ABBINGTON MANAGEMENT CORP.
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

Effective June 1, 2006; amended and restated June 1, 2010

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As used in this Summary Plan Description (SPD), "You" means an active Employee as described under "Who is Eligible."

PLAN PURPOSE

The purpose of the Abbington Management Corp. Health Reimbursement Arrangement Plan ("Plan") is to provide you with additional health coverage benefits. The benefits available under this Plan and other important information concerning the Plan, such as rules that must be satisfied before you become eligible and laws that protect your rights are outlined in this summary plan description.

WHO IS ELIGIBLE

With respect to the HRA, if you regularly work 30 or more hours per week and you have completed 90 consecutive days of active employment with the Company; Abbington Arlington Partners LP; Abbington Coshocton Corp.; Abbington Pickerington Partners LP; Abbington Powell Partners LP; Liberty Village Senior Communities Inc.; or any other affiliate of the Employer which adopts the Plan, ("Participating Employer"), and you are eligible to participate and are enrolled in the Abbington Management Corp. group Health Insurance Plan, you are eligible to participate in the HRA Plan.

There are certain employees who are not eligible to participate in the Plan. They are Employees who are not eligible to receive medical benefits under Abbington Management Corp. group Health Insurance Plan.

WHEN YOU MAY PARTICIPATE

You are eligible to participate in the Plan on the 91st day of active employment as an Eligible Employee and on the first day you become eligible to participate and are enrolled in the Abbington Management Corp. group Health Insurance Plan.

SCHEDULE OF BENEFITS

The Health Reimbursement Arrangement (HRA) benefits allow you to be reimbursed for certain out-of-pocket medical expenses which are incurred by you and your dependents. The expenses that qualify are those covered under your Major Medical Plan. Please refer to your Major Medical Plan Document for a complete listing of covered expenses.

The maximum allowed benefit each year is outlined in Schedule A.

Expenses are considered "incurred" when the service is performed, not necessarily when the expense is formally billed, charged, or paid for. Any amounts reimbursed to you under the Plan may

not be claimed as a deduction on your personal income tax return nor reimbursed by other health plan coverage.

HOW HEALTH REIMBURSEMENT ARRANGEMENTS (HRAs) WORK

Your employer has set aside a specific amount of funds each Plan Year from which you may be reimbursed for eligible medical expenses that you have incurred during your Period of Coverage. Normally, you would pay for these expenses out of pocket, with your own after-tax income. The HRA Account will only be a records-keeping account with the purpose of keeping track of contributions and available reimbursement amounts. Your employer is funding the account, and as such, there should be no tax liability to you.

To receive reimbursement, you must complete a claim form and submit it along with your paid bills or other substantiation of expenses, to the Plan Administrator. The Plan Administrator will provide you with acceptable forms for submitting these requests for reimbursement. In addition, you must submit to the Plan Administrator proof of the expenses you have incurred and that they have not been paid by any other health plan coverage. Please review the list of eligible medical expenses provided on Schedule A of this Summary Plan Description, as well as the list of any ineligible expenses listed on Schedule B of this Summary Plan Description. If your request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement check soon thereafter up to the amount available in your HRA Account.

You may submit expenses that you incur each "Coverage Period". A new "Coverage Period" begins each Plan Year.

FUTURE OF THE HEALTH REIMBURSEMENT ARRANGEMENT

The Plan is based on the Employer's understanding of the current provisions of the Internal Revenue Code. The Employer reserves the right to amend or discontinue the Plan if regulations or changes in the tax law make it advisable to do so. If the Plan is amended or terminated, it will not affect any benefit to which you were entitled before the date of the amendment or termination.

COBRA CONTINUATION COVERAGE *(Generally applicable to groups of 20+ employees)*

If you terminate employment, under Federal law, you, your spouse, and/or your covered dependents lose coverage under this Plan. You, your spouse, and/or your covered dependents may be

entitled to continuation of health care coverage. The Administrator will inform you of these rights if you lose coverage for any reason other than divorce, legal separation or a covered dependent ceasing to be a dependent. Generally, if your employer (and any related companies) employed twenty (20) or more employees "on a typical business day" in the preceding calendar year, health plan continuation must be made available for a period not to exceed eighteen (18) months if a loss of benefits occurs because of your termination of employment or reduction of hours, or for a period not to exceed three (3) years for any of the other reasons given in (b) and (c) below. Under certain circumstances, persons who are disabled at the time of termination of employment or reduction in hours and/or within the first 60 days of COBRA coverage may be eligible for continuation of coverage for a total of 29 months (rather than 18). You should check with the Administrator for more details regarding this extended coverage. However, in certain circumstances, this continuation coverage may be terminated for reasons such as failure to pay continuation coverage cost, coverage under another employer's plan (whether as an employee or otherwise, provided the other employer's health plan does not contain any exclusion or limitation with respect to any pre-existing condition of the beneficiary unless the pre-existing condition limit does not apply to, or is satisfied by, the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act), termination of the health plan, a "for cause" termination of coverage for reasons such as fraud, or you (or the person entitled to continued coverage) become enrolled in Medicare. However, if you become enrolled in Medicare, your covered dependents may still qualify for continuation coverage. The cost of continuation coverage must be paid by the individual choosing such coverage; however, the cost may not exceed 102% of the cost of the same coverage for a "similarly situated" employee or family member. When the continuation coverage for a disabled person is extended from 18 months to 29 months, the disabled person may be charged 150% (rather than 102%) of the cost of the coverage after expiration of the initial 18-month period.

(a) If you would otherwise lose your health plan coverage under this Plan because of a termination of employment or a reduction in hours, you may continue the health plan coverage provided under this Plan.

(b) Your spouse may choose continuation coverage for himself or herself if he or she loses group health coverage for any of the following reasons: (1) your death; (2) your divorce or legal separation; or (3) you become enrolled in Medicare.

(c) Your dependent children, including a child born to or placed for adoption with the Participant during the period of COBRA coverage, may choose continuation coverage for themselves if they lose group health coverage for any of the following reasons: (1) death of a parent; (2) your divorce or legal separation; (3) you become enrolled in Medicare; or (4) your dependent ceases to be a dependent child under the Plan.

It is your responsibility to notify the Plan Administrator of a divorce, legal separation or other change in marital status, change in a spouse's address, or a child losing dependent status under the plan, within sixty (60) days of the event. It is your Employer's responsibility to notify the Plan Administrator of your death, termination of employment or reduction in hours, the Employer's bankruptcy, or Medicare eligibility.

For purposes of this section the words "Dependent" and "Medicare" shall have the following meanings:

- "Dependent" means an individual who meets the definition of dependent under the Participating Employer health plan covering the Qualified Beneficiary. No person shall be considered a dependent of more than one Employee. If you and your spouse are employed by the Employer, dependent children may be covered by you or your spouse, but not by both.
- "Medicare" means the Health Insurance For the Aged and Disabled Act, Title XVIII of Public Law 89-97, Social Security, as amended.

FAMILY AND MEDICAL LEAVE *(Applicable to groups of 50+ employees)*

As an employee of Abbington Management Corp., you may be entitled under the federal Family and Medical Leave Act (FMLA) up to 12 work weeks of unpaid, job-protected leave in any 12-month period. You may be eligible if you have worked for Abbington Management Corp. for at least one year, and for 1,250 hours during the previous 12 months. Such leave may be available for the birth and care of a newborn child, placement of a child for adoption or foster care, a serious health condition of a family member (child, spouse or parent), FMLA military leave, or a personal serious health condition.

As a participant in the Health Reimbursement Arrangement, you have while on leave under the FMLA the option to continue your health benefits on the same terms and conditions as immediately prior to your taking FMLA leave. You and your eligible dependents shall remain covered under this plan while you are on FMLA leave as if you still were at work. Your coverage will be maintained

until you return to work or, if earlier, you notify Abbington Management Corp. that you will not return to work. If you choose not to remain covered under the plan while on FMLA leave, and subsequently return to work before, or at the end of FMLA leave, you and your eligible dependents shall immediately become covered under the health plan without proof of insurability and without regard to pre-existing conditions that arise while on FMLA leave. You and your eligible dependents may also be reinstated in the HRA Plan, on the same terms that applied to the Participant prior to his or her taking the FMLA. More details on your FMLA rights and benefits while on FMLA leave should be found in your employer's employee handbook.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

(Applicable to any size group)

A Participant who takes an unpaid leave of absence under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA Leave"), may revoke his election to participate under any group health insurance benefit offered under this Plan, for the remainder of the Plan Year in which such leave of absence commences. Such revocation shall take effect in accordance with such procedures as prescribed by the Plan Administrator. Upon such Participant's return from his or her USERRA Leave, the Participant may be reinstated in the Plan, on the same terms that applied to the Participant prior to his or her taking the USERRA Leave, and with such other rights to make enrollment changes as are provided to other Participants under the Plan. Notwithstanding the foregoing, a Participant on USERRA Leave shall have no greater rights to benefits for the remainder of the Plan Year in which the USERRA leave commences, as other Plan Participants.

NON-FMLA AND NON-USERRA LEAVES OF ABSENCE

A Participant who goes on a leave of absence that is not subject to FMLA or USERRA will be treated as having terminated participation.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Generally, your Plan benefits may not be assigned or alienated; however, an exception applies in the case of a "qualified medical child support order." Basically, a qualified medical child support order is a court–ordered judgment, decree, order or property settlement agreement in connection with state domestic relations law which either creates or extends the rights of an "alternate recipient" to

participate in a group health plan, including this Plan, or enforces certain laws relating to medical child support. An "alternate recipient" is any child of a Participant who is recognized by a medical child support order as having a right to enrollment under a Participant's group health plan.

A medical child support order satisfies certain specific conditions to be qualified. You will be notified by the Plan Administrator, if it receives a medical child support order that applies to you, and the Plan's procedures for determining whether the medical child support order is qualified.

DEFINITION OF "DEPENDENT" REVISED BY THE WFTRA OF 2005

The definition of "Dependent" has been revised under Section 152 of the Code by the Working Families Tax Relief Act of 2005, (WFTRA), effective January 1, 2005. An individual is considered to be a dependent if he or she is a qualifying child or qualifying relative of the taxpayer.

The following qualifying criteria now apply to be a "dependent child":

1) The individual has a specific family type relationship to the taxpayer
2) The individual does not provide more than half of his or her own support
3) The individual has the same place of residence as the taxpayer for more than half of the year
4) The individual does not turn age 19, (24 if a full-time student), by the end of the Plan Year

In addition, the following qualifying criteria apply to be a "dependent relative":

1) The individual has a specific family type relationship to the taxpayer
2) The individual is not a qualifying child of any other taxpayer
3) The individual receives more than half of his or her support from the taxpayer
4) The individual's annual gross income is less than the Section 151 limit (this criterion does <u>not</u> apply to health plans)

In the case of an individual who is permanently and totally disabled (as defined in Code Section 22(e)(3)) at any time during such calendar year, the age requirement for a qualifying child does not apply.

No person shall be considered a Dependent of more than one Employee. If both an Employee and an Employee's spouse are employed by Employer, dependent children may be covered by either spouse, but not by both.

NOTE: the Internal Revenue Service (the "IRS") **Notice 2010-38** (the "**Notice**") provides important guidance regarding the tax treatment of employer-provided health coverage to employees' adult children who have not attained age 27 as of the end of the employee's taxable year.

Retroactively to March 30, 2010, both the amounts paid by an employer for coverage for an employee's adult children and the amounts paid (or reimbursed) to the employee for such coverage are excluded from the employee's gross income, in the same manner as coverage that is provided to an employee's spouse or dependent defined under Section 152 of the Code. The **Notice** provides important guidance and further clarifications with regard to these issues.

MICHELLE'S LAW AND HOW IT EFFECTS YOUR HRA BENEFIT

Michelle's Law provides that a group health plan may not terminate the coverage of a dependent child who is covered as a full-time student at a post-secondary educational institution as a result of that individual ceasing to meet the definition of a full-time student due to a medically necessary leave of absence (or other change of enrollment, if medically necessary). In such a situation, the plan is required to continue the individual's coverage for up to a year while he or she is on a medically necessary leave of absence (unless coverage would otherwise terminate sooner under the terms of the plan). The student has to be full-time until the first day of the leave and must be medically certified by a treating physician. To be eligible, the treating physician must certify that the student's medical leave of absence (or change in enrollment) is medically necessary.

Michelle's Law amends ERISA, so it applies to any group health plan subject to ERISA, which includes both fully-insured and self-funded plans.

Because Michelle's Law did not amend Code section 152, reimbursements for eligible expenses of dependents covered under Michelle's law that do not meet the definition of dependent under Code section 152 may be subject to tax.

ADMINISTRATIVE FACTS

Plan Sponsor and Administrator

The Plan is sponsored by Abbington Management Corp., 5920 Venture Drive, Suite 200, Dublin, OH 43017-2237, 614-798-5110. The Abbington Management Corp. Federal Tax ID Number is 31-1454490. Abbington Management Corp. also acts as Plan Administrator. The Plan Administrator manages the overall operations of the Plan and decides all questions that come to it on a fair and equitable basis for participants and their Beneficiaries. If an Employee covered under the Plan has any questions about the Plan, the Employee should contact the Plan Administrator.

General Information

Abbington Management Corp. Health Reimbursement Arrangement is the name of the Plan.

Your Employer has assigned Plan Number 502 to this Plan.

The provisions of your Plan became effective on June 1, 2006; amended and restated June 1, 2010.

The Plan Year is January 1 to December 31.

Service of Legal Process

The Employer is the Plan's agent for service of legal process.

Classification and Funding

This employee benefit is a Health Reimbursement Arrangement as defined by Section 105 of the Internal Revenue Code. This Health Reimbursement Arrangement is funded solely by the Employer.

Not a Contract of Employment

No provision of the Plan is to be considered a contract of employment between you and Abbington Management Corp. or a Participating Employer. Abbington Management Corp.'s rights with regard to disciplinary action and termination of any Employee, if necessary, are in no manner changed by any provision of the Plan.

Your HIPAA Privacy Rights - Use and Disclosure of Protected Health Information (PHI)

Except for certain permitted uses and disclosures, the Privacy Rule issued by the federal government prohibits the HRA Plan from using or disclosing certain health information about you that is created or received by the HRA Plan without your written authorization. For additional information about your privacy rights, please either refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official: J. Michael Haemmerle.

Protected Health Information generally includes all information, whether written or oral, in connection with the HRA Plan that (1) is created or received by the HRA Plan; (2) relates to your past, present, or future physical or mental health, the provision of health care to you, or the past, present, or future payment for the provision of health care; and (3) identifies you or could be used to identify you.

If you wish to authorize the HRA Plan to use or disclose your PHI in a manner that is not otherwise permitted, you must submit a signed and completed authorization form to the HRA Plan. You may request a copy of the authorization form from Human Resources.

Permitted Uses and Disclosures

The HRA Plan is permitted under the Privacy Rule to use or disclose your PHI without your authorization only for purposes related to:

- Health care treatment;
- Payment for health care;
- Health care operations; and
- Other specifically permitted exceptions, such as disclosures to assist disaster relief, disclosures to lessen serious health or safety threats, or disclosures to business associates.

For a complete list of permitted exceptions, please refer to the HRA Plan's Privacy Notice or contact the HRA Plan's Privacy Official.

Disclosures to the Company

After the Company has certified to the HRA Plan that it is in compliance with the Privacy Rule, the HRA Plan may disclose PHI to the Company without your authorization to the extent that the PHI is necessary for the Company to perform HRA Plan administration functions. The HRA Plan may not disclose any more PHI to the Company than is necessary for the Company to fulfill its administration functions, and the HRA Plan may not disclose PHI to the Company for purposes of any employment-related actions or in connection with any other employee benefit provided by the Company.

To the extent that your PHI is disclosed to the Company, the Company will:

- Not use or further disclose PHI other than as permitted or required by the official HRA Plan document or as required by law;
- Ensure that any agents to whom the Company provides PHI (or certain electronic PHI) received from the HRA Plan agree to the same restrictions and conditions that apply to the Company with respect to PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by you;
- Not use or disclose PHI in connection with any other benefit provided by the Company unless

authorized by you;

- Report to the HRA Plan's Privacy Officer any misuse or improper disclosure of PHI;
- Make PHI available to you in accordance with the requirements of the Privacy Rule;
- Make PHI available to you for amendment and incorporate any amendments to PHI in accordance with the requirements of the Privacy Rule;
- Make available to you the information required to provide an accounting of disclosures in accordance with the requirements of the Privacy Rule;
- Make internal practices, books, and records relating to the Company's use and disclosure of PHI available to the Secretary of Health and Human Services for the purposes of determining the HRA Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the HRA Plan that the Company still maintains in any form, and retain no copies of the PHI, when the PHI is no longer needed for the purpose for which the disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

The Company may only disclose your PHI (or certain electronic PHI) to the following Company employees and may only do so to the extent that the Company employees perform HRA Plan administration functions:

- The Privacy Official;
- Employees in the Company's Human Resources Department;
- Employees in the Company's Office of General Counsel; and
- Any other class of employees designated in writing by the Privacy Official.

If a Company employee does not comply with the requirements of the Privacy Rule, then the Company may apply appropriate sanctions to the employee in order to ensure compliance with the Privacy Rule. If you become aware of any inappropriate use or improper disclosure of PHI, contact the Privacy Official immediately.

ERISA Rights Statement

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted to help assure that all employer-sponsored group benefit programs conform to standards set by Congress. An employee, who is a Participant in the Plan is entitled to certain rights and protections under ERISA, which provides that all Participants will be entitled to: (1) examine, without charge, at the Plan

Administrator's office and at other appropriate locations, all Plan documents and copies of documents filed with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions; (2) obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator, subject to a reasonable charge for the copies; and (3) receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report. Plan records are kept on a Plan year basis.

In addition to creating rights for plan Participants, ERISA imposes duties upon those responsible for the operation of the Plan who are called "fiduciaries" and who have a duty to operate the Plan prudently and in the interest of Participants and Beneficiaries. If a claim for a benefit is denied in whole or in part, the claimant must receive a written explanation of the reason for the denial. The claimant has the right to have the claim reviewed and reconsidered.

Under ERISA, there are steps the Employee covered under the Plan can take to enforce the above rights. For instance, if the person requests materials and does not receive them within 30 days, the person may file suit in a federal court. In such a case, the court may require the company to provide the materials and pay the person up to $110 a day until the person receives the materials, unless the materials were not sent because of reasons beyond the Employer's control.

If a person has a claim for benefits which is denied or ignored, in whole or in part, the person may file suit in a state or federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Employee covered under the Plan is discriminated against for asserting his or her rights, the person may seek assistance from the U.S. Department of Labor, or may file suit in federal court. The court will decide who should pay court costs and legal fees. If the claimant loses, the court may order the claimant to pay these costs and fees, for example, if it finds the claims to be frivolous.

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

The rights reserved in the Plan for the Plan Sponsor to terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time, are subject to the applicable provisions of the Plan.

Special Note: This is a Summary Plan Description only. Your specific rights to benefits under the Plan are governed solely, and in every respect by Abbington Management Corp. Health Reimbursement Arrangement Plan document, a copy of which is available from the company upon your request (see Statement of ERISA Rights). If there is any discrepancy between the description of the Plan as contained in this material and the official Plan document, the language of the Plan document shall govern.