan Administrator any use or disclosure of the information that is inconsistent with the uses or disclosures provided for in this section of which it becomes aware;

E. that it will make available Protected Health Information to the subject of such information, and allow amendment to such information as described in Section 9.4 and Section 9.5;

F. that it will provide an accounting in accordance with 45 C.F.R. § 164.528, upon the request of the subject of Protected Health Information, of the disclosure of such information by the Plan made within six (6) years of the request, except information exempted from such accounting under that section;

G. that it will make available its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan to the Secretary of the United States Department of Health and Human Services for the purpose of determining compliance by the Plan with the privacy provisions of HIPAA;

H. that it will, if feasible, return or destroy all Protected Health Information received from the Plan that the Company still maintains in any form, and that it will not retain any copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, that it will limit further uses and disclosures to those purposes which make the return or destruction of the information infeasible; and

I. that it will provide for adequate separation between the Plan and the Plan Sponsor by implementing the following procedures:

1. access to Protected Health Information will only be provided to the following categories of Company employees:

a. Chief Human Resources Officer and Senior Director of Benefits;

2. that access to and use by such employees or other persons as described above will be limited to the plan administration functions that the Company performs for the Plan; and

3. any non-compliance by such named individuals with the privacy provisions of this Plan will be addressed in accordance with the Company's established employee discipline and termination procedures.

10.4 ACCESS OF COVERED PERSONS TO PROTECTED HEALTH INFORMATION

A Covered Person or other individual has the right of access to inspect and obtain a copy of Protected Health Information about such person as long as such information is maintained by the Plan, except for:

A. psychotherapy notes;

B. information compiled in reasonable anticipation, or for use in a civil, criminal or administrative proceeding or action; or

C. as such information is otherwise exempted from disclosure under 45 C.F.R. § 164.524. Any such request must be made to the Plan Administrator a writing signed by the Covered Person whose information is being requested. The Plan Administrator will notify the Covered Person, writing, as to whether such request is approved or denied, and, if approved, will provide access to the information in accordance with 45 C.F.R. § 164.524(c), including the imposition of reasonable fees for the costs of providing such access.

10.5 AMENDMENT RIGHTS

A Covered Person or other individual has the right to have the Company amend Protected Health Information or other information about such individual as long as such information is maintained by the Plan. The Plan Administrator will deny such a request if:

A. the information was not created by the Plan, unless the individual provides a reasonable basis to believe that the originator of the Protected Health Information is no longer available to act on the requested amendment;
B. the information is not currently maintained in any record by the Plan;
C. the information would not be available for inspection under the reasons cited in Section 9.4; or
D. the information in the Plan’s records is accurate and complete.

Any request for amendment of Protected Health Information must be provided in writing to the Plan Administrator and signed by the Covered Person or individual who is the subject of the information with an explanation as to why such person believes the information is inaccurate, incomplete or incorrect. The Plan Administrator will notify the Covered Person, in writing, as to whether such request is approved or denied, and, if approved, will make the necessary corrections to the information in accordance with 45 C.F.R. § 164.526(c). The Plan Administrator will make reasonable efforts to inform all entities which it has knowledge of such entity’s receipt of any information which has been corrected. If the request is denied, the individual may submit a written statement disagreeing with the denial which includes the basis of such disagreement. The Plan Administrator may prepare a written rebuttal of such statement. The statement of disagreement, and the rebuttal, if any, will be included in any future disclosure of the information. Even if no statement of disagreement is submitted, the individual may request that the request for amendment and denial be included with any future disclosures of the information.

10.6 SECURITY OF PROTECTED HEALTH INFORMATION
The Company will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted on behalf of the Plan, including reasonable and appropriate security measures between the Company and the Plan to support the requirements of Section 9.3. The Company will further ensure that any agent, including a subcontractor, to whom it provides access to ePHI agrees to implement reasonable and appropriate security measures to protect the information, and will report any security incident of which it becomes aware to the Plan Administrator.

10 STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) requires that certain information be furnished to each Member in an employee benefit Plan. This information is outlined below.

- Plan Name: American Senior Communities Master Welfare Plan Prescription Drug Plan
- Plan Sponsor: American Senior Communities, LLC
- Plan Number:
- Employer I.D. Number:
- Type of Plan: The Plan is an Employee welfare benefit plan providing Prescription Drug benefits.
- Plan Year Ends: 12/31
- Type of Administration:

  Medical benefits are furnished under a health care plan funded by the Plan Sponsor on a self-funded basis with claims being administered by UMR, A United Healthcare Company, on behalf of American Senior Communities

- Plan Administrator and Named Fiduciary: American Senior Communities, LLC
- Agent for Service of Legal Process: American Senior Communities, LLC
- Description of Benefits:

  This Plan Description sets forth the benefits provided under this American Senior Communities Master Welfare Plan Prescription Drug Plan. A brief explanation of these benefits may be found in the section entitled "Schedule of Benefits". A more detailed description of the benefits appears in the sections entitled "Benefits".

- Eligibility for Participation:

  The eligibility requirements for participation under this American Senior Communities Master Welfare Plan Prescription Drug Plan are stated in and under the terms of the American Senior Communities Group Health Benefit Plan, which terms are incorporated by reference. See the section entitled "Eligibility".

- Claims Procedures:

  The Claims Procedure is stated herein. Note that the Claims Administrator under this American Senior Communities Group Health Benefit Plan is neither the Plan Administrator nor the administrator for any other the purposes of ERISA, and has only the role and authority stated herein.

- Funding of The Plan:

  Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.

- Benefit Plan Year:

  Benefits begin on January 1 and end on December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.

- ERISA Plan Year:

  January 1 through December 31

- ERISA and Other Federal Compliance:

  It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event of any conflict between this Plan and ERISA or other federal regulations, the provisions of ERISA and the federal regulations shall be deemed controlling, and any conflicting part of this Plan shall be deemed superseded to the extent of the conflict.

- Discretionary Authority and Claim Determinations:

  The Plan is administered by the Plan Administrator in accordance with the provisions of the Plan as implemented by the Claims Administrator. The Claims Administrator is defined herein. Benefits are payable as stated in this document. The Plan Administrator is not the fiduciary with respect to certain claim determinations made by the Claims Administrator. The Plan Administrator is otherwise responsible and is the fiduciary for all other determinations under the Plan. In such any determinations under this American Senior Communities Master Welfare Plan Prescription Drug Plan, whether taken by the Claims Administrator or by the Plan Administrator in its exercise of any rights hereunder, including the right to overrule the Claims Administrator, both the Plan Administrator and the Claims Administrator and each of them, have and are vested with full and absolute discretionary authority with respect to all determinations under the American Senior Communities Master Welfare Plan Prescription Drug Plan, including the determination of facts, the interpretation of American Senior Communities Master Welfare Plan Prescription Drug Plan and/or its terms, and with respect to all factual and legal decisions and determinations under this American Senior Communities Master Welfare Plan Prescription Drug Plan. This discretionary authority is to be interpreted in the broadest sense permitted under law.

General Information About ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) entitles You, as a Member of the Plan, to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by this Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions;

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for these copies; and

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

In addition to creating rights for You and other Employees, ERISA imposes duties on the people responsible for the operation of Your Employee benefit Plan. The people who operate Your Plan are called plan fiduciaries. They must handle Your Plan prudently and in the best interest of You and other Plan Members 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 right under ERISA. If Your claim for welfare benefits is denied, in whole or in part, You must receive a written explanation of the reason for the denial. You have the right to have Your claims reviewed and reconsidered.

Under ERISA, there are steps You can take to enforce the above rights. For instance, if You request materials from the Plan Administrator and do not receive them within 30 days, You may file suit in a federal court. In such case, the court may require the Plan Administrator to provide You the materials and pay You up to $110 a day until You receive the materials, unless the materials are not sent because of reasons beyond the control of the Plan Administrator. If Your claim for benefits is denied or ignored, in whole or in part, You may file suit in a state or federal court. If 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 may file suit in a federal court. The court will decide who should pay court costs and legal fees. It may order You to pay these expenses, for example, if it finds Your claim is frivolous. 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, 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.

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.

EXECUTION

The American Senior Communities Master Welfare Plan Prescription Drug Plan, integrated with the American Senior Communities Welfare Plan, is hereby adopted and approved, effective as stated herein.

American Senior Communities

By:___________________________________

Printed:_______________________________

Title:__________________________________

Date:________________________________