Behavior Frontiers, LLC Welfare Benefit Plan

WRAP PLAN

Note to Plan Administrator/Sponsor:

ERISA requires an employer to have a written Plan Document and Summary Plan Description (SPD) for each separate Welfare Benefit Plan. These documents must contain very specific information as required by law. However, the certificates of coverage (COCs or "booklet-certificates") provided by insurance carriers do not typically contain all of the required ERISA language. In order to maintain compliance with ERISA, it is customary for employers to add a Wrap SPD to the certificates of coverage. In combination, the certificates of coverage and this Wrap SPD form a complete Summary Plan Description in conformity with ERISA requirements.

ERISA PLAN NUMBER 501

ERISA Plan Year **December 1 - November 30**

Established as of **December 1, 2015**
Amended and Restated as of **February 1, 2020**

Medcom
BENEFIT SOLUTIONS

Behavior Frontiers, LLC Welfare Benefit Plan

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ARTICLE 1
VARIABLE PROVISIONS/DEFINITIONS

Section 1.01 DEFINITIONS

"Affiliated Employer" means any corporation which adopts the Plan and is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

"Business Associate" means any outside vendor who performs a function or activity on behalf of the Plan which involves the creation, use or disclosure of PHI, and includes any subcontractor to whom a Business Associate delegates its obligations.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986, as amended.

"Dependent" means any person who qualifies as a dependent under a Subsidiary Contract for purposes of that contract.

"Domestic Partner" means a person in a domestic partnership with an employee. The term "domestic partnership" is defined as a committed relationship between two adults, of the opposite sex or same sex, in which the partners—

(1) are each other's sole domestic partner and intend to remain so indefinitely;

(2) maintain a common residence, and intend to continue to do so (or would maintain a common residence but for an assignment abroad or other employment-related, financial, or similar obstacle);

(3) are at least 18 years of age and mentally competent to consent to a contract;

(4) share responsibility for a significant measure of each other's financial obligations;

(5) are not married or joined in a civil union to anyone else;

(6) are not a domestic partner of anyone else;

(7) are not related in a way that would prohibit legal marriage in the U.S. jurisdiction in which the partnership was formed;

(8) provide documentation demonstrating fulfillment of these requirements, including but not limited to an affidavit of the partnership, that may be required by the Employer.

"Eligible Employee"	is an employee of the Employer who meets the eligibility requirements for one or more of the benefits offered under this Plan. It is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not Eligible 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.
"Employer"	means the Plan Sponsor and any other entity that adopts the Plan with the consent of the Plan Sponsor.
"ERISA"	means the Employee Retirement Income Security Act of 1974, as amended from time to time.
"FMLA"	means the Family Medical Leave Act, as referenced under Public Law 103-3 enacted February 5, 1993, and as amended.
"HIPAA"	means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.
"Individual"	as referenced in Article 8, means the Participant or the Participant's covered dependents enrolled in any of the group health benefits under the Plan. This definition does not apply to the term, "individual," as referenced in other articles of this document.
"Initial Administrative Period"	means the time during which new Variable Hour Employees who have completed the Initial Measurement Period and have been determined to be Eligible Employees can enroll in or waive medical coverage. This period may not exceed ninety (90) days and may include a partial month prior to the beginning of the Initial Measurement Period. The Initial Administrative Period, or its second part, begins the next day after the end of the Initial Measurement Period.
"Initial Measurement Period"	means the period of time during which a new Variable Hour Employee's hours of service are measured to determine whether the employee will become an Eligible Employee.
"Initial Stability Period"	means the minimum period of time during which medical coverage must be offered to an employee who was previously a Variable Hour Employee and has been determined to be an Eligible Employee. The Initial Stability Period may not be shorter in duration than the Initial Measurement Period.
"Notice of Privacy Practices"	means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

"Ongoing Employee" means an employee who was employed with the Employer on the first day of a Standard Measurement Period.

"Participant" means an employee of the Employer that participates in one or more Subsidiary Contracts.

"PHI" or Protected Health Information means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that (1) is created or received by the Plan or the Plan Sponsor; (2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and (3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual. PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

"Placed for Adoption" The phrase refers to a child whom the Participant intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement of adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child.

"Plan" means the benefit programs that are described in this document, including all amendments thereto.

"Plan Administration Functions" means the administration functions performed by the Plan Sponsor on behalf of the Plan. Plan Administration Functions do not include functions performed by the Plan Sponsor in connection with any other benefit plan of the Plan Sponsor.

"Plan Year" means each 12-consecutive month period ending on: **November 30**.

"Seasonal Employee" means an employee who is hired for a position for which the customary annual employment period is six (6) months or less and which begins at approximately the same time of each calendar year. A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.

"Spouse" refers to an individual who is lawfully married under any state law or currently recognized under prevailing Federal law. This definition shall apply to the extent it is not inconsistent with the provisions of any applicable Subsidiary Contract, in which case the provisions of the Subsidiary Contract shall control.

"Standard Administrative Period"	means the time during which Ongoing Employees who have completed the Standard Measurement Period can enroll in or disenroll from medical coverage. This period occurs between the Standard Measurement Period and the Standard Stability Period and may neither reduce nor lengthen the Measurement Period or the Stability Period.
"Standard Measurement Period"	means the period during which the Employer counts each Ongoing Employee's hours of service. Such period cannot be less than three (3) months nor more than twelve (12) months.
"Standard Stability Period"	means the period of time during which an Ongoing Employee is eligible for medical coverage under the Plan. The Standard Stability Period may not be shorter in duration than the Standard Measurement Period.
"Subsidiary Contract"	means any agreement, writing, contract, plan or arrangement between the Employer and a welfare benefit provider, or any other statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage, where the benefits provided are subject to ERISA.
"Summary Health Information"	means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed: (1) names; (2) any geographic information which is more specific than a five digit zip code; (3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older); (4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers; (5) facial photographs or biometric identifiers (e.g., finger prints); and (6) any other unique identifying number, characteristic, or code.
"USERRA"	means the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.
"Variable Hour Employee"	means an employee for whom the Employer is not able to determine, at the employee's hire date, whether the employee is reasonably expected to work the required number of hours per week for eligibility, as described in Article 1, Section 1.05.
"Waiting Period"	means the time period during which a newly hired Eligible Employee must be employed by the Employer prior to becoming a Participant.

"Welfare Benefit Plan" means any plan, fund, or program which was heretofore or is hereafter established or maintained by the Employer, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its Participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in 29 U.S. Code § 186(c) (other than pensions on retirement or death, and insurance to provide such pensions).

Section 1.02 PLAN INFORMATION

This Plan is intended to qualify as a Welfare Benefit Plan of the Employer under ERISA.

General Plan Information

(a) Name of Plan Sponsor: **Behavior Frontiers, LLC**

(b) Plan name: **Behavior Frontiers, LLC Welfare Benefit Plan**

(c) Plan number: **501**

(d) Plan Effective Date: **December 1, 2015**

(e) Document Effective Date: **February 1, 2020**. This is a restatement of the Plan.

(f) The Plan Administrator shall be the **Plan Sponsor**. The Plan Administrator shall also be the primary named fiduciary within the meaning of ERISA section 402.

(g) For insured Subsidiary Contracts, the insurance company is a named fiduciary as it relates to the determination of the amount of, and entitlement to, the insured benefits. The insurance company shall maintain full power to interpret and apply the terms relevant to its benefits policy.

Section 1.03 INDEMNIFICATION

The Employer shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

Section 1.04 SUBSIDIARY CONTRACTS

Subsidiary Contracts shall include and are not limited to the terms of the Welfare Benefit Plans listed in Appendix A. In addition, any statements of coverage provided by the Plan Administrator setting forth a description of the scope of coverage under the Plan as well as the options, terms, conditions and limitations related thereto are herein incorporated as part of the Subsidiary Contracts.

Section 1.05 ELIGIBILITY

(a) Eligibility for Medical Benefits

(i) The following provisions apply only with respect to eligibility for medical benefits under the Plan. To the extent that this Section conflicts with any provision in the Plan or a subsidiary Contract, the terms of this Section shall control.

(ii) The Employer offers coverage to Eligible Employees, their Spouses, Domestic Partners, and/or Dependents.

(iii) The eligibility terms and conditions that apply to a Participant's biological children will also apply to Dependents who have been adopted or Placed for Adoption with a Participant.

(iv) An Employee (who is not a Seasonal Employee) who regularly works, or is expected to work, 30 hours or more per week on average shall be an Eligible Employee.

(v) The Waiting Period applicable to a newly hired Eligible Employee shall end the first of the month following 30 days after his initial date of employment with the Employer. Participation shall not begin prior to this date.

(vi) However, any Employee who works, or is expected to work on a regular basis, less than 30 hours per week on average, and is not designated as an Eligible Employee on the Employer's personnel records, shall not be eligible to participate in the Plan.

(vii) Enrollment

i. Newly hired Eligible Employees may participate in the Plan following completion of the Waiting Period.

ii. Variable Hour Employees who become Eligible Employees may participate in the Plan following completion of the Initial Administrative Period.

iii. Ongoing Employees who become Eligible Employees may participate in the Plan following completion of the Standard Administrative Period.

(viii) Healthcare Reform Provisions for Group Health Plan

i. The Employer intends to follow IRS regulations and any subsequent guidance when administering the measurement, administrative, and stability periods.

ii. Variable Hour Employees

Variable Hour Employees must first complete an Initial Measurement Period during which they are not eligible to enroll in medical benefits under the Plan. At the end of the Initial Measurement Period, if the employee is determined to be an Eligible Employee, that employee will be eligible for medical benefits under the Plan. The Employer will use the Initial Administrative Period to determine whether an employee is an Eligible Employee and to offer coverage to Eligible Employees during the enrollment period specified by the Plan Administrator. Coverage will be effective during the Initial Stability Period.

(b) All Other Benefits Eligibility

The Employer offers the group life, accidental death & dismemberment, employee assistance program (EAP), and travel assistance program benefits to all Employees as of the date of hire. Employees will automatically be enrolled in these benefits.

Unless otherwise here stated, the eligibility requirements of each separate welfare benefit can be found in the applicable Subsidiary Contract. To the extent that this Section conflicts with any provision in the Plan or a Subsidiary Contract, the terms of this Section shall control.

ARTICLE 2
BENEFITS

Section 2.01 INCORPORATION BY REFERENCE

The actual terms and conditions of the Subsidiary Contracts offered under this Plan are contained in separate, written documents governing each respective benefit, and, unless otherwise stated herein, shall govern in the event of a conflict between the individual plan document and this Plan. To that end, each such separate Subsidiary Contract, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

See other Welfare Benefit Plan documents, summary plan descriptions, and/or certificates of coverage that are component parts which apply to this plan.

ARTICLE 3
PLAN ADMINISTRATION

Section 3.01 PLAN ADMINISTRATOR

(a) Designation. The Plan Administrator shall be specified in Article 1. In the absence of a designation in Article 1, the Plan Sponsor shall be the Plan Administrator. If a Committee is designated as the Plan Administrator, the Committee shall consist of one or more individuals who may be employees appointed by the Plan Sponsor and the Committee shall elect a chairman and may adopt such rules and procedures as it deems desirable. The Committee may also take action with or without formal meetings and may authorize one or more individuals, who may or may not be members of the Committee, to execute documents in its behalf.

(b) Authority and Responsibility of the Plan Administrator. The Plan Administrator shall be the Plan "administrator" as such term is defined in section 3(16) of ERISA, and as such shall have total and complete discretionary power and authority:

(i) to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities and inconsistencies therein and to supply omissions thereto. Any construction, interpretation or application of the Plan by the Plan Administrator shall be final, conclusive and binding;

(ii) to determine the amount, form or timing of benefits payable hereunder and the recipient thereof and to resolve any claim for benefits in accordance with Article 5;

(iii) to determine the amount and manner of any allocations hereunder;

(iv) to maintain and preserve records relating to the Plan;

(v) to prepare and furnish all information and notices required under applicable law or the provisions of this Plan;

(vi) to prepare and file or publish with the Secretary of Labor, the Secretary of the Treasury, their delegates and all other appropriate government officials all reports and other information required under law to be so filed or published;

(vii) to hire such professional assistants and consultants as it, in its sole discretion, deems necessary or advisable; and shall be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions and reports which are furnished by same;

(viii) to determine all questions of the eligibility of employees and of the status of rights of Participants under the Plan;

(ix) to determine the validity of any judicial order;

(x) to retain records on elections and waivers by Participants;

(xi) to supply such information to any person as may be required;

(xii) to perform such other functions and duties as are set forth in the Plan that are not specifically given to any other fiduciary or other person.

(c) Procedures. The Plan Administrator may adopt such rules and procedures as it deems necessary, desirable, or appropriate for the administration of the Plan. When making a determination or calculation, the Plan Administrator shall be entitled to rely upon information furnished to it. The Plan Administrator's decisions shall be binding and conclusive as to all parties.

(d) Allocation of Duties and Responsibilities. The Plan Administrator may designate other persons to carry out any of his duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator shall serve without compensation for its services.

(f) Expenses. All direct expenses of the Plan, the Plan Administrator and any other person in furtherance of their duties hereunder shall be paid or reimbursed by the Employer.

(g) Allocation of Fiduciary Duties. A Plan fiduciary shall have only those specific powers, duties, responsibilities and obligations as are explicitly given him under the Plan. It is intended that each fiduciary shall not be responsible for any act or failure to act of another fiduciary. A fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

Section 3.02 MEDICAL CHILD SUPPORT ORDERS

In the event the Plan Administrator receives a medical child support order (within the meaning of ERISA section 609(a)(2)(B)), the Plan Administrator shall 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 qualified medical child support order (within the meaning of ERISA section 609(a)(2)(A)). Within a reasonable period, the Plan Administrator shall determine whether the order is a qualified medical child support order and shall notify the Participant and alternate recipient of such determination.

Section 3.03 THIRD PARTY RECOVERY/REIMBURSEMENT

(a) The Plan Administrator may, but is not required to, utilize the provisions of this subsection to the extent not inconsistent with the provisions of any applicable Subsidiary Contract, in which case the provisions of the Subsidiary Contract shall control.

(b) In General. When a Participant or covered dependent receives Plan benefits which are related to medical expenses that are also payable under workers' compensation, any statute, any uninsured or underinsured motorist program, any no fault or school insurance program, any other insurance policy or any other plan of benefits, or when related medical expenses that arise through an act or omission of another person are paid by a third party, whether through legal action, settlement or for any other reason, the Participant shall reimburse the Plan for the related Plan benefits received out of any funds or monies the Participant recovers from any third party.

(c) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan shall be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant or covered dependent may have against any third party. The Plan is granted a specific and first right of reimbursement from any payment, amount or recovery from a third party. This right to reimbursement is regardless of the manner in which the recovery is structured or worded, and even if the Participant or covered dependent has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery shall not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to such reduction. Further, the Plan's right to subrogation or reimbursement will not be affected or reduced by the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, "attorney's fund" doctrine, regulatory diligence or any other equitable defenses that may affect the Plan's right to subrogation or reimbursement.

The Plan may enforce its subrogation or reimbursement rights by requiring the Participant to assert a claim to any of the benefits to which the Participant or a covered dependent may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that a Participant or covered dependent has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and covered dependents until the reimbursable portion is returned to the Plan or offset against amounts that would otherwise be paid to or on behalf of the Participant or covered dependents.

(d) Participant Duties and Actions. By participating in the Plan each Participant and covered dependent consents and agrees that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party. In accordance with that constructive trust, lien or equitable lien by agreement, each Participant and covered dependent agrees to cooperate with the Plan in reimbursing it for Plan costs and expenses.

Once a Participant or covered dependent has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. And, at that time, the Participant (and the Participant's attorney, if applicable) must sign a subrogation/reimbursement agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle the Participant or covered dependent to any payment, amount or recovery from a third party.

If a Participant fails or refuses to execute the required subrogation/ reimbursement agreement, the Plan may deny payment of any benefits to the Participant or covered dependent until the agreement is signed. Alternatively, if a Participant fails or refuses to execute the required subrogation/reimbursement agreement and the Plan nevertheless pays benefits to or on behalf of the Participant or a covered dependent, the Participant's acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant and covered dependent consents and agrees that they shall not assign their rights to settlement or recovery against a third person or party to any other party, including their attorneys, without the Plan's consent. As such, the Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

Section 3.04 HIPAA PORTABILITY RULES

To the extent the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules, the Plan shall comply with the requirements of Code section 9801 et. seq. including the requirement to cover children until the attainment of at least age 26 if the Plan makes dependent coverage of children available.

Section 3.05 MEDICAID

If a group health plan is subject to ERISA § 609(b), then this Section shall apply.

Payment for benefits with respect to a Participant under a group health plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or a

beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

The fact that a Participant is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

To the extent that payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services.

Section 3.06 COORDINATION OF BENEFITS

(a) Applicability. If a Participant has health care coverage under more than one Arrangement (defined, for purposes of this Section, below), the following coordination of benefits rules shall apply to the extent the applicable Subsidiary Contract does not contain coordination of benefits rules. If an applicable Subsidiary Contract contains coordination of benefits rules, the rules of the Subsidiary Contract shall apply and shall supersede this section.

(b) General Rule. The primary Arrangement pays or provides benefits as if the secondary Arrangement does not exist. An Arrangement may consider the benefits paid or provided by another Benefit in determining its benefits only when it is secondary to that other Arrangement. A secondary Arrangement pays after the primary Arrangement and may reduce the benefits it pays so that payments from all Arrangements do not exceed 100% of the total Allowable Expense (defined, for purposes of this Section, below). The order of benefit determination rules determine which Arrangement is primary or secondary.

(c) Definitions. For purposes of this Section, the following definitions apply:

(i) Allowable Expense. Allowable Expense means a health care service or expense, including coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Arrangements covering the person. When an Arrangement provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Arrangements is not an Allowable Expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. If a person is covered by one Arrangement that computes its benefit payments on the basis of

reasonable or recognized charges and another Arrangement that provides its benefits or services on the basis of negotiated charges, the primary Arrangement's payment arrangements shall be the Allowable Expense for all the Arrangements. However, if the secondary Arrangement has a negotiated fee or payment amount different from the primary Arrangement and if the provider contract permits, that negotiated fee will be the Allowable Expense used by the secondary Arrangement to determine benefits. When an Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an Allowable Expense and a benefit paid.

(ii) Arrangement. An Arrangement includes any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Arrangement and there is no coordination of benefits among those separate contracts.

Arrangement includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Arrangements (defined, for purposes of this Section, below) or other forms of group or group-type coverage (whether insured or uninsured); medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

Arrangement does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage included or excluded above is a separate Arrangement. If an Arrangement has two parts and coordination of benefits rules apply to only one of the two, each of the parts is treated as a separate Arrangement.

(iii) Closed Panel Arrangement. A Closed Panel Arrangement is an Arrangement that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Arrangement, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

(iv) Custodial Parent. A Custodial Parent is a parent awarded custody by a court decree. In the absence of a court decree, the Custodial Parent is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

(d) Order of Benefit Determination. Except as provided in the following sentence, an Arrangement that does not contain a coordination of benefits provision is always primary. Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Arrangement provided by the contract holder. Examples include major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connected with a Closed Panel Arrangement to provide out-of-network benefits.

Each Arrangement that contains a coordination of benefits provision, and that does not meet the exception above, determines its order of benefits using the first of the following rules that apply:

(i) Non-dependent or Dependent. The Arrangement that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary Arrangement and the Arrangement that covers the person as a dependent is the secondary Arrangement. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Arrangement covering the person as a dependent; and primary to the Arrangement covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the Arrangements is reversed so that the Arrangement covering the person as other than a dependent is the secondary Arrangement and the other Arrangement is the primary Arrangement.

(ii) Dependent Child Covered Under More Than One Arrangement. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Arrangement, the order of benefits is determined as follows:

(A) For a dependent child whose parents are married or are living together, whether or not they have ever been married: the Arrangement of the parent whose birthday falls earlier in the calendar year is the primary Arrangement; or, if both parents have the same birthday, the Arrangement that has covered the parent the longest is the primary Arrangement.

(B) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Arrangement of that parent has actual knowledge of those terms, that Arrangement is primary. This rule applies to plan years commencing after the Arrangement is given notice of the court decree.

(2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage or the decree does not specify which parent is responsible for the dependent child's health care expenses or health care coverage, the provisions of Subsection 3.06(d)(ii)(A) shall determine the order of benefits;

(3) If there is no court decree allocating responsibility for the health care expenses/coverage of the dependent child, the order of benefits for the child is as follows: (I) The Arrangement covering the Custodial Parent (defined, for purposes of this Section, above); (II) The Arrangement covering the spouse of the Custodial Parent; (III) The Arrangement covering the non-Custodial Parent; and then (IV) The Arrangement covering the spouse of the non-Custodial Parent.

(C) For a dependent child covered under more than one Arrangement of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

(iii) Active Employee or Retired or Laid off Employee. The Arrangement that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary Arrangement. The Arrangement covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary Arrangement. If the other Arrangement does not have this rule, and if, as a result, the Arrangements do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

(iv) Continuation Coverage. If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another Arrangement, the Arrangement covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary, and the continuation coverage is secondary. If the other Arrangement does not have this rule, and if, as a result, the Arrangements do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

(v) Longer or Shorter Length of Coverage. The Arrangement that covered the person as an employee, member, or subscriber longer is primary.

(vi) If the preceding rules do not determine the primary Arrangement, the Allowable Expenses shall be shared equally between the Arrangements meeting the definition of Arrangement under this Section. Any Subsidiary Contract will not pay more than it would have paid had it been primary.

(e) Effect on the Arrangements. When an Arrangement is secondary, it may reduce its benefits so that the total benefits paid or provided by all Arrangements during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any

claim, the secondary Arrangement will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Arrangement that is unpaid by the primary Arrangement. The secondary Arrangement may then reduce its payment by the amount so that, when combined with the amount paid by the primary Arrangement, the total benefits paid or provided by all Arrangements for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Arrangement shall credit to its Arrangement deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more Closed Panel Arrangements and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed Panel Arrangement, coordination of benefits shall not apply between that Arrangement and other Closed Panel Arrangements.

(f) Right to Receive and Release Needed Information. Certain facts about health care coverage and services are needed to apply these coordination of benefits rules and to determine benefits under the Arrangements. The Arrangements have the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision. The Arrangements need not tell, or get the consent of, any person to do this. Each person claiming benefits under the Arrangements must give the Arrangements any facts it needs to apply those rules and determine benefits payable.

(g) Facility of Payment. Any payment made under an Arrangement may include an amount, which should have been paid under another Arrangement. If so, the Arrangement may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under paying Arrangement. No Arrangement will have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

(h) Right of Recovery. If the amount of the payments made by an Arrangement is more than it should have paid under this coordination of benefits provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Section 3.07 FMLA/USERRA

To the extent the Employer is subject to FMLA, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits shall be continued according to the established policy of the Employer. Participants continuing participation pursuant to the foregoing shall pay for such

coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. 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 (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) 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.

The Plan Administrator shall also permit Participants to continue benefit elections as required under USERRA and shall provide such reinstatement rights as required by such law. The Plan Administrator shall also permit Participants 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.

Section 3.08 COBRA

To the extent the Plan is subject to COBRA (Code section 4980B and other applicable state law), a Participant shall be entitled to continuation coverage with respect to his or her health benefits as prescribed in Code section 4980B (and the regulations thereunder) or such applicable state statutes.

ARTICLE 4
FUNDING

Section 4.01 NO FUNDING REQUIRED

Except as otherwise required by law:

(a) Any amount contributed by a Participant and/or the Employer to provide benefits hereunder shall remain part of the general assets of the Employer and all payments of benefits under the Plan shall be made out of the general assets of the Employer or the Subsidiary Contracts.

(b) The Employer shall have no obligation to set aside any funds, establish a trust, or segregate any amounts for the purpose of making any benefit payments under this Plan. However, the Employer may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making any benefit payments under this Plan.

(c) No person shall have any rights to, or interest in, any account other than as expressly authorized in the Plan.

Section 4.02 FUNDING POLICY

The Employer shall have the right to enter into a contract with one or more Subsidiary Contract providers for the purposes of providing any benefits under the Plan and to replace any of such Subsidiary Contracts. The Employer will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation shall include, but not be limited to, losses or obligations that pertain to the following:

(a) Once a Subsidiary Contract is applied for or obtained, the Employer will not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Employer;

(b) To the extent premium notices are received by the Employer, the Employer's liability for the payment of such premiums will be limited to such premiums and will not include liability for any other loss which results from such failure;

(c) When employment ends, the Employer will have no liability to take any step to maintain any policy in force except as may be specifically required otherwise in this Plan and the Employer will not be liable for or responsible to see to the payment of any premium with respect to periods after employment ends.

Section 4.03 SUBSIDIARY CONTRACT REBATES FOR FULLY-INSURED GROUP HEALTH PLANS

Any dividends, retroactive rate adjustments or other refunds of any type, including medical loss ratio rebates required under Section 2718 of the Public Health Service Act (hereinafter collectively referred to as "rebates" for purposes of this section) that may become payable under any such Subsidiary Contract shall not be assets of the Plan except to the extent such amounts can be attributed to Participant contributions. For example: a) if the Participants and the Employer each paid a fixed percentage of the cost, a percentage of the rebate equal to the percentage of the cost paid by Participants shall be Plan assets; b) if the Employer was required to pay a fixed amount and Participants were responsible for paying any additional costs, then the portion of the rebate under such a Subsidiary Contract that does not exceed the Participants' total amount of prior contributions during the relevant period shall be Plan assets; and c) if Participants paid a fixed amount and the Employer was responsible for paying any additional costs, then the portion of the rebate under such Subsidiary Contract that does not exceed the Employer's total amount of prior contributions during the relevant period shall not be Plan assets. Any rebates that are not categorized as Plan assets may be retained by the Employer.

The Plan Administrator may hold the rebated Plan assets in trust, refund the rebate to Participants, apply the rebate towards future premiums, or take other such action in accordance with his or her fiduciary judgment and in accordance with applicable timing and other requirements of Department of Labor Technical Release No. 2011-04 and any superseding guidance. In addition, if the rebate is a medical loss ratio rebate under Section 2718 of the Public Health Service Act, the Plan Administrator shall determine whether reporting of the rebate to the Centers for Medicare and Medicaid Services (CMS) is required.

ARTICLE 5
CLAIMS PROCEDURES

Section 5.01 CLAIMS PROCEDURES

(a) This Section 5.01 shall apply for any claim for benefits under a Subsidiary Contract unless the Subsidiary Contract has a claims procedure that is compliant with ERISA section 503. If the Subsidiary Contract has a claims procedure that is compliant with ERISA section 503, the claims procedure of the Subsidiary Contract shall govern.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan's claim filing guidelines. In general, claims must be filed in writing (except urgent care claims, which may be made orally) with the applicable Subsidiary Contract provider. Any claim that does not relate to a specific benefit under the Plan (for example, a general eligibility claim or a dispute involving a mid-year election change) must be filed with the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under these rules. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" under these rules, unless it is determined, at the Plan Administrator's sole discretion, that the inquiry is an attempt to file a claim. If a claim is received, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

Participants may designate an authorized representative if written notice of such designation is provided to the applicable provider identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice.

(b) Timing of Notice of Claim. The Plan Administrator shall notify the claimant of any adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Subsidiary Contract under which the claim for benefits arises.

(i) In General. Notice of an adverse benefit determination will be provided 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

(ii) Group Health Plan Claims. The timeframe for benefit determinations under group health plans shall be determined as provided under DOL Reg. section 2560.503-1(f)(2).

(A) Urgent Care Claims. An "urgent care" claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an "urgent care" claim is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Participant's medical condition determines is an "urgent care" claim will be treated as an "urgent care" claim by the Plan.

If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing a urgent care claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 24 hours following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (A) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the plan administrator will notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the Participant to provide the specified additional information.

(B) Pre-Service Claims. A "pre-service" claim is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If the Participant or the Participant's authorized representative fails to follow the Plan's

procedures for filing a pre-service claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 5 days following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph (A) applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(C) Post-Service Claims. A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify the Participant of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

(D) Concurrent Care Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

Any request by a Participant to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Notwithstanding anything herein to the contrary, the timeframe for benefit determinations under group health plans will be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this Section 5.01, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

(iii) Disability Plan Claims (or Claims Involving Disability). Notice of an adverse benefit determination will be provided 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if the Plan Administrator notifies the claimant prior to the expiration of the first 30-day extension period the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section shall explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the claimant shall be afforded at least 45 days within which to provide the specified information.

(c) Content of Notice of Denied Claim.

(i) If a claim is wholly or partially denied, the Plan Administrator shall provide the claimant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the claimant must take if he wishes to appeal the denial including a statement that the claimant may bring a civil action under ERISA.

(ii) In addition, if the wholly or partially denied claim is by a Subsidiary Contract providing group health or disability benefits, the following information must also be included in the written notice: (1) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request; or (2) if the adverse benefit determination is based on a medical

necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(iii) In the case of a wholly or partially denied claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) under a Subsidiary Contract providing group health benefits, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section 5.01(c) may be provided orally within the timeframe required under Section 5.01(b) provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

(d) Appeal of Denied Claim.

(i) If a claimant wishes to appeal the denial of a claim, he shall file a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal shall identify both the grounds and specific Plan provisions upon which the appeal is based. The claimant shall lose the right to appeal if the appeal is not timely made.

The claimant shall be provided, upon request and free of charge, documents and other information relevant to his claim. A written appeal may also include any comments, statements or documents that the claimant may desire to provide. The Plan Administrator shall consider the merits of the claimant's written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan Administrator may deem relevant. If the claim is under a Subsidiary Contract providing group health or disability benefits, the claims procedures shall be determined in accordance with DOL Reg. section 2560.503-1(h)(3) and 2560.503-1(h)(4).

(ii) If the claim is for group health plan or disability plan benefits, the following will apply:

(A) The review will not afford deference to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor a subordinate of such individual;

(B) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health

care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor a subordinate of any such individual;

(C) The Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

(D) In the case of an urgent care claim, the Plan will expedite review of the claim such that a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

(iii) The Plan Administrator shall ordinarily rule on an appeal within 60 days. However, if special circumstances require an extension and the Plan Administrator furnishes the claimant with a written extension notice during the initial period, the Plan Administrator may take up to 120 days to rule on an appeal. If the denied claim is by a Subsidiary Contract providing group health or disability benefits, the timing of the Plan Administrator's review shall be determined in accordance with DOL Reg. section 2560.503-1(i)(2) and 560.503-1(i)(3).

If a committee is designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the committee will instead make a benefit determination no later than the date of the meeting of the committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the committee following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator will provide the Participant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator will notify the Participant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator shall provide the claimant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) 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 claimant's claim for benefits, and (4) a statement describing the claimant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator shall be binding upon all parties. In addition, if the claim is under a Subsidiary Contract providing group health or disability benefits, the denial notice shall include additional information required under DOL Reg. section 2560.503-1(j)(5).

(f) Exhaustion of Remedies. Before a suit can be filed in federal court, claims must exhaust internal remedies.

(g) Additional Claims Processes.

(i) Applicability. This Subsection shall apply to the extent (1) the Plan constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the Plan is subject to HIPAA portability rules and (2) the Plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

(ii) Effective Date. This Subsection shall be effective the later of the first plan year beginning after September 23, 2010 or the date the Plan is no longer a grandfathered health plan under the Patient Protection and Affordable Care Act.

(iii) Internal Claims Process. The claims requirements above shall apply as the internal claims process except as provided under DOL Reg. 2590.715-2719 and any superseding guidance.

(A) Adverse Benefit Determination. An adverse benefit determination means an adverse benefit determination as defined in DOL Reg. 2560.503-1, as well as any rescission of coverage, as described in DOL Reg. 2590.715-2712(a)(2).

(B) Expedited Urgent Care Determinations. The requirements of DOL Reg. section 2560.503-1(f)(2)(i) apply as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(B) and any superseding guidance. Claimants must be notified of benefit determinations (whether adverse or not) with respect to a claim involving urgent care (as defined in DOL Reg. section 2560.503-1(m)(1)) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the receipt of the claim.

(C) Full and Fair Review. A claimant must be allowed to review the file and present evidence and testimony as part of the internal appeals process. Claimants must be provided, free of charge, with any new or additional evidence considered relied upon or generated by the Plan in connection with the claim sufficiently in advance of the final adverse benefit determination to give the claimant a reasonable opportunity to respond prior to that date. The Plan must also meet the conflict of interest requirements under DOL Reg. 2590.715-2712(b)(2)(D).

(D) Notice. A description of available internal and external claims processes and information regarding how to initiate an appeal must be provided. Notices of adverse benefit determinations must include the information required under DOL Reg. 2590.715-2719(b)(2)(ii)(E) as applicable. The final notice of internal adverse benefit determination must include a discussion of the decision. Notice must be provided in a linguistically appropriate manner as provided under DOL Reg. 2590.715-2719(e). The Plan must disclose the contact information for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

(E) Deemed Exhaustion of Internal Claims Process. If the Plan fails to adhere to the requirements of DOL Reg. 2590.715-2719(b)(2), except as provided under DOL Reg. 2590.715-2719(b)(2)(ii)(F)(2), the claimant may initiate an external review under Section 6.02(b)(2) or may bring an action under section 502(a) of ERISA as provided in DOL Reg. 2590.715-2719(b)(2)(ii)(F) and any superseding guidance.

(iv) External Claims Process.

(A) State Process. To the extent the Plan is required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the plan or issuer must comply with the state external claims process of DOL Reg. section 2590.715-2719(c).

(B) Federal Process. To the extent the Plan is not required under DOL Reg. section 2590.715-2719(c)(1)(i) or (c)(1)(ii) to comply with the State external claims process, then the plan or issuer must comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d) and any superseding guidance.

(h) Legal Action. Any legal action by a Participant or beneficiary cannot be brought more than one year after the final determination of the claim under the Plan's claims rules.

Section 5.02 MINOR OR LEGALLY INCOMPETENT PAYEE

If a distribution is to be made to an individual who is either a minor or legally incompetent, the Plan Administrator may direct that such distribution be paid to the legal guardian. If a distribution is to be made to a minor and there is no legal guardian, payment may be made to a parent of such minor or a responsible adult with whom the minor maintains his residence, or to the custodian for such minor under the Uniform Transfer to Minors Act, if such is permitted by the laws of the state in which such minor resides. Such payment shall fully discharge the Plan Administrator and the Employer from further liability on account thereof.

Section 5.03 MISSING PAYEE

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participants or other person after reasonable efforts have been made to identify or locate such person, such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited one year after the date any such payment first became due.

ARTICLE 6
AMENDMENT OR TERMINATION OF PLAN

Section 6.01 AMENDMENT

The Plan Sponsor has the right to amend the provisions of the Plan, including any list of Subsidiary Contracts and component benefit plans, in writing at any time and from time to time.

Section 6.02 TERMINATION

(a) It is the intention of the Plan Sponsor that this Plan will be permanent. However, the Plan Sponsor reserves the right to terminate the Plan at any time for any reason.

(b) Each entity constituting the Employer reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Employer shall be deemed to terminate its participation in the Plan if: (i) it is a party to a merger in which it is not the surviving entity and the surviving entity is not an affiliate of another entity constituting the Employer, or (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Employer.

(c) Upon termination, any assets remaining in the Plan shall be used to pay outstanding benefit claims. To the extent permitted by the Subsidiary Contracts and to the extent the assets do not revert to the Employer, any remaining assets shall be refunded to Participants.

ARTICLE 7
GENERAL PROVISIONS

Section 7.01 NONALIENATION OF BENEFITS

No Participant or Beneficiary shall have the right to alienate, anticipate, commute, pledge, encumber or assign any of the benefits, payments, or rights to legal action, which he may expect to receive, contingently or otherwise, under the Plan.

Section 7.02 NO RIGHT TO EMPLOYMENT

Nothing contained in this Plan shall be construed as a contract of employment between the Employer and the Participant, or as a right of any employee to continue in the employment of the Employer, or as a limitation of the right of the Employer to discharge any of its employees, with or without cause.

Section 7.03 GOVERNING LAW

(a) The Plan shall 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.

(b) The Plan hereby incorporates by reference any provisions required by state law to the extent not preempted by Federal law.

Section 7.04 TAX EFFECT

The Employer does not represent or guarantee that any pre-tax premiums or benefits made to or on behalf of the Participant will be treated as nontaxable for any particular federal, state or local income, payroll, or personal property tax, or that any other tax consequence will result from participation in this Plan. If it is determined that an amount paid as a benefit is includable in the Participant's gross income for income tax purposes, under no circumstances will the Participant nor any other covered person have any recourse against the Employer, the Plan Administrator or any Adopting Employer with respect to any increased taxes or any other losses or damages suffered by the Participant as a result. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 7.05 SEVERABILITY OF PROVISIONS

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

Section 7.06 HEADINGS AND CAPTIONS

The headings and captions herein are provided for reference and convenience only, shall not be considered part of the Plan, and shall not be employed in the construction of the Plan.

Section 7.07 GENDER AND NUMBER

Except where otherwise clearly indicated by context, the masculine and the neuter shall include the feminine and the neuter, the singular shall include the plural, and vice-versa.

Section 7.08 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 shall, 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 Employer from compensation paid by the Employer.

ARTICLE 8
HIPAA

The Plan will comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as set forth below.

Section 8.01 HIPAA PRIVACY COMPLIANCE

The Plan's HIPAA privacy compliance rules ("Privacy Rule") are as follows:

(a) Permitted Use or Disclosure of PHI by Plan Sponsor. Any disclosure to and use by the Plan Sponsor of any PHI will be subject to and consistent with this Section.

(1) The Plan and health insurance issuer, HMO, or Business Associate servicing the Plan may disclose PHI to the Plan Sponsor to permit the Plan Sponsor to carry out Plan Administration Functions, including but not limited to the following purposes:

(A) to provide and conduct Plan Administrative Functions related to payment and health care operations for and on behalf of the Plan;

(B) for auditing claims payments made by the Plan;

(C) to request proposals for services to be provided to or on behalf of the Plan; and

(D) to investigate fraud or other unlawful acts related to the Plan and committed or reasonably suspected of having been committed by a Plan Participant.

(2) The uses described above in (1) are permissible only if the Notice of Privacy Practices distributed to covered Individuals in accordance with the Privacy Rule states that PHI may be disclosed to the Plan Sponsor.

(3) The Plan or a health insurance issuer or HMO may disclose to the Plan Sponsor information regarding whether an Individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

(b) Restrictions on Plan Sponsor's Use and Disclosure of PHI.

(1) The Plan Sponsor will not use or further disclose PHI, except as permitted or required by the Plan or as required by law.

(2) The Plan Sponsor will ensure that any agent, including any subcontractor, to whom it provides PHI agrees to the restrictions and conditions of this Section.

(3) The Plan Sponsor will not, and will not permit a health insurance issuer or HMO to, use or disclose PHI for employment-related actions or decisions, or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(4) The Plan Sponsor will report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section promptly upon learning of such inconsistent use or disclosure.

(5) The Plan Sponsor will make a covered Individual's PHI available to the covered Individual in accordance with the Privacy Rule.

(6) The Plan Sponsor will make PHI available for amendment and will, upon notice, amend PHI in accordance with the Privacy Rule.

(7) The Plan Sponsor will track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rule.

(8) The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of PHI received from the Plan to the Secretary of the U.S. Department of Health and Human Services to determine the Plan's compliance with the Privacy Rule.

(9) The Plan Sponsor will, if feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control) received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Individual who is the subject of the PHI, when that PHI is no longer needed for the Plan Administration Functions for which the disclosure was made. If it is not feasible to return or destroy all such PHI, the Plan Sponsor will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

(10) When using or disclosing PHI, or when requesting PHI from another party, the Plan sponsor must make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

(11) The Plan Sponsor will not use any genetic information for any underwriting purposes.

(c) Adequate Separation between the Plan Sponsor and the Plan.

(1) Only those employees of the Plan Sponsor, as outlined in the Plan's HIPAA Policies and Procedures, may be given access to PHI received from the Plan or a health insurance issuer, HMO or Business Associate servicing the Plan.

(2) The members of the classes of employees identified in the Plan's HIPAA Policies and Procedures will have access to PHI only to perform the Plan Administration Functions that the Plan Sponsor provides for the Plan.

(3) The Plan Sponsor will promptly report to the Plan any use or disclosure of PHI in breach, violation of, or noncompliance with, the provisions of this Section of the Plan, as required under this Section, and will cooperate with the Plan to correct the breach, violation or noncompliance, will impose appropriate disciplinary action or sanctions, including termination of employment, on each employee who is responsible for the breach, violation or noncompliance, and will mitigate any deleterious effect of the breach, violation or noncompliance on any Individual covered under the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance. Regardless of whether a person is disciplined or terminated pursuant to this section, the Plan reserves the right to direct that the Plan Sponsor, and upon receipt of such direction the Plan Sponsor shall, modify or revoke any person's access to or use of PHI.

(d) Purpose of Disclosure of Summary Health Information to Plan Sponsor.

(1) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan.

(2) The Plan and any health insurance issuer or HMO may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of modifying, amending, or terminating the Plan.

(e) Plan Sponsor Certification. The Plan Sponsor will provide the Plan with a certification stating that the Plan has been amended to incorporate the terms of this Article and that the Plan Sponsor agrees to abide by these terms. The Plan Sponsor will also provide the certification upon request to its health insurance issuers, HMOs and Business Associates of the Plan.

(f) Rights of Individuals.

(1) Notice of Privacy Practices. The Plan Sponsor will provide a Notice of Privacy Practices to the Participant in accordance with HIPAA.

(2) Right to Request Restrictions. Each Individual has the right to request that the Plan restrict its uses and disclosures of the Individual's PHI.

(3) Right to Access. Each Individual has the right to obtain and inspect its PHI held by the Plan.

(4) Right to Amend. Each Individual has the right to ask the Plan to amend its PHI.

(5) Right to an Accounting. Each Individual has the right to request an accounting of disclosures of PHI made by the Plan for purposes other than treatment, payment or health care operations.

Section 8.02 HIPAA SECURITY COMPLIANCE

To ensure the Plan's compliance with HIPAA's privacy compliance rules ("Security Rule"), the Plan 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 the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule 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 Plan any security incident of which it becomes aware.

Section 8.03 HIPAA COMPLIANCE FOR FULLY INSURED GROUP HEALTH BENEFITS

Notwithstanding the foregoing, to the extent any of the Plan's group health benefits are fully insured, the Plan Sponsor has adopted a policy of not receiving, disclosing or using PHI or Summary Health Information regarding insured benefits for any purpose permitted under HIPAA, unless authorized by the Individual, when appropriate.

APPENDIX A
WELFARE BENEFIT PLANS

The following welfare benefits of the Plan Sponsor are subject to ERISA and are covered by the Plan:

WELFARE BENEFIT	FUNDING TYPE
Medical	Fully-insured
Dental	Fully-insured
Vision	Fully-insured
Group Life	Fully-insured
Accidental Death & Dismemberment	Fully-insured
Employee Assistance Program (EAP)*	Fully-insured
Travel Assistance Program	Fully-insured

*Not a standalone benefit. Bundled with Life/AD&D.

The Plan Sponsor has adopted this Plan as of this date:

_____

Behavior Frontiers, LLC:

Signature: _____

Print Name: _____

Title/Position: _____