Your Logo Here

Your Company Name Here

HEALTH & WELFARE BENEFIT PLAN

AND

SUMMARY PLAN DESCRIPTION

March 1 through February 28-29

Note: This plan document and summary plan description together with the applicable group insurance coverage information such as certificates of insurance, insurance booklets, brochures, ERISA plan documents, benefit summaries and/or group insurance contracts constitute the written plan document required by ERISA §402 making up the Your Company Name Here.

Effective Date: March 01, 2015

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Health & Welfare Benefit Plan Document

and

Summary Plan Description

SECTION 1: INTRODUCTION

The provisions that follow contain a summary of your rights and benefits under Your Company Name Here. Health & Welfare Benefit Plan (the "Plan"). The Plan and Summary Plan Description (SPD) summarizes important features of the Plan. Complete details can be found in the underlying component benefit program documents which govern the operation of the Plan, and are available with this document or through the Plan Administrator. In the event of any difference or ambiguity between your rights or benefits described in this Plan or SPD and the underlying component benefit program documents, the underlying component benefit program documents will control. For purposes of this document, component benefit programs are those benefit programs specified under Provider Companies found towards the end of this document and contained in the component plan documents. Component benefit program documents include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

This document and its attachments serve as both the written plan document required by ERISA section 402 and the SPD as required by section 102 of ERISA. If you have any questions about this document or its attachments contact your Plan Administrator listed below.

Each benefit option is summarized in component benefit program documents issued by providers or third party administrators, a summary plan description or another governing document prepared by the Company. When the Plan refers to these documents, it also refers to any attachments to such contracts, as well as documents incorporated by reference into such contract (such as the application, certificate of insurance, ERISA plan documents and any amendments). A copy of each certificate, summary or other governing document is included with this document. Information contained in the underlying component benefit program documents defines and governs specific benefits including your rights and obligations for each plan.

SECTION 2: PLAN INFORMATION

The following information concerns the Plan. If you need more information, contact the Plan Administrator.

NAME OF PLAN

Your Company Name Here.

EMPLOYER

Your Company Name Here.

PLAN SPONSOR

Your Company Name Here.

PLAN SPONSOR'S EMPLOYER IDENTIFICATION NUMBER

??-????????

TYPE OF PLAN

This Plan provides comprehensive medical, dental, vision, life/AD&D, supplemental, long term disability, short term disability, 125 POP, wellness program and Employee Assistance Program (EAP) benefits and is considered a "health & welfare benefit plan" under ERISA.

PLAN YEAR

March 1 - February 28-29

PLAN NUMBER: 501

PLAN ADMINISTRATOR AND LEGAL PROCESS AGENT

Your Company Name Here.

2.1. ADMINISTRATION & FIDUCIARY

This document and the component plan documents describe the various benefits, whether each benefit is insured or self-funded, and claims administration and other services under the group benefit contracts. The Plan Administrator may elect to use a Third Party Administrator (TPA) to administer a plan and adjudicate claims. The Plan Administrator will remain your point of contact for questions regarding any such plan, not the TPA, and has fiduciary responsibility. For fully-insured products, the insurance company is the fiduciary. See providers, policy numbers and their related contact information towards the end of this document.

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility.

The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan.

The Company will bear the incidental costs of administering the Plan. The Company may shift from time to time certain administration costs to Participants. The Company shall communicate to the Participants the details of any cost shifting arrangements.

Power and Authority of Insurer or Third Party Administrator

Certain benefits offered in the Plan are fully-insured and provided by the Insurer or third party administrator indicated in the Attachments or available through the Plan Administrator. Other benefits may be set up under a self-funded arrangement, if described in this document.

The Insurers or third party administrators are responsible for (1) determining eligibility for and the amount of any benefits payable under the respective component benefit program, and (2) prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective benefits.

The Insurance providers, not the Company, are responsible for paying claims with respect to these programs. The Company shares responsibility with the Insurers or third party administrators for administering these program benefits.

Insurance premiums for employees and their eligible family members are paid in part by the Company out of its general assets and in part by employees' pre-tax payroll deductions, where applicable. The Plan Administrator provides a schedule of the applicable premiums during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable. Contributions for the insured component benefit programs are also made in part or in whole by the Company and/or in part or in whole by employees' pre-tax or post tax payroll deductions.

Exclusive Benefit

No part of the Plan or its assets shall be used for purposes other than for the exclusive benefit of eligible Employees, their Spouses, their other designated Dependents and their designated beneficiaries, in accordance with the provisions of the Plan, other than the paying of reasonable expenses associated with administering the Plan.

2.2. ELIGIBILITY FOR PARTICIPATION AND BENEFITS

Summary of Eligibility and Participation Provisions

Full or Part Time employees working an average of 24 hours per week are eligible to participate in Plan benefits on the first day of the month following their date of hire.

Once an Employee has met the eligibility requirements and an appropriate Enrollment Form has been submitted to the Plan Administrator, the Employee's coverage will commence on the date specified in the eligibility requirements and selected component benefits program documents.

You may also enroll eligible family members in the Medical, Dental, Vision, Life/AD&D, Wellness Program, Supplemental and/or EAP (if includes counseling) plans. Eligible family members defined in this document are generic in nature. Refer to supporting component benefit plan documents for eligible family members and definitions.

Eligible family members include:

- Legal Spouse or Registered Domestic Partner ("spouse" means an individual who is legally married to a participant as determined under Revenue Ruling 2013-17, in accordance with federal and state law and as specified in each benefit plan);
- Child(ren) up to age 26 or as defined in component plan documents; and/or
- Unmarried child(ren) of any age who depend upon the employee for support because of a mental or physical disability (For specified benefits only as defined in component plan documents).

Refer to underlying component benefit program documents for more information about dependent eligibility, definitions of family members and spouse, and overall coverage. Your benefits eligibility may be affected if your status changes to inactive due to a family, medical, or personal leave of absence. Contact your Plan Administrator for additional information.

Certain benefits require that an eligible Employee make an annual election to enroll for coverage. Information regarding enrollment procedures, including when coverage begins and ends for the various benefits under the Benefit options, is set forth in the certificate of insurance, summary plan description or other governing documents. An eligible Employee may begin participating in any benefit based on his or her election to participate in accordance with the terms and conditions established for each benefit.

Qualified Medical Child Support Orders

With respect to component benefit programs that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order (QMCSO) (defined in ERISA Section 609(a)). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

In the event the Plan Administrator receives a qualified medical child support order, the Plan Administrator will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and the Plan's procedures for determining whether such an order is a QMCSO. Within a reasonable period the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

2.3. POSSIBLE LIMITS ON OR LOSS OF BENEFITS

Summary of Benefits

See component plan documents and Summary of Benefits and Coverage (SBC) for details regarding deductibles, co-pays, coverage, claims procedures, resources and provider company information.

Denial or Loss of Benefits

A Participant’s benefits under the Plan will cease when the eligible Employee’s participation in the Plan terminates. A Participant’s benefits will also cease on termination of the Plan. Other circumstances can result in termination, reduction or denial of benefits. Refer to the component benefit program documents for details regarding when a plan may terminate.

Coordination of Benefits

For Participants and Dependents who do not maintain coverage under a health and welfare plan sponsored by another unrelated employer's health and welfare plan, the Plan will be the primary payer for all eligible claims and benefits as defined in the underlying component benefit program documents. If participants or dependents are covered by another medical or insurance plan, the two plans will coordinate together eliminating duplication of payments as explained in the component plan documents. The insurer has primary responsibility to coordinate benefits for eligible expenses for other employer plans, government plans, Medicare or other coverage such as motor vehicle insurance.

Subrogation of Benefits

Refer to component benefit program documents for provisions regarding subrogation of benefits and the handling of situations where a Participant incurs a claim under the insurance benefits provided as a result of injuries caused by someone else’s negligence, wrongful act or omission, which may not be the Plan's responsibility to pay. If this happens, the Plan

Administrator, Claims Administrator, if applicable, or the Insurer or third party administrator may contact the Participant and ask him or her to sign a subrogation agreement. This means that the Company, the Claims Administrator (if applicable), Insurer or third party administrator can take steps to recover what it paid to under the benefits in the provided insurance programs from the third party that caused injury or illness. If the Participant does not sign a subrogation agreement, his or her claims for medical, dental and/or vision expenses related to the injury or illness may be denied.

The Participant will fully cooperate and do his or her part to ensure the Plan's right of recovery and subrogation are secured. If the Participant fails or refuses to honor the Plan's recovery and subrogation rights, the Plan may recover any costs to enforce its rights. This includes, but is not limited to attorney's fees, litigation, court costs and other expenses as covered in the underlying component benefit program documents.

2.4. HIPAA PRIVACY AND SECURITY PROVISIONS

HIPAA Privacy Rules Notice of Privacy Practices

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we maintain the privacy of protected health information, give notice of our legal duties and privacy practices regarding health information about you and follow the terms of our notice currently in effect. The Company will provide adequate protection of Personal Health Information (PHI), maintaining separation between the Covered Programs, and will not use or further disclose PHI other than as permitted or required by the underlying component benefit program documents or as required by all applicable law. Upon request, the Plan Administrator will provide you with more information about the Plan's privacy practices.

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

You have the right to inspect and copy, right to an electronic copy of electronic medical records, right to get notice of a breach, right to amend, right to an accounting of disclosures, right to request restrictions, right to request confidential communications, right to a paper copy of this notice and the right to file a complaint if you believe your privacy rights have been violated.

Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Employer information on whether the individual is participating in any medical benefits under provided insurance programs, or is enrolled in or has disenrolled in such benefits as required under HIPAA and HITECH.

For purposes of this article, Protected Health Information or "PHI" shall mean information designated in 45 CFR Section 164.501, as amended from time to time. Generally, PHI means individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to (a) the past, present or future physical or mental health, or condition of an individual; (b) a provision of health care to an individual; or (c) payment of the provision of health care to an individual. If the

information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information. Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Employer, provided the Employer requests the Summary Health Information for the purpose of (a) obtaining premium bids from medical plans for providing medical benefits; or (b) modifying, amending, or terminating the Plan or those benefits.

"Summary Health Information" means information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Employer had provided medical benefits under the insurance plans; and (b) from which the information described at 42 CFR Section 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 CFR Section 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

Conditions of Disclosure for Plan Administration Purposes

The Employer agrees that with respect to any PHI (other than Enrollment/Disenrollment Information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR Section 164.508, which are not subject to these restrictions) disclosed to it by the Plan (or an insurance company or third party administrator on behalf of the Plan), the Employer shall:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to PHI;

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company;

4. Report to the Plan any use or disclosure of PHI of which it becomes aware that is inconsistent with the uses or disclosures provided for;

5. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR Section 164.524;

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR Section 164.526;

7. Make available the information required to provide an accounting of disclosures in accordance with 45 CFR Section 164.528;

8. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

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

10. Ensure that the adequate separation between the Plan and the Employer (i.e. the "firewall"), required in 45 CFR Section 504(f)(2)(iii), is established.

The Employer further agrees that if it creates, receives, maintains or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary Health Information and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR Section 164.508, which are not subject to these restrictions) on behalf of the Plan, it will:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives maintains or transmits on behalf of the Plan;

2. Ensure that the adequate separation between the Plan and the Employer (i.e., the "firewall"), required by 45CFR Section 504(f)(2)(iii) is supported by reasonable and appropriate security measures;

3. Ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

4. Report to the Plan any security incident of which it becomes aware, as follows: the Employer will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition the Employer will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI.

Adequate Separation between Plan and the Employer

The Employer shall allow those classes of employees or other persons in the Employer's control designated by the Employer to be given access to PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the

Employer performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Employer for non-compliance pursuant to the Employer's employee discipline and termination procedures.

The Employer shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

HIPAA PRIVACY RULES

Application

The HIPAA Privacy Rules in this Section only apply to the extent that one or more of the Subsidiary Contracts constitutes a group health plan as defined in section 1171(5)(A) of the Social Security Act that is self-funded ("Covered Programs"). For purposes of this Section and the Plan, "HIPAA" will mean the Health Insurance Portability and Accountability Act of 1996, as amended.

Privacy Policy

The Covered Programs will adopt a HIPAA privacy policy, the terms of which are incorporated herein by reference.

Business Associate Agreement

The Covered Programs will enter into a business associate agreement with any persons as may be required by applicable law as determined by the Plan Administrator.

Notice of Privacy Practices

The Covered Programs will provide each Participant with a notice of privacy practices to the extent required by applicable law.

Disclosure to the Company

In General

This Subsection permits the Covered Programs to disclose PHI to the Company to the extent that such PHI is necessary for the Company to carry out its administrative functions related to the Covered Programs.

Permitted Disclosure

Permitted Disclosure of Enrollment/Disenrollment Information. The Covered Programs may disclose to the Company information on whether an individual is participating in the Covered Programs.

Permitted Uses and Disclosure of Summary Health Information. The Covered Programs may disclose Summary Health Information, as defined in the HIPAA privacy rules, to the Company, provided that the Company requests the Summary Health Information for the

purpose of (i) obtaining premium bids from health plans for providing health insurance coverage under the Covered Programs; or (ii) modifying, amending, or terminating the Covered Programs.

Permitted and Required Uses and Disclosure of Protected Health Information for Administration Purposes. Unless otherwise permitted by law, and subject to the conditions of disclosure described in Subsection 3 and obtaining written certification pursuant to Subsection 4, the Covered Programs may disclose PHI and electronic PHI to the Company, provided that the Company uses or discloses such PHI and electronic PHI only for plan administration purposes. "Plan administration purposes" means administration functions performed by the Company on behalf of the Covered Programs, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Company in connection with any other benefit or benefit plan of the Company or any employment-related actions or decisions.

Enrollment and disenrollment functions performed by the Company are performed on behalf of Participant and beneficiaries of the Covered Programs, and are not plan administration functions. Enrollment and disenrollment information held by the Company is held in its capacity as an employer and is not PHI.

Limitations//Restrictions

The Company agrees to the following limitations and requirements related to its use and disclosure of PHI received from the Covered Programs (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization that complies with the requirements of 45 CFR 164.508, which are not subject to these restrictions):

Use and Further Disclosure: The Company will not use or further disclose PHI other than as permitted or required by the Plan document or as required by all applicable law, including but not limited to the HIPAA privacy rules. When using or disclosing PHI or when requesting PHI from the Covered Programs, the Company will make reasonable efforts to limit the PHI to the minimum amount necessary to accomplish the intended purpose of the use, disclosure or request.

Agents and Subcontractors: The Company will require any agents, including subcontractors, to whom it provides PHI received from the Covered Programs to agree to the same restrictions and conditions that apply to the Employer, Company or Plan Sponsor with respect to such information.

Questions regarding use of PHI should be directed to the Insurer or third party administrator in question. The insurer or third party administrator will advise a Plan Participant who wants to exercise any of his/her rights concerning PHI, of the procedures to be followed.

Employment-Related Actions: Except as permitted by the HIPAA privacy rules and other applicable federal and state privacy laws, the Company will not use PHI for employment-related actions and decisions, or in connection with any other employee benefit plan of the Company.

Reporting of Improper Use or Disclosure: In accordance with (16 CFR Part 18), Health Breach Notification Rule, where applicable, agrees to notify both the participants, the Federal Trade Commission and Covered Programs of an use or disclosure of any PHI or electronic PHI provided for Plan Administration purposes that is inconsistent with the uses or disclosures provided for, or that represents a PHI Security Incident, or which the Plan Sponsor or any Business Associate of the Plan Sponsor becomes aware.

Adequate Protection: The Company will provide adequate protection of PHI and separation between the Covered Programs.

2.5. AFFORDABLE CARE ACT COMPLIANCE

The plan complies with all applicable Patient Protection and Affordable Care Act (PPACA) provisions, as detailed in component plan documents. PPACA applies only to health benefits, and also to dental and vision benefits if specified in the underlying documents. It does not apply to other benefits under the plan, such as life, disability, “excepted” benefits (as defined by law and regulations) or other categories of benefits.

Exceptions: Plans are not required to comply with certain PPACA requirements if they are “grandfathered” as defined under PPACA or “grandmothered” (certain non-ACA-compliant small insured plans that were allowed to renew for a limited period of time, under PPACA and certain states’ laws). See component plan document to clarify if your plan is "grandfathered" or "grandmothered".

PPACA compliance (for plans that are not grandfathered or grandmothered) includes, but is not limited to:

- Coverage of dependents up to age 26
- No annual or lifetime dollar limits on “Essential Health Benefits” as defined in PPACA and regulations
- No pre-existing conditions exclusions
- Prohibition on rescissions
- Patient protections – coverage and payment for emergency services, primary care provider designation, designation of pediatric physician as primary care provider, no prior authorization for access to obstetrical or gynecological care.
- Preventive care – specified preventive care services are covered on a first-dollar basis, not subject to co-payments, co-insurance, deductibles or other cost-sharing requirements.
- Nondiscrimination testing – this plan is intended to comply with current nondiscrimination rules.

2.6. COST SHARING PROVISIONS

If the plan has cost sharing, all employee contributions will be paid through a pre-tax payroll deduction starting the first pay period following enrollment, unless they are benefits that are not eligible for pre-tax deduction such as life or disability insurance or the employee requests post-tax deductions. Actual Contribution Rates will be published each year during the open enrollment period. See summary of coverage for additional deductible, coinsurance, copayments, services, and coverage, and enrollment documents for applicable rates and contribution levels.

Company Contribution Levels

Premium contributions for each of the health and welfare benefit plans provided by Your Company Name Here. are either attached to this document, given out separately or may be obtained from the Plan Administrator upon request.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by the eligible Employee's contributions. The Company will pay its contribution and the eligible Employee's contributions to the Insurer or third party administrator or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of the Participants from the Company's general assets. The eligible Employee's contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

With respect to offered group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws, such as COBRA, HIPAA, HITECH, MHPA, NMHPA, USERRA, GINA, MHPAEA, WHCRA, HCERA and PPACA.

2.7. PLAN AMENDMENT AND TERMINATION

Amendment of the Plan

The Employer reserves the right to amend, modify, or discontinue the Plan in any respect, including but not limited to, implementing a change in the amount or percentage of premiums or cost that must be paid by the Participant. No Participant shall have any vested right to any benefits under the Plan, subject to any duty to bargain that may exist. The Company shall have the right to amend the Plan at any time and to any extent deemed necessary or advisable; provided, however, that no amendments shall:

1. Have the effect of discriminatorily depriving, on a retroactive basis, any eligible Employee, dependent or beneficiary of any beneficial interest that has become payable prior to the date such amendment is effective; or

2. Have the result of diverting the assets of the Plan to any purpose other than those set forth in this Plan.

The Company shall promptly notify the Plan Administrator and all interested parties of any amendment adopted pursuant to this Section, and shall execute any instruments necessary in connection therewith.

2.8. TERMINATION OF BENEFITS

Medical, Dental, Vision, Long Term Disability, Life/AD&D, Supplemental, Short Term Disability, Section 125 Plan, Wellness Program and Employee Assistance Program (if providing counseling, not just referrals) benefits terminate the last day of the month in which eligibility ends. Plans may or may not have conversion options (check with Plan Administrator). See continuation options available for such benefits as medical, dental, vision and health flexible spending accounts, if applicable, under COBRA (Consolidated Omnibus Budget Reconciliation Act) as explained below. Check with the Plan Administrator for possible conversion options or questions on possible continuation rights. See each component benefit program documents for termination provisions.

An eligible Employee's participation and the participation of his or her eligible Dependents in the Plan will terminate on the date specified in the component benefit program documents. Other circumstances can result in the termination of benefits as described in the component benefit program documents.

Termination of Participation

Participation in the Plan may be terminated due to disqualification, ineligibility, or denial, loss, forfeiture, suspension, offset, reduction, etc. Refer to the corresponding component benefit program documents for detailed information. Your Company Name Here. Benefit Plan as it deems necessary.

Termination of the Plan

The Company has the right to terminate the Plan in its entirety, or any portion thereof at any time. In the event that the plan is terminated, a written notice shall be given 60 days in advance.

An officer, as designated by the Company, may sign insurance contracts for this Plan on behalf of the Company, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

Additionally, benefits for you and/or your enrolled dependent(s) will be terminated retroactively (this is known as *"rescission"*) if the carrier or plan administrator determines that you obtained benefits under the Plan as a result of fraud or intentional misrepresentation of a material fact. You will be given 30 days prior written notice, and coverage will be terminated back to the date of the fraud or intentional misrepresentation. You will be required to reimburse the Plan for any benefits you or your eligible dependent(s) received since the date of the fraud or material misrepresentation, and such amount will be offset against the premiums you paid before they are refunded to you, to the extent allowed by applicable law.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments or through the Plan Administrator, provide additional information.

2.9. ENROLLMENT IN THE PLAN

Enrollment Procedures

An Employee who is eligible to participate in this Plan shall commence participation on the first day after the eligibility requirements have been satisfied, provided that any enrollment forms are submitted to the Plan Administrator before the date that participation would commence. Such enrollment forms shall identify the Spouse and other Dependents who are eligible for benefits under the elected benefit plan.

Legislative rules dictate the benefit choices made will remain in effect for the entire plan year, March 1 to February 28-29, unless the employee experiences a Qualified Change in Status. While many of the guidelines relating to eligibility and enrollment are determined by Your Company Name Here. and its insurance carriers or third party administrator, the ability to make changes to your benefit Plan is governed by the IRS and the Internal Revenue Code. Under the Code you must enroll within a reasonable time period from your eligibility date. Once you are enrolled, you may only make changes to your benefit elections during Open Enrollment or if you have a Qualifying Change in Status that affects the eligibility of you or your dependents, and the requested election change corresponds with the effective date on your eligibility.

A Qualifying Life Event/Qualifying Change in Status includes:

- A change in your Legal Marital Status such as marriage, death of a spouse, divorce, legal separation or annulment.
- A change in your Number of Dependents such as birth, adoption, placement for adoption, or death of a child.
- A change in Employment Status such as commencement or termination of employment for you, your spouse, or your dependent.
- A change in Work Schedule such as a reduction or increase in hours, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse, or your dependent.
- If Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents due to factors such as age.
- A change in Residence or Worksite for you, your spouse, or your dependent.
- The receipt of a Qualified Medical Child Support Order.
- A change in Entitlement to Medicare or Medicaid for you, your spouse, or your dependent.

- A change in Eligibility for COBRA for you, your spouse, or your dependent while you are still an active employee.

- A change in a spouse's coverage such as benefit reduction, cost increase or decision not to join a plan during open enrollment.

- A change where an employee may qualify for exchange coverage because the employer coverage does not meet the affordability requirements.

All election changes must be requested within 30 days of the event in question unless otherwise required by state or federal laws or healthcare mandates (e.g. loss of coverage under Medicaid or CHIP allows up to 60 days to obtain coverage). *To make an election change, contact your Plan Administrator listed above.*

2.10. ANNUAL OPEN ENROLLMENT PERIOD

Each year Your Company Name Here. has a Medical open enrollment that takes place during February when participants can make plan changes or new participants can enroll.

2.11. BENEFIT PLAN PROVISIONS

All documents relating to the Your Company Name Here. Welfare Benefits Plan, including the Evidence/Certificate of Coverage for each plan, Listing of Network Providers, Contribution Rates, General COBRA Notice, Medicare Creditable Coverage Notice, and any other relevant Plan Documents or Notices, are available to employees and their dependents by contacting the Plan Administrator. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Administrator.

Please refer to the component plan documents for each plan's specific details, including a description of benefits, cost-sharing provisions, requirements for use of network providers, and circumstances by which benefits may be denied.

2.12. CLAIMS PROCEDURES

Generally, to obtain benefits from the insurer or third party administrator of a provided component benefit program, you must follow the claims procedures under the applicable component benefit program documents, which may require you to complete, sign, and submit a written claim on the insurer's or third party administrator's form. In that case, the form is available from the Plan Administrator.

The providers or third party administrator's component benefit program documents will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. See how to file a claim by referencing applicable component benefit program documents or contacting the Plan Administrator.

If you (or an eligible dependent) are covered by another employer’s plan, the two plans work together to avoid duplicating payments. This is called non-duplication or coordination of benefits.

The Insurer or third party administrator is responsible for ensuring that eligible expenses are coordinated with benefits from other employers' plans, certain government plans, and motor vehicle plans when required by law.

The Insurer or third party administrator may request information about other coverage you may have. You are required to provide this information to ensure that claims are properly paid.

If you or your dependent receives benefits in excess of the amount payable under the Plan, the Insurer or third party administrator has a right to subrogation and reimbursement. Subrogation applies when the Insurer or third party administrator has paid benefits for a sickness or injury for which a third party is considered responsible (e.g., an insurance carrier if you are involved in an auto accident).

The Plan Administrator has delegated all subrogation rights and third party recovery rights to the Insurer or administrator of each fully-insured plan or third party administrator for self-insured plans. The Insurer or third party administrator shall undertake reasonable steps to identify claims in which the Plan has a subrogation interest and shall manage subrogation cases on behalf of the Plan. You are required to cooperate with the Insurer or third party administrator to facilitate enforcement of its rights and interests.

Details regarding the Plan's claim procedures are furnished automatically, without charge, as a separate document, copies of which are included with this document.

Claims for Self-Funded Benefits, if applicable

For purposes of determining the amount of, and entitlement to benefits under the provided benefit program provided through the Company's general assets, the Claims Administrator or Plan Administrator shall have the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement. Refer to underlying Component Benefit Program documents for claims detail.

To obtain benefits from a self-funded arrangement, the Participant must complete, execute and submit to the Claims Administrator or Plan Administrator a written claim on the form available from either the Claims Administrator or Plan Administrator. The Claims Administrator or Plan Administrator, has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide the claim.

The Claims Administrator or Plan Administrator will decide the claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator or the Claims Administrator, has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide his or her claim. If the Claims Administrator or Plan Administrator denies the Participant's claim, in whole or in part, he or she will receive a written notification setting forth the reason(s) for the denial.

If a Participant's claim is denied, he or she may appeal to the Named Fiduciary, for a review of the denied claim. The Named Fiduciary will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the Participant doesn't appeal on time,

he or she will lose his or her right to file suit in a state or federal court, as he or she has not exhausted the internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court). The attached insurance documents or other governing documents contain more information about how to file a claim and for details regarding the claims procedures applicable to the claim.

After a Participant's appeal for Medical Benefits has been denied by Named Fiduciary, he or she shall be eligible to file a request for review under the external review procedure as provided under Treasury Regulations Section 54.9815-2719T(d)(1)(i); DOL Regulations Section 2590.715-2719(d)(1)(i) and HHS Regulations Section 147.136(d)(1)(i), if applicable.

2.13. COBRA

COBRA NOTICE

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the company plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation Coverage?

COBRA continuation coverage is a continuation of plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the plan is lost because of the qualifying event. Under the plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Employees and their qualified dependents are responsible for notifying the Company of any change in address or status (e.g., divorce, insurance eligibility, child becoming ineligible due to age, etc.) within 30 days of the event.

Supporting documentation like a divorce decree, death certificate, proof of other insurance may be required as proof of a qualifying event.

This general notice does not fully describe COBRA or the plan. More complete information is available from the plan administrator and in the summary plan document.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a dependent child.

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the employee must notify the Plan Administrator of the qualifying event.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Documentation from the Social Security administration certifying a disability will be required.

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

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

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the plan administrator indicated above or in the summary plan description. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Participation During Leaves of Absence

Notwithstanding any other provision to the contrary in this Plan, if a Participant is eligible for a qualifying leave under the Family Medical Leave Act (FMLA), then to the extent required by FMLA, as applicable, the Company shall continue to maintain those benefits in accordance with Family Medical Leave Act requirements. In such instances, the Participant may continue coverage during unpaid leave by paying for coverage. Check with your Plan Administrator for details on coverage options and requirements during medical leave.

If a Participant is eligible for a qualifying leave under USERRA (Uniformed Services Employment and Reemployment Rights Act), then to the extent required by USERRA, as applicable, the Company shall continue to maintain the required benefits on the same terms and conditions as under COBRA, as explained below.

2.14. ERISA RIGHTS AND NOTICES

Notice of Rights Under the Mothers & Newborns Health Protection Act*:* Group health plans and health insurance issuers or third party administrators generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging

the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of Women's Health & Cancer Rights Act: Group health plans, insurance companies, and health maintenance organizations offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymph edemas.

HIPAA Portability Rights

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that we notify you about two very important provisions in the plan. The first is your right to enroll in the plan under its "special enrollment provision" if you marry, acquire a new dependent, or if you decline coverage under the plan for an eligible dependent while other coverage is in effect and later the dependent loses that other coverage for certain qualifying reasons. Special enrollment must take place within 30 days of the qualifying event or as required by state or federal law (60 days if enrollment in or eligibility for, or loss of eligibility for Medicaid or CHIP).

Second, is the existence of any preexisting condition exclusion rules in the plan that may temporarily exclude coverage for certain preexisting conditions that you or a member of your family may have. These no longer apply as of the 2014 plan year, unless the medical coverage is provided under an insured small group policy that meets applicable federal and state requirements for renewal/extension as a non-PPACA compliant policy. You will receive notice from the insurer if this limited exception applies. If a preexisting condition exclusion applies, it cannot be longer than 12 months from your enrollment date (18 months for a late enrollee). A pre-existing condition exclusion that is applied to you must be reduced by the prior creditable coverage you have that was not interrupted by a significant break in coverage. You may show creditable coverage through a certificate of creditable coverage given to you by your prior plan or insurer (including an HMO) or third party administrator or by other proof. Refer to your plan document for additional details. A HIPAA certificate of creditable coverage notice is generally given by the provider when there is a loss of coverage, this notice should be retained for your records as proof of creditable coverage. All questions about preexisting condition exclusion, special enrollment rights and creditable coverage should be directed to your health plan provider or Plan Administrator listed above. Plans renewing or effective in 2014, are not subject to pre-existing conditions.

FAMILY MEDICAL LEAVE

To the extent the Plan is subject to the Family Medical Leave Act of 1993 (FMLA), the Plan Administrator will permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits will continue according to the established Company policy. Participants continuing participation pursuant to the

foregoing will pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying applicable regulations. Any Participant on FMLA leave who revoked coverage will be reinstated to the extent required by applicable regulations. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT (MHPAEA)

The MHAEA applies only to employers with more than 50 employees. If applicable to this Plan, the MHAEA applies to group health benefits provided under this Plan that provide both medical and surgical benefits as well as mental health or substance use disorder benefits. The MHAEA requires that:

- The financial requirements that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant financial requirements that apply to substantially all medical and surgical benefits under the Plan, and no separate cost-sharing requirements can be applied only to mental health or substance use disorder benefits.

- The treatment limitations that apply to mental health or substance use disorder benefits cannot be more restrictive than the predominant treatment limitations that apply to substantially all medical and surgical benefits under the Plan, and no separate treatment limitations can be applied only to mental health or substance use disorder benefits.

The component plan determines what mental health condition and/or substance use disorder coverage is provided.

USERRA

The Plan Administrator will also permit you to continue benefit elections as required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) and will provide such reinstatement rights as required by such law. The Plan Administrator will also permit you to continue benefit elections as required under any other applicable state law to the extent that such law is not pre-empted by federal law.

GINA - Genetic Information Nondiscrimination Act of 2008 (“GINA”)

The Genetic Information Nondiscrimination Act of 2008 (“GINA”) prohibits the Plan from discriminating against individuals on the basis of genetic information in providing any the benefits under included benefit plans.

GINA generally:

- Prohibits the Plan from adjusting premium or contribution amounts for a group on the basis of genetic information;

- Prohibits the Plan from requesting or mandating that an individual or family member of an individual undergo a genetic test, provided that such prohibition does not limit the authority of a health care professional to request an individual to undergo a genetic test, or preclude a group health plan from obtaining or using the results of a genetic test in making a determination regarding payment;

- Allows the Plan to request, but not mandate, that a participant or beneficiary undergo a genetic test for research purposes if the Plan does not use the information for underwriting purposes and meets certain disclosure requirements; and

- Prohibits the Plan from requesting, requiring, or purchasing genetic information for underwriting purposes, or with respect to any individual in advance of or in connection with such individual's enrollment.

Participant's Responsibilities

Each Participant shall be responsible for providing the Plan Administrator, Claims Administrator, if applicable, and the Company and, if required by an insurance company or third party administrator, with respect to a fully-insured benefit, the insurance company with his or her current address. If required by the insurance company, with respect to a fully-insured benefit, each employee who is a Participant shall be responsible for providing the insurance company with the address of each of his or her covered eligible dependents. Any notices required or permitted to be given to a Participant hereunder shall be deemed given if directed to the address most recently provided by the Participant and mailed by first class United States mail. The insurance companies, the Plan Administrator and the Company shall have no obligation or duty to locate a Participant.

Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully-insured benefit, the insurance company or third party administrator with such information and documentation as may be necessary to verify eligibility for and/or entitlement to benefits under the Plan. Refer to details in the component benefit program documents.

The Plan Administrator, Claims Administrator, if applicable, (and, with respect to a fully-insured benefit, the insurance company) shall have the right and opportunity to have a Participant examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan.

2.15. STATEMENT OF ERISA RIGHTS

The Employee Retirement Income Security Act of 1974 (ERISA) provides that all Plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the plan, including insurance contracts and if the group has 100 or

more participants, a copy of the latest annual report (Form 5500 Series) filed by the plan with the US Department of Labor. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series, if 100 or more participants) and updated Summary Plan Description. Receive a summary of the Plan's annual financial report. If a pension plan is provide, obtain a statement telling you whether you have a right to receive a pension at normal retirement age (age 65) and if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a pension, the statement will tell you how many more years you have to work to get a right to a pension. This statement must be requested in writing and is not required to be given more than once every 12 months.

Foreign Language

This document contains a summary in English of your plan rights and benefits under the group health plan. If you have difficulty understanding any part of this document, contact the Plan Administrator indicated above.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a pension/welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefit Security Administration (EBSA) US Department of Labor, listed in your telephone directory or (866) 444-3272. You may also EBSA contact information at: https://www.dol.gov/ebsa/contactEBSA/consumerassistance.html. You may further obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

SECTION 3: GENERAL PROVISIONS

3.1. No Right to Employment

Nothing contained in this Plan will be construed as a contract of employment between the Company and you, or as a right of any employee to continue in the employment of the Company, or as a limitation of the right of the Company to discharge any of its employees, with or without cause "at will".

3.2. Governing Law

The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by federal law. The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

3.3. Tax Effect - Notice About Pre-tax Payments and Possible Effect on Future Social Security Benefits

Where possible, the Company provides benefits under the Plan on a pre-tax basis in accordance with federal tax law. Some benefits may be obtained on an after tax basis. The Company does not represent or guarantee that any particular federal, state or local income, payroll, personal property or other tax consequence will result from participation in this Plan. You should consult with your professional tax advisor to determine the tax consequences of your participation in this Plan.

If this Plan allows you to pay for benefits on a pre-tax basis, you will not pay Social Security taxes on the pre-tax dollars you use to pay for coverage. As a result, the earnings used to calculate your Social Security benefits at retirement will not include these contributions. This could result in a small reduction in the Social Security benefit you receive at retirement. However, your savings on current taxes under the Plan normally will be greater than any eventual reduction in Social Security benefits.

3.4. Refund of Premium Contributions

For fully-insured component benefit programs, the plan will comply with (DOL) Department of Labor guidance regarding refunds (e.g., dividends, demutualization, experience adjustments, and/or medical loss ratio rebates (MLR) of insurance premiums). To the extent

that the Company receives rebates determined to be plan assets to the extent amounts are attributable to insurance premiums paid by Participants, the rebates will (a) be distributed within 90 days of receipt to the Participants covered by the policy to which the rebate relates under a reasonable, fair, and objective allocation method or (b) if distributing the rebates would not be cost-effective because the amounts are small or would give rise to tax consequences to the Participants, the rebates may be used to pay future Participant premiums or for benefit enhancements which benefit the Participants covered by the policy to which the rebate relates. Such determination will be made by the Plan Administrator, acting in its fiduciary capacity, after weighing the cost to the Plan and the competing interest of participants. Any rebates attributable to insurance premiums paid by the Company shall be retained by the Company.

3.5. Facility of Payment

When, in the Company or its designated representative's opinion, any Participant under the Plan is under a legal disability or is incapacitated in any way so as to be unable to manage his financial affairs, the Company or its representative may direct that payments be made to such Participant's legal representative or withhold payment pending an adjudication of the Participant's legal capacity and the appointment of a legal representative. The Company or its designated representative may also direct that payment be applied for the benefit of the Participant any way the Company considers advisable. Any payment made by the Plan in good faith pursuant to this provision shall fully discharge the Plan, the Company or the Employer to the extent of such payment. Any payment requirement shall include payments to a Participant’s beneficiary in the case of death benefits paid under the Plan.

3.6. Data

Participants who may receive benefits under the Plan must furnish the Company, or its designated representatives such documents, evidence, information, releases or authorizations, as it considers necessary or desirable for the purpose of administering the Plan, or to protect the Company. It shall be a condition of the Plan that each such person must furnish such information promptly and sign such documents as the Company may require before any benefits become payable under the Plan.

3.7. Electronic Communications

Whenever an Employee, Participant, Spouse, other Dependent or beneficiary is required to provide information or perform a written process, the Plan Administrator may, in its discretion, permit or require that electronic means be used. In addition, meetings of Plan Administrator may be held in person or through electronic or telephonic means or a combination thereof and written actions of the Plan Administrator may be taken using electronic or conventional means. In the use of electronic communication, the Plan Administrator shall follow all guidelines published by the Department of Labor and the Internal Revenue Service.

3.8. Non-assignability and Spendthrift Clause

To the extent permitted by law, the benefits or payments under the Plan will not be subject to alienation, sale, assignment, pledge, attachment, garnishment, execution, encumbrance or other transfer, nor will they be subject to any claim by any creditor of any Participant under the Plan other than a physician or treatment facility so authorized by the Participant or to legal process by an creditor of any Participant (except in the case of death or obligations owed to the Company). Any attempt to circumvent these provisions shall be considered null and void.

3.9. Severability of Provisions

If any provision of the Plan is held invalid or unenforceable, such invalidity or unenforceability will not affect any other provisions hereof, and the Plan will be construed and enforced as if such provisions had not been included.

3.10. Effect of Mistake

In the event of a mistake as to the eligibility or participation of an employee, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Company from Compensation paid by the Company.

3.11. Compliance with State and Federal Mandates

With respect to all benefit plans, the Plan will comply, to the extent applicable, with the requirements of all applicable laws, such as USERRA, COBRA, FMLA, HIPAA, WHCRA, the Health Information Technology for Economic and Clinical Health Act, the Newborns' and Mothers' Health Protection Act of 1996, as amended, the Mental Health Parity Act, the Mental Health Parity Addiction Equity Act, and the Genetic Information Nondiscrimination Act of 2008 ("GINA"). In accordance with Title I of GINA, in no event will the Plan or any of its insurers or third party administrators discriminate against any Participant on the basis of genetic information with respect to eligibility, premiums, or contributions.

3.12. COMPONENT BENEFIT PROGRAM - PROVIDER COMPANIES

Type: Medical Insurance

Name of Provider: Your Company Name Here.

Type or Plan Name: Your Company Name Here.

Plan Funding: Self-Insured, Group Medical Insurance

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Dental Insurance

Name of Provider:

Plan Funding: Fully-Insured, Group Dental Insurance

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Dental Insurance

Name of Provider:

Plan Funding:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Vision

Name of Provider:

Plan Funding:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Life/AD&D

Name of Provider:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Supplemental

Type or Plan Name: Voluntary Life

Name of Provider:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Supplemental

Type or Plan Name: Voluntary Plans

Name of Provider:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Long-Term Disability

Name of Provider:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Short-Term Disability

Name of Provider:

Policy Number:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: 125 Premium Only Plan

Name of Provider:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Employee Assistance Program (EAP)

Name of Provider:

Administration:

Provider Address:

Provider Phone:

Provider URL:

Type: Wellness Program

Name of Provider:

Administration:

Provider Address:

Provider Phone:

Provider URL:

SECTION 4: DEFINITIONS

The following words and phrases used herein shall have the following meanings, unless a different meaning is plainly required by the context. Masculine pronouns used in this Plan shall include masculine and feminine gender unless the context indicates otherwise, and words in the singular also include the plural. These are general definitions and the presence of any definition in this section is not, in and of itself, an indication of the existence of a benefit.

"**Cafeteria Plan**" means a cafeteria plan under Code Section 125 sponsored by the Company.

"**Claims Administrator**" means the entity or provider responsible for reviewing an approving insurance claims.

“**COBRA**” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

“**Code**” means the Internal Revenue Code of 1986, as amended.

“**Company**” means the entity or entities designated in the Adoption Agreement or any successor to it by merger, purchase or otherwise and any predecessor which has maintained this Plan or any corporation, sole proprietor, partnership or association that assumes the obligations of this Plan.

"**Component Benefit Programs**" are those benefit programs specified under Provider Companies and contained in the attached documents or through the Plan Administrator.

"**Component benefit program or plan documents**" include certificates of insurance, group insurance contacts, ERISA plan documents (if self-funded) and governing benefit plan documents for non-insurance benefit programs.

“**Dependent**” means an Employee’s Spouse or other dependents that satisfies the dependent eligibility requirements of the applicable insurance plans.

“**Employee**” means any current or former employee of the Employer who satisfies the eligibility provisions as specified in the applicable benefit plans. The determination of whether an individual is an Employee, an independent contractor or any other classification of worker or service provider and the determination of whether an individual is classified as a member of any particular classification of employees shall be made solely in accordance with the classifications used by the Company and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

“**Employer**” means the Company and any related employers who are participating u**nder this Plan.**

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“**FMLA**” means the Family Medical Leave Act of 1993, as amended. FMLA only applies to covered organizations with 50 or more employees within a 75 mile radius.

“**GINA**” means the Genetic Information Nondiscrimination Act of 2008.

“**HCERA**” means the Health Care and Education Reconciliation Act of 2010.

“**HIPAA**” means the Health Insurance Accountability and Portability Act of 1996, as amended.

“**HITECH**” means the Health Information Technology for Economic and Clinical Health Act.

“**Insurer**” means any insurance company, health maintenance organization, preferred provider organization or any similar organization with whom the Company has contracted for an insured or contractually-established benefit.

“**MHPA**” means the Mental Health Parity Act of 1996.

“**MHPAEA**” means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act.

“**NMHPA**” means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

“**Named Fiduciary**” means the individual(s) or entity or entities responsible for either administering benefit plans or the insurance company providing coverage.

“**NMHPA**” means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

“**Participant**” means an eligible enrolled Employee and/or eligible covered Dependents.

“**Plan**” means this employee benefit plan, which includes all benefits described in this document.

“**Plan Administrator**” means the person, the committee or the entity specified in this document to be the administrator, as defined in ERISA Section 3(16)(A).

"**Plan Year**" means a twelve (12) month period specified in this document. The Plan Year also is the accounting period for the Plan.

“**Protected Health Information**” (“PHI”) is individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in 45 CFR § 150.103.

“**PPACA**” means the Patient Protection and Affordable Care Act.

“**Spouse**” means an individual who is legally married to a Participant as determined under Revenue Ruling 2013-17 or otherwise defined in component plan documents.

“**USERRA**” means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

“**WHCRA**” means the Women's Health and Cancer Rights Act of 1998, as amended.