MyPlanAdvocate Insurance Solutions Inc (MyPlanAdvocate)

HEALTH AND WELFARE PLAN

PLAN DOCUMENT & SUMMARY PLAN DESCRIPTION

Restated Effective: January 01, 2026

MyPlanAdvocate Insurance Solutions Inc (MyPlanAdvocate) HEALTH AND WELFARE PLAN

This Plan and Summary Plan Description is hereby amended and restated, effective for all purposes as of January 01, 2026.

ARTICLE I.
INTRODUCTION

I.1 Purpose of Plan. The purpose of this Plan is to provide Participants and Beneficiaries with a variety of welfare benefits pursuant to the Component Plans identified in Exhibit A.

I.2 Plan Document. This Plan document, together with all Component Plans, constitutes the written instrument required for the Plan under Title I of ERISA, and constitutes the Summary Plan Description.

ARTICLE II.
DEFINITIONS AND CONSTRUCTION

II.1 Definitions. The following definitions shall apply to this document and to the Component Plans. However, in the event of a conflict between a definition below and a definition in a Component Plan, the definition in the Component Plan shall apply to that Component Plan.

a. "Affiliate" means an entity that: (i) with respect to the Sponsor, is in the the same "controlled group" (as defined by Code Section 414(b)), is under "common control" (as defined by Code Section 414(c)), or is in the same "affiliated service group" (as defined by Code Section 414(b)); (ii) Sponsor allows to participate in the Plan; and (iii) chooses to participate in the Plan.

b. "Beneficiary" means a person designated by a Participant who is or may become entitled to a Benefit under the Plan.

c. "Benefits" means the services provided or amounts paid to or on behalf of Participants and Beneficiaries under the Plan.

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

e. "Code" means the Internal Revenue Code of 1986, as amended.

f. "Component Plan" means any component of this Plan, as identified in Exhibit A.

g. "Covered Component" means each Component Plan that, if it were a separate employee benefit plan, would be a "Covered Entity" within the meaning of HIPAA.

h. "Covered Person" means a Participant or Beneficiary who is enrolled in a Component Plan providing medical, dental, or vision coverage.

i. "Dependent" means a dependent as defined by Code Section 152. A Component Plan may expand or limit the meaning of Dependent.

j. "Employee" means any person reported on the payroll records of the Employer as a common law employee of the Employer. It is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not Employees and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors. Notwithstanding the foregoing, Employee shall not include (i) any employee of the Employer who is a member of a collective bargaining unit covered under a collective bargaining agreement unless the collective bargaining agreement provides for the Employee's participation in the Plan; (ii) any leased employee as defined under Code Section 414(n); (iii) any person who is not classified by the Employer as a common law employee, notwithstanding the later reclassification by a court or any administrative agency of the person as a common law employee of the Employer; (iv) any person classified by the Employer as a temporary employee; or (v) any nonresident alien with no U.S. source income.

k. "Employer" means the Sponsor and each Affiliate, individually.

l. "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

m. "FMLA" means the Family and Medical Leave Act of 1993, as amended.

n. "FMLA Leave" means leave taken pursuant to the FMLA.

o. "HIPAA" means the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996, as amended, including the applicable implementing regulations.

p. "Notice of Privacy Practices" means the notice required for entities covered by HIPAA, pursuant to 45 C.F.R. § 164.520.

q. "Participant" means an Employee who is eligible to be and becomes a Participant in accordance with Section 3.1.

r. "PHI" means "protected health information," as that term is defined in HIPAA, but limited to the protected health information created or received by or on behalf of a Covered Component.

s. “Plan” means this MyPlanAdvocate Insurance Solutions Inc (MyPlanAdvocate) Health and Welfare Plan including all Component Plans, which are hereby incorporated by reference into this document.

t. “Plan Administrator” means the Sponsor, unless the Sponsor designates another person to hold the position of Plan Administrator pursuant to Section 8.3.

u. “Plan Year” means the fiscal year of the Plan, a twelve (12) consecutive month period ending every December 31.

v. “Recover,” “Recovered,” “Recovery” or “Recoveries” means all moneys paid to the Covered Person to compensate for all losses due to injury or illness resulting from the actions or omissions of a Third Party, whether or not said losses reflect expenses covered by the Plan. These terms include all moneys paid by way of judgment, settlement, or otherwise. These terms include but are not limited to, moneys for medical, dental, or vision expenses, attorneys’ fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other form of damages or compensation whatsoever.

w. “Reimbursement” means repayment to the Plan for medical, dental, or vision benefits that the Plan has paid toward care and treatment of the Covered Person’s illness or injury.

x. “Sponsor” means the Plan Sponsor as defined by ERISA, which for this Plan is MyPlanAdvocate Insurance Solutions Inc

y. “Subrogation” means the Plan’s right to pursue and place a lien upon the Covered Person’s claims for medical, dental, or vision expenses against a Third Party.

z. “Third Party” means a person or business entity other than a Covered Person or the Plan, and includes the insurer of such person or business entity.

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

ab. “USERRA Leave” means the Employee’s absence from employment due to service in the uniformed services as defined by USERRA.

II.2 Construction. As used in this Plan, the masculine gender includes the feminine, and the singular may include the plural, unless the context clearly indicates to the contrary.

ARTICLE III.
PARTICIPATION & ENROLLMENT

III.1 Eligibility for Participation. An Employee becomes a Participant in this Plan when the Employee first becomes a Participant in any Component Plan. Eligibility for Benefits under a Component Plan shall be determined in accordance with the provisions of that Component Plan.

III.2 Cessation of Participation. Participation in this Plan ceases when an individual is no longer eligible for participation and enrolled in any Component Plan.

III.3 Reinstatement of Participation. If an individual’s participation in a Component Plan ceases as set forth in Section 3.2, such participation may be reinstated upon the individual’s satisfaction of the requirements contained in Section 3.1. Such participation may be reinstated earlier pursuant to the terms of an applicable Component Plan.

III.4 Enrollment. An eligible Employee may enroll in Component Plan upon first becoming eligible or during an open enrollment period. An eligible Employee may change his or her enrollment in a Component Plan for any reason specified in 26 C.F.R. § 1.125-4. Notwithstanding the foregoing, in the event of a conflict between this paragraph and a Component Plan or an Employer’s cafeteria plan (as defined by Code Section 125), the Component Plan or cafeteria plan shall control.

ARTICLE IV.
BENEFITS

IV.1 Benefits. The Benefits under this Plan shall be provided to each Participant and Beneficiary as described in the applicable Component Plan.

IV.2 Termination of Benefits. Except as otherwise provided in any applicable Component Plan, Benefits under any Component Plan will terminate upon the earliest of the following:

a. The Participant elects to drop coverage during an annual enrollment period or during any other period when such a change is permitted under the applicable Component Plan.

b. The Participant fails to make the required contribution.

c. The Participant or Beneficiary, as applicable, ceases to be eligible for Benefits under the terms of the applicable Component Plan.

d. A Component Plan (or an option under a Component Plan) is terminated in accordance with Article IX.

ARTICLE V.
CONTINUATION COVERAGE

V.1 USERRA. In the event of a conflict between this Section and a provision in a Component Plan, the terms of the Component Plan shall apply. If an Employee is covered under a Component Plan and takes a USERRA Leave lasting 30 days or fewer, the Employee will continue to be covered by the applicable Component Plan as a regular, active Employee. If an Employee is covered under a Component Plan and takes a USERRA Leave of 31 days or more, the Employee will be deemed to be on an approved unpaid leave of absence while on Military Leave, and will be covered by the Component Plan (including with regard to reinstatement) to the same extent as any employee on another approved unpaid leave of absence. Any Component Plan that is a "health plan" within the meaning of USERRA will offer continuation coverage to an Employee (and any eligible Dependents) to the extent required by USERRA. Any continuation coverage provided pursuant to this paragraph will be concurrent with any COBRA continuation coverage elected by the Employee or Dependent, as applicable.

V.2 FMLA. This Section applies only if the Employer is subject to the FMLA. If an Employee takes FMLA leave, coverage under a Component Plan that is a "group health plan" within the meaning of the FMLA will be continued under the same terms and conditions as for active Employees, unless the Employee elects to not continue the coverage during leave. If coverage continues during FMLA leave, the Employee must continue to pay any contributions which the Employee was required to pay on the day immediately prior to the FMLA Leave, except that the Employee's cost may be increased or decreased in the same manner and to the same extent as for active Employees.

V.3 COBRA. This Section applies only if the Employer is subject to COBRA. A Component Plan that is a "group health plan" within the meaning of COBRA shall offer continuation coverage to the extent required by COBRA.

V.4 State Continuation Rights. Each Component Plan shall provide continuation rights to the extent required by an applicable state law that is not preempted by ERISA.

ARTICLE VI.
HIPAA PRIVACY AND SECURITY

VI.1 Applicability. This Plan is a "hybrid entity" within the meaning of HIPAA. This Plan elects to provide the privacy and security protections required by HIPAA only to the Covered Components.

VI.2 Uses and Disclosures of PHI by Sponsor. The Sponsor may use or disclose PHI pursuant to this Section, which may be further limited by the Sponsor's HIPAA policies and procedures.

a. Permitted Uses and Disclosures. The Sponsor may use and disclose any PHI obtained pursuant to this Article only for the purposes of administrative functions that the Sponsor performs for or on behalf of a Covered Component.

b. Required Uses and Disclosures. The Sponsor is required to use and/or disclose PHI: (i) to an individual, when requested under and required by 45 C.F.R. § 164.524 in order to provide an individual with access to his or her own PHI; (ii) to an individual, when requested under and required by 45 C.F.R. § 164.528 in order to provide an individual with an accounting of disclosures of that individual's PHI; and (iii) when required by the Secretary of the Department of Health and Human Services or those acting under the authority or at the direction of the Secretary to investigate or determine the Plan's compliance with HIPAA.

VI.3 Restrictions on Sponsor's Use and Disclosure of PHI.

a. The Sponsor will not use or disclose Participants' PHI, except (i) as required by law, or (ii) as permitted or required by this Plan Document.

b. The Sponsor will ensure that any agent, including any subcontractor, to whom it provides Participants' PHI, agrees to the restrictions and conditions of this Article with respect to Participants' PHI.

c. The Sponsor will not use or disclose Participants' PHI: (i) for the purpose of employment-related actions or decisions; (ii) in connection with a non-Covered Component; or (iii) in connection with any employee benefit of an Employer that is not a group health plan.

d. Promptly upon learning of any use or disclosure of Participants' PHI that is inconsistent with the uses and disclosures allowed under this Article, the Sponsor will report such inconsistent use or disclosure to the applicable Covered Component.

e. The Sponsor will make PHI available to the Participant who is the subject of the information, in accordance with 45 C.F.R. § 164.524.

f. The Sponsor will make Participants' PHI available for amendment, and will amend Participants' PHI, in accordance with 45 C.F.R. § 164.526.

g. The Sponsor will make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528.

h. The Sponsor will make its internal practices, books and records (as they relate to its use and disclosure of Participants' PHI) available to the U.S. Department of Health and Human Services for the purpose of determining compliance with 45 C.F.R. Parts 160-64.

i. If feasible, the Sponsor will return or destroy all Participants' PHI that the Employer 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, the Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

VI.4 Adequate Separation Between Sponsor and the Plan. The following members of the Sponsor's workforce may be given access to Participants' PHI: employees in the Benefits Department, Human Resources Department, and Accounting Departments, or if the Sponsor does not have such Departments, the executive employees of Sponsor and employee of Sponsor responsible for Sponsor's employee benefit programs. These individuals will have access to Participants' PHI only to perform the administrative functions that the Sponsor conducts for the Covered Components. These individuals will be subject to disciplinary action and sanctions, including termination of employment, for any use or disclosure of Participants' PHI in violation of the provisions of this Article, of HIPAA, or of the Employer's HIPAA policies and procedures. The Sponsor will promptly report any such violation to the Covered Component, and will cooperate with the Covered Component in order to correct the violation; impose appropriate disciplinary action or sanctions on each person causing the violation, and mitigate any negative effect of the violation on any Participant, the privacy of whose PHI may have been compromised by the violation.

VI.5 Disclosure to Sponsor. Any use or disclosure of PHI to the Sponsor pursuant to this Section must be in accordance with the policies and procedures of the Covered Component and of the Sponsor.

a. For the purpose of conducting administrative functions on behalf of a Covered Component, the Sponsor shall be entitled to receive PHI from: (i) a Covered Component; (ii) any business associate of a Covered Component; (iii) any person or entity that contracts with such business associate; (iv) any person or entity that contracts with the Employer to provide services to or on behalf of the Covered Component; (v) any health insurer or health insurance issuer or HMO that provides health benefits coverage or services to or on behalf of the Covered Component; (vi) any health care clearinghouse that provides services to or on behalf of the Plan or with respect to Participants; and (vii) any other person or entity that maintains, or has the authority to direct the disclosure of, PHI related to any Participant.

b. Notwithstanding the foregoing, PHI shall not be disclosed to the Sponsor: (i) for the purpose of employment-related actions or decisions; (ii) in connection with a non-Covered Component; or (iii) in connection with any other employee benefit of an Employer that is not a group health plan.

c. A Covered Component may disclose PHI to the Sponsor if the PHI summarizes the claims history, claims expenses, or types of claims experienced by individuals under the Covered Component, provided that the information described in 45 C.F.R. § 164.514(b)(2)(i) has been deleted (except that geographic information need only be aggregated to the level of a 5-digit zip code).

d. A Covered Component may disclose to the Sponsor information on whether an individual is participating in a Covered Component or is enrolled or has disenrolled from a particular coverage options within a Covered Component.

VI.6 Minimum Necessary. The Sponsor will make reasonable efforts to limit its use or disclosure of PHI to the minimum information necessary to accomplish the intended purpose of the use or disclosure. When requesting PHI from another party, the Sponsor will make reasonable efforts to limit its request to the minimum information necessary to satisfy the purpose of the request.

VI.7 Sponsor Certification of Compliance. Neither a Covered Component nor any health insurance issuer or business associate providing services to a Covered Component will disclose Participants' PHI to the Sponsor unless the Sponsor certifies that this Plan includes the terms of this Article and that the Sponsor agrees to abide by this Article.

VI.8 Security Provisions. The Sponsor will:

a. 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 a Covered Component;

b. Ensure that the adequate separation required by 45 C.F.R. § 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

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

d. Report to the Covered Component any security incident of which it becomes aware.

ARTICLE VII.
REIMBURSEMENT/SUBROGATION

VII.1 Applicability. In the event of a conflict between the provisions of this Article and the provisions of a Component Plan, whichever provisions provide the greatest rights to this Plan and/or the Component Plan shall govern.

VII.2 Obligations of the Covered Person.

a. No Prejudicial Acts. A Covered Person shall take no action to prejudice the rights of the Component Plan.

b. Notice. A Covered Person must notify the Plan Administrator immediately of any potential causes of action or claims for a Recovery that the Covered Person may have against a Third Party. A Covered Person must provide the Plan Administrator with a copy of any summons, complaint, or other process serviced in any lawsuit in which the Covered Person seeks a Recovery. A Covered Person must notify the Plan Administrator immediately of any settlement offer regarding a potential Recovery.

c. Cooperation. A Covered Person must cooperate and assist the Component Plan in enforcing its Subrogation and Reimbursement rights. Upon request, the Covered Person must: (i) provide details of the illness or injury; (ii) authorize the release of information, including the names of all providers from whom the Covered Person received service or

treatment; (iii) provide information about other insurance coverage and benefits; (iv) provide such other information as may be requested by the Component Plan; (v) assist the Component Plan in any action against the Third Party; and (vi) execute a Subrogation Agreement, Assignment of Recoveries, and Reimbursement Agreement in favor of the Component Plan.

d. Reimbursement. In the event that a Recovery is paid from a Third Party directly to the Covered Person, the Covered Person must reimburse the Component Plan the amount of any payments previously made to the Covered Person by the Component Plan (or for which the Component Plan may have future responsibility) with respect to that illness or injury.

e. Trust. The Covered Person must hold any Recovery (including amounts paid for future medical expenses) and any right of Recovery against the Third Party in trust for the Component Plan.

f. Settlement. The Covered Person must obtain written consent from the Plan Administrator before entering into any settlement agreement with a Third Party.

VII.3 Rights of the Component Plan.

a. Subrogation. The Component Plan may take action against any party (including, but not limited to, an attorney or trust) in possession of property or funds awarded or paid as a result of the Covered Person's illness or injury, if such property or funds should be or should have been paid to the Component Plan under this Article. The Component Plan has the right to seek a temporary restraining order against such party to prevent disbursement of such property or funds. In addition, the Component Plan may seek restitution in equity (through the imposition of a constructive trust for the Plan's benefit) from such party for the full amount of benefits paid by the Component Plan or for which it may have future responsibility.

b. Reimbursement. The Component Plan shall legally succeed the Covered Person's right of Recovery against a Third Party, up to the amount of benefits it has paid (or for which the Component Plan may have future responsibility) with respect to that illness or injury. The Component Plan shall have first priority on any money Recovered from the Third Party, including any amounts paid for medical costs over the uninsured or underinsured motorist's coverage, homeowner's or renter's coverage, medical malpractice or any liability plan. The Component Plan's contractual right to Reimbursement is in addition to and separate from equitable Subrogation, and may be enforced under the same terms as discussed in this Section.

c. Fees and Costs. If the Component Plan files suit in order to enforce its right to Recover from the Covered Person, the Component Plan reserves the right to be reimbursed for its court costs and attorneys' fees in relation to such suit.

VII.4 Settlement Agreements/Judgment Awards. The Covered Person must obtain written consent from the Plan Administrator before entering into any settlement agreement with a Third Party. If a settlement agreement or a judgment award includes payment for future medical expenses, a trust account may be established by the Plan Administrator or the Component Plan. In the absence of such a trust, the Component Plan has the right to exclude coverage for the Covered Person's future medical expenses, related to the illness or injury, up to the full amount of the settlement or award.

VII.5 Priority; Other Legal Doctrines. If the Third Party makes any payment to the Covered Person, his or her attorney, or an trust for his or her benefit, such payment must first be used to provide equitable restitution to the Component Plan, to the full extent of benefits paid by or payable under the Plan. This priority of the Component Plan applies despite other legal doctrines or theories. The Component Plan's rights of Subrogation and Reimbursement under this Article shall not be affected, reduced, or eliminated by the make-whole doctrine, the common fund doctrine, the doctrine of comparative fault theory, or any other legal doctrine or theory. Each Component Plan expressly rejects the common fund doctrine with regard to attorneys' fees. The rights of the Component Plan shall not be affected, reduced, or eliminated by any allocation which purports to allocation Recovery amounts in whole or in part to nonmedical damages.

VII.6 Conditions Precedent.

a. Cooperation. If a Covered Person refuses to comply with its obligations under this Article, fails to cooperate with the Component Plan in regard to Subrogation and Reimbursement rights, or refuses to execute and deliver such papers as the Component Plan may require in furtherance of its Subrogation and Reimbursement rights, then the Component Plan shall have no obligation to pay benefits to the Covered Person.

b. Minors. If the Covered Person is a minor, the Component Plan shall have no obligation to pay benefits related to the illness or injury caused by a Third Party until after the Covered Person's legal representative obtains valid court recognition and approval of the Component Plan's 100%, first-dollar Subrogation and Reimbursement rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement of such rights.

VII.7 Right to Offset Benefits. If a Covered Person fails to reimburse the Component Plan as provided in this Article, the Component Plan may offset any future benefits otherwise payable to the Covered Person or any member of the Covered Person's family unit, until the amount required to be reimbursed under this Article is fully offset.

VII.8 Termination of Coverage. If a Covered Person fails or refuses to comply with this Article, the Component Plan may terminate the Covered Person's coverage.

VII.9 Rights of Plan Administrator. The Plan Administrator has a right to request reports on all settlements. The Plan Administrator has full discretionary authority to approve all settlements.

ARTICLE VIII.
ADMINISTRATION OF PLAN

VIII.1 Funding. The Benefits under a Component Plan may be funded by an insurance policy, by the Employer's general assets, by Employee contributions, or by some combination of these. Contributions are established by the Employer. The Employer reserves the right to modify the cost sharing of contributions between the Employer and Participants, in such amounts as the Employer in its absolute discretion shall determine from time to time.

VIII.2 Limitation of Rights. Nothing in this document requires the Sponsor, any Employer, or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant. No Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account or asset of Employer from which any payment under the Plan may be made. Nothing in this Plan shall give any Employee any right to continued employment.

VIII.3 Power of Appointment. The Sponsor has the power to appoint the Named Fiduciary and the Plan Administrator.

VIII.4 Named Fiduciary. The Sponsor is the Named Fiduciary of the Plan.

VIII.5 Plan Administrator. The Sponsor is the Plan Administrator. The Sponsor may appoint either an individual or a committee to serve as the Plan Administrator on its behalf. An individual so appointed may resign by providing written notice to the Sponsor. A committee so appointed may act by a majority of its members at the time in office, either by vote at a meeting or in writing without a meeting. Such a committee may authorize any one or more of its members, or an Employee, to execute any document or documents on behalf of the Plan Administrator.

VIII.6 Powers and Duties of the Plan Administrator. Except as otherwise provided in or delegated by any applicable Component Plan, the Plan Administrator shall have full power to administer the Plan, in accordance with its terms, for the exclusive benefit of Participants and Beneficiaries. For this purpose, the Plan Administrator's full and discretionary powers include, but are not limited to, the following:

a. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable law;

b. To consider and decide claims and appeals filed under the Plan and any Component Plan;

c. To determine the eligibility, participation, status, and rights of all individuals under the Plan and any Component Plan;

d. To construe or interpret any and all terms of the Plan and any Component Plan;

e. To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan; and

f. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan. Any such allocation, delegation or designation shall be in writing.

All decisions by the Plan Administrator will be afforded the maximum deference permitted by law.

VIII.7 Governing Law. This Plan is established in the State of Ohio To the extent federal law does not apply, this Plan shall be construed in accordance with and governed by the laws of the State of Ohio

VIII.8 No Alienation. No Benefits under this Plan may be subject to anticipation, garnishment, attachment, execution or levy of any kind, or be liable for any Participant's or Beneficiary's debts or obligations.

VIII.9 No Assignment. No Benefits under this Plan may be assigned without the Plan Administrator's express written consent. Notwithstanding the foregoing, if specifically permitted by a Component Plan with a provider network, Benefits may be assigned to an in-network provider. In addition, the Claims Administrator may, in its discretion, pay a non-network provider directly for services rendered to a Participant or Beneficiary.

VIII.10 Indemnification of Plan Administrator. The Sponsor agrees to indemnify and to defend, to the fullest extent permitted by law, any member (or former member) of a committee appointed by the Sponsor to serve as the Plan Administrator, or any Employee (or former Employee) appointed by the Sponsor to serve as the Plan Administrator, against all liabilities, damages, costs and expenses (including attorneys' fees and amounts paid in settlement of any claims approved by the Employer) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

VIII.11 Claims Procedures. In the event that a Component Plan lacks a claims procedure, or in the event that the claims procedure of a Component Plan fails to comply with ERISA, Exhibit B shall apply to such Component Plan.

VIII.12 Qualified Medical Child Support Order ("QMCSO"). This Section applies to any Component Plan that is a "group health plan" within the meaning of ERISA § 607. To the extent required by law, if an Employee's Dependent is an "alternate recipient" described in a medical child support order, and if the Plan Administrator determines the order to be a QMCSO under ERISA § 609, this Plan and the applicable Component Plan will provide Benefits to such Dependent. Except as otherwise provided in any applicable Component Plan, the procedures in Exhibit C shall be used by the Plan Administrator in determining whether an order is a QMCSO. If you would like the Plan Administrator to determine whether an order is a QMCSO, submit the order to the Plan Administrator at the address set forth in Section 11.5. Upon receipt, the Plan Administrator or shall promptly notify the Participant and each alternate recipient of the receipt of such order and the procedures for determining whether the medical child support order is a QMCSO.

ARTICLE IX.
AMENDMENT AND TERMINATION

IX.1 Amendment. This Plan may be amended at any time and from time to time by a written instrument approved by the Sponsor and executed by a duly authorized officer or employee of the Sponsor.

IX.2 Termination. This Plan is established with the intention of being maintained for an indefinite period of time. Nevertheless, the Sponsor expressly reserves the right to discontinue or terminate this Plan or any Component Plan. After the Sponsor has discontinued or terminated the Plan, no Employee, Participant, Dependent or Beneficiary shall have or attain any vested right, contractual or otherwise, to any further contributions to or benefits from the Plan.

ARTICLE X.
MISCELLANEOUS

X.1 Employment Not Guaranteed. The Employer may terminate the employment of any Employee as freely and with the same effect as if this Plan and any Component Plans were not in existence. Participation in this Plan or any Component Plans by an Employee shall not constitute an express or implied contract of employment between the Employer and the Employee.

X.2 Tax Consequences Not Guaranteed. The Sponsor, Employer, and/or Plan Administrator make no any commitment or guarantee that any amounts paid to or for the benefit of a Participant or Beneficiary will be excludable from the gross income of such person for federal or state income tax purposes or that any other federal or state tax treatment will apply to or be available to any Participant or Beneficiary. It shall be the obligation of each Participant and Beneficiary to determine whether any payment under this Plan or any Component Plan is excludable from gross income for federal and state income tax purposes and to take appropriate action if there is reason to believe that any payment or amount withheld is not excludable. The Sponsor, Employer, and/or Plan Administrator is not liable for any taxes or penalties owed by any Participant or Beneficiary with respect to such amounts.

X.3 Additional Taxes or Penalties. If there are any taxes or penalties payable by the Employer on behalf of any Employee, such taxes or penalties shall be payable by the Employee to the Employer to the extent such taxes would have been originally payable by the Employee had this Plan not been in existence.

X.4 No Rights Against Employer. Neither the establishment of the Plan or a Component Plan, nor any modification of the Plan or a Component Plan, nor any distributions from the Plan or a Component Plan shall be construed as giving to any current or former Employee, Participant or Beneficiary under the Plan or a Component Plan any legal or equitable rights against the Employer, its shareholders, directors or officers, as such, or as giving any person the right to be retained in the employ of the Employer.

X.5 Payments Due Minors or Incapacitated Persons. If any person entitled to a payment under this Plan or a Component Plan is a minor, or if the Plan Administrator determines that any such person is incapacitated by reason of physical or mental disability, whether or not legally adjudicated as incompetent, the Plan Administrator shall have the power to cause the payment to be made to another for his benefit, without responsibility of the Plan Administrator, the Employer, or any other person or entity to see to the application of such payment. Payments made pursuant to this power shall operate as a complete discharge of the Plan Administrator, the Employer, and the Plan.

ARTICLE XI.
ERISA INFORMATION

XI.1 Exclusive Benefit and Legal Enforceability. This Plan is maintained for the exclusive benefit of Participants and Beneficiaries. The Employer intends that the terms of this Plan, including those relating to coverage and benefits, are legally enforceable.

XI.2 Plan Name. The Name of the Plan is the MyPlanAdvocate Insurance Solutions Inc (MyPlanAdvocate) Health and Welfare Plan.

XI.3 Plan Identification Number. The Identification Number for this Plan is 501.

XI.4 Type of Plan. The Plan is an umbrella or wraparound plan, which provides the welfare benefits described in Exhibit A.

XI.5 Plan Sponsor Information.
- Name: MyPlanAdvocate Insurance Solutions Inc
- Address: 460 West 50, North Suite 500, Salt Lake City, UT 84101
- EIN: 872644457

XI.6 Plan Administrator Information. The Plan Sponsor is the Plan Administrator. The Plan Sponsor's name and address are set forth in the previous section.

XI.7 Type of Administration. Each Component Plan is administered pursuant to an insurance contract, pursuant to a service agreement, or by an Employer, as specified in the Component Plan itself.

XI.8 Agent for Service of Legal Process. Service of legal process may be made upon the Plan Administrator.

XI.9 Named Fiduciary. The Sponsor is the Named Fiduciary of the Plan.

XI.10 Trustees. The Plan does not use a trust and therefore does not have any Trustees.

XI.11 Health Insurance Issuers and Vendors. The following chart identifies the health insurance issuers and other vendors that are responsible, in whole or in part, for financing or administering any of the benefits available under the Plan:

BENEFIT	NAME & ADDRESS OF ISSUER/VENDOR	EXTENT TO WHICH BENEFITS ARE GUARANTEED BY ISSUER/VENDOR	ADMIN. SERVICES PROVIDED BY ISSUER/VENDOR
Medical	Cigna - Ohio	100%	Claims Administration
Dental	Delta Dental - Ohio	100%	Claims Administration
Vision	VSP - Ohio	100%	Claims Administration

XI.12 Newborns' and Mothers' Health Protection Act Notice. This notice applies to any Component Plan that is a "group health plan" as defined by Part 7 of ERISA. Group health plans and health insurance issuers 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).

XI.13 ERISA Rights Notice

As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

Receive Information about Your Plan and Benefits

ERISA provides that all Plan participants shall be entitled to:

- Examine, without charge, through the Plan Administrator's office and at other specified locations, such as work sites and union halls, all documents governing the Plan, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series), and updated Summary Plan Descriptions. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

If the Employer is a certain size, you will be entitled to continue health care coverage for yourself, your spouse or children, if there is a loss of coverage under the Plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation of coverage rights.

Duties of the Plan Fiduciaries

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

Steps You Can Take to Enforce Your Rights

ERISA specifically provides for circumstances under which you may take legal action as a Plan participant.

If your claim for a benefit is ignored or denied, 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 or your beneficiary 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 Administrator, and do not receive them within 30 days, you may bring suit in federal court. The court may require the Plan Administrator to provide the materials, and pay you up to $110 a day until you receive the materials. The provision does not apply, however, if the materials were not sent to you for reasons beyond the control of the Plan Administrator.

If you have a claim for benefits that is ignored or denied, in whole or in part, you or your beneficiary 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 a federal court.

If the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you or your beneficiary may seek assistance from the U.S. Department of Labor or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you or your beneficiary is successful, the court may order the person you have sued to pay these costs and fees. But if you lose (if, for example, the case is considered frivolous) you or your beneficiary may have to pay all costs and fees.

If You Have Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210. You may also obtain certain publications concerning your rights and responsibilities under ERISA by calling the publications Hotline of the Employee Benefits Security Administration.
IN WITNESS WHEREOF, this Plan has been duly executed as of the day and year written below.

MyPlanAdvocate Insurance Solutions Inc

Signature:

Employee signature

Print Name: Sean Gallagher
Print Title: CFO

Date: Employee signature date

EXHIBIT A

COMPONENT PLANS

Medical • Cigna - Consumer Core • Cigna - Copay Core • Cigna - Consumer Enhanced • Cigna - Copay Enhanced
Dental • Delta Dental - Enhanced • Delta Dental - Core
Vision • VSP - Core
Life • Unum - Life and AD&D Coverage
Voluntary Life • Unum - Supplemental Life and AD&D Benefit
Short Term Disability • Unum - Short Term Disability Benefit
Long Term Disability • Unum - Unum Voluntary Long Term Disability Plan
Accidental Death & Dismemberment N/A
Voluntary Accidental Death & Dismemberment N/A

EXHIBIT B

CLAIMS PROCEDURES

1. Applicability. In the event that a Component Plan lacks a claims procedure, or in the event that the claims procedure of a Component Plan fails to comply with ERISA, this Article shall apply to such Component Plan.

2. Definitions. For purposes of this Article:

   a. "ACA" means the Patient Protection and Affordable Care Act of 2010, as amended.

   b. "Claim" means a Disability Claim, a Medical Claim, or a Standard Claim.

   c. "Claimant" means any person who submits a Claim, including any authorized representative who submits a Claim on another's behalf.

   d. "Disability Claim" means a written request for a disability benefit under this Plan or a Component Plan.

   e. "Medical Claim" means a written request for medical, dental, vision, or EAP benefits, or for reimbursement of other health care expenses, under this Plan or a Component Plan. There are three types of Medical Claims:

   f. "Pre-Service Claim" means a Medical Claim, if receipt of the benefit is conditioned, in whole or in part, on approval of the benefit in advance of obtaining medical care.

   g. "Post-Service Claim" means any Medical Claim other than an Urgent Care Claim or a Pre-Service Claim.

   h. "Urgent Care Claim" means any Medical Claim with respect to which medical care decisions, if made on a nonurgent time frame, (i) could seriously jeopardize the life or health of the Claimant, (ii) could seriously jeopardize the Claimant's ability to regain maximum function, or (iii) in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

   i. "Rescission" means the retroactive cancellation or discontinuation of coverage under a Component Plan that is a nongrandfathered group health plan subject to the ACA or a plan providing disability benefits. Rescissions constitute a denial (an adverse benefit decision) and may be appealed similar to other types of claims.

   j. "Standard Claim" means a written request for benefits under this Plan or a Component Plan, other than a Disability Claim or a Medical Claim.

3. Initial Claim.

   a. Submitting an Initial Claim. In order to receive benefits under a Component Plan, a Claimant must submit a Claim to the Plan Administrator.

   b. Timing of Initial Claim. Claims must be filed no later than one year after the date on which the applicable service was rendered or after the applicable event occurred.

   c. Claimant's Failure to Follow Procedures.

      i. Pre-Service Claims. If a Claimant fails to follow the procedures for filing a Pre-Service Claim (including an Urgent Care Claim), the Plan Administrator will notify the Claimant of the failure and of the proper procedures to be followed. The notice will be given as soon as possible, but not later than 5 days following receipt of the failed claim (24 hours if the failed claim is an Urgent Care Claim). The notification may be oral, unless the Claimant requests written notification. Such a notification is required only if the failed Claim (A) is received by a person or organizational unit customarily responsible for handling benefit matters, (B) names a specific Claimant, names a specific medical condition or symptom, and names a specific treatment, service or product for which approval is requested.

      ii. Other. Any other Claimant failure to follow the claims procedures shall be treated as if the Claim had not been filed. The Plan Administrator shall have no obligation to notify the Claimant of such failures.

   d. Approval of Initial Claim. If a Claim is approved, the Plan Administrator will provide the Claimant with written or electronic notice of such approval. The notice will include:

      i. The amount of benefits to which the Claimant is entitled;

      ii. The duration of such benefit;

      iii. The time the benefit is to commence; and

      iv. Other pertinent information concerning the benefit.

   e. Notice of Denial of Initial Claim. If a Claim is denied (in whole or in part), the Plan Administrator will provide the Claimant with written or electronic notification of such denial. The notice of denial of the Claim will include:

      i. The specific reason that the Claim was denied;

ii. A reference to the specific provisions of the Plan on which the denial was based;

iii. A description of any additional material or information necessary to perfect the Claim and an explanation of why this material or information is necessary;

iv. A description of the appeal procedures and the time limits that apply to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA § 502(a) if the Claim is denied on appeal;

v. If the denial is of an Urgent Care Claim, a description of the expedited appeal procedures;

vi. If the denial is of a Medical Claim under a group health plan subject to the ACA: (A) information sufficient to identify the claim, as prescribed by ACA; (B) a description of any standard that was used by the Plan or insurer in denying the claim; (C) a description of additional internal and/or External Review procedures; and (D) contact information for any applicable office of health insurance consumer assistance or ombudsman;

vii. If the denial is of a Medical Claim or Disability Claim, and if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

viii. If the denial is of a Medical Claim or Disability Claim, and if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and

ix. If the denial is of a Disability Claim:

(A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant (if such views were provided by the Claimant to the Plan), (ii) the views of medical or vocational experts whose advice was obtained by the Plan in connection with the Claim, without regard to whether the advice was relied upon in deciding the Claim; and (iii) a disability determination regarding the Claimant made by the Social Security Administration (if such a determination is provided by the Claimant to the Plan); and

(B) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim (whether a document, record, or other information is relevant to a Claim will be determined by reference to 29 C.F.R. § 2560.503-1(m)(8)).

f. Timing of Claims Decision. The notice required by this Section will be provided within the following time frames, unless special circumstances require an extension of time for processing the Claim.

i. For a Standard Claim, no more than 90 days after receipt of the Claim by the Plan Administrator.

ii. For a Disability Claim, no more than 45 days after receipt of the Claim by the Plan Administrator.

iii. For a Post-Service Claim, no more than 30 days after receipt of the Claim by the Plan Administrator.

iv. For a Pre-Service Claim, no more than 15 days after receipt of the Claim by the Plan Administrator.

v. For an Urgent Care Claim, no more than 72 hours after receipt of the Claim by the Plan Administrator. Notice of a decision on an Urgent Care Claim may be provided orally within this time frame, provided that written or electronic notice is provided no less than 3 days after the oral notification. If the Claimant fails to provide sufficient information for the Plan Administrator to decide an Urgent Care Claim, the Plan Administrator will notify the Claimant of the specific information necessary to complete the Claim as soon as possible, but no later than 24 hours after receipt of the Claim. The Plan Administrator will allow additional time for the Claimant to provide the specified information. The additional time will be a reasonable amount of time, taking into account the circumstances, but not less than 48 hours. In such cases, the Plan Administrator will notify the Claimant of its benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the receipt of the specified additional information or (2) the expiration of the period afforded the Claimant to provide the specified additional information.

g. Concurrent Care Decisions. If the Plan Administrator has previously approved a Medical Claim for an ongoing course of treatment to be provided over a period of time or numbers of treatments:

i. Any decision reducing or terminating the course of treatment (other than by amendment or termination of this Plan or the applicable Component Plan) before the end of an approved period of time or number of treatments shall constitute a Claim denial. The Plan Administrator shall provide the Claimant with a notice denying the Claim sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain an appeal decision before the benefit is reduced or terminated.

ii. If an Urgent Care Claim seeks to extend the course of treatment beyond the period of time or number of treatments previously approved, the Plan Administrator will decide the Claim as soon as possible, taking into account the

medical exigencies. If such a Claim is made at least 24 hours prior to the expiration of the approved period of time or number of treatments, the Plan Administrator will decide the Claim and notify the Claimant of the decision (no matter whether the Claim is granted or denied) within 24 hours after receipt of the Claim.

h. Coverage Pending Appeal. The Plan will continue to provide coverage pending the outcome of an Appeal in accordance with Department of Labor regulations and requirements.

4. Internal Appeals.

a. Filing an Internal Appeal. In the event that a Claim is denied (in whole or in part) the Claimant may appeal the denial by providing a written notice of appeal to the Plan Administrator within 180 days after the Claimant receives the notice of denial of the Claim. At the same time the Claimant submits a notice of appeal, the Claimant may also submit written comments, documents, records, and other information relating to the Claim. The Claimant is entitled to review and receive, free of charge, copies of all documents, records, and other information relevant to the initial Claim (whether a document is relevant will be determined pursuant to 29 C.F.R. § 2560.503-1(m)(8)).

b. General Appeal Procedure. The Plan Administrator may hold a hearing or otherwise ascertain such facts as it deems necessary and will render a decision which shall be binding upon both parties. In deciding the appeal:

i. No deference will be given to the decision denying the initial Claim.

ii. The appeal will be decided by an individual who did not decide the initial Claim and who is not a subordinate of anyone who decided the initial Claim.

iii. The individual deciding the appeal will review and consider all information submitted by the Claimant, without regard to whether the information was submitted or considered in conjunction with the initial Claim.

iv. If the appeal is based, in whole or in part, on a medical judgment, the individual deciding the appeal will consult with a health care professional who has appropriate training and experience in the relevant field; the health care professional will not be an individual who participated in the denial of the initial Claim and will not be the subordinate of any such individual.

v. If the Plan Administrator obtained advice from any medical or vocational experts in conjunction with the initial Claim, such experts will be identified to the Claimant (this identification must occur even if the Plan Administrator did not rely on the advice obtained).

vi. If the Plan obtains new or additional evidence that it intends to consider or rely upon in making its determination, the Plan will provide the new information or evidence to the Claimant as soon as possible and will give the Claimant a reasonable opportunity to respond.

c. Special Appeal Procedure for Urgent Care Claims. In addition to the procedures set forth in the preceding section, the following will apply to the appeal of an Urgent Care Claim:

i. A request for expedited review must be made to the Plan Administrator, but may be made either orally or in writing.

ii. All necessary information will be transmitted from the Plan Administrator to the Claimant by telephone, facsimile, or similarly expeditious means.

d. Special Appeal Procedure for Disability Claims.

i. If any new or additional evidence is considered, relied upon, or generated by the person or entity deciding the appeal of a Disability Claim, then before the Plan can issue an appeal decision that is adverse to the Claimant, the Plan Administrator must provide the Claimant, free of charge, with the evidence. The evidence must be provided as soon as possible, and sufficiently in advance of the deadline for the Plan to provide a notice of the appeal decision, to give the Claimant a reasonable opportunity to respond prior to that deadline.

ii. If the a new or additional rationale is the basis for the appeal decision of a Disability Claim, then before the Plan can issue an appeal decision that is adverse to the Claimant, the Plan Administrator must provide the Claimant, free of charge, with the rationale. The rationale must be provided as soon as possible, and sufficiently in advance of the deadline for the Plan to provide a notice of the appeal decision, to give the Claimant a reasonable opportunity to respond prior to that deadline.

e. Notice of Decision on Appeal. The appeal decision will be provided in written or electronic form to the Claimant. If the appeal decision is adverse to the Claimant, the written decision will include the following:

i. The specific reason or reasons for the appeal decision;

ii. Reference to the specific provisions of the Plan on which the appeal decision is based;

iii. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim (whether a document, record, or other information is relevant to a Claim will be determined by reference to 29 C.F.R. § 2560.503-1(m)(8));

iv. A statement describing any voluntary appeal procedures and the Claimant's right to obtain the information about such procedures;

v. A statement of the Claimant's right to bring an action under ERISA § 502(a);

vi. If the denial is of a Medical Claim or Disability Claim, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency." If the denial is of a Disability Claim, the statement must also describe any limitations period imposed by the Plan on the Claimant's right to bring such an action, including the calendar date on which such limitations period expires.

vii. If the denial is of a Medical Claim or a Disability Claim, and if an internal rule, guideline, protocol, or other similar criterion was relied upon in deciding the Claim, either (A) the specific rule, guideline, protocol, or other similar criterion, or (B) a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request;

viii. If the denial is of a Medical Claim or a Disability Claim, and if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either (A) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or (B) a statement that such explanation will be provided free of charge upon request; and

ix. If the denial is of a Disability Claim:

(A) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views of health care professionals treating the claimant and vocational professionals who evaluated the claimant (if such views were provided by the Claimant to the Plan), (ii) the views of medical or vocational experts whose advice was obtained by the Plan in connection with the Claim, without regard to whether the advice was relied upon in deciding the Claim; and (iii) a disability determination regarding the Claimant made by the Social Security Administration (if such a determination is provided by the Claimant to the Plan); and

(B) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim (whether a document, record, or other information is relevant to a Claim will be determined by reference to 29 C.F.R. § 2560.503-1(m)(8)).

f. Timing of Notice of Decision on Appeal. The Plan Administrator will render a decision on appeal within the following time frames, unless special circumstances require an extension of time.

i. For a Standard Claim, no more than 60 days after receipt of the appeal by the Plan Administrator.

ii. For a Disability Claim, no more than 45 days after receipt of the appeal by the Plan Administrator.

iii. For a Post-Service Claim, no more than 60 days after receipt of the appeal by the Plan Administrator.

iv. For a Pre-Service Claim, no more than 30 days after receipt of the appeal by the Plan Administrator.

v. For an Urgent Care Claim, no more than 72 hours after receipt of the appeal by the Plan Administrator.

5. Extensions of Time.

a. Notice of Extension. If the Plan Administrator requires an extension of time to review a Claim or an appeal, the Plan Administrator will provide the Claimant with written or electronic notice of the extension before the first day of the extension. The notice of the extension will include:

i. An explanation of the circumstances requiring the extension, which circumstances must be matters beyond the control of the Plan Administrator;

ii. The date by which the Plan Administrator expects to render a decision;

iii. The standard on which the Claimant's entitlement to a benefit is based; and

iv. The unresolved issues (if any) preventing a decision on the Claim or on appeal, and the information needed to resolve those issues. In the event such information is needed, the Claimant will have at least 45 days in which to provide the specified information. In addition, the time for determining an initial Claim will be tolled from the date on which the notice of extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

b. Extensions for Initial Claims. The Plan Administrator's ability to extend the time for deciding an initial Claim is subject to the following limitations:

i. For a Standard Claim, no more than one extension of 90 days.

ii. For a Disability Claim, no more than two extensions of 30 days.

iii. For a Post-Service Claim, no more than one extension of 15 days.

iv. For a Pre-Service Claim, no more than one extension of 15 days.

v. For an Urgent Care Claim, no extensions allowed.

c . Extension for Appeals. The Plan Administrator's ability to extend the time for deciding an appeal is subject to the following limitations:

i. For an appeal of a Standard Claim, no more than one extension of 60 days.

ii. For an appeal of a Disability Claim, no more than one extension of 45 days.

iii. For an appeal of a Medical Claim, no extensions allowed.

6. External Review. This Section applies only to Component Plans that are group health plans subject to the ACA. To the extent set forth in this Section, Claimants have the opportunity to pursue External Review following exhaustion of the Internal Appeals procedures.

a . Requesting an External Review. In the event that an Internal Appeal results in a denial based upon medical judgment or a Rescission (in whole or in part), the Claimant may request an External Review by giving written notice of the appeal to the Plan Administrator within 120 days after the Claimant receives the notice of decision on the Internal Appeal.

b . Eligibility for External Review. Within 5 business days following the date of receipt of the External Review request, the Plan Administrator will complete a preliminary review of the request to determine whether the matter is eligible for External Review. A matter is eligible for External Review only if it meets all of the following requirements:

i. The Claimant is or was covered under the Plan at the time the health care item or service was requested;

ii. The denial does not relate to the Claimant's failure to meet the eligibility requirements under the terms of the Plan (in other words, the External Review process does not apply to eligibility determinations);

iii. The Claimant has exhausted the Plan's internal appeal process; and

iv. The Claimant has provided all the information required to process an External Review.

c . Notice of External Review Eligibility. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. The notification will advise Claimant that:

i. The claim is not eligible for External Review;

ii. The claim is eligible and ready for External Review; or

iii. It is unclear whether the claim is eligible for External Review because Claimant has not provided all the information required.

d . External Review Process. If the claim is eligible and ready for External Review, the Plan Administrator will assign an Independent Review Organization ("IRO") that is accredited by URAC (a nonprofit organization promoting healthcare quality by accrediting healthcare organizations) or by a similar nationally recognized accrediting organization to conduct the external review.

i. The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for External Review, including a statement that the Claimant may submit in writing, within 10 business days, additional information which the IRO must then consider when conducting the External Review; and

ii. Within 5 business days after the date of assignment to the IRO, the Plan Administrator will provide the IRO the documents and any information considered in deciding the Initial Claim and the Internal Appeal.

iii. Within 45 days after it receives the request for External Review, the IRO will deliver a notice of decision to Claimant.

iv. The IRO's decision shall be binding on all parties unless and until there is a judicial decision otherwise.

e . Eligibility for Expedited External Review. Claimant may request an "expedited" External Review in the following circumstances:

i. Claimant has (a) received a decision on an initial claim involving either urgent care or concurrent care, (b) filed a request for an Appeal, and (c) a medical condition for which the timeframe for completion of an Appeal would seriously jeopardize Claimant's life or health or would jeopardize Claimant's ability to regain maximum function.

ii. Claimant has (a) completed an Internal Appeal, and (b) a medical condition for which the timeframe a standard External Review would seriously jeopardize Claimant's life or health, would jeopardize Claimant's ability to regain maximum function.

iii. Claimant has completed an Internal Appeal, and (a) the Appeal concerns an admission, availability of care, continued stay, or health care item or service for which Claimant received emergency services, and (b) Claimant has not been discharged from the facility.

f. Expedited External Review Process.

i. A request for an expedited External Review must be accompanied by a written statement from Claimant's physician that Claimant's medical condition meets the criteria above.

ii. The IRO will provide notice of its decision on an expedited External Review as expeditiously as Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO's receipt of Claimant's request. If the notice is not in writing, the IRO will provide written notice to Claimant within 48 hours after its decision.

7. Culturally and Linguistically Appropriate Notices. With respect to a Disability Claim, any notice of denial, whether of the initial claim or of an appeal, shall be provided in a culturally and linguistically appropriate manner, as specified in 29 CFR § 2560.503-1(o).

8. Legal Action. A Claimant must exhaust his or her administrative remedies under these procedures prior to bringing any legal action with respect to a Claim.

EXHIBIT C

QMCSO PROCEDURES

1. Introduction

This document sets forth the procedures to be followed by Plan Sponsor's group health plans upon receipt of "qualified medical child support orders" (QMCSOs), including National Medical Support Notices (NMSNs). These procedures do not apply to benefits that are not "group health plan" benefits under ERISA, such as life insurance benefits and retirement benefits. All actions related to QMCSOs and NMSNs must be taken in accordance with these procedures and must be performed on a timely basis.

a. What Is a QMCSO?

A QMCSO is a judgment, decree, or order, issued by a court or through a state administrative process, that requires health plan coverage for the child of a participant (called an "alternate recipient") and that meets certain legal requirements. Such orders typically are issued as part of a divorce or as part of a state child support order proceeding, and are typically drafted by divorce lawyers. Unlike NMSNs, they are not required to follow a standard format. As a result, they may vary widely in terminology, format, and sophistication. Federal law requires a group health plan to provide benefits in accordance with such an order, if it is "qualified."

A QMCSO may apply to an employer's major medical plan, as well as to other types of group health plans such as dental plans, vision plans, and health FSAs.

In general, a child who is an alternate recipient under a QMCSO must be treated the same as any other child covered by the plan. If the Medical Child Support Order is not qualified, the group health plan will not provide group health plan coverage to the child, unless the child is otherwise eligible for and enrolled in the plan.

b. What Is an NMSN?

State child support enforcement agencies are required to use an NMSN when enforcing the provision of health care coverage to children under an employment-related group health plan. This is a standard form that was jointly developed by the DOL and HHS. When properly completed by the issuing agency, the NMSN will constitute a QMCSO.

In some cases, orders will refer to or require a plan to comply with state laws enacted in response to Section 1908A of the Social Security Act, which requires states to enact certain medical child-support laws in order to receive federal Medicaid funds. These state laws are designed to help state governments and non-employee parents obtain private-sector health coverage for children, including coverage under employer-sponsored group health plans.

The NMSN will normally be sent to the employer. If the employer determines that the NMSN cannot be implemented, the employer is required to notify the issuing agency, which is then responsible for notifying the child and/or parents. If the employer determines that the specified conditions that might prevent the NMSN from being are not present, the employer is then required to forward Part B of the NMSN to the Plan Administrator, at which point the Plan Administrator becomes responsible for complying with the applicable notification requirements.

c. What Are the Plan's Rights and Responsibilities Relating to QMCSOs and NMSNs? Plans are not required to provide coverage in accordance with a child support order or other court order unless the order is "qualified" in accordance with ERISA §609(a). The Plan Administrator has the authority to determine whether an order meets the requirements of ERISA §609(a). If the order does not meet these requirements, the Plan need not (and should not) provide any benefits to the alternate recipient, unless the child is otherwise eligible for and enrolled in the Plan or the order's deficiencies are corrected by the parties.

2. Procedures for Determining Whether Orders Are QMCSOs

a. Upon Receipt of Any Order Other Than an NMSN

i. Notification to the Participant and the Alternate Recipient Upon Receipt of the Order. Upon receipt of any order other than an NMSN, the Plan Administrator must promptly provide written notification to both the participant and the alternate recipient(s) named in the order. The notification must inform the participant and the alternate recipient(s) that the Plan has received the order and should include a copy of the Plan's QMCSO procedures. For the participant, the Plan Administrator should send the notification to the participant at the address shown in the employer's records. If the participant is represented by legal counsel, the notification may be sent to the participant in care of the participant's legal counsel. For the alternate recipient(s), the Plan Administrator should send the notification to the address in the order, or if the order does not specify such an address, to the last-known address shown in the employer's records. If there are multiple alternate recipients named in the order, a single notification may be sent addressed to those alternate recipients who are, so far as the Plan Administrator is aware, residing at the same address. If the alternate recipients are minors, the notification may be sent to them in care of the parent with whom they are residing or, if they are represented by legal counsel, in care of their legal counsel.

ii. Review of the Order. The Plan Administrator must review the order to determine if it meets the legal requirements for a QMCSO. If the Plan Administrator considers it to be necessary or advisable, the Plan Administrator may seek the assistance of legal counsel in reviewing a proposed QMCSO.

iii. Notification to the Participant and the Alternate Recipient Following Review of the Order. Within a reasonable time after receipt of the order, the Plan Administrator must notify the participant and alternate recipient of the determination that it has reached as to whether the order is, or is not, a QMCSO. If the Plan Administrator

determines that the order is not a QMCSO, an explanation of the defective or missing provisions should be included.

iv. Time Period for the Plan Administrator's Review. The Plan Administrator should review a proposed QMCSO as quickly as possible. Under normal circumstances, the Plan Administrator's review must be completed within 40 business days following receipt of the proposed QMCSO.

v. Combining Notifications to the Participant and Alternate Recipient. When the Plan Administrator is able to review a proposed QMCSO immediately upon its receipt of the proposed order, the Plan Administrator may provide a single notification to the participant and the alternate recipient(s) informing them of its receipt of the proposed order, of the Plan's QMCSO procedures, and of the determination it has made as to whether the proposed order should be recognized as a valid QMCSO. Alternatively, the Plan Administrator may include separate notifications in the same envelope sent to the participant or to the alternate recipient(s).

b. Upon Receipt of an NMSN. Upon receipt of an NMSN, the Plan Administrator must follow the "Instructions to Plan Administrator" that are included in Part B of the NMSN. In addition, because a properly completed NMSN is deemed to be a QMCSO under ERISA, the Plan Administrator must also ensure that the notifications to the participant and to the alternate recipient(s) that are required upon the receipt of a proposed QMCSO are also provided upon the receipt of an NMSN. The required notifications can generally be provided by sending copies of the completed "Plan Administrator Response" to the NMSN to the parties using the addresses on Part B of the NMSN. In addition, if the NMSN is determined to be a QMCSO, the parties must be provided with certain information, such as the effective date of the child's coverage (or the steps necessary to effectuate coverage), a description of the coverage, and any forms or documents necessary to enroll in the Plan. (See the instructions to the NMSN.)

c. Designation of Representative. An alternate recipient may designate a representative to receive copies of notices that are sent to him or her with respect to an order. If an alternate recipient is a minor, the custodial parent or, in the case of an NMSN, the issuing agency, will be deemed to be the representative of the alternate recipient unless contrary instructions have been provided. If any party is represented by legal counsel, that party's legal counsel will be deemed to be that party's representative for purposes of the notification requirements in these procedures.

d. Disputes. Within 30 days after the date of the Plan Administrator's notice as to whether an order is a QMCSO, the parties (or their legal counsel) will have the right to submit written comments regarding the determination. After considering any comments received, the Plan Administrator will make a final determination as to the qualified status of the order. If no comments are received during the 30-day period, the decision will become final.

e. Resubmitted Orders. If an order (including an NMSN) is determined to not be a QMCSO, the parties or agency may submit a revised order to cure the deficiencies. If a revised order is submitted, the evaluation process in subsection A or B is repeated.

3. Additional Considerations

a. Forms and Information. Additional forms and information may be necessary to effectively administer benefits under an order that has been determined to be a QMCSO and to enroll the alternate recipient in the applicable plans. These forms and information include the following:

i. The name and address of the alternate recipient's custodial parent, legal guardian, or other person(s) to whom the SPDs and other plan-related information and correspondence should be furnished following the alternate recipient's enrollment. Where an agency is involved (as in the case of a National Medical Support Notice), it may be necessary or appropriate to provide certain plan information and/or correspondence to the agency as well.

ii. A completed enrollment form, if required under the Plan.

iii. A change in the participant's cafeteria plan election, if applicable. If benefits required to be provided under a QMCSO are paid for on a pre-tax basis, the QMCSO may qualify as a permitted election change event under the company's cafeteria plan. If applicable, and if the cafeteria plan document permits an election change on account of the QMCSO, the participant may submit a change in his or her cafeteria plan election in accordance with the cafeteria plan's rules.

iv. The name and address of an individual to whom it is expected that benefit reimbursements may be made for the alternate recipient's child's claimed expenses. The QMCSO rules provide that if medical expenses are paid by either the alternate recipient or the alternate recipient's custodial parent or legal guardian, a plan must reimburse that person (not the employee) for those expenses. If expenses are submitted for reimbursement, information identifying the individual to receive payment should be provided to the Plan.

Note that a QMCSO may provide that a person or entity other than the participant is responsible to pay for the alternate recipient's coverage. In such cases, the Plan Administrator should indicate how and when payment is to be made. For example, payments might be required concurrent with each payroll period or on a monthly basis as required of qualified beneficiaries receiving COBRA continuation coverage. The Plan Administrator should also make sure that it has contact information for the person or entity who will be making the payments.

c. Alternate Recipient as Beneficiary. In general, the alternate recipient must be treated like any other covered child under each plan in which he or she is enrolled. Unless a QMCSO is more restrictive, the alternate recipient should be given the same coverage as would be provided to any other dependent child under the Plan. The alternate recipient should be treated as a qualified beneficiary and offered COBRA continuation coverage upon the occurrence of a COBRA qualifying event (such as the participant's termination of employment or the alternate recipient's ceasing to qualify as a dependent child under the Plan due to age).

d. Alternate Recipient as Participant. With respect to ERISA reporting and disclosure rules, the alternate recipient generally is to be treated like a participant under each plan in which he or she is enrolled. Therefore, the alternate recipient should be sent copies of all applicable disclosures as required by ERISA or other applicable laws, including, for example, summary plan descriptions and summaries of material modifications. These items generally should be furnished to the alternate recipient's custodial parent or guardian. (If the alternate recipient is an adult, the Plan Administrator may provide copies to both the alternate recipient and the custodial parent or guardian.) Where an agency is involved (as in the case of an NMSN), it may be necessary or appropriate to provide copies of these items to the agency as well. Note that the alternate recipient need not be counted as a participant for purposes of the annual report (Form 5500).

e. Effective Date of Enrollment. If an order is determined to be a QMCSO or an NMSN is determined to be valid, that order will be given effect as soon as administratively practicable following such determination or, if later, as of the date specified in the order. Retroactive coverage will not, however, be provided. If an employee is eligible for the Plan but is not enrolled, he or she will also be enrolled if his or her enrollment is necessary for the alternate recipient to have the coverage required under the QMCSO. However, if the employee has not yet satisfied the Plan's waiting period, enrollment of the alternate recipient and employee will be delayed until the employee has completed the waiting period.

f. Termination of Coverage. Coverage for the alternate recipient will cease, subject to COBRA, if the alternate recipient ceases to be eligible to participate in the Plan for any reason, including the following:

i. The period for coverage under the QMCSO ends;

ii. The QMCSO is revoked or materially amended by a court of competent jurisdiction or through an administrative process;

iii. The participant ceases to be a participant under the terms of the Plan or an applicable component plan of the Plan;

iv. The participant ceases to be eligible for coverage under the terms of the Plan or an applicable component plan of the Plan; or

v. Similarly situated beneficiaries cease to be eligible for coverage under the terms of the Plan or an applicable component plan of the Plan.

g. Child Already Enrolled. The parties may submit an order (including a National Medical Support Notice) that purports to require that a child be covered under a plan in which he or she is already enrolled. In this circumstance, the plan administrator should process the order under these procedures but should also inform the parties of the child's status as a current beneficiary under the Plan.

h. Plans With Multiple Options. An otherwise-qualified order may identify a plan or type of coverage with multiple options without designating the option in which the alternate recipient is to be enrolled or the manner in which an option is to be chosen. In the case of an NMSN, the Plan Administrator should follow the instructions in the NMSN regarding plans with multiple options. For other orders, the Administrator should enroll the alternate recipient in the same option as the employee if the employee is enrolled in the Plan. Otherwise, the Plan Administrator may follow procedures similar to those in the NMSN. That is, the Plan Administrator may, instead of rejecting the order, provide the parties with information about the available options and direct them to make a selection. If the Plan has a default option, the Plan Administrator may also notify the parties that the alternate recipient and employee will be enrolled in this option if a response is not received within a specified time period (e.g., 20 business days).