FOTH & VAN DYKE LLC COMPREHENSIVE HEALTH AND WELFARE BENEFIT PLAN

Established as of **January 1, 1986**
Amended and Restated as of **January 1, 2022**

FOTH & VAN DYKE LLC COMPREHENSIVE HEALTH AND WELFARE BENEFIT PLAN
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ARTICLE 1. INTRODUCTION & DEFINITIONS

Foth & Van Dyke, LLC (the "Plan Sponsor") hereby adopts and maintains this **Foth & Van Dyke LLC Comprehensive Health and Welfare Benefit Plan** (the "Plan") to provide health and welfare benefits to its eligible employees and their dependents. The Plan number is **507**. The Plan is originally effective as of **January 1, 1986.**

This Plan is intended to comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA") and will be administered in accordance with that intent. The Plan includes this document and any Subsidiary Contracts incorporated herein by reference.

DEFINITIONS

Company
: means the Plan Sponsor and any other entity that adopts the Plan with the consent of the Plan Sponsor. Additional Participating Companies are identified in any Joinder Agreement signed by representatives of each Participating Company, which may be amended by the Plan Sponsor from time to time without amending the Plan.

Eligible Employee
: means an employee of the Company who is eligible to participate in one or more Subsidiary Contracts.

Participant
: means an employee of the Company, spouse, or dependent who is enrolled in one or more Subsidiary Contracts.

Plan
: means this Foth & Van Dyke LLC Comprehensive Health and Welfare Benefit Plan, as may be amended from time to time.

Plan Administrator
: is Foth & Van Dyke, LLC

Plan Year
: means each 12-consecutive month period ending on December 31.

Subsidiary Contract
: means any agreement, writing, contract, plan, or arrangement between the Company and the welfare benefit provider(s) specified in the Subsidiary Contracts Appendix to this document, where the benefits provided are subject to ERISA. In addition, any statements of coverage, benefit booklet, insurance certificate, or summary plan description 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.

ARTICLE 2. ELIGIBILITY & BENEFITS

Section 2.01 ELIGIBILITY

Eligibility for benefits under the Subsidiary Contracts will be determined by the Subsidiary Contracts. The terms of eligibility need not be identical or similar among Subsidiary Contracts. An individual will cease participation in a Subsidiary Contract in accordance with the terms of the Subsidiary Contract. Eligibility information relating to group health benefits that provide minimum essential coverage offered under this Plan is further specified in the ACA Eligibility section of the Appendix to this document.

Section 2.02 BENEFITS

The terms and conditions of benefits offered under this Plan are contained in the Subsidiary Contracts, which are incorporated herein by reference as if fully recited herein.

ARTICLE 3. PLAN ADMINISTRATION

Section 3.01 PLAN ADMINISTRATOR

(a) Designation. If a committee is designated as the Plan Administrator (the "Committee"), the Committee will consist of one or more individuals appointed by the Plan Sponsor. The Committee may adopt such rules and procedures as it deems desirable to discharge its duties under the Plan. 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 on its behalf. If no Committee or other designee has been designated as the Plan Administrator, the Plan Sponsor will be the Plan Administrator.

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

(1) 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 will be final, conclusive, and binding;

(2) 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;

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

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

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

(6) 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;

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

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

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

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

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

(12) 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 will be entitled to rely upon information furnished to it. The Plan Administrator's decisions will be final, 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 its duties and responsibilities under the Plan.

(e) Compensation. The Plan Administrator will 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 will be paid or reimbursed by the Company.

(g) 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 INDEMNIFICATION

The Company will indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) and any employees of the Plan Administrator 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.

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 Company to provide benefits hereunder will remain part of the general assets of the Company and all payments of benefits under the Plan will be made out of the general assets of the Company or the Subsidiary Contracts.

(b) The Company will 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 Company may in its sole discretion, set aside funds, establish a trust, or segregate amounts for the purpose of making benefit payments under this Plan.

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

Section 4.02 FUNDING POLICY

The Company will have the right to enter into a contract with, and or replace, one or more Subsidiary Contract providers for the purposes of providing any benefits under the Plan. Any dividends, retroactive rate adjustments, rebates, or other refunds of any type (except for any portion of medical loss ratio rebates that can be attributed to participant contributions) that may become payable under any such Subsidiary Contract or in connection with a Subsidiary Contract will not be assets of the Plan but will be the property of, and will be retained by, the Company. The Company will not be liable for any loss or obligation relating to any insurance coverage except as is expressly provided by this Plan. Such limitation will 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 Company 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 Company;

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

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

ARTICLE 5. CLAIMS PROCEDURES

Section 5.01 CLAIMS PROCEDURES

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

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 and any procedures provided by 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" for purposes of this Section 5.01. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this Section 5.01, unless it is determined by the Plan Administrator in its sole discretion that the inquiry is an attempt to file a claim. If the Plan Administrator or its delegate receives a claim, 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 by providing to the Plan Administrator or its delegate written notice of such designation and 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. A "health care professional" is a physician or other health care professional licensed, accredited, or certified to perform specified health services, consistent with state law.

(b) Timing of Notice of Claim. The Plan Administrator will 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. An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination

of a Participant's eligibility to participate in the Plan, and including, with respect to a group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(1) In General. The Plan Administrator (or its delegate) will provide notice of an adverse benefit determination within 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.

(2) Group Health Plan Claims.

(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 an 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 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).

(3) Disability Plan Claims (or Claims Involving Disability). The Plan Administrator will provide notice of an adverse benefits determination to the Participant within 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 Participant, 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 Plan Administrator notifies the Participant 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 will 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 Participant will be afforded at least 45 days within which to provide the specified information.

(c) Content of Notice of Adverse Benefit Determination.

(1) If a claim is wholly or partially denied, the Plan Administrator will provide the Participant 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 Participant must take if he wishes to appeal the denial including a statement that the Participant may bring a civil action under ERISA.

(2) In addition, if the wholly or partially denied claim is by a group health plan or disability plan under the Plan, 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 Participant 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 Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(3) In the case of a wholly or partially denied urgent care claim by a group health plan under the Plan, 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 Adverse Benefit Determination.

(1) A Participant may appeal the denial of a claim by filing 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 will identify both the grounds and specific Plan provisions upon which the appeal is based. The Participant will lose the right to appeal if the appeal is not made timely.

The Plan will provide the Participant, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefit. The Participant may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The Plan Administrator will consider the merits of the Participant'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.

(2) If the claim is for group health plan or disability plan benefits,

(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 the 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 determinations 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 the 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.

(3) The Plan Administrator will ordinarily rule on an appeal of an adverse benefit determination for any benefit other than a group health plan or disability benefit within 60 days following receipt of the claimant's request for review by the plan. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to the Participant prior to the termination of the initial 60-day period. If the claim is for disability benefits, the 60-day initial period and extension period referred to in this paragraph shall be shortened to 45 days.

If a Committee 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.

(4) If the claim is for group health plan benefits, the Plan Administrator will notify the Participant of the Plan's benefit determination on review as follows:

(A) Urgent Care Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Participant's request for review of an adverse benefit determination by the Plan.

(B) Pre-Service Claims. The plan administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after

receipt by the Plan of the Participant's request for review of an adverse benefit determination.

(C) Post-Service Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

(5) The period of time within which a benefit determination on review is required to be made will begin at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

(e) Denial of Appeal. If an appeal is wholly or partially denied, the Plan Administrator will provide the Participant 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 Participant 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 Participant's claim for benefits, and (4) a statement describing the Participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

(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 rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;

(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 Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(3) 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."

(f) Exhaustion of Remedies. A Participant must exhaust all internal remedies before a claim or lawsuit can be filed in court.

(g) Additional Claims Processes.

(1) Applicability. This Subsection will apply to benefits under (1) a plan that 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.

(2) Internal Claims Process. The claims requirements set forth in Section 5.01 above will apply as the internal claims process, except that

(A) an "adverse benefit determination" will also include any cancellation or discontinuance of coverage under the applicable plan that has retroactive effect.

(B) the Plan will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to the Participant to give the Participant a reasonable opportunity to respond prior to that date; and

(C) before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the Participant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to the Participant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the Participant has a reasonable opportunity to respond. After the Participant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator will notify the Participant of the Plan's benefit determination as soon as the Plan, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies.

(D) the Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical

expert) must not be made based upon the likelihood that the individual will support the denial of benefits;

(E) the Plan must provide notice to Participants, in a culturally and linguistically appropriate manner;

(F) the Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

(G) the Plan must provide to Participants, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;

(H) the Plan must ensure that the reason or reasons for the adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision;

(I) the Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

(J) the Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist Participant's with the internal claims and appeals and external review processes.

(K) the Plan will continue to provide continued coverage under the Plan as required by DOL Reg. section 2590.715-2719(b)(2)(iii) pending the outcome of an appeal.

(3) External Claims Process.

(A) State Process. To the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719(c)(1) 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 will 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 pursuant to DOL Reg. section 2590.715-2719(c)(1) to comply with the State external claims

process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d).

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 individual's 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 will fully discharge the Plan Administrator and the Company 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 Participant 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 will 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 provisions of the Plan may be amended in writing at any time and from time to time by the Plan Sponsor or Plan Administrator.

Section 6.02 TERMINATION

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

(b) Each entity constituting the Company reserves the right to terminate its participation in this Plan. In addition, each such entity constituting the Company will 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 Company, (ii) it sells all or substantially all of its assets to an entity that is not an affiliate of another entity constituting the Company, or (iii) it at any time is not under common control with the Plan Sponsor pursuant to Section 3(37)(B) of ERISA.

(c) Upon termination, any assets remaining in the Plan will be used to pay outstanding benefit claims. After all claims and Plan liabilities have been paid, any surplus will revert to the Company, unless the Plan Sponsor determines that the assets will be refunded to Participants and the Subsidiary Contracts do not provide otherwise.

ARTICLE 7. GENERAL PROVISIONS

Section 7.01 INTERPRETATION

Each separate Subsidiary Contract, as amended or subsequently replaced, is hereby incorporated by reference. In the event of a conflict between the Subsidiary Contracts and this Plan, the Subsidiary Contracts will govern.

Section 7.02 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 will notify the affected Participant and any alternate recipient identified in the order of the receipt of the order and of 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 of receiving the medical child support order, the Plan Administrator will determine whether the order is a qualified medical child support order and will notify the Participant and alternate recipient of such determination.

Section 7.03 FMLA/USERRA

The Plan Administrator will permit Participants in any group health benefit under this Plan to continue Participation in the Plan as required under the Family Medical Leave Act (FMLA) and the Uniformed Services Employment and Reemployment Rights Act (USERRA), and will provide such reinstatement rights as required by law. The Plan Administrator will also permit Participants to continue to participate in any benefit under the Plan as required by USERRA and/or any other applicable state law to the extent that such law is not pre-empted by federal law. Participants continuing participation under this section will be responsible for paying 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. Participants whose coverage has terminated during a period of FMLA leave and is later reinstated will not be entitled to receive benefits for claims incurred during the period of leave.

Section 7.04 CONTINUATION OF COVERAGE

To the extent that any group health benefit under this Plan is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), a Participant will be entitled to COBRA continuation coverage to the extent required under Code section 4980B (and the

regulations thereunder). A Participant will be entitled to continuation coverage under the Plan as required by applicable state law to the extent that such law is not pre-empted by federal law.

To the extent that any group health benefit under this Plan is not an excepted benefit defined in Treas. Reg. section 54.9831-1 or if the Plan Administrator otherwise 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 7.05 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 will control.

(b) In General. When a Participant receives Plan benefits 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 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 Plan will be entitled to reimbursement by the Participant or his or her representatives of benefits paid from the Plan.

(c) Specific Requirements and Plan Rights. Because the Plan is entitled to reimbursement, the Plan will be fully subrogated to any and all rights, recovery or causes of actions or claims that a Participant 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 has not been paid or fully reimbursed for all of their damages or expenses.

The Plan's share of the recovery will 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 may be entitled. The Plan will not pay attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Company.

If the Plan should become aware that a Participant 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 any 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.

(d) Participant Duties and Actions. By participating in the Plan each Participant 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 agrees to cooperate with the Plan in reimbursing the Plan for costs and expenses.

Once a Participant has any reason to believe that the Plan may be entitled to recovery from any third party, the Participant must notify the Plan. 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 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, the Participant's acceptance of such benefits will constitute agreement to the Plan's right to subrogation or reimbursement.

Each Participant consents and agrees that they will 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.

This Section 7.05 will apply even after an individual is no longer a Participant in the Plan. The Plan Administrator has the authority and discretion to resolve all disputes regarding the interpretation of these subrogation and reimbursement rights and to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

Section 7.06 NONALIENATION OF BENEFITS

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

Section 7.07 NO RIGHT TO EMPLOYMENT

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

Section 7.08 GOVERNING LAW

(a) The Plan will be construed in accordance with and governed by the laws of the state or commonwealth of organization of the Plan Sponsor to the extent not preempted by Federal law.

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

Section 7.09 TAX EFFECT

The Company does not represent or guarantee that any particular federal, state, or local income, payroll, personal property or other tax consequence will result from participation in this Plan. A Participant should consult with professional tax advisors to determine the tax consequences of his or her participation.

Section 7.10 SEVERABILITY OF PROVISIONS

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

Section 7.11 HEADINGS AND CAPTIONS

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

Section 7.12 GENDER AND NUMBER

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

Section 7.13 EFFECT OF MISTAKE

In the event of a mistake as to the eligibility or participation of any individual, or the allocations made to the account of any Participant, or the amount of distributions made or to be made to a

Participant or other person, the Plan Administrator will, to the extent it deems possible, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as will in its judgment accord to such Participant or other person the credits to the account or distributions to which he is properly entitled under the Plan. Such action by the Administrator may include withholding of any amounts due the Plan or the Company from Compensation paid by the Company as permitted by applicable law.

ARTICLE 8. HIPAA

This Article 8 applies to those benefits under the Plan that are subject to the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations ("HIPAA") as set forth below.

Section 8.01 DEFINITIONS

For purposes of this Article 8, the following terms have the following meanings:

(a) Business Associate means a person or entity who qualifies as a "business associate" as defined in Section 160.103 of the HIPAA Privacy Regulations, including but not limited to a vendor who performs a function or activity on behalf the Plan which involves the creation, use or disclosure of PHI, and any subcontractor to whom a Business Associate delegates its obligations.

(b) Group Health Benefits means an employee welfare benefit plan (as defined in ERISA §3(1)) to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents directly or through insurance, reimbursement, or otherwise.

(c) Individual means the Participant or the Participant's covered dependents enrolled in any of the Group Health Benefits under the Plan.

(d) 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.

(e) 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.

(f) Protected Health Information (PHI) 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.

(g) 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.

Section 8.02 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 available 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 will, 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 8.03 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 8.04 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 other health information (except for information described in 45 C.F.R. 164.530(k)(1)(ii)) regarding insured benefits for any purpose permitted under HIPAA, unless authorized by the Individual, when appropriate.

EXECUTION

The undersigned agree to be bound by the terms of this Adoption Agreement and Wrap Plan Document and acknowledge receipt of same. Foth & Van Dyke, LLC caused this Plan to be executed this

_____ day of _____, 20_____.

FOTH & VAN DYKE, LLC:

Signature: _____

Print Name: _____

Title/Position: _____

SUBSIDIARY CONTRACTS APPENDIX

"Subsidiary Contract" means any agreement, writing, contract, plan or arrangement between the Company and the following benefit provider(s) for the benefit(s) indicated:

UMR - Major Medical
HCC Life - Stop-Loss
CVS Caremark - Major Medical (Pharmacy Benefit Manager)
Delta Dental - Dental
Superior Vision - Vision
Voya (Reliastar Life Insurance Company) - Life/AD&D
Voya (Reliastar Life Insurance Company) - Supplemental Life Insurance
Unum Life Insurance Company of America - Long-Term Disability
ComPsych - Employee Assistance Plan
Federal Insurance Company (Chubb) - Group Travel Accident

AFFORDABLE CARE ACT (ACA) ELIGIBILITY APPENDIX

Effective **January 1, 2015**, the following Eligibility provisions apply with respect to eligibility for any Medical Benefit offered 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.

ACA 1.01 APPLICABLE DEFINITIONS

Administrative Period

means the time allowed during which employees can enroll in or disenroll from medical benefits coverage under the Plan. An Administrative Period for all ongoing employees starts **November 1** and ends on **December 31.** The Administrative Period for new employees is **two full calendar months after the IMP ends**.

Break in Service

means, following an employee's termination of employment, a period of **13** or more consecutive weeks during which the employee did not have an hour of service.

Full-time Employee

is an Employee who is reasonably expected to work, on average, **at least 30 hours per week or 130 hours per calendar month**.

Initial Measurement Period

means the period of time during which a new employee's hours of service are measured to determine whether the employee is a Full-time Employee. The Initial Measurement Period is **12 months long**. The Initial Measurement Period starts on **the employee's date of hire**.

Medical Benefit

means any group health benefit that provides minimum essential coverage as defined under the Patient Protection and Affordable Care Act of 2010, as amended (ACA).

Ongoing Employee

means an employee who has been employed by the Company for at least one complete Standard Measurement Period.

Part-time Employee

means a new employee who the Company reasonably expects to work, on average, less than 30 hours per week during the Initial Measurement Period.

Seasonal Employee

means an employee who is hired into a position for which the customary annual employment period is **six months or less** and which begins at approximately the same time of each calendar year.

Stability Period

means the period of time during which an employee is treated as a Full-time Employee for purposes of determining eligibility for medical benefits under the Plan. The Stability Period for all employees starts **January 1** and ends on **December 31.**

Standard Measurement Period

means the period during which the Company counts an employee's hours of service. The Standard Measurement Period for all ongoing employees starts **November 1** and ends on **October 31.**

Variable Hour Employee

means an employee for whom the Company cannot determine, at the employee's hire date, whether the employee is reasonably expected to work an average of at least 30 hours per week.

ACA 2.01 ELIGIBILITY

The Company offers medical benefits coverage to Full-time Employees, their dependent children and/or spouses. Dependent children and spouses are defined in the separate subsidiary Contracts for medical benefits.

As of January 1, 2015, the Company uses the Look-Back Measurement Method to determine whether an employee is a Full-time Employee for purposes of medical benefits coverage under the Plan.

A rehired employee who was enrolled in medical benefits coverage under the Plan on the date of his termination of employment may resume participation in the medical benefits under the Plan on the employee's rehire date if the employee has not had a Break in Service and the Stability period that would apply (if applicable to that employee) on the date of reemployment is the same as the Stability Period in effect on the date of the individual's prior termination of employment. If reemployment begins during a new Stability Period, participation in the medical benefit under the Plan will begin on this date if, based on the applicable Measurement Period, the individual is a Full-time Employee on the date of reemployment.

If the employee had not satisfied any applicable waiting period prior to his termination of employment, upon rehire, the waiting period will be reduced by the period of prior employment.

If the employee is reemployed after a Break in Service, eligibility to become a participant in the medical benefits under the Plan will be based on the individual's status on the date of rehire.

ACA 2.02 LOOK-BACK MEASUREMENT PERIOD

The Company intends to follow IRS regulations and any subsequent guidance when administering the Look-Back Measurement Period.

(a) Ongoing Employees. For Ongoing Employees, the Company will determine whether an individual is a Full-time Employee by looking at the employee's hours of service during the Standard Measurement Period. If an Ongoing Employee is a Full-time Employee during the Standard Measurement Period, he or she will be eligible for medical benefits under the Plan during the entire Stability Period. The employee will remain eligible for medical benefits during the entire Stability Period, regardless of the employee's actual number of hours of service during the Stability Period, as long as he remains an employee of the Company. Similarly, if an employee is not a Full-time Employee during the Standard Measurement Period, he will not be eligible for medical benefits during the entire Stability Period.

(b) New Employees Expected to Work Full Time. If the Company reasonably expects a new employee to be a Full-time Employee as of the employee's hire date, the Company will determine the employee's status as a Full-time Employee using the employee's hours of service for each calendar month. If the employee's hours of service average at least thirty (30) hours per week or one hundred thirty (130) hours per month, the employee will be offered medical benefits coverage under the Plan pursuant to the standard eligibility and enrollment waiting periods required by the Plan, as detailed in the relevant Subsidiary Contract.

(c) New Part-time, Seasonal or Variable Hour Employees. Newly hired Part-time, Seasonal and 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 a Full-time Employee, that employee will be eligible for medical benefits under the Plan as of completion of Measurement and Administrative Periods, and for the Stability Period.

(d) Enrollment. The Company will use the Administrative Period to determine whether an employee is a Full-time Employee and to offer coverage to those Full-time Employees during an open enrollment period. Medical benefits coverage will be effective during the Stability Period.