AXIOM STAFFING GROUP
PLAN DOCUMENT AMENDMENT NUMBER 1

Axiom Staffing Group Welfare Benefits Plan is hereby amended effective December 1, 2016 as follows:

Item 1: Article 1 Variable Provisions/Definitions: Section 1.05: Eligibility *(this section has been amended as follows)***:**

Section 1.05 ELIGIBILITY

(a) An individual shall not be an "Eligible Employee" if such individual is not reported on the payroll records of the Employer as a common law employee. In particular, it is expressly intended that individuals not treated as common law employees by the Employer on its payroll records are not "Eligible Employees" and are excluded from Plan participation even if a court or administrative agency determines that such individuals are common law employees and not independent contractors.

(b) "Participant" means an employee of the Company that participates in one or more Subsidiary Contracts.

MEDICAL BENEFITS ELIGIBILITY

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

Applicable Definitions

"Eligible Employee" is an Employee who is reasonably expected to work, on average, at least 30 hours per week.

"Initial Administrative Period" means the time during which new variable hour employees who have completed the Initial Measurement Period and have been determined to be Eligible Employees can enroll in or waive medical coverage. This period may not exceed ninety (90) days and may include a partial month prior to the beginning of the Initial Measurement Period. The Initial Administrative Period, or its second part, begins the next day after the end of the Initial Measurement Period.

"Initial Measurement Period" means the period of time during which a new Variable Hour Employee's hours of service are measured to determine whether the employee will become an Eligible Employee.

"Initial Stability Period" means the minimum period of time during which medical coverage must be offered to an employee who was previously a Variable Hour Employee and has been determined to be an Eligible Employee. The Initial Stability Period may not be shorter in duration than the Initial Measurement Period.

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

"Seasonal Employee" means an employee who is hired into a position for which the customary annual employment period is six (6) months or less and which begins at approximately the same time of each calendar year.

"Standard Administrative Period" means the time during which ongoing employees who have completed the Standard Measurement Period can enroll in or disenroll from medical coverage. This period occurs between the Standard Measurement Period and the Standard Stability Period and may neither reduce nor lengthen the Measurement Period or the Stability Period.

"Standard Measurement Period" means the period during which the Company counts an employee's hours of service; however, such period cannot be less than three (3) months nor more than twelve (12) months.

"Standard Stability Period" means the period of time during which an employee is eligible for medical coverage under the Plan. The Standard Stability Period may not be shorter in duration than the Standard Measurement Period.

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

"Administrative Period" means the time allowed during which employees can enroll in or disenroll from medical benefits coverage under the Plan. However, any Administrative Period between the Standard Measurement Period and the Stability Period may neither reduce nor lengthen the Measurement Period or the Stability Period.

Eligibility

The Company offers medical benefits coverage to Eligible Employees, their dependent children and/or spouses. “Spouse” refers to an individual who is lawfully married under any state law or currently recognized under prevailing Federal law. This definition is subject to the underlying Subsidiary Contracts. “Dependent children” is defined in the separate subsidiary Contracts for medical benefits.

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

Ongoing Employees

For Ongoing Employees, the Company will determine whether an individual is an Eligible Employee by determining the hours that the employee is reasonably expected to work going forward. If the employee is a Variable Hour Employee, his eligibility will be determined by looking at the employee's hours of service during the Standard Measurement Period. If a Variable Hour Employee is an Eligible Employee during the Standard Measurement Period, he or she will be eligible for medical benefits under the Plan during the entire Stability Period. The employee will remain eligible for medical benefits during the entire Stability Period, regardless of the employee's actual number of hours of service during the Stability Period, as long as he

remains an employee of the Company unless that employee is transferred to a known part-time position. The final IRS regulations include an exception for certain employees who have been continuously offered Plan coverage and who transfer to part-time positions during the stability period. If certain conditions are met, Plan eligibility for these transferred employees may end during a stability period. Similarly, if an employee is not an Eligible Employee during the Standard Measurement Period, he will not be eligible for medical benefits during the entire Stability Period.

New Employees Expected to Be Eligible Employees

If the Company reasonably expects a new, salaried employee (who is not a Seasonal Employee) to be an Eligible Employee as of the employee's hire date, the employee will be offered medical benefits coverage under the Plan as of the first of the month following the date of hire.

If the Company reasonably expects a new, hourly employee (who is not a Seasonal Employee) to be an Eligible Employee as of the employee's hire date, the employee will be offered medical benefits coverage under the Plan as of the first of the month following 30 days from the date of hire.

Seasonal Employees

A Seasonal Employee will be treated as a Variable Hour Employee with respect to eligibility.

All Other Employees

All other newly hired Employees must first complete an Initial Measurement Period during which they are not eligible to enroll in medical benefits under the Plan. At the end of the Initial Measurement Period, if the employee is determined to be an Eligible Employee, that employee will be eligible for medical benefits under the Plan.

Enrollment

The Company will use the Administrative Period to determine whether an employee is an Eligible Employee and to offer coverage to those Eligible Employees during an open enrollment period. Medical benefits coverage will be effective during the Stability Period.

ALL OTHER BENEFITS ELIGIBILITY

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

Item 2: Article 3 Plan Administration: Section 3.02 HIPAA Privacy Rules: *(this section has been deleted).*

Item 3: Article 3 Plan Administration: Section 3.04 FMLA/USERRA *(this section has been amended as follows)***:**

To the extent the Employer is subject to the Family Medical Leave Act (FMLA), as referenced under Public Law 103-3 enacted February 5, 1993 and as amended, including the Final Rule under 29 CFR §§ 825.102 and 825.122(b) with regard to definition of "spouse" enacted March 27, 2015, the Plan Administrator shall permit a Participant taking unpaid leave under the FMLA to continue medical benefits under such applicable law. Non-medical benefits shall be continued according to the established Company policy. Participants continuing participation pursuant to the foregoing shall pay for such coverage (on a pre-tax or after-tax basis) under a method as determined by the Plan Administrator satisfying Treas. Reg. 1.125-3 Q&A-3. Any Participant on FMLA leave who revoked coverage shall be reinstated to the extent required by Treas. Reg. 1.125-3. If the Participant's coverage under the Plan terminates while the Participant is on FMLA leave, the Participant is not entitled to receive reimbursements for claims incurred during the period when the coverage is terminated. Upon reinstatement into the Plan upon return from FMLA leave, the Participant has the right to (i) resume coverage at the level in effect before the FMLA leave and make up the unpaid premium payments, or (ii) resume coverage at a level that is reduced by the amount of unpaid premiums and resume premium payments at the level in effect before the FMLA leave.

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

Item 4: Article 3 Plan Administration: Section 3.08 Medicaid *(this section has been added as follows)***:**

Section 3.08 MEDICAID

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

Payment for benefits with respect to a Participant under a group health plan will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

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

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

Item 5: Article 3 Plan Administration: Section 3.09 Coordination of Benefits *(this section has been as follows):*

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

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

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

(i) Allowable Expense. Allowable Expense means a health care service or expense, including coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Arrangements covering the person. When an Arrangement provides benefits in the form of services (for example a health maintenance organization), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Arrangements is not an Allowable Expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. If a person is covered by one Arrangement that computes its benefit payments on the basis of reasonable or recognized charges and another Arrangement that provides its benefits or services on the basis of negotiated charges, the primary Arrangement's payment arrangements shall be the Allowable Expense for all the Arrangements. However, if the secondary Arrangement has a negotiated fee or payment amount different from the primary Arrangement and if the provider contract permits, that negotiated fee will be the Allowable Expense used by the secondary Arrangement to determine benefits. When an Arrangement provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an Allowable Expense and a benefit paid.

(ii) Arrangement. An Arrangement includes any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts

of the same Arrangement and there is no coordination of benefits among those separate contracts.

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

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

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

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

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

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

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

(i) Non-dependent or Dependent. The Arrangement that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber or retiree is the primary Arrangement and the Arrangement that covers the person as a Dependent is the secondary Arrangement. However, if the person is a Medicare beneficiary and, as a result of

federal law, Medicare is secondary to the Arrangement covering the person as a Dependent; and primary to the Arrangement covering the person as other than a Dependent (e.g. a retired employee); then the order of benefits between the Arrangements is reversed so that the Arrangement covering the person as other than a Dependent is the secondary Arrangement and the other Arrangement is the primary Arrangement.

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

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

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

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

(2) If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage or the decree does not specify which parent is responsible for the Dependent child's health care expenses or health care coverage, the provisions of Subsection 3.09(d)(ii)(A) shall determine the order of benefits;

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

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

(iii) Active Employee or Retired or Laid off Employee. The Arrangement that covers a person as an employee who is neither laid off nor retired or as a Dependent of an active employee, is the primary Arrangement. The Arrangement covering that same person as a retired or laid off employee or as a Dependent of a retired or laid off employee is the secondary Arrangement. If the other Arrangement does not have this rule, and if, as a result, the

Arrangements do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.

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

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

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

(e) Effect on the Arrangements. When an Arrangement is secondary, it may reduce its benefits so that the total benefits paid or provided by all Arrangements during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary Arrangement will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Arrangement that is unpaid by the primary Arrangement. The secondary Arrangement may then reduce its payment by the amount so that, when combined with the amount paid by the primary Arrangement, the total benefits paid or provided by all Arrangements for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Arrangement shall credit to its Arrangement deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

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

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

(g) Facility of Payment. Any payment made under an Arrangement may include an amount, which should have been paid under another Arrangement. If so, the Arrangement may

pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under paying Arrangement. No Arrangement will have to pay that amount again. The term "payment made" means reasonable cash value of the benefits provided in the form of services.

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

Item 6: Article 4 Funding; Section 4.03 Subsidiary Contract Rebates for Fully-Insured Group Health Plans *(this section is added as follows):*

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

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

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

Item 7: Article 8 HIPAA *(this Article and the sections thereunder have been added as follows)***:**

ARTICLE 8
HIPAA

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

Section 8.01 DEFINITIONS

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

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

(b) "Group Health Benefits" means the medical benefits, dental benefits, vision benefits and, if applicable, employee assistance program benefits offered under the Plan.

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

(d) "Notice of Privacy Practices" means a notice explaining the uses and disclosures of PHI that may be made by the Plan, the covered Individuals' rights under the Plan with respect to PHI, and the Plan's legal duties with respect to PHI.

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

(f) "Protected Health Information ("PHI")" means information about an Individual, including genetic information, (whether oral or recorded in any form or medium) that:

(1) is created or received by the Plan or the Plan Sponsor;

(2) relates to the past, present or future physical or mental health or condition of the Individual, the provision of health care to the Individual, or the past, present or future payment for the provision of health care to the Individual; and

(3) identifies the Individual or with respect to which there is a reasonable basis to believe the information may be used to identify the Individual.

PHI includes Protected Health Information that is transmitted by or maintained in electronic media.

(g) "Summary Health Information" means information summarizing the claims history, claims expenses, or types of claims experienced by an Individual, and from which the following information has been removed:

(1) names;

(2) any geographic information which is more specific than a five digit zip code;

(3) all elements of dates relating to a covered Individual (e.g., birth date) or any medical treatment (e.g., admission date) except the year; all ages for a covered Individual if the Individual is over age 89 and all elements of dates, including the year, indicative of such age (except that ages and elements may be aggregated into a single category of age 90 and older);

(4) other identifying numbers, such as, Social Security, telephone, fax, or medical record numbers, e-mail addresses, VIN, or serial numbers;

(5) facial photographs or biometric identifiers (e.g., finger prints); and

(6) any other unique identifying number, characteristic, or code.

Section 8.02 HIPAA PRIVACY COMPLIANCE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(f) Rights of Individuals.

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

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

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

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

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

Section 8.03 HIPAA SECURITY COMPLIANCE

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

(a) Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(b) Ensure that the adequate separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

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

(d) Report to the Plan any security incident of which it becomes aware.

Section 8.04 HIPAA COMPLIANCE FOR FULLY INSURED GROUP HEALTH BENEFITS

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

Item 8: Appendix A Welfare Benefit Plans *(this Appendix is amended as follows):*

APPENDIX A
WELFARE BENEFIT PLANS

The following employer sponsored welfare benefits of the plan sponsor are subject to ERISA and are covered by the Plan:

- Medical - 2 separate carriers
- Dental
- Vision
- Basic Life
- Supplemental life
- Short Term Disability
- Long Term Disability
- Healthcare Flexible Spending Account
- Telemedicine
- Hospital Indemnity - only offered to temp population

Except as stated above, all Plan provisions remain the same.

This amendment is hereby approved and adopted by the undersigned. It supersedes and/or changes any previous amendment(s) in regards to the Plan provisions specified in this amendment. This signed amendment shall be attached to and form a part of the Plan Document on the above stated Effective Date.

Approved and Adopted By:

Signature	*Title*
Printed Name	*Date Signed*