HireRight
Health & Welfare Plan

Plan Document and
Summary Plan Description

Amended and Restated as of January 1, 2019

Genuine Financial Holdings LLC reserves the right to amend this Plan at any time or from time-to-time without the consent of or, to the extent permitted by law, prior notice to any employee or participant. Although Genuine Financial Holdings LLC expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan benefit option, feature or component at any time without liability.

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I. INTRODUCTION

We are pleased to provide you with this Plan Document and Summary Plan Description ("SPD") summarizing the HireRight Health & Welfare Plan (the "Plan") sponsored by Genuine Financial Holdings LLC for eligible employees and their eligible dependents, as well as those of its subsidiaries or affiliates that have been selected by Genuine Financial Holdings LLC to participate in the Plan and designated in Schedule B. In this document, the term "Participating Employers" refers to Genuine Financial Holdings LLC and the participating employers listed in Schedule B.

The Plan is composed of the following benefit options ("Component Plans"):

Attachment	Component Plan
1, 2, 3	HireRight Medical Plans ("Medical Plan")
4	HireRight Dental Plan ("Dental Plan")
5	HireRight Vision Plan ("Vision Plan")
6	HireRight Basic Life, Basic Accidental Death & Dismemberment, Voluntary Life and Voluntary Accidental Death & Dismemberment Plan ("Life and AD&D Plan")
7	HireRight Long Term Disability ("LTD")
8	HireRight New York Statutory Disability Plan ("NY DBL")
9	Summary of Benefits for the HireRight Flexible Benefit Plan, including the Pre-Tax Payment Feature (also known as the cafeteria plan), the Health Care Flexible Spending Account Plan ("Health Care FSA"), the Dependent Care Flexible Spending Account Plan ("Dependent Care FSA"), and the Health Savings Account ("HSA") ("Flex Plan")
10	HireRight Business Travel Accident Insurance Plan ("Business Travel Plan")
11	HireRight Employee Assistance Plan ("EAP")
12	HireRight Employee Legalshield Expense Plan ("Legal Assistance Plan")

A summary of each Component Plan provided under the Plan is set forth in the benefit booklet, certificate of insurance, or other governing document identified in Attachments #1-12.

This document, together with Attachments #1-12, and their respective policies, descriptions and other materials (either written or electronic), constitute the written plan and the summary plan description to the extent required by Section 102 of the Employee Retirement Income Security Act of 1974 ("ERISA") and U.S. Department of Labor Regulation Sections 2520.102-2 and 2520.102-3, and Section 125 of the Internal Revenue Code of 1986, as amended (the "Code") for the Plan. This document also summarizes certain terms of the Dependent Care FSA and the HSA. The Dependent Care FSA and the HSA are not employee benefit plans under ERISA and the benefits under the Dependent Care FSA and the HSA are not covered by ERISA.

The policies, contracts or booklets for each Component Plan govern the benefits to be provided and include more details on how the Component Plans operate. If there is any conflict between this document and such policies, contracts or booklets, then such other documents will control unless otherwise required by law or specified in this Plan document. Participants and beneficiaries should not rely on any oral description of the Plan because the written terms of the Plan will always govern.

II. GENERAL INFORMATION ABOUT THE PLAN

This section contains general information that you may need to know about the Plan.

A. Plan Name

HireRight Health & Welfare Plan

B. Plan Number

Genuine Financial Holdings LLC has assigned Plan Number 501 to the Plan.

C. Effective Dates

This Plan document and SPD were effective as of January 1, 2011, and amended and restated as of January 1, 2019 (except as otherwise provided).

D. Plan Year

The Plan Year for the Plan is January 1 – December 31.

E. Plan Sponsor

Genuine Financial Holdings LLC
3349 Michelson Dr. Suite 150
Irvine, CA 92612
Employer Identification Number (EIN): 81-5023164

F. Plan Administrator

HireRight, LLC
3349 Michelson Dr. Suite 150
Irvine, CA 92612
1-949-428-5800

The Plan Administrator has delegated certain day-to-day administration of the Plan and claims fiduciary responsibility for the processing and review of claims for benefits under the Plan, including COBRA claims and administration, to the third party administrators and claims administrators listed in Schedule A. The Plan Administrator will also answer any questions you may have about the Plan.

G. Service of Legal Process

The name and address of the Plan's agent for service of legal process is:

Genuine Financial Holdings LLC
3349 Michelson Dr. Suite 150
Irvine, CA 92612

Service of legal process may also be made upon the Plan Administrator. Service for the third party administrators, claims administrators and COBRA Administrator may be made at the addresses provided in Schedule A.

H. Type of Plan

The Plan, except for the Dependent Care FSA and the HSA, is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

The Plan is also intended, in part, to be a "cafeteria plan" within the meaning of Section 125 of the Code.

The Health Care FSA is intended to qualify as a qualified benefits plan that is a health care flexible spending arrangement as defined under Section 106(c)(2) of the Code. The benefits provided thereunder are intended to be eligible for exclusion from income to the extent provided under Sections 105(b), 106 and 125(a) of the Code, as applicable.

The Dependent Care FSA is intended to qualify as a dependent care assistance program under Section 129 of the Code. The benefits provided thereunder are intended to be eligible for exclusion from income under Sections 125(a) and 129(a) of the Code.

I. Type of Administration and Funding

Plan benefits are funded in the manner indicated in Schedule A for each Component Plan. With respect to benefits that are furnished through the purchase of insurance policies and contracts, Participating Employers will collect employee premiums and will pay when due all premiums required to keep such policies and contracts in force. Funding is derived from the funds of each Participating Employer and contributions made by the employees. The level of any employee contributions is set by HireRight and will be communicated to employees prior to any initial, open, or special enrollment period. Employee contributions will be used in funding the cost of the Plan benefits as soon as practicable after they have been received from the employee or withheld from the employee's pay through payroll deduction.

In general, participant contributions under the Medical Plan, the Dental Plan and the Vision Plan may be made on a pre-tax basis under the Plan's Pre-Tax Payment Feature, described below, except for contributions made on behalf of an individual who is not your husband or wife, dependent as defined in Code section 152 (without regard to subsections (b)(1), (b)(2), and (d)(1)(B)), or dependent child as defined in Code section 152(f)(1) who is under age 26. Contributions made on behalf of such an individual, such as your same-sex domestic partner who does not qualify as your dependent as defined in Code section 152 (without regard to subsections (b)(1), (b)(2), and (d)(1)(B)), must be made on a post-tax basis.

III. ELIGIBILITY

A. Employee Eligibility

Except as provided below, all active employees of the Participating Employers who are regularly scheduled to work at least 30 hours per week are eligible to participate in the Plan as of the first day of the month following their date of hire, or coincident with their hire date (if hired on the first day of the month). Rehired employees generally are treated as new hires for purposes of eligibility to participate in the Plan, except that employees rehired within 30 days of their termination date and in the same Plan Year automatically are reinstated immediately in their prior benefit elections. Notwithstanding the foregoing, employees in the following categories are not eligible to participate in the Plan:

- Employees covered by a collective bargaining agreement to which a Participating Employer is a party and which does not provide for participation in the Plan;
- "Leased employees" within the meaning of Code Section 414(n);
- Individuals who are classified by a Participating Employer as temporary workers, interns, co-ops, intermittent employees, independent contractors or consultants (except to the extent provided in III.A.1 below regarding the Medical Plan); or
- Individuals from whom a Participating Employer does not withhold federal income and employment taxes from such person's compensation, including without limitation nonresident aliens with no U.S. source income.

Except to the extent provided in III.A.1 below regarding the Medical Plan, any individual who is classified as a "leased employee," "temporary worker," "intern," "co-op," "independent contractor," or "consultant," or similar classification by a Participating Employer (which status may be evidenced by the payroll practices or records of a Participating Employer, or by a written or oral agreement or arrangement with the individual or with another organization that provides the services of the individual to a Participating Employer, under which the individual is treated as an independent contractor or is otherwise treated as an employee of an entity other than a Participating Employer (such as a leasing organization)), is not eligible to participate in the Plan during the period so classified, irrespective of (i) whether the individual is considered an employee of a Participating Employer under common law employment principles; (ii) whether such characterization is subsequently challenged, changed or upheld by a Participating Employer or any court or governmental authority, including, without limitation, an individual classified by a Participating Employer as a "leased employee" (as described in Code Section 414(n)); and (iii) how such individual may be treated by a Participating Employer for other purposes (such as employment tax purposes).

Notwithstanding the foregoing provisions of this Section III.A, the following eligibility exceptions apply:

1. *Medical Plan*

You are eligible for the medical plan if you are an active employee, including individuals classified as an intern or temporary employee, of a Participating Employer and you are employed, on average, at least 30 hours per week. You are eligible for the medical plan if you are a former employee of a Participating Employer who is serving on a Board of Managers or Board of Directors of a member of the controlled or affiliated service group of Genuine Financial Holdings LLC.

2. *Health FSA and HSA*

Eligible employees enrolled in one of the HSA options under the Medical Plan are not eligible for the Health Care FSA.

3. *Business Travel Plan*

Except as provided below, all active employees of the Participating Employers are eligible to participate in all portions of the Business Travel Plan, and will be covered by that plan when they are on business travel. The following groups of employees are excluded from certain portions of the Business Travel Plan:

- Employees enrolled in one of the HSA options under the Medical Plan are not eligible to participate in the Out of County Medical Expense Benefit portion of the Business Travel Plan.

4. *Legal Assistance Plan*

Eligible Employees: You must be a full-time employee who is a resident of the United States to be eligible to participate in the Legal Assistance Plan. Full time means active employees of the Employer who generally work at least 30 hours per week. You must provide a valid Social Security number that will serve as your plan identification number. If you do not have an assigned number, you must obtain one before your enrollment in the Plan is accepted. Covered Persons under the Plan Contract include an eligible employee who is currently enrolled in the Plan and his or her eligible spouse and dependents, as described in the Plan Contract.

Entry Dates: You will become a member of the Plan on the date of enrollment and acceptance by Legal Shield

B. Dependent Eligibility

Subject to the eligibility requirements set forth below for a specific Component Plan, you may enroll the following members of your family in the Plan ("Eligible Dependents"):

- **Your spouse**. "Spouse" means the individual to whom you are legally married. The Plan Administrator shall have the sole discretion to determine the legal status of a participant's marriage, which determination shall be based upon the laws of the state in which the marriage occurred.

- **Your domestic partner.** "Domestic partner" means the individual of the same sex or of the opposite sex together with whom you satisfy the requirements:

Same Sex Domestic Partner Criteria
The employee and his/her same sex domestic partner must meet the following criteria:

- Be at least 18 years old,
- Not be legally married, under federal law, to anyone else or part of another domestic partnership during the previous 12 months,

- Currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent,
- Currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently,
- Have agreed to share responsibility for each other's common welfare and basic financial obligations, and
- Not related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Opposite Sex Domestic Partner Criteria

- Opposite sex partners who are registered as domestic partners in jurisdictions that maintain such registries will be covered. Employees should inquire with their local jurisdiction whether such registries exist and whether they may register an opposite sex domestic partnership.

    - **Note regarding domestic partner taxes.** Unless your domestic partner (and your domestic partner's children, as applicable) is a dependent for group health plan purposes under federal law, *you* will be subject to Federal and state income tax on the value of the coverage provided to your domestic partner (and his or her children, as applicable) if covered under the Plan. If the coverage provided to your domestic partner (and his or her children, as applicable) is taxable, then the value of the coverage is considered imputed income and will be reflected as income to you in each paycheck and on your Form W-2. It is important that you understand the tax and legal implications of creating a domestic partner relationship and covering your domestic partner and his or her eligible children. Therefore, you may want to consult your tax and legal advisors to determine the impact on you.

- **Your children.** "Child" means:

    - Each of your children through the end of the month in which he or she turns 26. Your child is eligible regardless of whether he or she is married or unmarried, regardless of his or her student or employment status, regardless of whether your home is his or her principal place of abode, or regardless of whether you support him or her financially; and

    - Each of your children who (i) is age 26 or more, (ii) was physically or mentally disabled prior to attaining age 26, (iii) is unmarried, (iv) was covered under the Plan immediately prior to attaining age 26, (v) is incapable of self-sustaining employment by reason of a mental or physical disability, (vi) is primarily supported by you, and (vii) is allowed to be claimed by you as an exemption for federal income tax purposes.

    - For purposes of this definition, "child" or "children" includes the following: your biological children, your stepchildren, your domestic partner's children who reside with you, your legally adopted children, your foster children, any children placed with you for adoption, any children for whom you are responsible under court order, and children for whom you are appointed legal guardianship, and any children for whom you are responsible to provide medical coverage under a Qualified Medical Child Support Order.

- Unless your eligibility ends earlier, your children will generally be covered under the Medical Plan, Dental Plan, Vision Plan and Health Care FSA until the end of the month in which they attain age 26.

1. *Health Care FSA and Pre-Tax Payment Feature*

For purposes of the Health Care FSA and the Pre-Tax Payment Feature (also known as the cafeteria plan), an Eligible Dependent is your spouse, any individual who is a tax dependent of yours as defined in Section 152 of the Code (determined without regard to Sections 152(b)(1), (b)(2) or (d)(1)(B), and your child (as defined in Section 152(f)(1) of the Code) through the end of the month in which he or she attains age 26.

2. *Dependent Care FSA*

For purposes of the Dependent Care FSA, an Eligible Dependent is any individual who is your "qualifying child," your "qualifying relative" or your spouse who is physically and mentally incapable of caring for himself or herself and who lives with you for more than half of the calendar year.

- A "qualifying child" generally includes someone who:
  - bears a familial relationship to you (e.g., a child or stepchild, sibling, or step-sibling, or a descendant of any such relative),
  - lives with you for more than half of the calendar year,
  - does not provide more than one-half of his or her own support for the calendar year, and
  - has not reached age 13 or is permanently and totally disabled at any time during the calendar year.
- A "qualifying relative" generally includes someone who:
  - bears a familial relationship to you (e.g., a child or stepchild, sibling or step-sibling, parent or step-parent, grandparent, niece, nephew, in-law) or is a member of your household (excluding an individual who is your spouse at any time during the taxable year),
  - is mentally and physically incapable of self-care,
  - lives with you for the entire calendar year,
  - does not provide more than one-half of his or her support for the calendar year, and
  - is not a qualifying child of you or any other taxpayer for the calendar year.

3. *EAP*

For purposes of the EAP, in addition to the above individuals, any additional members of your household

will be Eligible Dependents.

4. *Legal Assistance*

For purposes of the Legal Assistance Plan, eligible dependents include a spouse or domestic partner, any never-married dependent under 21 years of age who are permanent residents of the member's household, any never-married dependent children under age 23 years of age who are full-time college students, any child under 18 years of age for whom the member is legal guardian, any dependent child, regardless of age, who is incapable of sustaining employment by reason of mental or physical handicap and is chiefly dependent upon the member for support.

NOTICE TO ALL ELIGIBLE EMPLOYEES AND THEIR ELIGIBLE DEPENDENTS:

IF YOU APPLY FOR OR CONTINUE COVERAGE FOR ANYONE WHO IS NOT AN ELIGIBLE DEPENDENT, YOU MAY BE GUILTY OF FRAUD OR INTENTIONAL MISREPRESENTATION AND YOUR AND THIS INDIVIDUAL'S COVERAGE MAY BE RESCINDED RETROACTIVELY, TO THE EXTENT PERMITTED BY LAW, UPON 30 DAYS NOTICE. YOU MAY ALSO BE SUBJECT TO DISCIPLINE UP TO AND INCLUDING TERMINATION OF EMPLOYMENT. IN ADDITION, IF THE PLAN EXPENDS FUNDS FOR COVERAGE OF INELIGIBLE INDIVIDUALS, YOU MAY BE LIABLE FOR PREMIUMS AND ALL COSTS RELATED TO COVERAGE FOR SUCH INDIVIDUALS WHO ARE NOT ELIGIBLE DEPENDENTS.

IV. ENROLLMENT

A. General

You are automatically enrolled in the basic life, basic AD&D and long-term disability portions of the Life, AD&D and Disability Plan, the Business Travel Plan, and the EAP upon becoming eligible. You may elect to participate in the various other Component Plans available under the Plan by complying with the enrollment procedures established by the Plan Administrator with respect to each Component Plan as in effect from time to time. These procedures may include, but are not limited to, completing and filing with your Participating Employer an enrollment form authorizing payroll deductions of your compensation from a Participating Employer or completing an online enrollment process.

During each annual open enrollment, except as set forth in any material provided to you in connection with that annual open enrollment period, your current benefit elections will continue unchanged during the following year. The foregoing sentence does not apply to the Health Care FSA and Dependent Care FSA: you must actively elect your benefit options under these Component Plans every year.

In order to enroll your Eligible Dependents in any Component Plan, you must also enroll in that Component Plan. You will be required to affirm that the individuals you enroll are in fact eligible for coverage under the Component Plan, and you may be required to verify the eligibility of your Eligible Dependents for coverage (*e.g.*, by providing a birth or marriage certificate or any other qualifying documents). If you fail to timely provide the documentation upon request to prove the eligibility of any of your Eligible Dependents or if the Plan Administrator (or its delegate) is unable to verify the submitted documentation, your dependent (or dependents) will lose coverage under the Component Plan, whether or not he or she (they) is (are) otherwise eligible for benefits under that Component Plan.

B. Pre-Tax Payment Feature

Under the Pre-Tax Payment Feature, you may choose to redirect a portion of your compensation to pay for your share of the costs of benefits under the Component Plans and/or set aside money to pay for unreimbursed qualifying medical expenses (Health Care FSA or HSA) and/or qualifying dependent care expenses (Dependent Care FSA), all with pre-tax dollars. This means that you will pay less in taxes each year.

To enroll, you may be required to complete an enrollment form/salary reduction agreement, which may be electronic. However, even if you do not complete an enrollment form/salary reduction agreement, you will automatically be enrolled in the Pre-Tax Payment Feature once you enroll in the Medical Plan, Dental Plan or Vision Plan.

C. Election Changes During the Plan Year

The elections you make (or are deemed to have made) will apply to your coverage beginning each January 1st. You may change your elections with respect to any of your benefits during the Plan Year only as described below, each of which is called a "permitted election change event." Your mid-year election change must be consistent with the permitted election change event and must be submitted to the Plan Administrator within 30 days of the event. In general, your mid-year election change will be effective on the day of the qualified life status change date. For example, if you contact the Plan Administrator to add your spouse to your medical coverage on June 1 due to your marriage on May 27, your spouse will be added to your medical coverage effective May 27. Changes to employee supplemental life coverages are effective no sooner than the date of the change request.

1. *Qualified Life Status Change Events*

You may change your elections before the next annual open enrollment period if you experience a "qualified life status change event" which includes events that:

- change your marital status (e.g., marriage, divorce, annulment);
- change the number of your children (e.g., birth, death, or adoption or placement of adoption of a child);
- change the employment status of you or your spouse or children (e.g., termination or commencement of employment, commencement of or return from extended unpaid leave of absence, change in worksite);
- cause your spouse or children to satisfy or cease to satisfy requirements for coverage on account of, among other things, attainment of a certain age; or
- change the place of residence for you or your spouse or children.

Any change in your elections pursuant to a qualified life status change event must be on account of and consistent with such event. However, if you or your Eligible Dependent becomes eligible for continuation coverage pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985

("COBRA"), as described in Section VII, then you may elect to increase your payments under the applicable Component Plan(s) in order to pay for the continuation coverage.

2. *Cost Changes*

If there is a significant increase or decrease in the cost of your coverage under one or more Component Plans, as determined by the Plan Administrator, you may be permitted to:

- make a corresponding change to your election;
- in the case of a significant decrease in cost, revoke your election and elect coverage under the less expensive option, or elect such less expensive option for the first time if you previously declined coverage; or
- in the case of a significant increase in cost, revoke your existing election and elect coverage under another option providing similar coverage (if no alternative similar coverage is available, you may revoke your election with respect to such coverage).

Any insignificant change in the cost of your coverage will result in an automatic increase or decrease, as applicable, in your share of the total cost.

Note that you may not change your election with respect to the Health Care FSA before the next annual open enrollment period due to a cost change.

3. *Coverage Changes*

- Curtailment or Loss of Coverage. If your benefits coverage under one or more Component Plan(s) is significantly curtailed or ceases entirely, you may revoke your elections for that plan or option and elect coverage under another option providing similar coverage, if one is available. Coverage is significantly curtailed if there is an overall reduction in coverage generally. If the curtailment is equivalent to a complete loss of coverage, and no other similar coverage is available, you may revoke your existing election for coverage.
- Addition to or Improvement in Coverage. If Genuine Financial Holdings LLC adds or significantly improves a Component Plan during the year, and you had elected a program or option providing similar coverage, you may revoke your existing election and instead elect the newly added or newly improved program or option or elect the significantly improved option if you previously declined coverage.
- Changes in Coverage Under Another Employer Plan. If your Eligible Dependent's health plan allows for a change in his or her coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Code), you may be able to make a corresponding election change. For example, if your spouse elects family medical coverage during his or her employer's open enrollment period, you may drop your Medical Plan coverage.
- ***Salary Reduction Contributions.*** Corporate Risk Holding, LLC will allow participants to change their elections to make salary reduction contributions to purchase group medical coverage in the following situations

(a) If you have made an election to pay for group medical coverage through the Plan, you may ***revoke*** that payment election if the following conditions are satisfied:

- (i) You have been in an employment status under which you were reasonably expected to average at least thirty (30) hours of service per week;
- (ii) You have experienced a change in employment status such that after that change you will reasonably be expected to average less than thirty (30) hours of service per week (but you nevertheless will remain eligible for group medical coverage);
- (iii) You cancel your group medical coverage in accordance with the requirements of that plan; and
- (iv) You represent to the Employer that you, and any related individuals who were also enrolled in the group medical coverage, have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage and that other coverage will be effective no later than the first day of the second month following the month in which your group medical coverage under the Employer's plan ends.

(b) If you have made an election to pay for group medical coverage through the Plan, you may ***revoke*** that payment election if the following conditions are satisfied:

- (i) You are eligible to enroll in a qualified health plan through the Marketplace (i.e., a public exchange) via a special enrollment period (in accordance with the Marketplace's enrollment rules) ***OR*** you seek to enroll in a qualified health plan through the Marketplace during the Marketplace's annual open enrollment period;
- (ii) You cancel your group medical coverage in accordance with the requirements of that plan; and
- (iii) You represent to the Employer that you, and any related individuals who were also enrolled in the group medical coverage, have enrolled or intend to enroll in a qualified health plan through the Marketplace and your Marketplace coverage will be effective no later than the day immediately following the last day for which the Employer's group medical coverage was effective (i.e., you will not have a break in coverage).

Note that you may not change your election with respect to the Health Care FSA before the next annual open enrollment period due to a coverage change.

4. *Entitlement to Governmental Benefits*

If you or your Eligible Dependent becomes entitled to, or loses entitlement to, Medicare, Medicaid or certain other governmental group medical programs, you may make a corresponding change under the relevant Component Plan(s).

5. *Judgment, Decree, or Order*

If a judgment, decree or order (including a Qualified Medical Child Support Order) requires a Component Plan to provide coverage to your child, then the Plan Administrator automatically may change your election under the Component Plan to provide coverage for that child on a prospective basis. In addition, you may make corresponding election changes as a result of such judgment, decree or order, if you desire.

If the judgment, decree or order requires another person (such as your spouse or former spouse) to provide coverage for the child, then you may cancel coverage for that child if you provide proof to the Plan Administrator that such other person actually provides the coverage for the child.

D. Special Enrollment Rights

If you do not enroll yourself and your Eligible Dependents in any of the Component Plans that are group health plans, as identified in the Attachments, after you become eligible or during annual open enrollment, you may be able to enroll under the special enrollment rules under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") that apply when an individual initially declines coverage and later wishes to elect it.

Generally, special enrollment is available if (i) you initially declined coverage because you had other health care coverage that you have now lost through no fault of your own; or (ii) since declining coverage initially; you have acquired a new dependent (through marriage or the birth or adoption of a child) and wish to cover that person. In either case, as long as you meet the necessary requirements, you can enroll both yourself and all Eligible Dependents in any of the Component Plans that are group health plans, as identified in the Attachments, within 30 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child.

You may also enroll yourself and your Eligible Dependents in a Component Plan that is a group health plan if you or your Eligible Dependents' coverage under Medicaid or the state Children's Health Insurance Program (SCHIP) is terminated as a result of loss of eligibility, or if you or one of your Eligible Dependents become eligible for premium assistance under a Medicaid or SCHIP plan. Under these two circumstances, the special enrollment period must be requested within 60 days of the loss of Medicaid or SCHIP coverage or of the determination of eligibility for premium assistance under Medicaid or SCHIP.

E. Leaves under Family Medical Leave Act ("FMLA")

If you take a leave of absence (i) for your own serious health condition, (ii) to care for family members with a serious health condition, (iii) to care for a newborn or adopted child, (iv) to care for an injured or ill covered service member of the Armed Forces or (v) due to a qualifying exigency arising out of a covered service member's active duty, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work assuming you pay any contributions required for the coverage. See Section II.H.5. of the Flex Plan Summary of Benefits for additional information regarding your FMLA rights.

F. Military Leaves of Absence

If you enter the United States Armed Forces (including the United States Armed Forces, the Coast Guard, the Army National Guard, the commissioned corps of the Public Health Service, and certain other categories of service), you may be entitled to continue your (and your Eligible Dependents') coverage under the Plan during your military service for a period of up to 24 months. If you are absent from work due to military service for a period of 31 days or less, your coverage under the Component Plans will continue during the 31 days, except for the Dependent Care FSA which will be suspended as of the date of you begin your military leave. Your and your Participating Employer's contributions for coverage that will remain in effect will be the same as for similarly situated active participants in the Plan. Upon your return to work, you must pay your portion, if any, of the premiums for coverage that continued during your military leave of 31 days or less.

Your coverage under the Dependent Care FSA will be automatically reinstated without any waiting period upon your active return to work after a military leave of 31 days or less. If your military leave of 31 days or less occurs at the same time as a change in plan year (i.e. January 1st) you may be required to make new plan elections effective for the new plan year. Additionally, if you experience a qualified change-in-status event or a HIPAA special enrollment event while on military leave you may make benefit election changes, consistent with the change, upon your return.

Your participation in the Dependent Care FSA will be suspended during your military leave of 31 days or less, but you may submit claims for reimbursement of eligible dependent care expenses incurred prior to the effective date of your military leave through March 31 of the year after the plan year in which your leave begins. If you return to active employment with a Participating Employer during the same plan year, your original Dependent Care FSA election will be reinstated or you may make a new election for the remainder of the plan year. Your Dependent Care FSA will be adjusted for any payments made before the start of, or during, your leave.

Claim reimbursement from your Health Care FSA during your military leave of 31 days or less will be the same as for similarly situated active participants in the Health Care FSA.

If you are absent from work due to military service for a period in excess of 31 days, your coverage under the Medical Plan, Dental Plan, Vision Plan and Health Care FSA that were in effect at the end of the 31 days may be continued for up to 24 months from the first day of absence greater than 31 days (or if earlier, until the day after the date you're required to apply for or return to active employment with your Participating Employer). Your contributions for the continued coverage will be the same as for a COBRA beneficiary.

Whether or not you continue coverage during military service, you may reinstate coverage under the Plan effective as of the date you return to active employment under the provisions of the Uniformed Services Employment and Re-employment Rights Act ("USERRA"). No waiting period or exclusion will be imposed in connection with such reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of illness or injury connected with your military service. Separation for uniformed service that is dishonorable or based on bad conduct, on grounds less than honorable, absent without leave, or ending in a conviction under court martial would disqualify you from any rights under USERRA.

G. Loss of Benefits

As noted above, Genuine Financial Holdings LLC reserves the right to change or eliminate any Component Plan and may amend or terminate the Plan in whole or in part. Except in the case of certain health care continuation rights under Federal law discussed below and subject to the terms of any severance agreement or policy of your Participating Employer, benefits terminate at the end of the month in which you terminate active employment (except that Health Care FSA, Dependent Care FSA and disability benefits terminate when your active employment terminates) or when you are no longer eligible or when a group insurance policy terminates, whichever occurs first. You should consult the applicable Attachments for specific information about termination and continuation of coverage in accordance with an insurance policy to which a required premium is paid.

V. DISCLOSURES AND NOTICES

A. Your Rights Under ERISA

As a participant in certain Component Plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). The Dependent Care FSA and the HSA are not employee benefit plans under ERISA. Therefore, this section of the Plan and SPD does not apply to the Dependent Care FSA or the HSA. ERISA provides that all participants in the ERISA-governed Component Plans are entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;

- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report;

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan particularly the rules governing your COBRA continuation coverage rights; and

- Receive a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in any subsequent health coverage after you cease to be covered under the Plan.

1. *Prudent Actions by Plan Fiduciaries*

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

2. *Enforce Your Rights*

If your claim for a benefit is denied or ignored, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain schedules.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within thirty (30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting the Plan's claims procedures, provided such suit is filed within 12 months after such exhaustion. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

3. *Assistance with Your Questions*

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA and other laws affecting the Plan or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. You may also visit their website at **www.dol.gov/ebsa**.

B. <u>Qualified Medical Child Support Orders</u>

A Qualified Medical Child Support Order ("QMCSO") is an order by a court for a parent to provide a child or children with health insurance under a group health plan. The Plan Administrator will comply with the terms of any QMCSO it receives, and will:

- Establish reasonable procedures to determine whether medical child support orders are qualified medical child support orders as defined under ERISA Section 609;
- Promptly notify you and any alternate recipient (as defined in ERISA Section 609(a)(2)(C)) of the receipt of any medical child support order, and the Plan's procedures for determining whether medical child support orders are qualified medical child support orders; and
- Within a reasonable period of time after receipt of such order, the Plan Administrator will determine whether such order is a qualified medical child support order and will notify you and each alternate recipient of such determination.

C. Special Rule for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, group health plans and health insurance issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

D. Special Rule for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers and HMOs that provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage includes (i) reconstruction of the breast on which the mastectomy has been performed, (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and (iii) prostheses and physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other medical or surgical benefits provided under the Medical Plan. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in the Medical Plan documents attached as Attachments #1 – 2.

E. Designation of Primary Care Physicians

Certain benefit options under the Medical Plan require or allow you to designate a primary care physician ("PCP"). You have the right to designate any participating PCP who is available to accept you or your family members. For children, you may designate a pediatrician as the PCP. Until you make this designation under a benefit option that requires designation of a PCP, the Plan designates one for you. For information on how to select a PCP and for a list of participating PCPs, contact the provider of your benefit whose contact information is described in the Medical Plan documents attached as Attachments #1 – 4.

F. Access to OB/GYN Care

You do not need prior authorization from the Medical Plan or from any other person, including your PCP, in order to obtain access to obstetrical or gynecological care from a health care professional who

specializes in obstetrics or gynecology. You or the provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the provider of your benefit whose contact information is described in the Medical Plan documents attached as Attachments #1 – 2.

VI. RESPONSIBILITIES FOR PLAN ADMINISTRATION

A. Plan Administrator

The Plan Administrator has (i) the power and authority in its sole, absolute and uncontrolled discretion to control and manage the operation and administration of the Plan and (ii) all powers necessary to accomplish these purposes.

The Plan Administrator will administer the Plan in accordance with established policies, interpretations, practices, and procedures and in accordance with the requirements of ERISA and other applicable laws. With respect to the Plan, the Plan Administrator has discretion (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, (iv) to determine the conditions under which benefits become payable under the Plan and (v) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Subject to any applicable claims procedure, any determination made by the Plan Administrator will be final, conclusive and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity.

A claims administrator may, at the discretion of the Plan Administrator, have the sole and absolute discretionary authority to administer, apply, and interpret Plan provisions. All claims should be directed to the applicable administrator (either the claims administrator or the Plan Administrator) identified in Schedule A and the entire claims and appeals process, as described in this Plan document or in the Attachments, will be handled through that administrator.

Under the terms of any insurance contracts issued for the Component Plans, the insurance company issuing the contract has full discretionary authority to make all benefit decisions concerning eligibility for benefits under the contract, payment of claims or benefits, and interpretation of the terms and provisions of the insurance contract. Only the insurance company can resolve insurance contract ambiguities, correct errors or omissions in the contract, and interpret contract terms. The insurance company has the full discretionary authority to interpret, construe and administer the terms of such policies, and its decisions are final and binding on all parties. The Plan Administrator does not guarantee the payment of any benefit described in an insurance coverage contract and you must look solely to the insurance carrier for the payment of benefits.

B. Duties of the Plan Administrator

The Plan Administrator will (i) administer the Plan in accordance with its terms, (ii) decide disputes which may arise relative to a Plan participant's rights, (iii) keep and maintain the Plan documents and all other records pertaining to the Plan, (iv) pay or arrange for the payment of claims, (v) establish and communicate procedures to determine whether a medical child support order is qualified under Section 609 of ERISA, and (vi) perform all necessary reporting as required by ERISA.

C. Plan Administrator Compensation

While the Plan Administrator serves without compensation, all expenses for administration, including compensation for hired services, will be paid by the Plan unless paid by the Participating Employers.

D. Fiduciary Duties

A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to eligible employees and their eligible dependents and defraying reasonable expenses of Plan administration. These duties must be carried out with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation and in accordance with Plan documents to the extent that they are consistent with ERISA.

E. The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. The Plan Administrator has delegated certain day-to-day administration of the Plan and claims fiduciary responsibility for the processing and review of claims for benefits under the Plan, including COBRA claims and administration, to certain third party administrators and claim administrators listed in Schedule A. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures or (ii) the named fiduciary breached its fiduciary responsibility under ERISA Section 405(a).

VII. COBRA

A. Introduction

The right to COBRA continuation coverage was created by a Federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Medical Plan, the Dental Plan, the Vision Plan, the Health Care FSA and/or the EAP (the "COBRA-Eligible Component Plans") when you would otherwise lose such group health plan coverage. **The following generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.** This notice gives only a summary of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the COBRA-Eligible Component Plans and under Federal law, you should ask the Plan Administrator.

The Plan Administrator has delegated authority for administering COBRA continuation coverage to the following COBRA Administrator:

PlanSource
625 Kenmoor Avenue SE
Suite 102

Grand Rapids, MI 49546
Telephone Number: 888-266-1732
https://COBRApoint.benaissance.com

B. COBRA Continuation Coverage

1. *Eligibility*

COBRA continuation coverage is a continuation of group health plan, dental, vision, and/or medical flexible spending account when coverage would otherwise end because of a life event known as a COBRA "qualifying event." Specific qualifying events are listed later. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under a COBRA-Eligible Component Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and children of employees may be qualified beneficiaries. Qualified beneficiaries who elect COBRA continuation coverage under a COBRA-Eligible Component Plan must pay for COBRA continuation coverage.

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

- You no longer work, on average, at least 30 hours per week; or
- Your employment ends for any reason other than your gross misconduct.

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

- Your spouse dies;
- Your spouse's regularly-scheduled hours of employment are reduced to less than 30 hours per week;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare (Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your children will become qualified beneficiaries if they will lose coverage under a COBRA-Eligible Component Program because any of the following qualifying events happen:

- The parent-employee dies;
- The parent-employee's regularly-scheduled hours of employment are reduced to less than 30 hours per week;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as an Eligible Dependent.

2. *Notification by Participating Employers*

The COBRA-Eligible Component Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or entitlement of the employee to Medicare (Part A, Part B, or both), the Participating Employers must notify the COBRA Administrator of the qualifying event within 30 days of the date the event occurs or the date you would otherwise lose coverage under the COBRA-Eligible Component Plan due to a qualifying event, whichever is later.

3. *Notification by the Employee*

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as an Eligible Dependent), you must notify the COBRA Administrator. The Plan requires you to notify the COBRA Administrator within 60 days after the qualifying event occurs or the date you would otherwise lose coverage under the COBRA-Eligible Component Plan due to a qualifying event, whichever is later. You must send this notice to the COBRA Administrator in accordance with the procedures set forth below under "Furnishing Notice to the COBRA Administrator."

4. *Election*

Within 14 days of the COBRA Administrator receiving notice that a qualifying event has occurred, the COBRA Administrator will send out an election notice, offering COBRA continuation coverage to each of the qualified beneficiaries. In general, you will have 60 days after the date that you lose coverage under the COBRA-Eligible Component Plan, or, if later, 60 days after the date of the election notice, to make your COBRA election.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that coverage under the COBRA-Eligible Component Plan would otherwise have been lost.

5. *Period of Continuation Coverage*

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both), your divorce or legal separation, or a child losing eligibility as an Eligible Dependent, COBRA continuation coverage lasts for up to 36 months.

The maximum COBRA continuation coverage period is 24 months for employees on military leave who are covered by USERRA.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

6. *Disability extension of 18-month period of continuation coverage*

If you or any of your Eligible Dependents covered under a COBRA-Eligible Component Plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the COBRA Administrator in a timely fashion, you and your Eligible Dependents can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the COBRA Administrator is notified of the Social Security Administration's determination within 60 days of the latest of the date of the determination, the date of the qualifying event or the date you would otherwise lose coverage under the COBRA-Eligible Component Plan due to a qualifying event, and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures set forth below under "Furnishing Notice to COBRA Administrator."

7. *Second qualifying event extension of 18-month period of continuation coverage*

If your Eligible Dependents experience another qualifying event while receiving COBRA continuation coverage, and such event would result in loss of coverage under a COBRA-Eligible Component Plan if the first qualifying event had not already occurred, your Eligible Dependents can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to your Eligible Dependents if you die, become entitled to Medicare (Part A, Part B, or both), or get divorced or legally separated. The extension is also available to a child when that child stops being an Eligible Dependent under the COBRA-Eligible Component Plan. In all of these cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event or the date you would otherwise lose coverage under a COBRA-Eligible Component Plan due to a qualifying event, whichever is later. This notice must be sent to the COBRA Administrator in accordance with the procedures set forth below under "Furnishing Notice to COBRA Administrator."

C. Furnishing Notice to COBRA Administrator

YOU SHOULD FOLLOW THESE PROCEDURES WHEN NOTIFYING THE COBRA ADMINISTRATOR OF A QUALIFYING EVENT OR A DISABILITY DETERMINATION. FAILURE TO FOLLOW THESE PROCEDURES MAY CAUSE LOSS OF COVERAGE.

When furnishing a notice to the COBRA Administrator with respect to the occurrence of a qualifying event or with respect to a disability determination by the Social Security Administration, such notices must be delivered to the COBRA Administrator (i) by hand-delivery, (ii) via facsimile, followed by written confirmation by first class mail; (iii) via email; or (iv) by registered or certified mail, return receipt requested. Such notices must include the name(s) of the covered employee and/or qualified beneficiaries, as applicable, a general description of, and circumstances surrounding, the qualifying event or disability determination, and the date of such qualifying event or disability determination. Once the COBRA Administrator receives such notice, it reserves the right to make further inquiry to verify the circumstances surrounding such qualifying event or disability determination.

D. Keep the Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the COBRA Administrator.

E. If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

F. Special COBRA Rules

Former employees of General information Solutions LLC ("GIS") and their covered dependents on COBRA as of December 31, 2018 through the GIS health and welfare plans will be entitled to benefits subject to COBRA under the Plan. In addition, former GIS employees eligible for COBRA as of December 31, 2018 and their covered dependents, but who have not yet elected COBRA will also be entitled to benefits subject to COBRA under the Plan, but only to the extent that they elect COBRA in accordance with applicable procedures.

VIII. HIPAA PRIVACY PROVISIONS

A. Disclosure of Information

The Component Benefits of the Plan that are a "group health plan" shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), in accordance with this Section. The Component Benefits of the Plan that are not subject to HIPAA shall not be subject to this Section.

The Plan and Participating Employers may only use and/or disclose Protected Health Information (as such term is defined in 45 C.F.R. §164.501) as permitted by the "Standards for Privacy of Individually Identifiable Health Information" under the Health Insurance Portability and Accountability Act of 1996, P.L.104-191, and applicable guidance (the "Rule"). For this purpose, the Plan is deemed a Hybrid Entity under the Rule, and the provisions of this Section shall be administered and interpreted to apply only to that portion of the Plan that constitutes a Covered Entity under the Rule. In addition, the Plan (including the coverage options offered under the Plan), and the other fully insured and self-insured medical options offered or maintained by a Participating Employer, shall be deemed part of an Organized Health Care Arrangement, to the fullest extent permitted under the Rule.

The Plan may disclose Summary Health Information, as defined in 45 CFR § 164.504, to a Participating Employer if the Participating Employer requests such information for the purpose of obtaining premium bids for providing health insurance coverage under the Plan or for modifying, amending or terminating the Plan, including analyzing Plan costs and the effectiveness of the Plan's administration or for such other purposes as may be permitted under 45 CFR § 164.504(f)(1)(ii) and the provisions of this Section VIII.

Protected Health Information disclosed by the Plan to a Participating Employer in accordance with the provisions of this Section VIII may only be used by the Participating Employer for purposes related to Health Care Treatment, payment for Health Care and Health Care Operations (all as defined in 45 CFR § 164.501) without the covered Individual's written authorization (that meets the requirements of 45 CFR § 164.508).

Except as otherwise provided in the preceding paragraphs, a Component Plan that is a "group health plan" (as defined by the Rule) will disclose Protected Health Information to a Participating Employer only upon its receipt of a certification by Genuine Financial Holdings LLC that the Component Plan has been amended to incorporate the following provisions and that the Participating Employer agrees to:

- Not use or further disclose the information other than as permitted or required by the Component Plan documents or as required by law;

- Ensure that any agents, including subcontractors, to whom it provides Protected Health Information received from the Component Plan agree to the same restrictions and conditions that apply to the Participating Employer with respect to such information;

- Not use or disclose the Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of any Participating Employer**;**

- Report to the Component Plan any use or disclosure of the Protected Health Information that is inconsistent with the uses or disclosures permitted by the Rule of which it becomes aware;

- Make available Protected Health Information based on HIPAA's access requirements in accordance with 45 C.F.R. §164.524;

- Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 C.F.R. §164.526;

- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528;

- Make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Component Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Component Plan with the Rule;

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

- Ensure that adequate separation of the Component Plan and any Participating Employer is established as required by 45 C.F.R. §164.504(f)(2)(iii) as described below.

There are some special rules under HIPAA related to "electronic protected health information." Electronic protected health information is generally protected health information that is transmitted by, or maintained in, electronic media. "Electronic media" includes electronic storage media, including memory devices in a computer (such as hard drives) and removable or transportable digital media (such as magnetic tapes or disks, optical disks and digital memory cards). It also includes transmission media used to exchange information already in electronic storage media, such as the internet, an extranet (which uses internet technology to link a business with information accessible only to some parties),

leased lines, dial-up lines, private networks and the physical movement of removable/transportable electronic storage media.

Please be advised that, as required by HIPAA, Component Plans that are "group health plans" (as defined by the Rule) will take additional action with respect to the implementation of security measures (as defined in 45 C.R.F. §164.304) for electronic protected health information. Specifically, the Component Plan will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains or transmits on behalf of the Component Plan;

- Ensure that the adequate separation required to exist between the Plan and any Participating Employer is supported by reasonable and appropriate administrative, physical and technical safeguards in its information systems;

- Ensure that any agent, including a subcontractor, to whom it provides electronic protected health information, agrees to implement reasonable and appropriate security measures to protect that information;

- Require a Participating Employer to report to the Component Plan if it becomes aware of any attempted or successful unauthorized access, use, disclosure, modification or destruction of information or interference with system operations in its information systems; and

- Comply with any other requirements that the Secretary of the U.S. Department of Health and Human Services may require from time to time with respect to electronic protected health information by the issuance of additional regulations or other guidance pursuant to HIPAA.

B. Certification of Genuine Financial Holdings LLC

A Component Plan (or a health insurance issuer with respect to a Component Plan if applicable) will disclose Protected Health Information to a Participating Employer only upon the receipt of a certification by Genuine Financial Holdings LLC that the Component Plan incorporates the provisions of 45 CFR §164.504(f)(2)(ii), and that Genuine Financial Holdings LLC agrees to the conditions of disclosure set forth above. The Component Plan will not disclose and may not permit a health insurance issuer to disclose Protected Health Information to a Participating Employer as otherwise permitted herein unless the statement required by 45 CFR §164.520(b)(1)(iii)(C) is included in the appropriate notice.

C. Separation of Plan and Participating Employers

The following employees (or classes of employees) or other persons under the control of any Participating Employer will be treated as the workforce of the Participating Employer that are permitted to have access to Protected Health Information disclosed by a Component Plan ("Permitted Employees"):

- HIPAA Privacy Officer and his or her delegates
- HIPAA Security Officer and his or her delegates
- Legal Department
- VP of Benefits, Compensation & HRIS

- Benefits Manager
- Benefits Administrator
- Benefits Specialist
- Benefits Assistant

Despite the foregoing, any employee or person not described above who receives Protected Health Information relating to payments under, health care operations of, or other matters pertaining to a Component Plan in the ordinary course of business, will also be included in the definition above of Permitted Employees. The Permitted Employees may only use the Protected Health Information for administrative functions of a Component Plan that the Participating Employer performs for the Component Plan.

Any instances of noncompliance with the permitted uses and disclosures of Protected Health Information set forth above by the Permitted Employees shall be addressed. The Plan shall establish and communicate a set of sanctions that are applicable to a wide variety of breaches of covered health policies and procedures. The range of sanctions may include:

- Additional/remedial privacy training;
- Counseling by supervisor;
- Notation in personnel files;
- Letter of reprimand from supervisor;
- Removal from being within the firewall;
- Removal from current position;
- Suspension from current position;
- Termination of employment; and
- Other sanctions as the Privacy Officer shall deem appropriate.

The Plan, in consultation with the HIPAA Privacy Officer, shall develop a procedure for:

- Determining the appropriate sanction to be administered to a member of its "workforce" for a breach of a covered health policy or procedure.
- Determining who (e.g., the Privacy Officer, etc.) has responsibility for assessing the sanction against the "workforce" member; and
- Determining a process for administering any sanctions.

For purposes of this subparagraph, "workforce" shall mean an employee, volunteer, trainee or other person who performs duties under the direct control of the Plan, whether or not he or she is paid by the Plan.

The Privacy Officer, on behalf of the Plan, shall develop and implement a system for maintaining a record of each sanction administered. The record of sanctions shall conform to the record keeping and documentation standards and implementation specifications required under HIPAA. The Plan will have the option of having this record maintained by the Privacy Officer or his or her designee.

D. HIPAA Notice of Privacy Practices

Genuine Financial Holdings LLC or the health insurance issuers maintain a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information will be used or maintained by the Component Plans that are "group health plans" (as defined by the Rule). If you would like a copy of the HIPAA Notice of Privacy Practices, please contact the HireRight Benefits Service Center (Your Benefits Center) at 844-217-8215.

IX. CLAIMS PROCEDURES

A. Group Health Plan Claim Processing

Your claims under the Plan's group health plan Component Plans will be processed under the following procedures, except to the extent inconsistent with the insurer's or claim administrator's claims procedures as set forth in an Attachment, *in which case the insurer's or claims administrator's claims procedures will apply as long as such other claims procedures comply with the Patient Protection and Affordable Care Act of 2010 and guidance issued thereunder, to the extent they are applicable to the Component Plan, and DOL Regulation § 2560.503-1.* For more detailed information, you should review the applicable Attachment, or you may contact the claims administrators directly to obtain specific claim/appeal processes.

1. *Internal Review*

a. *Initial Claim Processing*

i. Post-Service and Rescission Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. Rescission Claims are those claims that relate to the cancellation or discontinuation of your coverage that has a retroactive effect, except if the cancellation or discontinuation is attributable to your failure to timely pay required premiums or contributions toward the cost of coverage. A rescission claim exists only with respect to benefits under the Medical Plan. If your Post-Service Claim or Rescission Claim is denied, you will receive a written notice from the insurer within 30 days of receipt of the claim, as long as all needed information was provided with the claim. The insurer will notify you within this 30 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame and the claim is denied, the insurer will notify you of the denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

ii. Pre-Service Claims

Pre-Service Claims are those claims that require notification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the claims administrator within 15 days of receipt of the claim. If you filed a pre-service claim improperly, the claims administrator will notify you of the

improper filing and how to correct it within 5 days after the pre-service claim was received. The claims administrator will notify you within the 15 day period if additional information is needed to process the claim, and may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day time frame, the claims administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

iii. Urgent Claims that Require Immediate Action

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition, could cause severe pain. In these situations, you will receive notice of the benefit determination as soon as possible, but no later than 72 hours unless you fail to provide sufficient information to determine whether, or to what extent, benefits are covered under the Component Plan. Notice of denial may be provided orally with a written or electronic confirmation to follow within 3 days.

If you filed an Urgent Care Claim improperly, the claims administrator will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was received. If additional information is needed to process the claim, the claims administrator will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after:

- The claims administrator's receipt of the requested information; or

- The end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

iv. Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

v. Notification of Claim Denial

If the claims administrator denies any part or all of a benefit claim, it will provide you with a written notice (although initial notice of a denied urgent care claim may be provided to you orally). The written notice will include

- the specific reasons for the determination;
- a reference to the specific Plan provisions on which the determination is based;
- a description of any additional material or information necessary to complete the claim and why such information is necessary; and
- a description of Plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court under ERISA section 502(a) after an adverse benefit determination is rendered on appeal with respect to any benefit plan that is governed by ERISA.

If your claim is for group health care benefits (i.e., dental, vision or EAP benefits) or disability benefits, the notice will also:

- disclose any internal rule, guidelines, protocol, or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the adverse benefit determination is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or state that such information will be provided free of charge upon request); and
- for urgent group health care benefit claims, the adverse benefit determination notice will include a description of the expedited review process applicable to such claims. This determination may be given orally, provided that a written or electronic notification is furnished to you no later than three days after the oral notification.

If your claim is for benefits under the Medical Plan, the notice will be provided in a culturally and linguistically appropriate manner, as determined under regulations implementing the Patient Protection and Affordable Care Act of 2010, and will include the following:

- Identifying Claim Information – information identifying the claim involved, including the date of service, the health care provider, and the claim amount. The diagnosis code, the treatment code and the corresponding meaning of these codes are available upon request from the Plan Administrator, and will be provided as soon as practicable following your request;
- Reason for the Denial – the specific reason or reasons for the denial, the denial code(s), and the corresponding meaning of the code(s);
- Standard for the Denial – a description of the specific standard, if any, used in denying the claim;
- Reference to Plan Provisions – reference to the specific Plan provisions on which the denial is based;

- Description of Additional Material – a description of any additional material or information necessary for you to perfect your claim and an explanation as to why such information is necessary;

- Description of Any Internal Rules – a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the initial determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request;

- Description of Scientific or Clinical Judgment – if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided to you free of charge upon your request;

- Description of Claims Appeals Procedures – a description of the Plan's internal appeals procedures and external review process, including information on how to initiate an appeal, and the time limits applicable for such procedures (such description will include a statement that you are eligible to bring a civil action in Federal court under Section 502 of ERISA to appeal any adverse decision on appeal and a description of any expedited review process for urgent care claims); and

- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

b. *Appealing the Denial of a Claim*

If your claim is denied, you may appeal that decision. To appeal, you must submit a written request to the claims administrator within 180 days of receiving the initial claim denial. If the written request for appeal is not submitted within 180 days of receiving the initial claim denial, you lose the right to appeal under the Plan. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A different person than the one who made the initial claim determination will conduct the appeal review of claims for group health care benefits, and such person will not work under the original decision maker's authority. If the adverse benefit determination was on the grounds of medical judgment, the Plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the Plan in connection with the adverse benefit determination, the Plan will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the Plan and you by telephone, fax, or other similar method.

i. Pre-Service, Post-Service and Rescission Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

For appeals of Pre-Service Claims (as defined above), you will be notified by the claims administrator of the decision within 30 days from receipt of a request for appeal of a denied claim.

For appeals of Post-Service Claims or Rescission Claims (as defined above) the appeal will be conducted by the claims administrator and you will be notified by the claims administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

Please note that the claims administrator's decision is based only on whether or not benefits are available under the relevant Component Plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary or appropriate is between you and your doctor.

ii. Urgent Claim Appeals That Require Immediate Action

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your doctor should call the claims administrator as soon as possible, and provide the claims administrator with the information identified above under "How to Appeal a Claim Decision." The claims administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

In the case of an appeal of a denied concurrent care review claim, the claims administrator will respond to you before the concurrent or ongoing treatment in question is reduced or terminated.

iii. Notification of Claim Denial on Appeal

If the claims administrator denies all or part of your appeal, it will provide you with a written notice. The notice will contain the following information:

- the specific reasons for the determination;
- a reference to the specific Plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all document, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about these procedures; and

- a statement describing your right to bring a civil lawsuit under ERISA section 502(a) with respect to any benefit plan that is governed by ERISA.

If your claim is for group health care benefits (i.e., dental, vision or EAP claims) or disability benefits, the notice will also include:

- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the adverse determination is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying Plan terms to your medical condition (or state that such information will be provided free of charge, upon request); and
- the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

If your claim is for benefits under the Medical Plan, this notice will be provided in a culturally and linguistically appropriate manner, as determined under regulations implementing the Patient Protection and Affordable Care Act of 2010, and will include the following:

- Identifying Claim Information – information identifying the claim involved, including the date of service, the health care provider, and the claim amount. The diagnosis code, the treatment code and the corresponding meaning of these codes are available upon request from the Plan Administrator, and will be provided as soon as practicable following your request.

- Reason for the Denial - the specific reason or reasons for the denial, including the denial code(s) and the corresponding meaning of the code(s) and a discussion of the decision;

- Standard for the Denial – a description of the specific standard, if any, used in denying the claim, and a discussion of the Plan's decision;

- Reference to Plan Provisions – reference to the specific Plan provisions on which the denial is based;

- Statement of Entitlement to Documents – a statement that you are entitled to receive, upon request and free of charge, access to and copies of, all documents, records and other information that are relevant to your claim and/or appeal for benefits;

- Description of Any Internal Rules – a copy of any internal rule, guideline, protocol, or other similar criterion relied upon in making the appeal determination or a statement that such a rule, guideline, protocol, or other criterion was relied upon in making the appeal determination and that a copy of such rule will be provided to you free of charge at your request;

- Description of Scientific or Clinical Judgment – if the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, an explanation of the

scientific or clinical judgment for the determination will be provided to you free of charge upon your request;

- Statement of Right to Initiate External Review Process or Bring Action – a statement that you are entitled to initiate external review of your claim or bring a civil action in Federal court under Section 502 of ERISA to pursue your claim for benefits; and

- Contact Information – the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the internal claims and appeals and external review processes.

The decision of the claims administrator will be final and conclusive, and binding on all persons claiming benefits under the Plan, subject to applicable law. If you challenge the decision of the claims administrator, the external review or review by a court of law will be limited to the facts, evidence and issues presented during the internal claims procedure set forth above. The internal appeal process described herein must be exhausted before you can initiate an external review as described below or pursue the claim in Federal court, unless: (i) the Plan failed to follow the internal claims procedures described above and the Plan's failure is more than de minimis and is likely to cause prejudice or harm to you; or (ii) with respect to the external review, requiring you to exhaust the internal claims and appeals procedure would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, in which cases you will be deemed to have exhausted such process. Facts and evidence that become known to you after having exhausted the appeals procedure may be submitted for reconsideration of the appeal in accordance with the time limits established above. Issues not raised during the appeal will be deemed waived.

c. *Coordination of Benefits*

If you or your Eligible Dependent has or is entitled to benefits under another health plan, you are subject to a coordination of benefits process. Coordination of benefits is designed to prevent the payment of benefits from exceeding 100% of any allowable expenses that have been incurred. The Plan Administrator may request an Explanation of Benefits which provides detailed claim reimbursement information from any other plans under which you are covered. If any of these plans provide coverage for services that are also covered under the Plan, the carrier will determine which plan is considered primary before any payments are made. The Attachments provide more detailed information on how your benefits under this Plan will be coordinated with other coverage you may have.

2. *Voluntary External Review*

If your claim involves Medical Judgment under the Medical Plan (excluding those that involve only contractual or legal interpretation without any use of Medical Judgment) or a Rescission of Coverage under the Medical Plan, and you exhaust the internal group health plan claim and appeal procedures (or earlier, if you are deemed to have exhausted such procedure due to the Plan's failure to comply with the procedure), you will have the right to request an external (i.e., independent) review with respect to that claim. You must request this external review within four months after receiving notice of an adverse benefit determination or final internal adverse benefit determination.

Within five business days after receiving your request, a preliminary review will be completed to determine whether: (i) you are/were covered under the Plan; (ii) the denial was based on an issue

involving Medical Judgment or a Rescission of Coverage; (iii) you exhausted the Plan's internal claims and appeals process, if required; and (iv) you provided all information necessary to process the external review. Within one business day after completing the preliminary review, you will be notified in writing if your request is not eligible for an external review or if it is incomplete. If your request is complete but not eligible, the notice will include the reason(s) for ineligibility. If your request is not complete, the notice will describe any information needed to complete the request. You will have the remainder of the four month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, your request will be assigned to an independent review organization ("IRO"). The IRO will provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will cover the claim.

In addition, you will have the right to an expedited external review in the following situations:

- Following an adverse benefit determination involving a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal.

- Following a final internal adverse benefit determination involving (i) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request**.**

For purposes of the external review process, the term "Medical Judgment" means, in connection with a claim for benefits, judgment with respect to medical necessity, appropriateness of care, health care setting, level of care, effectiveness of a covered benefit, or a determination of whether a treatment or a procedure is experimental or investigational. Also for this purpose, the term "Rescission of Coverage" means a legally permissible retroactive termination of Plan coverage.

B. Life, AD&D and Long-Term Disability Claim Processing

Your claims under the Life, AD&D and Disability Plan, the Voluntary AD&D Plan and the Business Travel Plan will be processed under the insurers' claims procedures. For more detailed information, please review the applicable Attachment, or you may contact the claims administrator directly to obtain specific claims/appeal processes.

C. Limited Time Period for Filing a Lawsuit

Notwithstanding any applicable statutory statute of limitations, no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review decision by the claims administrator has been rendered (or deemed rendered).

X. MISCELLANEOUS PROVISIONS

A. Amendment and Termination

Genuine Financial Holdings LLC reserves the right to amend any one or more of the Component Plans or underlying Plan features at any time and, to the extent permitted by law, without the consent of or prior notice to any employee or participant. Genuine Financial Holdings LLC has delegated to the Chief Human Resources Officer and Chief Financial Officer of HireRight, LLC the authority to adopt and approve, on behalf of the Genuine Financial Holdings LLC, changes, amendments or enhancements to the Plan (including the Component Plans) that are advisable for administrative, compliance or competitive practice purposes as long as the cost of these changes, amendments or enhancements do not exceed five hundred thousand dollars ($500,000) per plan amendment. Although Genuine Financial Holdings LLC expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan, any Component Plan, or any feature thereof at any time without liability. Upon the termination of the Plan, any Component Plan, or feature, as the case may be, all elections and reductions in compensation relating to the Plan, Component Plan, or feature will terminate, and the rights of a participant covered under the Plan are limited to the payment of eligible expenses incurred prior to termination.

B. Right of Recovery; Termination of Coverage for Cause Including Fraud or Intentional Misrepresentation

There are times that you will be required to furnish information or proof necessary to determine your or an Eligible Dependent's right to a Plan benefit. When inaccurate information and/or proof is provided, this ultimately can result in the improper use of Plan assets, which adversely affects the ability of the Plan to provide the highest possible level of benefits.

Accordingly, Genuine Financial Holdings LLC reserves the right to terminate, prospectively without notice for cause, your and/or your Eligible Dependents' coverage under the Plan, if, as determined by the Plan Administrator, you and/or your Eligible Dependents are ineligible for coverage under the Plan. In addition, if you or an Eligible Dependent commits fraud, or intentional misrepresentation with respect to enrolling in the Plan's group health plan Component Plans, in a claim or appeal for benefits under such Component Plans, or in response to any request for information in connection with such Component Plans by the Plan Administrator or its delegates (including a claims administrator), the Plan Administrator may terminate your coverage under such Component Plan retroactively upon 30 days notice. Failure to inform such persons that you or your Eligible Dependent is covered under another group health plan or knowingly providing false information to obtain coverage for an ineligible dependent are examples of actions that constitute fraud under the Plan's group health plan Component Plans. Of course, if the Plan pays benefits actually incurred or in excess of allowable amounts, due to error (including for example, a clerical error) or for any other reason (including, for example, your failure to notify the Plan Administrator or its delegates regarding a change in family status), the Plan Administrator reserves the right to recover such overpayment through whatever means are necessary, including, without limitation, deduction of the excess amounts from future claims and/or legal action.

C. Unclaimed Payments

As a condition of entitlement to a benefit under the Plan, you must keep the Plan informed of your (and your Eligible Dependents', if different) current mailing address and other relevant contact information. If the Plan Administrator is unable to locate any individual otherwise entitled to a benefit payment hereunder after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator), the individual is not entitled to a benefit hereunder and forfeits any rights to any benefits. In addition, as a further condition to any benefit entitlement under the Plan, any person claiming the benefit must present for payment the check evidencing such benefit within one year of the date of issue. If any check for a benefit payable under the Plan is not presented for payment within one year of the date of issue, the Plan shall have no liability for the benefit payment, the amount of the check shall be deemed a forfeiture, and no funds shall escheat to any state.

D. Subrogation and Reimbursement

Immediately upon paying or providing any benefit under the Plan's group health plan Component Plans, such Component Plans shall be subrogated to all rights of recovery a covered person has against any party potentially responsible for making any payment to a covered person due to a covered person's injuries or illness, to the full extent of benefits provided or to be provided by the Component Plans. In addition, if a covered person receives any payment from any potentially responsible party as a result of an injury or illness, the Component Plans have the right to recover from, and be reimbursed by, the covered person for all amounts such Component Plans have paid and will pay as a result of that injury or illness, up to and including the full amount the covered person receives from all potentially responsible parties. Covered person includes, for the purposes of this provision, anyone on whose behalf the Component Plans pay or provide any benefit, including but not limited to the minor child or dependent of any participant or person entitled to receive any benefits from the Component Plans.

As used throughout this provision, the term responsible party means any party possibly responsible for making any payment to a covered person due to a covered person's injuries or illness or any insurance coverage, including but not limited to uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, med-pay coverage, workers' compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

The covered person shall do nothing to prejudice the applicable Component Plan's subrogation and reimbursement rights and shall, when requested, fully cooperate with the Component Plan's efforts to recover its benefits paid. It is the duty of the covered person to notify the Plan Administrator within 30 days of the date when any notice is given to any party, including an attorney, of the intention to pursue or investigate a claim to recover damages due to injuries sustained by the covered person. Any and all such funds recovered by the covered person shall remain traceable from the responsible party to the covered person and in the hands of the covered person. A covered person shall not dissipate any such funds received before reimbursing the Plan.

The covered person acknowledges that the applicable Component Plan's subrogation and reimbursement rights are a first priority claim against all potentially responsible parties and are to be paid to such Component Plan before any other claim for the covered person's damages. The applicable Component Plans shall be entitled to full reimbursement first from any potentially responsible party payments, even if such payment to the Component Plan will result in a recovery to the covered person

which is insufficient to make the covered person whole or to compensate the covered person in part or in whole for the damages sustained. The Component Plan will pay an equitable portion of the attorneys' fees associated with recovering the covered person's damage claim.

The terms of this entire subrogation and reimbursement provision shall apply, and the applicable Component Plan is entitled to full recovery regardless of whether any liability for payment is admitted by any potentially responsible party and regardless of whether the settlement or judgment received by the covered person identifies the specific benefits the Component Plan provided. The Component Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering or non-economic damages only.

If any claim is made that any part of this subrogation and reimbursement provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Plan Administrator or group health insurance issuer in the case of the insured Medical Plan benefit options have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

E. Plan is Not an Employment Contract

The Plan will not be construed as a contract for or of employment.

F. Nonassignability of Rights

Your right to receive any benefit or reimbursement under the Plan is not alienable by you by assignment or any other method and is not be subject to being taken by your creditors by any process whatsoever, and any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

G. No Guarantee of Tax Consequences

The Participating Employers do not make any commitment or guarantee that any amounts paid to you or for your benefit will be excludable from your gross income for federal or state income employment tax purposes, or that any other federal or state tax treatment will apply to or be available to you. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income and employment tax purposes, and to notify your employer if you have reason to believe that any such payment is not so excludable.

H. Indemnification of Employer by Participants

If you receive one or more payments or reimbursements under the Health Care FSA that are not for qualified medical expenses or under the Dependent Care FSA that are not for qualified dependent care expenses, you shall indemnify and reimburse your Participating Employer for any liability it may incur for failure to withhold federal or state income tax or social security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional federal and state income tax that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on such compensation, plus any applicable fines or penalties assessed against the employer, less any such additional income and Social Security tax actually paid by you.

I. Severability

If any provision of this Plan is held invalid, unenforceable or inconsistent with any law, regulation or requirement, its invalidity, unenforceability or inconsistency will not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision were not a part of the Plan.

J. Construction of Terms

Words of gender shall include persons and entities of any gender, the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

K. Applicable Law

The Plan shall be construed and enforced according to the laws of the state of Virginia to the extent not preempted by any federal law.

L. No Vested Interest

Except for the right to receive any benefit payable under the Plan in regard to a previously incurred claim, no person shall have any right, title, or interest in or to the assets of any Participating Employer because of the Plan.

M. Legal Action

No action at law or in equity may be brought to recover benefits allegedly due under the Plan before the claimant has exhausted the applicable claims procedures. Nothing contained in the Plan gives any person or organization any right to join a Participating Employer as a codefendant in any action against a Plan participant nor may a Participating Employer be impleaded in such action by a participant or his or her legal representative.

N. Employer Records

The records of the Participating Employers with respect to any person's employment, employment history, absences, illnesses, and all other relevant matters are conclusive for Plan administration purposes.

O. Changes in Law

Unless the context clearly indicates to the contrary, a reference to a Plan provision, statute, regulation or document shall be construed as referring to any subsequently enacted, adopted or executed counterpart; provided, however, that any other provision of this Plan to the contrary notwithstanding, this Plan may be operated in accordance with legal requirements before it is amended to reflect them.

****

IN WITNESS WHEREOF, Genuine Financial Holdings LLC has caused this Plan to be executed in its name and on its behalf this ___ day of December 2018 by a duly authorized officer of Genuine Financial Holdings LLC or his or her authorized delegate.

_____	_____
Signature	Title

SCHEDULE A

HireRight Health & Welfare Plan
Component Plans Available As Of January 1, 2018

HireRight Medical Plan	
Component Plan:	HireRight Medical Plan –BCBS of SC 2000 Plan, BCBS of SC 1350 Plan and BCBS of SC Core Plan
Type of Benefits:	Medical and prescription drug
Eligible Employee Groups:	All eligible employees
Health Care Reform Status:	This Component Plan is **not** a grandfathered group health plan for purposes of health care reform.
Insured by:	Blue Cross Blue Shield of South Carolina
Policy/Group Number:	70-53630-00
Claims (other than Prescription Drug) Administered by:	Blue Cross Blue Shield of South Carolina P.O. Box 100300 Columbia, South Carolina 29202 Telephone Number: 800-845-6067 www.bcbssc.com
Prescription Drug Claims Administered by:	CVS Caremark P.O. Box 100300 Columbia South Carolina 29202 Telephone: 888-963-7290 www.caremark.com
COBRA Administered by:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 888-266-1732 https://COBRApoint.benaissance.com
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is shared by the Participating Employers and the employees.

HireRight Dental Plan	
Component Plan:	HireRight Dental Plan
Type of Benefits:	Dental
Health Care Reform Status:	Not applicable
Insured by:	This Component Plan is self-funded by the Participating Employers and employees.
Policy/Group Number:	600253
Claims Administered by:	Delta Dental of Virginia 4818 Starkey Road Roanoke, VA 24018 Telephone Number: 800-237-6060 www.deltadentalva.com
COBRA Administered by:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 888-266-1732 https://COBRApoint.benaissance.com
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is shared by the Participating Employers and the employees.

HireRight Vision Plan	
Component Plan:	HireRight VSP Vision Plan
Type of Benefits:	Vision
Health Care Reform Status:	Not applicable
Insured by:	VSP
Policy/Group Number:	30010629
Claims Administered by:	VSP P.O. Box 997105 Sacramento, CA 95899-7105 Telephone Number: 800-877-7195 www.vsp.com
COBRA Administered by:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 888-266-1732 https://COBRApoint.benaissance.com
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is paid by the employees.

HireRight Basic Life, Basic Accidental Death & Dismemberment (AD&D), Voluntary Life, Voluntary AD&D	
Component Plan:	HireRight Basic Life, Basic Accidental Death & Dismemberment ,Voluntary Life, Voluntary Accidental Death & Dismemberment Plan and Business Travel Accident Plan
Type of Benefits:	Basic Life, Voluntary Life, Basic AD&D, Voluntary AD&D and Business Travel Accident
Health Care Reform Status:	Not applicable
Insured by:	The Hartford
Policy/Group Number:	681505
Claims Administered by:	The Hartford Attn: Group Life/ADD Claims Unit P.O. Box 14299 Lexington, KY. 40512-4299 Telephone: (866) 563-1124 Fax: (866) 954-2621
COBRA Administered by:	Not applicable
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of basic life and basic AD&D is paid by the Participating Employers. The cost of voluntary life and voluntary AD&D benefits is paid by the employees.

HireRight Long Term Disability Plan	
Component Plan:	HireRight Long Term Disability (LTD) Plan
Type of Benefits:	LTD
Health Care Reform Status:	Not applicable
Insured by:	The Hartford
Policy/Group Number:	681505
Claims Administered by:	The Hartford Attn: Group LTD Claims P.O. Box 14302 Lexington, KY. 40512-4302 Telephone: (800) 549-6514 Fax: (866) 411-5613
COBRA Administered by:	Not applicable
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is paid by the employees.

HireRight NY Statutory Disability	
Component Plan:	HireRight Long Term Disability (LTD) Plan
Type of Benefits:	New Your Statutory Disability Policy
Health Care Reform Status:	Not applicable
Insured by:	The Hartford
Policy/Group Number:	681505
Claims Administered by:	The Hartford Attn: Group LTD Claims P.O. Box 14302 Lexington, KY. 40512-4302 Telephone: (800) 549-6514 Fax: (866) 411-5613
COBRA Administered by:	Not applicable
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is paid by the Participating Employers.

Business Travel Accident Plan	
Component Plan:	Business Travel Accident Plan
Type of Benefits:	Life insurance and emergency medical services for business travel
Health Care Reform Status:	Not applicable
Insured by:	Not applicable
Policy/Group Number:	ADDN14292500
Claims Administered by:	ACE American Insurance Company P.O. Box 1000 Philadelphia, PA 19105
COBRA Administered by:	NA
Enrollment Administration:	HireRight Benefits 3349 Michelson Drive, Suite 150 Irvine, CA 92612
Sources of Contributions:	The cost of the benefits is paid by the Participating Employers.

Health Care Flexible Spending Account Plan	
Component Plan:	Health Care Flexible Spending Account Plan
Type of Benefits:	Health care flexible spending account
Health Care Reform Status:	Not applicable
Insured by:	Not applicable
Policy/Group Number:	L06786
Claims Administered by:	PlanSource P.O. Box 161940 Almonte Springs, FL 32714 Telephone Number: 888-266-1732 www.mywealthcareonline.com/PlanSource
COBRA Administered by:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 888-266-1732 https://COBRApoint.benaissance.com
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is paid by the employees with administrative fees paid by forfeitures and/or the Participating Employers.

Dependent Care Flexible Spending Account Plan	
Component Plan:	Dependent Care Flexible Spending Account Plan
Type of Benefits:	Dependent care flexible spending account
Health Care Reform Status:	Not applicable
Insured by:	Not applicable
Policy/Group Number:	L06786
Claims Administered by:	PlanSource P.O. Box 161940 Almonte Springs, FL 32714 Telephone Number: 888-266-1732 www.mywealthcareonline.com/PlanSource
COBRA Administered by:	Not applicable
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of the benefits is paid by the employees with administrative fees paid by forfeitures and/or the Participating Employers.

HireRight Employee Assistance Program	
Component Plan:	HireRight Employee Assistance Plan
Type of Benefits:	Counseling, referral services, assistance with completing substance abuse treatments
Health Care Reform Status:	Not applicable
Insured by:	Not applicable
Policy/Group Number:	EAP Business
Claims Administered by:	ComPsych Corporation NBC Tower 455 N. Cityfront Plaza Drive Chicago, IL 60611-5322 Telephone Number: 312-595-4000 www.compsych.com
COBRA Administered by:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 888-266-1732 https://COBRApoint.benaissance.com
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of benefits is paid by the Participating Employers.

HireRight Employee Legalshield Expense Plan	
Component Plan:	HireRight Employee Legalshield Expense Plan
Type of Benefits:	Legal services
Health Care Reform Status:	Not applicable
Insured by:	Not applicable
Policy/Group Number:	Legalshield Business
Claims Administered by:	Plan benefits are provided under the Plan Contract issued by: LegalShield One Pre-Paid Way Ada, Oklahoma 74820 Telephone: 800-654-7757 www.legalshield.com
COBRA Administered by:	Not applicable
Enrollment Administration:	PlanSource 625 Kenmoor Avenue SE Suite 102 Grand Rapids, MI 49546 Telephone Number: 844-217-8215 www.yourbenefitscenter.com
Sources of Contributions:	The cost of benefits is paid by the employees.

SCHEDULE B

HireRight Health & Welfare Plan

List of Participating Employers as of January 1, 2019

HireRight, LLC

National Diagnostics, LLC

Corporate Risk Holdings, LLC

backgroundchecks.com LLC

General Information Solutions LLC

ATTACHMENT #1- HIRERIGHT MEDICAL PLAN

BCBS of SC 1350 MEDICAL PLAN

ATTACHMENT #2- HIRERIGHT MEDICAL PLAN

BCBS of SC 2000 MEDICAL PLAN

ATTACHMENT #3- HIRERIGHT

BCBS of SC CORE MEDICAL PLAN

ATTACHMENT #4- HIRERIGHT

DENTAL PLAN

ATTACHMENT #5- HIRERIGHT

VISION PLAN

ATTACHMENT #6- HIRERIGHT

BASIC & VOLUNTARY LIFE & ACCIDENTAL DEATH & DISMEMBERMENT PLAN

ATTACHMENT #7- HIRERIGHT

LONG TERM DISABILITY PLAN

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ATTACHMENT #8- HIRERIGHT

NEW YORK STATUTORY DISABILITY PLAN

ATTACHMENT #9- HIRERIGHT

FLEXIBLE BENEFIT PLAN

ATTACHMENT #10-HIRERIGHT

BUSINESS TRAVEL ACCIDENT INSURANCE PLAN

ATTACHMENT #11-HIRERIGHT

EMPLOYEE ASSISTANCE PLAN

ATTACHMENT #12-HIRERIGHT

EMPLOYEE LEGALSHIELD EXPENSE PLAN