Axiom Staffing Group, Inc. Employee Welfare Benefit Plan

Type of Plan

Welfare Benefits Plan subject to the provisions of ERISA

Current Plan Year

June 1 to May 31

The Plan Number

502

Plan Sponsor's Federal Employer Identification Number

58-2449544

This document, together with each Component Benefit Plan's related Plan Documents establish the **Summary Plan Description.** This document supplements each Component Benefit Plan's related Plan Documents. The Summary Plan Description summarizes the rights and responsibilities of Plan Participants and/or Beneficiaries and is produced with the intent to comply with the minimum federal legal requirements for Summary Plan Descriptions. These Plan Documents, the terms of which are hereby incorporated by reference as if fully recited herein, shall be considered a part of this Plan. If the terms of this document conflict with the terms of the related Plan Documents of any Component Benefit Plan, such terms will control unless otherwise required by law. **This information and other important Plan information may be available in a (your) non-English language**. You may request information or assistance from each Plan offered (see contact information provided in **Addendum A** herein) or contact the **Plan Administrator** by making your request, in writing, to:

Axiom Staffing Group, Inc.
Plan Administrator for Axiom Staffing Group, Inc. Employee Welfare Benefit Plan
2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009
Phone: (678) 762-0285

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In accordance with efforts to comply, the following information is enclosed and related to the Component Benefit Plans offered this plan year. For more details, refer to **Addendum A** or contact the Plan Administrator.

Please Note:

The benefits described herein are subject to change with or without advance notice to covered employees, at any time, and at the discretion of the Plan Administrator.

This document does not replace or supplement any Component Benefit Plan or related Plan Documents or state or federal law. If a conflict of either law or Plan Document exists herein, law and correct application of actual Plan terms shall supersede.

1. INTRODUCTION

Welcome to Axiom Staffing Group, Inc.!

We hope you will support our efforts to create a healthy, happy and safe workforce culture.

This document is prepared as ~~an~~ amended/restated document to the plan dated August 1, 2018 for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan. This document is adopted and effective as of the date authorized within the Board Resolution of Axiom Staffing Group, Inc. (the "Employer" and/or "Plan Sponsor").

Axiom Staffing Group, Inc. adopts the Plan, in part or in whole, in accordance with the provisions of the Board Resolution adopting the Plan.

Currently, the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan represents a sole (single) employer Plan.

Axiom Staffing Group, Inc. maintains the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan an "Employee Welfare Benefit Plan" (the "**Plan**"), as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA). Title I of the ERISA is administered by the Employee Benefits Security Administration (EBSA). The provisions of Title I of ERISA cover most private sector employee benefit plans. Such plans are voluntarily established or maintained by an Employer, an employee organization, or jointly by one or more such Employers and an employee organization. As such, the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan provides for the payment or reimbursement of certain benefits for eligible Employees (and eligible Dependents of such Employees, if any) as noted, but not limited to, certain Welfare Plans (hereinafter "Component Benefit Plans") identified in **Addendum A**. The determination of all benefits under the Plan is expressly subject to all the provisions, including amendments, of this Plan Document, as well as the terms and conditions of the Component Benefit Plans, including amendments, to said Component Benefit Plans (the terms of which are hereby incorporated by reference as if full recited herein).

Notwithstanding the number and types of benefits incorporated hereunder, the Plan is and shall be treated as a **single benefit plan** to the extent permitted under ERISA. The Plan is intended to meet all applicable requirements of ERISA, as well as rulings and regulations issued thereunder. Terms that are capitalized are defined in the section entitled "**Terms & Conditions**."

The purpose of this Plan Document is to set forth the essential terms and provisions of the Plan and to consolidate and combine into a single Plan Document maintained by Axiom Staffing Group, Inc. to provide Participants and their Beneficiaries with the benefits described herein and in each Component Benefit Plan's Documents which are incorporated into this Plan and to provide uniform administration of such Welfare Benefit Plans. In the event that the provisions of any Component Benefit Plans conflict with the provisions of this Plan Document or any other Component Benefit Plan documents, the Plan Administrator shall, at its discretion, interpret the terms and purpose of the Plan so as to resolve any conflict. However, the terms of this Plan document or any other Component Benefit Plan may not increase the rights of a Participant or Participant's Beneficiary to benefits available under any Component Benefit Plan. As well, if greater or additional legal rights are afforded to you by any Component Benefit Plan or applicable state law *not pre-empted by ERISA (a federal law)*, those legal rights shall supersede the rights set forth in this Summary Plan Description.

It is the intent of the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan to comply in a prudent manner with Title I of ERISA, which requires that Plans and Plan funds are managed:

- For the exclusive benefit of Participants and Beneficiaries;
- To carry out duties in a prudent manner and refrain from conflict of interest transactions expressly prohibited by law;
- To fund benefits in accordance with the law and plan rules;
- To report and disclose information on the operations and financial conditions of plans to the government and Participants; and
- To provide documents required in the conduct of investigations to ensure compliance with the law.

Stay Informed and Keep Us Informed

It is Axiom Staffing Group, Inc.'s intent to provide Participants and Beneficiaries, as applicable, with the information necessary to be informed of individual rights, responsibilities and the general

terms applicable to participating in each Component Benefit Plan.

Copies of Participant and Beneficiary notices, and related Plan Documents, including this EverWrap™ Summary Plan Description, are made available at no charge by requesting a copy, in writing, from the Plan Administrator.

Contact the Component Benefit Plan, as listed in **Addendum A**, or the Plan Administrator for more information.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

Keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

2. TERMS & CONDITIONS

The following gives an overview of the definitions that are pertinent to understanding the Plan and Participants' and Beneficiaries' rights and responsibilities. For more information or to request clarity of the below terms, contact the Component Benefit Plan (disclosed in **Addendum A**) or the Plan Administrator.

APPLICABLE LARGER EMPLOYER (ALE) is defined by the Patient Protection and Affordable Care Act (ACA) as any Employer or controlled group of Employers sponsoring a Group Health Component Benefit Plan that has an average of at least 50 Full-Time Employees ("Full-Time equivalents" or "FTEs"). For the purposes of the ACA, the required average number of hours per week during each calendar month as expressed for the Group Health Component Benefit Plan in **Addendum A**.

BENEFICIARY means a person designated by a Participant, or by the terms of a Component Benefit Plan, who is or may become entitled to a benefit thereunder. A Beneficiary has the rights provided under the Plan, and the plan's fiduciaries owe Fiduciary duties to plan Beneficiaries as well as plan Participants. A Beneficiary may sue under ERISA Section 502 for plan benefits and to remedy violations of ERISA Title I. A Beneficiary also has the right to examine and request copies of Plan Documents.

CONTRIBUTIONS are the sum of the monies necessary to fund (whether fully insured or self-funded) any Component Benefit Plan, as described in **Addendum A**. Contributions are made by the Employer and/or Eligible Employees, including continuants as defined by state or federal law, as applicable. *Normally*, the necessary contributions are established prior to the Plan Year. Such contributions may be made on a pre- or post-tax basis as identified in **Addendum A**. Any Group Component Benefit Plan benefits insured by an Insurance Company are paid solely from the general assets of the Insurance Company. Any Component Benefit Plan benefits self-funded by the Employer are paid solely from the general assets of the Employer. All group benefits funded by a Trust are paid solely from the general assets of the Trust.

A **CLAIM** is a request for a Plan benefit made in accordance with the Plan's procedures by a claimant (Participant or Beneficiary) or a claimant's authorized representative. Questions concerning Plan benefits, coverage and eligibility and casual inquiries are generally *not* considered claims for Plan benefits.

COBRA PARTICIPANT or **BENEFICIARY** means an individual is receiving continuation coverage and who is entitled to the same benefits, choices and services that a similarly situated Participant or Beneficiary is currently receiving under the Plan.

CONTRACT means the agreements, amendments or riders that control services provided to the Plan as well as the eligibility and benefits of *each* Component Welfare Plan as described in **Appendix A** for such period(s) during which each Component Welfare Plan is in effect. Any amendment or replacement of any of the documents comprising the Component Benefit Plan as listed in **Appendix A** may be certified by a duly authorized officer of the Company and may be updated as required, without need to amend this Document.

DEPENDENT shall mean:

- a **legal spouse,** including a **bona fide domestic partner**, unless legally separated by court decree in which instance the governing federal or state law recognizes such.
- any child born to you or legally adopted; a stepchild; a foster child; or a child for whom you are the legal guardian, including a child of your bona fide Domestic Partner; or a child for whom a court holds you responsible such as with a qualified medical child support order under ERISA Sec. 609 *who is under the age limits specified by each Component Benefit Plan.*

A Dependent may be eligible to participate in and receive benefits under one or more of the Component Benefit Plans due to their relationship to an eligible Employee. Information about such eligibility and coverage is found in each respective underlying Component Benefit Plan's related Plan Documents.

Most often, Employees must elect coverage in or be a Participant of a Component Benefit Plan in order to request Dependent coverage, if available or offered.

Dependent age limitations or benefit reductions that occur as a result of a certain age are described in each Component Benefit Plan's related Plan Documents.

The Plan Administrator has the sole and absolute authority to determine an individual's status as a Dependent of a Participant for the purposes of the Plan, and any such determination shall be final, binding and conclusive on all parties ever claiming an interest in the Plan. The Plan Administrator may require the Participant to provide proof of Dependent status. Such proof may include but is not limited to: evidence of marriage, a birth certificate, court order, evidence of the domestic partnership, which may include an affidavit, or other official documentation satisfactory to the Plan Administrator.

Refer to **Addendum A, Addendum B** and each Component Benefit Plan's related Plan Documents; or contact the Plan Administrator for more details regarding Plan eligibility.

Contact the **Plan Administrator** immediately if you believe eligibility or benefits for yourself or a Dependent have been calculated incorrectly.

ELIGIBLE EMPLOYEE means any Employee who satisfies the eligibility and participation requirements under each respective Component Benefit Plan. In general, to be eligible for benefits under the Plan, Employees must meet and maintain all of the following requirements:

- is a W2 Employee who is a legal US resident or citizen or covered under an approved and valid Temporary Worker Visa;
- resides in the **contiguous United States**, a **covered territory or country** as defined by each Component Benefit Plan in **Addendum A**;
- maintains an **'actively at work'** employment status;
- expects to work a **minimum number of hours** per week as defined by each Component Benefit Plan in **Addendum A**;
- satisfies the enrollment requirements specified by the Plan or Plan Administrator in a timely manner

Hereinafter, the term "Employee" shall mean "Eligible Employee" unless otherwise stated, inferred or imposed by law or contract or regulation thereof.

Employees of Axiom Staffing Group, Inc. and such other trades or businesses designated by a proper officer of the Employer are specifically included or excluded as Employees hereunder as such officer shall reasonably determine in good faith. Employees are eligible to participate in the Plan if eligible to participate in any of the Component Benefit Plan(s) as described in summary in **Addendum A** and within each respective Component Benefit Plan's related Plan Documents. In the event eligibility and/or participation requirements are not stated in the related Plan Documents, the eligibility requirements described above and in **Addendum A** shall apply.

Exceptions may apply to the "actively at work" employment status and minimum hours requirements in the event of paid time off or hours not worked due to a covered medical leave or disability.

Refer to **Addendum A, Addendum B** and each Component Benefit Plan's related Plan Documents or contact the Plan Administrator for more details regarding Plan eligibility or if you believe eligibility or benefits for yourself or a Dependent have been calculated incorrectly.

EMPLOYEE shall mean any individual employed by an Employer unless otherwise defined by each respective Component Benefit Plan listed in **Addendum A** and may be described as one of the following:

- **Full-Time Employee** is a Employee who is expected to work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A.**
- **Hourly Employee** is an Employee who is paid an hourly wage for their services, as opposed to a fixed salary. This Employee may or may not work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A.**
- **Non-Resident Alien** is an Employee who is assigned a classification by the Internal Revenue Service as a non-U.S. citizen, has foreign national status, or is an individual who has not passed the green card test or the substantial presence test. This Employee may or may not work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A.**
- **Part-Time Employee** is an Employee who is not expected to work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A**.
- **Salaried Employee** is an Employee who is paid a fixed amount of money or compensation (also known as a salary).
- **Seasonal Employee** is an Employee who performs labor or services on a seasonal basis and who is hired into a position for which the customary annual employment is six months or less. Generally, this employee is not eligible for some or all of the Component Benefit Plans offered in the Plan.
- **Variable Hour Employee** is an Employee for whom, based on the facts and circumstances at the start date, it cannot be determined that such Variable Hour Employee is reasonably expected to work, on average, the required number of hours per week during the testing period as described in **Addendum B** and as expressed for plan eligibility for each Component Benefit Plan in **Addendum A**.

An "Employee" shall not include any individual who, in good faith, is classified as an independent contractor by the Employer, even if such individual is later determined by any governmental agency or court to have been a common law employee of the Employer.

Contact the **Plan Administrator** immediately if you believe eligibility or benefits for yourself or a Dependent have been calculated incorrectly.

EMPLOYEE WELFARE BENEFIT PLAN (also called "**WELFARE PLAN**" or "**COMPONENT BENEFIT PLAN**") shall mean each Component Benefit Plan as identified in **Addendum A** and may be identified as any Plan, fund or program which was heretofore or is hereafter established or maintained by an Employer or by an Employee Organization, or by both, to the extent that such Plan, fund or program was established or is maintained for the purpose of providing for its Participants or their Beneficiaries, through the purchase of insurance or otherwise:

- medical, surgical or hospital care
- benefits for sickness, accident, disability or death
- certain unemployment benefits
- vacation benefits
- apprenticeship and training programs
- day care centers
- scholarship funds
- prepaid legal services
- holiday or severance pay

PLAN DOCUMENTS shall include the related documents that, together, make up the governances of each Component Benefit Plan. Certificates of Insurance, contracts, agreements, amendments, riders, Summary of Benefits and Coverage, Summary Plan Description, Summary Annual Reports, Summary(s) of Material Modifications and/or Summary of Material Reductions and any other related documents make up the Component Benefit Plan Documents as it relates to each Component Benefit Plan offered under the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan.

Any information or description of the scope of coverage under the Plan as well as the options, terms, conditions, rights, restrictions and limitations herein are incorporated as a part of the Component Benefit Plan Contract and are intended to comply with the Plan Documents and state and federal law, as applicable. As such, the Plan Documents control the Plan for the purpose of determining benefits; define the provisions and restrictions of the Plan; identify Participants' and Beneficiaries' benefits, limitations, exclusions, rights and responsibilities; and define the arrangement between the Employer and a Component Benefit Plan provider subject to ERISA. Such Plan Documents, the terms of which are hereby incorporated by

reference as if fully recited herein, shall be considered a part of this Plan.

The provisions of each Employee Welfare Benefit Plan described as a Component Benefit Plan in **Appendix A** includes the Plan's related Plan Documents for such period(s) during which the document is in effect. Any amendment or replacement of any of the Plan Documents comprising a Component Benefit Plan as listed in **Appendix A**, may be certified by a duly authorized officer of the Company and may be updated as required, without any need to amend this document.

EMPLOYER means any person acting directly as an Employer, or indirectly in the interest of an Employer, in relation to a Component Benefit Plan. An Employer includes a group, organization or association of Employers acting for an Employer in such capacity. A Corporation, Limited Liability Company or other business entity that is under common control as per IRS Section 414(b) or Section 414(c); is an Affiliated Employer as per IRS Section 414(m); or an Aggregated Employer as per IRS Section 414(o) may be a participating Employer of the Plan.

For the purpose of this Plan, Employer shall mean Axiom Staffing Group, Inc., a Sub S Corporation of the State of Georgia and its successors or assigns.

If the Employer merges or is otherwise consolidated with any participating Employer, the surviving Employer shall become the Controlling Employer for the group of Employees covered by the Plan immediately before such merger, acquisition or consolidation and for the group of Employees of the participating Employers thereafter adopting the Plan, unless the Controlling Employer that will be merged out of existence specifies in writing to the contrary.

ENTRY DATE means the date on which an Eligible Employee has satisfied, timely, the enrollment and eligibility requirements of the Plan or such Employee Welfare Benefit Plan, as specified by the Plan Administrator, and becomes a Participant in this Plan or such Component Welfare Plan. Details regarding Entry Date are found in each Component Benefit Plan's related Plan Documents and in summary herein as listed in **Addendum A**.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as amended.

FIDUCIARY (also called "**NAMED FIDUCIARY**") is a person or entity named in the written Plan, or through a process described in the Plan, as having control over the plan's operation. The Named Fiduciary can be identified by office or by name. For some Plans, it may be an administrative committee or a company's board of directors. A Plan's Named Fiduciary may ordinarily include Plan Administrators, Trustees, individuals exercising discretion in the administration of the Plan, all members of a Plan's administrative committee (if it has such a committee), and those who select committee officials. Attorneys, accountants and actuaries generally are not fiduciaries when acting solely in their professional capacities. Similarly, a Third-Party Administrator, recordkeeper or claims reviewer who performs solely ministerial tasks is not a Named Fiduciary; however, that may change if such individual or entity exercises discretion in making decisions regarding a Participant's eligibility for benefits. Additionally, a Third-Party Administrator may assume some Fiduciary responsibility if such assumption is identified and agreed upon by mutual consent, in writing, of both parties within the related Plan Documents or service Contract. For purposes of determination of the amount of, and entitlement to, benefits of an insured Component Welfare Plan provided by an Insurance Policy, the Insurance Company is the Named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the Insurance Policy.

The primary responsibility of fiduciaries is to run the plan solely in the interest of participants and beneficiaries and for the exclusive purpose of providing benefits and paying plan expenses. Fiduciaries must act prudently. In addition, fiduciaries must follow the terms of the Plan Documents to the extent that the terms are consistent with ERISA and other governing law or regulation. Fiduciaries also must avoid conflicts of interest. In other words, they may not engage in transactions on behalf of the plan that benefit parties related to the Plan, such as other fiduciaries, service providers or the plan sponsor.

INSURANCE COMPANY (or "**INSURANCE COMPANIES**") means any Insurance Company licensed to do business in the state of Axiom Staffing Group, Inc. and/or such other states in which the Employer does business, with which the Employer has entered into a contract for the purposes of providing benefits under the Plan.

PARTICIPANT means any Employee or former Employee of an Employer or any member or former member of an Employee group, organization or association who is or may

become eligible and properly enrolled to receive a benefit of any type from a Component Benefit Plan which covers Employees of such Employer or members of such group, organization or association, or whose Beneficiaries may be eligible to receive any such benefit. A Participant has the rights provided under the Plan and the Plan's fiduciaries owe fiduciary duties to Plan Participants. A Participant may sue under ERISA Section 502 for plan benefits and to remedy violations of ERISA Title I. A Participant also has the right to request and examine copies of Plan documents and the related Plan Documents of any Component Benefit Plan. When applicable, Participants may also receive and be entitled to copies of Summary Annual Reports.

POLICY or **POLICIES** shall mean the insurance Contracts, as such Contract or Contracts may be amended or replaced with other Insurance Contracts, issued to the Employer by an Insurance Company or Companies (or such other contracts between the Employer and a benefit provider) for the purpose of providing benefits under the Plan. All such Policies (or Contracts), the terms of which are hereby incorporated by reference as if fully recited herein, shall be considered a part of this Plan.

PLAN ADMINISTRATOR shall refer to the Employer, unless the Employer has designated another person, committee or entity to act in its place. The Plan Administrator as provided herein is specifically designated by the terms of the Plan. If the Plan does not make such a designation, then the Plan Sponsor is generally the Plan Administrator. As such, the term Administrator means the person or entity specifically so designated by the terms of the instrument under which the Plan is operated. In the case of a Plan for which a Plan Administrator is not designated and a Plan Sponsor cannot be identified, such other person as the Secretary may, by regulation, prescribe. A Plan Administrator performs many of the actions involved in operating, administering and managing a plan or controlling the Plan's assets.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

The Plan Administrator's duties include, but are not limited to:

- Interpreting the Plan
- Prescribing applicable procedures
- Determining benefits eligibility
- Authorizing benefit payments
- Obtaining the information necessary to administer the Plan

The Plan Administrator's interpretations and decisions are conclusive and binding on all Plan Participants and Beneficiaries, if any.

PLAN YEAR generally means each 12 consecutive month period beginning June 1 and ending May 31. A Plan Year may or may not coincide with a calendar year and may not have any relevance as to how benefits are provided under each Component Benefit Plan.

However, in some rare instances the Plan Year may be shortened.

PLAN SPONSOR means the Employer in the case of a Component Benefit Plan established or maintained by a single Employer; the Employee organization in the case of a plan established or maintained by an Employee organization; or in the case of a plan established or maintained by two or more Employers or jointly by one or more Employers and one or more Employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the Plan.

The **CONTROLLING EMPLOYER** of the Plan (or "**Plan Sponsor**") of the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

PLAN TRUSTEE is defined as someone who has the exclusive authority and discretion to manage and control the Plan benefits. The Trustee can be subject to the direction of a named Fiduciary, and the named Fiduciary can appoint one or more delegates/service providers to the Plan.

SUMMARY ANNUAL REPORT (SAR) is a narrative summary of a specific Component Benefit Plan's financial status and summarizes the information on the Plan's annual report (Form 5500). If a SAR is required of the Company, it will be

produced and made available/provided to Plan Participants as applicable.

SUMMARY MATERIAL MODIFICATION (SMM) is a document that is provided to plan Participants any time there is a material modification to a Component Benefit Plan or the Plan itself, or any time there is a change to the information that is required to be provided in the Summary Plan Description (SPD). The Summary Plan Description, as amended or as restated from time to time, shall be considered a part of the Plan, and is hereby incorporated by reference as if fully recited herein.

SUMMARY PLAN DESCRIPTION shall mean the document that describes the specific benefits under each respective Component Benefit Plan. The Summary Plan Description, as amended or as restated from time to time, shall be considered a part of the Plan, and is incorporated herein by reference.

THIRD-PARTY ADMINISTRATOR (TPA) shall mean the person or organization that processes claims and performs certain administrative and claims payment services in accordance to the terms of the Contract governing a Component Benefit Plan.

TRUSTEE shall mean the entity or group of individuals who hold the assets of the plan in trust.

General Terms of the Plan

This EverWrap™ and related Component Benefit Plan Documents and applicable Plan notices provide supplemental and important information about Participant and Beneficiary rights and responsibilities with respect to each Component Benefit Plan identified in **Addendum A**.

The purpose of this document is to summarize the more significant provisions of the Plan and is provided as an additional vehicle for communicating such rights and responsibilities.

This document is not intended to imply or give any additional fundamental rights to benefits that are not provided for by each Component Benefit Plan and is not intended to replace or supplement the Contract or related Plan Documents associated with or issued by any Component Benefit Plan. As such, the actual terms of each Component Benefit Plan, Contract and related Plan Documents are contained in separate, written documents governing each respective Component Benefit Plan and shall rule in the event of a conflict between the respective Component Benefit Plan and this Plan. To that end, such separate documents include—but are not limited to—each Component Certificate of Insurance, contract, agreement, amendment, rider, Summary of Benefits and Coverage, and/or Summary Plan Description and any other related Plan Documents making up the Component Benefit Plan, including a Summary of Material Modification and/or Summary Annual Reports (as applicable), law or other governing regulation or document(s), as adopted, amended or subsequently replaced and are hereby incorporated by reference as if fully recited herein.

Generally, the documents provided and/or made available are a summary of the material provisions of each Component Benefit Plan, which is intended to be understandable to the average person.

Contact the Component Benefit Plan or the Plan Administrator for more information.

Give the Plan Notice of Changes

For all qualifying events related to Dependent coverage (such as divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify and supply any documentation required to the Plan Administrator within **30 days** after the qualifying event occurs. You must provide this to the Plan Administrator.

In any instance, keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. If you are unsure if you have incurred a change that affects eligibility, contact the Plan and the Plan Administrator. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
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Phone: (678) 762-0285

3.
PLAN ADMINISTRATION

Axiom Staffing Group, Inc. has the right to appoint the Plan Administrator of the Plan. The Plan Administrator has the discretion to interpret the provisions of the Plan and any Component Benefit Plan. The Plan is administered by the Plan Administrator, various Insurance Companies, Trustees and/or Third-Party Administrators and is governed by state and/or federal law, as applicable, and the provisions of the Component Benefit Plan Contract(s) and any other documents. The Plan Sponsor is the Administrator of such Component Benefit Plan, unless otherwise specified in **Addendum A**.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

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The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan, and to supply omissions to the Plan to the extent not delegated to another named Fiduciary. Any construction, interpretation or application of the Plan by the Plan Administrator is final, conclusive and binding. The Plan Administrator shall also be the **Named Fiduciary** within the meaning of ERISA section 402.

In addition, if a party has accepted Named Fiduciary status in considering, accepting, denying and paying claims (including any appeals relating to such claims), that party is identified in the respective Component Benefit Plan Contract or related Plan Documents.

The Plan Administrator may delegate to any committee, person, Employee, officer or agent of the Plan Sponsor or an affiliated or aggregated Employer and its successors or assigns participating in the Plan any one or more of its powers, functions, duties or responsibilities with respect to the Plan. Any such delegation of responsibilities may be amended from time to time, in writing, by the Plan Administrator and may be revoked, in whole or in part, by written notice from one party to the other. Unless the Controlling Employer has delegated such responsibility, the Controlling Employer shall be the Plan Administrator.

In administering the Plan, the Plan Administrator is entitled, to the extent permitted by law, to rely on all tables, valuations, certificates, opinions and reports which are furnished by accountants, counsel or other experts employed or engaged by the Plan Administrator.

The Insurance Company(s) of a Component Benefit Plan that is funded by an insurance contract (also known as "fully insured") is also a Named Fiduciary and shall have the full power to interpret and apply the terms of the Plan as they relate to the benefits provided by the respective insurance policy(s). The Insurance Company associated with any fully insured Component Benefit Plan is described in **Addendum A** and is responsible for considering, accepting, denying and paying claims for the insured benefits and for considering any appeals to the insured benefits made following a Component Benefit Plan's claim procedures and, if applicable, to apply the claim procedures designated in the related Plan Documents, law or other governing regulation or document(s) as adopted, amended or subsequently replaced and hereby incorporated by reference as if fully recited herein.

Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. Any Named Fiduciary hereunder may, pursuant to such other formal procedures as it shall establish, designate persons (including Third-Party Administrators) other than the Named Fiduciaries to carry out its Fiduciary responsibilities under the Plan.

It is intended that this Plan shall allocate to each Named Fiduciary individual responsibility for the prudent execution of the functions assigned to each. In instances in which a Component Benefit Plan is self-funded, a Third-Party Administrator may share in the fiduciary responsibilities for the prudent execution of the functions assigned to each. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. No responsibility is intended to be shared by two (2) or more of such Fiduciaries, unless such sharing shall be provided by a specific provision of the Plan. Whenever one Named Fiduciary is required by the Plan to follow the directions of another Named Fiduciary, the two shall not be deemed to have been assigned a shared responsibility. The Fiduciary giving the direction shall be deemed to have that action as its sole responsibility, and the responsibility of the Fiduciary receiving such direction shall be to follow the direction insofar as such direction is on its face proper under the Plan and applicable law.

Stay Informed and Keep Us Informed

It is Axiom Staffing Group, Inc.'s intent to provide Participants and Beneficiaries, as applicable, with the information necessary to be informed of individual rights, responsibilities and the general terms applicable to participating in each Component Benefit Plan. Helpful resources may include, but are not limited to:

- The Plan Administrator
- State, federal and local government agencies, such as the Department of Labor, Health & Human Services, Centers for Medicare/Medicaid Services, Etc.
- Insurance Company(s)
- Third-Party Administrator(s)

Refer to **Addendum A** to contact the Component Benefit Plan or the Plan Administrator for more information.

Copies of Participant and/or Beneficiary notices, and related Component Plan Documents, including this EverWrap™ Summary Plan Description are made available, at no charge, by requesting a copy, in writing, from the Plan Administrator.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

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Alpharetta, GA 30009
Phone: (678) 762-0285

Keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

4.
AGENT FOR SERVICE OF LEGAL PROCESS

The Agent for Service of Legal Process for Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

Service may be also made on a Plan Trustee or the Plan Administrator.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

5.
INDEMNIFY/HOLD HARMLESS

Except as otherwise provided under Sections 404 through 409 of ERISA, neither the Employer, Plan Administrator nor any person delegated to carry out Fiduciary responsibilities pursuant to this Section of the Plan, shall be liable for any act, or failure to act, that is made in good faith pursuant to the provisions of the Plan.

All Plan fiduciaries who are also Employees or officers of the Plan Administrator or any Employer participating in the Plan shall be fully indemnified by the Employer against all liabilities, losses, damages, costs and expenses (including but not limited to reasonable attorneys' fees and related expenses) imposed upon them in connection with any duties, action, suit or proceeding to which he or she may be a party by virtue of being a Plan Fiduciary and arising out of any act, or failure to act, that constitutes or is alleged to constitute a breach of such person's responsibilities in connection with the Plan, unless such act or failure to act is determined to be due to gross negligence or willful misconduct.

Unless liability is otherwise provided under Section 405 of ERISA, a Fiduciary shall not be liable for any act or omission of any other party to the extent that (a) such responsibility was properly allocated to such other party as a Fiduciary, or (b) such other party has been properly designated to carry out such responsibility pursuant to the procedures set forth above.

6.
ADDITIONAL INFORMATION

This Plan incorporates the terms of all Component Benefit Plans described in **Addendum A** which are subject to ERISA and sponsored by the Employer.

Additional and/or important related Plan information can be found in each respective Component Benefit Plan's related Plan Documents Certificate of Insurance, contracts, agreements, amendments, riders, Summary of Benefits and Coverage, and/or Summary Plan Description and any other documents making up the Component Benefit Plan, Summary Plan Description, Summary of Material Modification and/or Summary Annual Reports (as applicable), law or other governing regulation or document(s), as adopted, amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein. Such documents and other benefit-related notices may be from time to time provided, posted and/or made available to Participants and/or Beneficiaries. In each separate document, additional information is provided about eligibility, benefits, contributions, and the rights and responsibilities of the Employee and Employer and the general terms of each Component Benefit Plan available under the Plan as described in **Addendum A**.

These documents contain important information (as applicable), not limited to but including:

- Any cost-sharing provisions, including premiums, deductibles, coinsurance and copayment amounts for which the Participant will be responsible
- Any annual or lifetime caps or other limits on benefits under the Plan
- The extent to which preventive services are covered under the Plan
- Whether, and under what circumstances, existing and new drugs or treatment regimens are covered
- Whether, and under what circumstances, benefit coverage is provided for medical tests, devices and procedures
- Provisions governing the use of network providers
- The composition of the provider network and whether, and under what circumstances, coverage is provided for out-of-network services (services not rendered by a network provider)
- Any conditions or limits on the selection of primary care providers or providers of specialty medical care;
- Any conditions or limits applicable to obtaining emergency medical care
- Any provisions requiring preauthorizations or utilization review as a condition to obtaining a benefit or service under the Plan.

Stay Informed and Keep Us Informed

It is Axiom Staffing Group, Inc.'s intent to provide Participants and Beneficiaries, as applicable, with the information necessary to be informed of individual rights, responsibilities and the general terms applicable to participating in each Component Benefit Plan.

Copies of Participant and Beneficiary notices, and related Plan Documents, including this EverWrap™ Summary Plan Description are made available, at no charge, by requesting a copy, in writing, from the Plan Administrator.

Refer to **Addendum A**, contact the Component Benefit Plan or the Plan Administrator for more information.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

Keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

7.
NO EFFECT OF EMPLOYMENT

The Plan is not intended to, and does not, either directly or indirectly, constitute any form of employment contract or other employment arrangement by any Employer and is not intended to be consideration or inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to interfere with the right of the Employer to terminate any Employee at any time, regardless of the effect which such discharge shall have upon such Employee as a Participant in the Plan.

8.
SOURCE OF BENEFIT FUNDS

The Employer may enter into a contract with one or more Component Benefit Plan Contract providers for the purposes of providing benefits under the Plan.

Each Component Benefit Plan is funded by one or more of the following methods selected by the Employer, either as mandated by law or as the Employer deems advisable, for each Component Benefit Plan:

- Fully insured benefits;
- Self-funded benefits (funded by general assets of the Employer or through a trust); or
- A combination of insured benefits, self-funded benefits and trust benefits.

For specifics on the funding status of each Component Benefit Plan offered, see **Addendum A.**

The claims procedures of each Component Benefit Plan will apply in accordance with reasonable claims procedures, as required by ERISA (to the extent that ERISA applies) and other applicable law. To obtain benefits, a Participant or Beneficiary may be required to provide certain information or complete certain forms and follow the claims procedures set forth under the applicable Contract or related Plan Documents.

Funding for the Plan may include funding through a Flexible Spending Account or Premium Only Plan, these plans offer pre-tax benefits to eligible Employees. If a Healthcare Flexible Spending Account is available it is identified in **Addendum A**. Any benefit funded by the purchase of insurance shall be payable solely by the Insurance Company. Self-funded benefits, if any, may be funded by general assets of the Employer or through a trust and are identified in **Addendum A**. To the extent funds are transferred to or accumulated in a trust to provide any benefit, that benefit will be payable from the assets of such trust.

Periodically, the Employer may review, change and/or amend the method by which benefits are funded and/or services are offered. Additionally, the Employer has the right to revise, modify or terminate any method or methods used to fund the payment of benefits under the Plan, including, but not limited to, any trust or Insurance Policy or Contract.

Fully Insured Component Benefit Plan Contracts

Any fully insured benefit is provided under an insurance Contract between the Employer and the Insurance Company. The Insurance Company and the Plan Sponsor share responsibility for administering the Plan. The respective Insurance Company is the Named Fiduciary under the Plan, with the full power to interpret and apply the terms, prescribing claims procedures and forms necessary to administer the Plan in accordance to the benefits provided under the applicable insurance contract. Claims for fully insured benefits are sent to the Insurance Company's Claims Administrator, the party responsible for paying claims correctly and timely. The Insurance Company has the right to obtain independent medical or other advice and to require information as it deems necessary for the proper administration of claims and benefits. Fully insured plans may, from time to time, issue, as applicable, dividends, demutualization and Medical Loss Ratio (MLR) insurance refunds. Payments made, if any, are paid pursuant to applicable governing law.

Please refer to each Component Benefit Plan Contract and related Plan Documents or contact the Plan or Plan Administrator for more details. If the terms of this document conflict with the terms of the Component Benefit Plan Insurance Contract, the terms of the Insurance Contract will control unless superseded by applicable law.

Self-Funded Component Benefit Plan Contracts

For claims related to self-funded benefits provided from the Employer's general assets, the Plan or Named Fiduciary under the Plan, unless otherwise stated in the Contract or related Plan Documents, has the full power to make determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through the self-funded arrangement.

To obtain benefits, you may be required to provide certain information or complete certain forms in a timely manner and follow the claims procedures set forth by the Plan.

The Plan or Third-Party Administrator has the right to obtain independent medical or other advice and to require information as it deems necessary for the proper administration of claims and benefits. The claims procedures of each Component Benefit Plan will apply in accordance with reasonable claims procedures, as

required by ERISA (to the extent that ERISA applies) and any other applicable law.

It is important to know that self-funded Component Benefit Plans are *not* subject to state law unless such law preempts ERISA law.

9. NO FUNDING REQUIRED

The terms of each Component Benefit Plan shall govern the amount and timing of any Participant contribution required to be made by the Employee. Except as otherwise required by law, the Employer shall have no obligation to set aside any funds, establish a trust or segregate any amounts for the purpose of making any benefit payments under the Plan. The Employer may, in its sole discretion, set aside funds, establish a trust or segregate amounts for the purpose of making any benefit payments under the Plan. The Employer has the right to alter, modify, replace or terminate any method or methods used to fund any eligible benefit payments, trust, third party service or underlying Plan Component Benefit Plan Contract.

No person shall have any rights to, or interest in, any account than as expressly required in the Plan. No Participant or Beneficiary shall have any right to or interest in the assets of the Employer.

10. EXPENSES OF THE PLAN

The appropriate expenses necessary to carry out the responsibilities of the Plan Administrator and to provide said Plan benefits to Participants and Beneficiaries will be paid by the Plan if not paid by the Employer.

11. SOURCE OF CONTRIBUTIONS

There may be multiple sources of Plan contributions to each Component Benefit Plan. Insurance premiums may be paid by the Employer out of its general assets and/or, in part or in whole, by Employees' payroll deductions. Self-funded benefits, if any, may be funded by general assets of the Employer or through a trust.

Premium Only or Cafeteria Plan contributions, if any, may be paid by the Employer out of its general assets and/or, in whole or in part, by Employees' payroll deductions. Payroll deductions or deferrals may be made on a pre-tax basis, when eligible, by election (explicit or expressed) under a Premium Only or Cafeteria Plan. Component Benefit Plans eligible for pre-tax contributions or deferrals are described in **Addendum A**. If offered, Health Savings Account deferrals may also be made on a pre-tax basis.

In the event the Plan provides benefits intended to be non-taxable, the Plan Administrator or any Fiduciary or party associated with the Plan will not be in any way liable for any taxes or any other liability incurred by you or any person claiming through you.

Please refer to the Component Benefit Plan Document for more details regarding the benefits, limitations, exclusions, rights, responsibilities and general terms applicable to participating in a Premium Only or Cafeteria Plan, as applicable.

12. TAXATION OF BENEFITS

The Plan provides benefits that may be intended to be non-taxable if the Plan provides for a Cafeteria or Premium Only Plan under IRS Code Section 125. As such, Employee premium contributions or deferrals for certain Component Benefit Plans offered under the Plan may be made on a pre-tax basis.

If pre-tax Healthcare Flexible Spending Account benefits are offered under a Cafeteria Plan, such Plan will be identified in **Addendum A**. However, a Premium Only Plan or Dependent Care Assistance (Flexible Spending) Account is not subject to the requirements of ERISA, even though such benefits may be considered part of the Cafeteria Plan, and as such will not be identified in **Addendum A**.

The Plan Administrator, any Named Fiduciary or Third Party associated with the Plan shall not be liable, in any way, for any taxes or any other liability incurred by you or any person claiming through you.

13.
PLAN ELIGIBILITY

Plan eligibility and participation requirements may vary for each Component Benefit Plan and are determined by the written terms of each Component Benefit Plan. Where eligibility and/or participation requirements are not specifically stated in the Contracts or any other related Plan Document(s), the eligibility and/or participation requirements identified for each Component Benefit Plan in **Addendum A** will apply.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Welfare Benefit Plan or exercising your rights under ERISA.

If you need additional information and/or believe Plan eligibility or benefits has been calculated incorrectly, please contact the Plan Administrator immediately for assistance.

Age Limitations

Some or all non-Group Health Component Benefit Plans limit or restrict eligibility and/or reduce coverage based on a covered Employee and/or Dependent's age. The Component Benefit Plan's Contracts and any other related Plan Documents disclose age limitations. If your over age 18 Dependent child is enrolled in a non-Group Health Component Benefit Plan, proof of legal Dependent and/or full-time student status may be required and requested by the Plan to maintain eligible Dependent coverage. Proof of a Dependent child's full-time student status may be requested at the following times:

- Upon initial enrollment;
- Prior to, during or after annual open or re-enrollment;
- At the time of claim; and
- At such time designated by the Component Benefit Plan

The Component Benefit Plan will terminate coverage for over age or ineligible Dependent children.

Exceptions to age limits may apply for Dependent children primarily supported by you and who are incapable of self-sustaining employment by reason of mental or physical disability for handicapped or mentally incapacitated Dependent children. Proof of a Dependent's qualified incapacitation or handicap must be provided to the Component Benefit Plan and Plan Administrator in order to extend coverage beyond the normal Dependent child age limits.

Age Limitations Applied to Group Health Component Benefit Plans

As a result of Healthcare Reform, all legal Dependent children are eligible for group health plan coverage, if offered, up to age 26. Proof of full-time student status is not required for group health plan coverage for Dependent children under the age of 26.

The group health plan coverage will terminate coverage for over age or ineligible Dependent children.

Exceptions to age limits may apply for Dependent children primarily supported by you and who are incapable of self-sustaining employment by reason of mental or physical disability for handicapped or mentally incapacitated Dependent children.

For questions regarding age limitations or age reductions or to provide proof of eligibility to extend Dependent Group Health Component Benefit Plan coverage for a qualified Dependent over the age of 26, please contact the Component Benefit Plan (as listed in **Addendum A**) or Plan Administrator.

Rehire Provisions

In the event an Employee previously was eligible to participate in the Plan and is re-hired, the Employee shall be subject to the same terms as a newly eligible Employee as described herein and in summary in **Addendum A**.

However, in general, if an Employee is re-hired within 30 days of the date of the break in (employment) service, said Employee and eligible Dependents, if any, are reinstated in the Plan when eligible as they were previously participating. Such reinstatement shall occur retroactively, *as though there were no break in service.*

Additionally, if a **Group Health Component Benefit Plan** is sponsored by the Plan of an Applicable Large Employer (ALE), Section 4980H of the Affordable Care Act shall apply. In such instance, a Variable Hour Employee who resumes employment to said ALE after a period during which the Employee was not credited with any Hours of Service for the purpose of determining Variable Hour Employee *Group Health* Component Benefit Plan eligibility, may be treated as having terminated employment and been rehired as a new Employee if the following apply:

- Employee had no Hours of Service for a period of at least 13 consecutive weeks (26 weeks for an Educational Organization Employer); *or*
- Employee had a break in service of a shorter period of at least 4 consecutive weeks with no credited hours of service and the break in service exceeds the number of weeks of the Employee's prior period of employment.

In such instance, said Variable Hour Employee will be required to satisfy any new hire waiting period as described in the Component Benefit Plan Contracts or as described in summary in **Addendum A**.

No Eligibility Discrimination Due to a Health Factor

The Plan does not discriminate based on any health factor as it relates to that individual or a Dependent of that individual. As such, there is no rule of eligibility (including continued eligibility) applicable to any individual required to enroll in group health benefits. For purposes of this section, **rules for eligibility** include, but are not limited to:

- Enrollment
- The effective date of coverage
- Waiting (or elimination) periods
- Late and special enrollment
- Eligibility for Component Benefit Plans (including rules for individuals to change their selection among Component Benefit Plans)
- Benefits (including rules relating to covered benefits, benefit restrictions and cost-sharing mechanisms such as coinsurance, copayments and deductibles)
- Continued eligibility
- Terminating coverage (including disenrollment) of any individual under the plan

Stay Informed and Keep Us Informed

It is Axiom Staffing Group, Inc.'s intent to provide Participants and Beneficiaries, as applicable, with the information necessary to be informed of individual rights, responsibilities and the general terms applicable to participating in each Component Benefit Plan.

Copies of Participant and Beneficiary notices, and related Plan Documents, including this EverWrap™ Summary Plan Description are made available, at no charge, by requesting a copy, in writing, from the Plan Administrator.

Refer to **Addendum A,** contact the Component Benefit Plan or the Plan Administrator for more information.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

Keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

14.
LOSS OF BENEFIT ELIGIBILITY

An individual ceases to be a Participant *or* Beneficiary in any Component Benefit Plan on the earliest date in which such individual:

- becomes ineligible to receive any plan benefit, even if the contingency for which the benefit is provided occurs; and
- is not designated by the Plan as an eligible Participant or Beneficiary.

Benefits will terminate (end) if you no longer meet the eligibility requirements, when you stop participating in the Plan or no longer make the necessary contributions to the Plan. In most instances, enrollment of a covered spouse and/or Dependent children, if any, ends when your coverage ends.

EXAMPLES OF EVENTS THAT MAY TRIGGER AN EMPLOYEE'S LOSS OF BENEFIT ELIGIBILITY

- failure to maintain an 'actively at work' status;
- no longer working the required number of hours;
- resigns, retires or is terminated;
- exhausts FMLA, if eligible;
- exceeds the age limitations of the plan;
- no longer meets the definition of an Eligible Employee or Dependent;
- permanently moves out of the plan's network service area.

EXAMPLES OF EVENTS THAT MAY TRIGGER A DEPENDENT'S LOSS OF BENEFIT ELIGIBILITY

- exceeds the age limitations of the plan;
- loss of eligibility due to Employee's loss of eligibility;
- death of a covered Employee;
- loss of eligibility due to a divorce;
- permanently moves out of the plan's covered network service area.

A summary of Employee and Dependent eligibility for each Component Benefit Plan can be found in **Addendum A**. Plan rules governing each Component Benefit Plan determine when coverage ends and instances in which benefits are limited, reduced, denied or terminated and when they may be subject to subrogation or reimbursement; they can be found in *each* Component Benefit Plan's Contract and related Plan Documents.

***Generally*, benefits will end the date you are no longer eligible**. However, there may be instances when coverage extends benefits beyond the date of loss of eligibility as described in **Addendum A**. If a loss of eligibility is due to age, benefits may end **at the end of the birth month** in which age deems you or your Dependent ineligible for coverage, if covered. For specific details regarding when coverage ends in the event you or a covered dependent no longer meet the eligibility rules of the plan, you can contact the Plan (Plan contact information is provided in **Addendum A**) or the Plan Administrator for more details.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

Give the Plan Notice of Changes

For all qualifying events related to Dependent coverage (such as divorce or legal separation of the Employee and spouse or a Dependent child's loss of eligibility for coverage as a Dependent child), you must notify and supply any documentation required to the Plan Administrator within **30 days** after the qualifying event occurs. You must provide this to the Plan Administrator.

In any instance, keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. If you are unsure if you have incurred a change that affects eligibility, contact the Plan and the Plan Administrator. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
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Creditable Coverage

The Insurance Company, Trustee or Plan or Third-Party Administrator *may* provide you with a Certificate of Creditable Coverage (COC) for any Group Health Component Benefit Plan when coverage ends. To the extent required by law, this certificate may help you establish coverage under another qualified Group health plan.

Conversion, Continuation & Portability

Should you have benefits with Axiom Staffing Group, Inc. and your employment ends or you or a covered Dependent no longer meet the eligibility requirements, existing coverage may be eligible for continuation, conversion or portability at your expense. Specific plan rules governing each Component Benefit Plan determine the ability to continue, convert or port coverage. These rules can be found in *each* Component Benefit Plan's Certificates and other related Plan documents.

The table below explains the various methods in which an Employee, Dependent or Beneficiary may be eligible to retain coverage in the event of loss of eligibility by one of three common Plan provisions.

CONTINUATION

- A provision that allows certain Employees and Dependents to continue certain Group Health & Welfare Component Benefit Plans at the same cost and coverage as that offered to actively at work and similarly situated Employees for a specified period of time. Rules vary from as to the benefits offered under state versus federal Continuation, and when such apply.

CONVERSION

- A provision that allows certain Employees to convert Employee Group Life Insurance to an individually owned policy (typically converted to a form of permanent life). Usually, very expensive but, can be helpful in certain circumstances, particularly if the Employee has health issues.

PORTABILITY

- A provision that allows Employees to elect to continue certain benefits, on an individual basis, at the same rate structure as that offered to active Employees or similarly situated individuals. This feature may contain limitations on coverage amounts and the amount of time coverage can continue.

Other than for the purpose of COBRA Continuation, if available to you, **you will not receive any information regarding continuation, conversion or portability** other than what is provided here within or that information which is contained in each Component Benefit Plan's related plan documents. **It is your responsibility to request conversion or portability, if eligible for such, within 30 days of a covered loss of eligibility.**

In any instance, in order to carry on coverage, under any of the provisions described above, the loss of coverage or benefits eligibility cannot be a result of:

- failure to pay or pay timely any required premiums or contributions; or
- the Component Benefit Plan being terminated either in its entirety or with respect to an Employee class to which the individual belonged.

Contact the Plan (Plan contact details can be found in **Addendum A**) or your Plan Administrator **within 30 days of a covered loss of eligibility** to determine and/or secure continuation, conversion or portability options, if any, and to make payment arrangements**.**

More information regarding continuation (such as with benefits made available under State or Federal law) is provided herein. Axiom Staffing Group, Inc. may also use a Third-Party Administrator to assist you with *continuation* benefits, as applicable.

The **COBRA Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan **i**s:

Admin America
1720 Windward Concourse, Suite 290
Alpharetta, Georgia 30005
Phone: (770) 992-5959

15. PLAN ENROLLMENT

If eligible, the Employee must submit a timely request to enroll themselves and/or eligible Dependents in the Plan by completing the necessary form(s) or electronic election as provided by Insurance Company(s) or Third-Party Administrators, or otherwise properly comply with the Employer's enrollment procedures.

When You Can Enroll

A newly eligible Employee or Dependent must generally enroll or decline enrollment as per the Employer's enrollment procedures **previous to the Employee's eligibility date** as described within

each Component Benefit Plan's Contract and other related Plan documents (summarized in **Addendum A**). **In some instances, an Employee or Dependent may be able to enroll *within 30 days*** of being deemed eligible to enter the Plan as described within each Component Benefit Plan's Contract and other related Plan Documents (summarized in **Addendum A**). In any case, thereafter, enrollment is generally limited to:

- an **(annual) open enrollment** or **re-enrollment period** that occurs prior to the start of the Plan Year; and
- any **Special Enrollment** periods as described herein and/or within each Component Benefit Plan's Certificates and other related Plan Documents.

Unless otherwise stated, once deemed an Eligible Employee you must make a formal election by completing the necessary form(s) or electronic election or otherwise properly comply with the Plan Administrator's enrollment procedures. If you do not properly and timely enroll as required by the Plan Administrator (or upon subsequent eligibility upon rehire), you will be deemed to have declined coverage in any Component Benefit Plans that require a contribution from you for the remainder of the Plan Year following eligibility to participate in the Plan. In such instance, you shall be required to wait until the next open enrollment or re-enrollment period to elect or apply to participate in the Plan (usually held prior to the beginning of each plan year) and any such corresponding Component Benefit Plans unless you experience a Special Enrollment or Qualifying Mid-Year Event that might otherwise make you or a dependent eligible to enroll or apply for coverage previous to the next open or re-enrollment period.

Before the beginning of any Plan Year, Axiom Staffing Group, Inc. will extend to Participants and Beneficiaries an open or re-enrollment period. During this time, you are eligible to make changes, apply for coverage, enroll, re-enroll or decline the benefits offered under the Plan. You will be notified of the dates of open or re-enrollment.

Unless otherwise advised, the elections made when you are newly eligible or during the annual open or re-enrollment period will be effective for the (remainder of) the Plan Year.

In some instances, to be considered for enrollment, an Employee or Participant may be required to provide proof of good health (called Evidence of Insurability "EOI") for benefits other than group health plan benefits, if such benefits are offered. If you are required to provide an EOI, you will be advised of such and will generally complete a written or telephonic health questionnaire (form). In rare instances, you may be required to have a physical exam before being considered for enrollment. **If proof of good health (EOI) is required, benefits will not begin until you have been notified of *acceptance* of your request to enroll and you have contributed to the Plan for such benefits.** You will be notified, in writing, of approval or denial by the Insurer or Third-Party Administrator for coverage in the Component Benefit Plan. Group health plans *do not* require proof of good health for Plan enrollment.

If a Component Benefit Plan is funded through a Cafeteria Plan or Premium Only (pre-tax) Plan, a pre-tax election into such Plan pertains to the entire Plan Year as it applies to the Component Benefit Plan and ***cannot*** be changed or cancelled during such time, except in certain limited situations, which are described in the Cafeteria Plan or Premium Only Plan Document. Refer to the Premium Only or Cafeteria Summary Plan Description and related documents for more details. Exceptions to entry and exit rules may apply to Component Benefit Plans in which an Employee's deduction is made on a post-tax basis (refer to **Addendum A**), as well as non-health and welfare offerings such as Health Savings Accounts deferrals, if applicable. For example, you may cancel a pre-taxed Health Savings Account deferral, on a prospective basis, *at any time* during the Plan Year. However, re-entry into any Component Benefit Plan may be limited by your Employer's payroll practices.

No Enrollment Discrimination Due to Health Factor

There is no requirement for a Participant or Beneficiary, as a condition of enrollment or continued enrollment, if offered, to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the Plan based on any health factor that relates to the individual or a Dependent of the individual.

HIPAA (Group Health Plan) Special Enrollment Rights

If you are declining *group health* (Component Benefit Plan) enrollment for yourself or your Dependents (including your spouse) because of other (qualified) *health* insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this plan *if you or your Dependents lose eligibility* for that other coverage (or after the Employer stops contributing toward your or your Dependents' coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within **30 days** after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact the Plan Administrator timely.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

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The impacted individual must notify the Plan in writing or otherwise comply with the enrollment procedures (supplying any required documentation) timely.

Give the Plan Notice of Changes

For all qualifying events related to Dependent coverage (such as divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify and supply any documentation required to the Plan Administrator within **30 days** after the qualifying event occurs. You must provide this to the Plan Administrator.

In any instance, keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. If you are unsure if you have incurred a change that affects eligibility, contact the Plan and the Plan Administrator. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

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16. PLAN PARTICIPATION

When eligible and properly enrolled in any Component Benefit Plan, a Plan Participant and/or Beneficiary is required to maintain eligibility status in order maintain ongoing Plan participation.

As well, the Plan may require an Employee or Participant to make timely annual elections during the Plan's (annual) open or re-enrollment period that customarily occurs *prior to the start* of the Plan Year in order to maintain Plan coverage. Such election will be indicated by completing the necessary form(s) or electronic election as provided by Insurance Company(s) or Third-Party Administrators or otherwise properly comply with the Plan Administrator's enrollment procedures.

Give the Plan Notice of Changes

For all qualifying events related to Dependent coverage (such as divorce or legal separation of the Employee and spouse or a Dependent child's loss of eligibility for coverage as a Dependent child), you must notify and supply any documentation required to the Plan Administrator within **30 days** after the qualifying event occurs. You must provide this to the Plan Administrator.

In any instance, keep the Plan Administrator informed of address or other changes that may affect eligibility for yourself or a Dependent. If you are unsure if you have incurred a change that affects eligibility, contact the Plan and the Plan Administrator. Failure to provide important information to the Plan that affects a Participant or Beneficiary's eligibility may result in a reduction of or temporary or permanent loss of benefits under the Plan.

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Phone: (678) 762-0285

17. CLAIMS PROCEDURES AND BENEFIT PAYMENTS

Component Benefit Plans must establish and maintain reasonable claims procedures that allow Participants and Beneficiaries to apply for and receive the Plan's promised benefits. The Department of Labor issued rules setting minimum standards for benefit claims determinations for Welfare Plans (including insured and self-funded Plans) covered by ERISA.

A Plan Participant or Beneficiary may be entitled to benefits from the Component Benefit Plan (a "claimant") and may apply for such benefits by completing and filing a claim in accordance with the claim filing guidelines.

It is the intent of the Plan to protect claimants from conflicts of interest, increase transparency and to ensure claimants have a full and just review, fair opportunity to respond to the evidence and reasoning behind a claim denial.

Each Component Benefit Plan is responsible for evaluating all benefit claims under the Plan and to pay or deny such claims in accordance with reasonable claims procedures as per regulation (29 CFR 2560.503-1). Such regulation provides minimum procedural requirements for the processing of benefit claims for all Component Benefit Plans covered under the Employee Retirement Income Security Act of 1974 (ERISA). Each Component Benefit Plan's procedures will be followed unless inconsistent with the requirements of ERISA. The claims procedures and standards for retirement, group health, disability and other Welfare Benefit plans are different for the various Component Benefit Plans.

The claims rules and guidelines referred to herein do not pertain to any Cafeteria Plan which is a Premium Only Plan or to any Dependent Care Assistance Flexing Benefits Plan benefits offered.

Most often, the Plan will hire Third-Party Administrators or Insurance Companies to process claims on behalf of the Plan. The Component Benefit Plan's related Plan Documents provide information on where to file, what to file and whom to contact if you have questions about your Plan, such as the process for providing a required pre-approval for health benefits. These documents are furnished without charge.

The address of the Insurance Company that is providing benefits, Trust, Plan Administrator and/or Third-Party Administrator that reviews and processes claims made under any Component Benefit Plan is set forth in the Component Benefit Plan's related Plan Documents and summarized in **Addendum A**. If such information is unavailable, write your Plan Administrator to notify them that you have a claim. Keep a copy of the letter for your records. You may also want to send the letter by Certified Mail, return receipt requested, so you will have a record that the letter was received and by whom.

General Guidelines

Most Component Benefit Plans impose a waiting period to pass before you can enroll and receive benefits or impose age limits in which a Participant or Dependent is not covered after a certain age or benefits reduce at a certain age. These provisions are stated herein or within each Component Benefit Plan's related Plan documents. Make sure you meet the requirements (documentation and time frame) to file a claim and to receive benefits. Check the respective Component Benefit Plan's related Plan documents for details regarding how and when benefits are paid.

To obtain any benefits from an insured or self-funded Component Benefit Plan, the Participant or Beneficiary must follow the claims procedures prescribed under each Component Benefit Plan. The self-funded claims procedures described herein shall apply with respect to such self-funded Component Benefit Plan claims in the event:

- a self-funded Component Benefit Plan does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA
- the Plan Administrator determines that the claims procedures described in a self-funded Component Benefit Plan shall not apply
- a self-funded Component Benefit Plan is subject to the Affordable Care Act (ACA)

The Affordable Care Act (ACA) provides additional health protections for Group Health Component Benefit Plans. In the case of a group health plan, any procedures for obtaining prior approval as a prerequisite for obtaining a benefit, such as preauthorization procedures or utilization review procedures, are described in the respective group health plan related Plan Documents and incorporated herein.

The Plan may exercise discretion to withhold a Participant's or Beneficiary's PHI to protect vulnerable individuals.

Authorized Representative

You may exercise your rights directly or indirectly by an authorized representative. You may only have one authorized representative at a time to assist in submitting claims to the Plan or filing an appeal.

The Plan may require you to complete a form to name an authorized representative before that person is given access to your Protected Health Information (PHI) or to take action on your behalf, such as to file a claim for you.

Authority may be granted by the Plan's receipt of the following:

1. an executed and notarized Healthcare Power of Attorney
2. a court order of appointment of the person as the conservator or guardian of the individual
3. documentation providing proof an individual is the parent or guardian of a covered minor child

If a claim is related to an emergency, the treating physician can automatically become your authorized representative without you having to complete a form.

An assignment of benefits does not constitute a designation of an Authorized Representative.

Filing a Claim: Fully Insured Benefits

For claims related to fully insured benefits, the respective Insurance Company is the named Fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the available benefits provided under the applicable Insurance Policy.

To obtain benefits from the Insurance Company of a Component Benefit Plan, you must follow the claims procedures within the applicable Component Benefit Plan (Insurance) Contract, which may require you to complete, sign and submit a written claim on the Insurance Company's form within a specified time frame.

The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (to the extent that ERISA applies) and other applicable law. The Insurance Company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Insurance Company denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Insurance Company for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (to the extent that ERISA applies) and other applicable law. Under certain circumstances, you may also have the right to obtain external review (i.e., review by an independent review organization outside of the Insurance Company). If you fail to file an appeal timely, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

Filing a Claim: Self-Funded Benefits

For claims related to self-funded benefits provided from the Employer's general assets, the Plan Administrator is the named Fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement. A Third-Party Administrator, recordkeeper or claims reviewer who performs solely ministerial tasks is not a Named Fiduciary; however, that may change if such individual or entity exercises discretion in making decisions regarding a Participant's eligibility for benefits. Additionally, a Third-Party Administrator may assume some Fiduciary responsibility if such assumption is identified and agreed upon by mutual consent, in writing, of both parties within the related Plan Documents or service Contract.

To obtain benefits from the Plan Administrator of a Component Benefit Plan, you must follow the claims procedures within the applicable Component Benefit Plan Summary, which may require you to complete, sign and submit a written claim on the form, provided by the Plan Administrator, within a specified time frame.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA (to the extent that ERISA applies). The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim. If the Plan Administrator denies your claim in whole or in part, then you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures as required by ERISA (to the extent that ERISA applies). Under certain circumstances, you may also have the right to obtain external review (i.e., review by an independent review organization outside of the plan). If you fail to file an appeal timely, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

The Different Types of Claims

GROUP HEALTH CLAIMS may involve three types of claims: urgent care, concurrent care claims, pre-service care claims or post-service claims.

The type of claim determines how quickly a decision must be made, described herein. The plan must decide what type of claim it is except when a physician determines that the urgent care is needed.

URGENT CARE CLAIMS are a special kind of pre-service claim that requires a quicker decision because your health would be threatened if the plan took the normal time permitted to decide a pre-service claim.

If a physician with knowledge of your medical condition tells the plan that a pre-service claim is urgent, the plan must treat it as an urgent care claim.

PRE-SERVICE CLAIMS are requests for approval that the plan requires in which the Plan requires proof of medical necessity prior to receiving care, such as preauthorization or a decision on whether a treatment or procedure is medically necessary.

POST-SERVICE CLAIMS are all other claims for benefits under your group health plan, including claims after medical services have been provided, such as requests for reimbursement or payment of the costs of the services provided. Most claims for group health benefits are post-service claims.

CONCURRENT CLAIMS are those claims that occur when you have been prescribed an ongoing course of treatment, to be provided over a period of time or number of treatments.

DISABILITY CLAIMS are requests for benefits where the plan must make a determination of disability to decide the claim. The Plan maintains protections for disability claimants that parallels protections under the Affordable Care Act (ACA) that apply when Employees file claims for group health benefits. These protections apply to all ERISA disability benefit claims, whether the claim arises under a Component Welfare Plan (e.g., a long-term or short-term disability plan) or a qualified retirement plan.

Claims Timeline in Summary

ERISA sets specific periods of time for Plans to evaluate your claim and inform you of the decision. Benefit claims must be decided within a specific time limit, depending on the type of claim filed (group health or disability). Thus, each Component Benefit Plan follows the prescribed claims processes as set forth by regulations prescribed by the type of Welfare Benefit Plan.

The time limits are counted in calendar days, so weekends and holidays are included. These limits do not govern when the benefits must be paid or provided.

The Plan will notify the claimant of any benefit determination within a reasonable period of time but not later than the timeframe limits as per the type of claim.

URGENT CARE CLAIMS

These claims must be decided as soon as possible, taking into account the medical needs of the patient, but no later than 72 hours after the plan receives the claim. The Plan must tell you within 24 hours if more information is needed; you will have no less than 48 hours to respond.

Then the Plan must decide the claim within 48 hours after the missing information is supplied or the time to supply it has elapsed. The Plan cannot extend the time to make the initial decision without your consent.

The Plan must give you notice that your claim has been granted or denied before the end of the time allotted for the decision. The Plan can notify you orally of the benefit determination so long as a written notification is furnished to you no later than 3 days after the oral notification for expedited determinations.

PRE-SERVICE CLAIMS DETERMINATION (REQUEST)

The determination must be approved within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after the Plan has received the request. The Plan may extend the time period up to an additional 15 days if, for reasons beyond the Plan's control, the decision cannot be made within the first 15 days. The Plan Administrator must notify you within 30 days of receiving the request, explaining the reason for the delay, requesting any additional information, and advising you when the Plan expects to make the decision. If more information is requested, you have at least 45 days to supply it.

The Plan then must decide the request no later than 15 days after you supply the additional information or after the period of time allowed to supply it ends, whichever comes first. If the Plan wants more time, the plan needs your consent. The Plan must give you written notice that your request has been granted or denied before the end of the time allotted for the decision.

CONCURRENT CARE CLAIMS

A request for an extension to an ongoing course of treatment must be filled in accordance with the Plan's claim procedures and must be made at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. The Plan will notify you of any benefit determination concerning the request to extend the course of treatment within 24 hours after its receipt of the claim.

If the Plan reduces or terminates a course of treatment before the end of the course previously approved, the reduction or termination is considered an adverse benefit determination. The Plan will notify you, in advance, of the reduction or termination so that you may appeal and obtain an answer on the appeal before the benefit is reduced or terminated.

The Plan will notify a claimant of any reduction or termination of a course of treatment (other than by plan amendment or termination) before the end of such period of time or number of treatments at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

POST-SERVICE CLAIMS

These claims must be decided within a reasonable period of time, but not later than 30 days after the Plan has received the claim. If, because of reasons beyond the Plan's control, more time is needed to review your request, the Plan may extend the time period up to an additional 15 days. However, the Plan Administrator has to let you know before the end of the first 30-day period, explaining the reason for the delay, requesting any additional information needed and must advise you when a final decision is expected.

If more information is requested, you have at least 45 days to supply it. The claim then must be decided no later than 15 days after you supply the additional information or the period of time given by the Plan to do so ends, whichever comes first. The Plan needs your consent if it wants more time after its first extension. The Plan must give you notice that your claim has been denied in whole or in part (paying less than 100 percent of the claim) before the end of the time allotted for the decision.

DISABILITY CLAIMS

Disability claims must be decided within a reasonable period of time, but not later than 45 days after the Plan has received the claim. If, because of reasons beyond the plan's control, more time is needed to review your request, the Plan can extend the timeframe up to 30 days.

The Plan must tell you prior to the end of the first 45-day period that additional time is needed, explaining why, any unresolved issues and additional information needed, and when the Plan expects to render a final decision. If more information is requested during either extension period, you will have at least 45 days to supply it.

The claim then must be decided no later than 30 days after you supply the additional information or the period of time given by the Plan to do so ends, whichever comes first. The plan administrator may extend the time period for up to another 30 days as long as it notifies you before the first extension expires. For any additional extensions, the Plan needs your consent.

The Plan must give you notice whether your claim has been denied before the end of the time allotted for the decision.

If your claim is denied, the plan administrator must send you a notice, either in writing or electronically, with a detailed explanation of why your claim was denied and a description of the appeal process.

In addition, the Plan must include the plan rules, guidelines or exclusions (such as medical necessity or experimental treatment exclusions) used in the decision or provide you with instructions

on how you can request a copy of these documents from the Plan. The notice may also include a specific request for you to provide the Plan with additional information in case you wish to appeal your denial.

Improvements to Disability Claims

The Plan complies with additional standards for disability claims filed and denial notices, as noted below, in accordance with an amendment to the Department of Labor's claims procedure regulation at 29 C.F.R. §2560.503-1, issued after June 1, 2019.

These improvements are summarized below:

IMPROVEMENT TO BASIC DISCLOSURE REQUIREMENTS

Benefit denial notices must contain a more complete discussion of why the plan denied a claim and the standards used in making the decision. For example, the notices must include a discussion of the basis for disagreeing with a disability determination made by the Social Security Administration if presented by the claimant in support of his or her claim.

RIGHT TO CLAIM FILE AND INTERNAL PROTOCOLS

Benefit denial notices must include a statement that the claimant is entitled to receive upon request, the entire claim file and other relevant documents. Benefit denial notices will also include the internal rules, guidelines, protocols, standards or other similar criteria of the plan that were used in denying a claim or a statement that none were used.

In the event such a rule, guideline, protocol, standard or other similar criteria was relied upon, a copy of such will be provided for free upon request.

RIGHT TO REVIEW AND RESPOND TO NEW INFORMATION BEFORE FINAL DECISION

The Plan shall not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to respond.

AVOIDING CONFLICTS OF INTEREST

The Plan must ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. For example, a claims adjudicator or medical or vocational expert could not be hired, promoted, terminated or compensated based on the likelihood of the person denying benefit claims.

DEEMED EXHAUSTION OF CLAIMS AND APPEAL PROCESSES

If the Plan does not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the Plan, unless the violation was the result of a minor error and other specified conditions are met.

If the claimant is deemed to have exhausted the administrative remedies available under the Plan, the claim or appeal is deemed denied on review without the exercise of discretion by a Fiduciary and the claimant may immediately pursue his or her claim in court. The plan must treat a claim as re-filed on appeal upon the Plan's receipt of a court's decision rejecting the claimant's request for review.

CERTAIN COVERAGE RESCISSIONS ARE ADVERSE BENEFIT DETERMINATIONS SUBJECT TO THE CLAIMS PROCEDURE PROTECTIONS

Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (e.g. errors in the application for coverage) must be treated as adverse benefit determinations, thereby triggering the Plan's appeals procedures. Rescissions for non-payment of premiums are not covered by this provision.

NOTICES WRITTEN IN A CULTURALLY AND LINGUISTICALLY APPROPRIATE MANNER

Benefit denial notices will be provided in a culturally and linguistically appropriate manner in certain situations. Specifically, if a disability claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language services.

The Plan would also be required to provide a verbal customer assistance process in the non-English language and provide written notices in the non-English language upon request.

Other Claims

The claimant will be notified of any adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the claim. This period may be

extended one time by the Plan for up to 90 days, provided that the claim reviewer both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial review period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Denied Claims

Claims are denied for various reasons. Perhaps you are not eligible for benefits. Perhaps the services you received are not covered by the Plan. Or, perhaps the Plan simply needs more information about your claim. Whatever the reason, you have at least 180 days to file an appeal (check your Insurance Certificate or related Plan documents to see if your Plan provides a longer period).

If your claim is denied, in whole or in part, by the Insurance Company, Plan Administrator or Third-Party Administrator, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may, within certain time frames:

- Have the right to know why the claim was denied and the standards behind the decision, including a discussion of the basis for disagreeing with any Disability determination presented by the claimant, the treating health care professionals or the Social Security Administration;
- Obtain copies of the pertinent Plan provisions, rules, guidelines, protocols, standards or other similar criteria the Plan relied on in denying the claim, or a statement that none exist;
- Obtain the material or information needed to grant the claim and an explanation of why the additional information is necessary;
- Obtain an explanation of the steps that the claimant must take if he/she wishes to appeal the denial including a statement that the claimant may bring a civil action under ERISA;
- Appeal any denial of the claim to the Plan Administrator, Insurance Company, Trustee or related Third-Party Administrator for a review of the denied claim; and
- Have the right to obtain an external or independent review of your claim, in certain circumstances.

In addition to the above information, if it is a group health plan or a Plan providing disability benefits, the following information must be included with the notice of claims denial described above:

- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the claimant upon request; or
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In addition, in the case of an adverse benefit determination by a group health plan concerning a claim involving urgent care, a description of the expedited review process applicable to such claims must be included with the notice described above and may be provided to the claimant orally within the time frame described above, provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

In addition, Disability benefit denial notices will be provided in a culturally and linguistically appropriate manner in certain situations. Specifically, if a disability claimant's address is in a county where 10 percent or more of the population is literate only in the same non-English language, benefit denial notices must include a prominent statement in the relevant non-English language about the availability of language services. The Plan is also required to provide a verbal customer assistance process in the non-English language and provide written notices in the non-English language upon request.

Appeal of Denied Claim

You may use the information in your claim denial notice in preparing your appeal. You should also be aware that the Plan must provide claimants, on request and free of charge, copies of documents, records and other information relevant to the claim for benefits. The Plan also must identify, at your request, any medical or vocational expert whose advice was obtained by the Plan. Be sure to include in your appeal all information related to your claim, particularly any additional information or evidence that you want the Plan to consider and reply to the entity or individual specified in the denial notice before the end of the 180-day period.

If a claimant wishes to appeal the denial of a claim, they must file an appeal with the Plan on or before the 180th day (or the 60th day in the case of a claim other than a Group health plan benefit or a Disability benefit) after they receive the notice that the claim has been wholly or partially denied. The appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The claimant will be provided, upon request and free of charge, documents and other information relevant to his claim. An appeal may also include any comments, statements or documents that the claimant may desire to provide. The Plan will consider the merits of the claimant's presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the Plan may deem relevant. The claimant will lose the right to appeal if the appeal is not timely made.

In consideration of an appeal of a group health plan benefit or a disability benefit, the Plan will:

- Provide for a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate Named Fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual
- Provide that, in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate, the appropriate named Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment
- Provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination
- Provide that the health care professional engaged for purposes of a consultation will be an individual who was neither consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual

In addition, in the case of a claim involving urgent care, the Plan will provide for an expedited review process pursuant to which:

- A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
- All necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the claimant by telephone, facsimile or other available similarly expeditious method.

In general, the Component Benefit Plan has specific periods of time within which to review your appeal, depending on the type of claim as described, in summary, below:

URGENT CARE CLAIMS

These claims must be reviewed as soon as possible, taking into account the medical needs of the patient, but not later than 72 hours after the Plan receives your request to review a denied claim.

PRE-SERVICE CLAIMS

These claims must be reviewed within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Plan receives your request to review a denied claim.

POST-SERVICE CLAIMS

These claims must be reviewed within a reasonable period of time, but not later than 60 days after the Plan receives your request to review a denied claim.

If the Plan needs more time, the Plan must get your consent. If you do not agree to more time, the Plan must complete the review within the permitted time limit.

DISABILITY CLAIMS

These claims must be reviewed within a reasonable period of time, but not later than 45 days after the Plan receives your request to review a denied claim.

If the Plan determines special circumstances exist, and if an extension is needed, the Plan may take up to an additional 45 days to decide the appeal. However, before taking the extension, the Plan must notify you in writing during the first 45-day period explaining the special circumstances, and the date by which the Plan expects to make the decision.

There are two exceptions to these time limits:

- In general, collectively bargained single-Employer Plans may use a collectively bargained grievance process for their claims appeal procedure if it has provisions on filing, determination and review of benefit claims.
- Multi-employer collectively bargained plans are given special timeframes to allow them to schedule reviews for an appeal of post-service claims and disability claims for the regular quarterly meetings of their boards of trustees.

If you are a participant in one of those plans and you have questions about your plan's procedures, you can consult your plan's Certificate and related Plan documents and collective bargaining agreement or contact the Department of Labor's Employee Benefits Security Administration (EBSA).

The Plan shall not deny benefits on appeal based on new or additional evidence or rationales that were not included when the benefit was denied at the claims stage, unless the claimant is given notice and a fair opportunity to review and respond to any new or additional evidence the Plan relied upon in connection with the claim.

The Plan shall also ensure that disability benefit claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision.

If the Plan does not adhere to all claims processing rules, the claimant is deemed to have exhausted the administrative remedies available under the Plan, unless the violation was the result of a minor error and other specified conditions are met.

If the claimant is deemed to have exhausted the administrative remedies available under the Plan, the claim or appeal is deemed denied on review without the exercise of discretion by a Fiduciary and the claimant may immediately pursue his or her claim in court.

Failure to comply doesn't include minor violations or matters beyond the Plan's control when these violations are not reflective of a pattern of noncompliance on the part of the Plan. The plan must treat a claim as re-filed on appeal upon the Plan's receipt of a court's decision rejecting the claimant's request for review.

Rescissions of coverage, including retroactive terminations due to alleged misrepresentation of fact (e.g. errors in the application for coverage), must be treated as adverse benefit determinations, thereby triggering the Plan's appeals procedures requiring that the Participant be given the opportunity to appeal the decision. Rescissions for non-payment of premiums are not covered by this provision.

Plans can require you to go through two levels of review of a denied health or disability claim to finish the plan's claims process. If two levels of review are required, the maximum time for each review generally is half of the time limit permitted for one review. For example, in the case of a group health plan with one appeal level, as noted above, the review of a pre-service claim must be completed within a reasonable period of time appropriate to the medical circumstances but no later than 30 days after the plan gets your appeal. If the plan requires two appeals, each review must be completed within 15 days for pre-service claims. If your claim on appeal is still denied after the first review, the plan must allow you a reasonable period of time (but not a full 180 days) to file for the second review.

Once the final decision on your claim is made, the Plan must send you a written explanation of the decision. The notice must be in plain language that can be understood by Participants of the Plan. It must include all the specific reasons for the denial of your claim on appeal, refer you to the Plan provisions on which the decision is based, tell you if the Plan has any additional voluntary levels of appeal, explain your right to receive documents that are relevant to your benefit claim free of charge, and describe your rights to seek judicial review of the Plan's decision.

If the Plan's final decision denies your claim, you may want to seek legal advice regarding your rights to bring an action in court to challenge the denial. Normally, you must complete your Plan's claim process before filing an action in court to challenge the denial of a claim for benefits. However, if you believe the Plan failed to establish or follow a claims procedure consistent with the Department of Labor's rules, you may want to seek legal advice regarding your right to ask a court to review your benefit claim without waiting for a decision from the Plan.

Additional Non-Grandfathered Health Plan Protections under the Affordable Care Act

Under the Affordable Care Act (ACA), consumers have the right to appeal decisions made by health plans created after March 23, 2010. The law governs how initial appeals must be handled and how consumers can request a reconsideration of a decision to

deny payment. If a group health plan upholds its decision to deny payment, the law provides consumers with the right to appeal the decisions to an outside, independent decision-maker, regardless of the type of insurance or state an individual lives in.

If a group health plan denies a benefit or refuses to pay for a service that has already been received, this is called an adverse benefit determination. If a group health plan upholds its earlier decision to deny a benefit or payment for a service, this is called a final internal adverse benefit determination. Axiom Staffing Group, Inc.'s group health plan(s), or insurers to those plans, must provide additional internal claims and appeal rights and a process for external review of benefit claim denials by an independent party. These rights also apply to rescissions (retroactive cancellations) of coverage.

The notice of the denial of your claim from your Plan will describe the external review process and your rights. To request an external review of your claim denial, follow the steps provided in your denial notice.

INTERNAL APPEAL

An internal appeal is a review by the group health plan itself. You may file an internal appeal to ask your group health plan to reconsider its decision to deny your:

- request for approval to get a service or treatment (pre-authorization)
- claim for payment for a service or treatment
- coverage is denied or ends.

Internal claims and appeal protections include:

- Providing you with new or additional evidence or rationale, and the opportunity to respond to it, before the final decision is made on the claim
- Ensuring that claims and appeals are adjudicated in an independent and impartial manner
- Providing detail on the claim involved, the reason for denial (including the denial code and meaning), the internal and external appeals processes that are available, and information on consumer assistance, in all claims denial notice
- Providing, on request, diagnosis and treatment codes (and their meanings) for any denied claim
- Providing notices in a culturally and linguistically appropriate manner
- Allowing you to begin the external review process if the Plan fails to follow the internal claims requirements (unless the plan's violation is minimal)
- Allowing you to resubmit an internal claim if a request for immediate external review is rejected

EXTERNAL REVIEW/APPEAL

An external review is a review of the group health plan's decision by an independent third party. An external review is an easy way to appeal the group health plan's denial. An external review will either uphold the group health plan's decision or decide in favor of the claimant by overturning all or some of the group health plan's decision. Sometimes an external review is called an external appeal. The external review process used depends on whether the group health plan is self-funded or provides benefits through an Insurance Policy.

Rules issued by the U.S. Departments of Health and Human Services (HHS), Treasury, and Labor (DOL) provide for three different ways to process external reviews. In some states, consumers will use their state's external review process. This method is for states determined by the federal government to have a process that meets the federal standards for consumer protections. To determine if a state's external review process meets such standards, go to:
www.cms.gov/cciio/resources/files/external_appeals.html.

If the state's process does not meet the federal consumer protection standards, issuers must use a federally administered external review process and may choose one of the following external review processes to offer to consumers:

- The accredited Independent Review Organization (IRO) contracting process
- The HHS-Administered Federal External Review Processes.

A state may change its external review process in the future. Claimants must, at a minimum, be notified at the time the claim is filed of the process to be followed. Where the HHS-administered process applies, a separate claims document should be provided to the claimant by HHS.

To confirm which of the three external appeals review process options described above has been adopted by a particular state, you can visit:
www.cms.gov/cciio/resources/files/external_appeals.html

The HHS-Administered Federal External Review Process applies to denials (called "adverse benefit determinations") that involve medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational) and rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time).

The HHS-Administered Federal External Review Process is available at no cost to the consumer, or a consumer's authorized representative. Issuers that elect to use the HHS-Administered Federal External Review Process and consumers whose group health plan is participating in the HHS-Administered Federal External Review Process will work with the designated federal contractor which performs all functions of the external review. This contractor is MAXIMUS Federal Services, Inc. (MAXIMUS). MAXIMUS also provides technical assistance to consumers related to external review requests. For more information, please visit the MAXIMUS website at: www.externalappeal.com.

A consumer may file a request with MAXIMUS within four months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination.

After MAXIMUS receives an external review request, MAXIMUS contacts the group health plan. The group health plan must provide all documents and information related to the denial to MAXIMUS within five business days.

Claimants may also submit any additional information they want MAXIMUS to consider during the external review.

MAXIMUS will review all of the information and documents that are submitted on time.

For a standard external review, the MAXIMUS examiner must provide written notice of the final external review decision as expeditiously as possible and no later than 45 days after the examiner receives the request for the external review. Claimants will receive external review determinations in writing. For urgent care situations, claimants may file an expedited external review for either an adverse benefit determination or a final internal adverse benefit determination if:

- an adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant, or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
- a final internal adverse benefit determination involves a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a facility.

For an expedited external review, the MAXIMUS examiner must provide notice of the final external review decision as expeditiously as the medical circumstances require and within 72 hours once the examiner receives the request for the external review. MAXIMUS must deliver the notice of final external review decision to the claimant and the health insurance issuer. This notice can be initially provided orally but must be followed up in writing within 48 hours.

If you are interested in learning more about the HHS-Administered Federal External Review Process, please visit the CMS External Appeals web page at: http://www.cms.gov/cciio/Programs-and-Initiatives/Consumer-Support-and-Information/External-Appeals.html.

Notice of Denied Appeal Review

If a claim is wholly or partially denied, the Component Benefit Plan will provide the Claimant with a notice identifying all the information identified above, plus a discussion of the decision and available external claims processes and information regarding how to initiate an appeal.

On appeal, your claim must be reviewed by someone new who looks at all the information submitted and consults with qualified medical professionals if a medical judgment is involved. This reviewer cannot be the same person or a subordinate of the person who made the initial decision and the reviewer must give no consideration to that decision.

Plans have specific periods of time within which to review your appeal, depending on the type of claim.

APPEAL TIMELINE IN SUMMARY

URGENT CARE CLAIMS

These claims must be reviewed as soon as possible, taking into account the medical needs of the patient, but not later than 72 hours after the Plan receives your request to review a denied claim.

PRE-SERVICE CLAIMS

These claims must be reviewed within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the Plan receives your request to review a denied claim.

POST-SERVICE CLAIMS

These claims must be reviewed within a reasonable period of time, but not later than 60 days after the Plan receives your request to review a denied claim. If a group health plan needs more time, the plan must get your consent. If you do not agree to more time, the plan must complete the review within the permitted time limit.

DISABILITY CLAIMS

These claims must be reviewed within a reasonable period of time, but not later than 45 days after the plan receives your request to review a denied claim. If the plan determines special circumstances exist and an extension is needed, the plan may take up to an additional 45 days to decide the appeal. However, before taking the extension, the plan must notify you in writing during the first 45-day period explaining the special circumstances, and the date by which the plan expects to make the decision.

There are two exceptions to these time limits. In general, collectively bargained single-employer plans may use a collectively bargained grievance process for their claims appeal procedure if it has provisions on filing, determination, and review of benefit claims. Collectively bargained multi-employer plans are given special timeframes to allow them to schedule reviews on an appeal of post-service claims and disability claims for the regular quarterly meetings of their boards of trustees. If you are a participant in one of those plans and you have questions about your plan's procedures, you can consult your plan's Contract, related Plan Documents and collective bargaining agreement or contact the Plan Department of Labor's Employee Benefits Security Administration (EBSA) at 866-444-3272.

Plans can require you to go through two levels of review of a denied health or disability claim to complete the Component Benefit Plan's claims process. If two levels of review are required, the maximum time for each review generally is half of the time limit permitted for one review. For example, in the case of a group health plan with one appeal level, as noted above, the review of a pre-service claim must be completed within a reasonable period of time appropriate to the medical circumstances but no later than 30 days after the plan gets your appeal. If the plan requires two appeals, each review must be completed within 15 days for Pre-Service claims. If your claim on appeal is still denied after the first review, the plan has to allow you a reasonable period of time (but not a full 180 days) to file for the second review.

Once the final decision on your claim is made, the plan must send you a written explanation of the decision. The notice must be in plain language that can be understood by Participants or Beneficiaries in the plan. The notice must also include all the specific reasons for the denial of your claim on appeal, refer you to the plan provisions on which the decision is based, tell you if the plan has any additional voluntary levels of appeal, explain your right to receive documents that are relevant to your benefit claim free of charge and describe your rights to seek judicial review of the plan's decision.

Except as provided below for group health plan urgent care, pre-service claims and post-service claims, the plan will notify the claimant of the plan's benefit determination on review within 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination (45 days in the case of a claim involving disability benefits). If the claim reviewer determines that an extension of time for processing is required, written notice of the extension will be furnished to the claimant prior to the termination of the initial 60-day period (45 days in the case of a claim involving disability benefits).

In no event will such extension exceed a period of 60 days from the end of the initial period (45 days in the case of a claim involving disability benefits). The extension notice will indicate the special circumstances requiring an extension of time and the date by which the plan expects to render the determination on review.

URGENT CARE CLAIMS

In the case of an urgent care claim, the plan will notify the claimant of the plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the plan.

PRE-SERVICE CLAIM

In the case of a pre-service claim, the plan will notify the claimant of the plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than 30 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

POST-SERVICE CLAIMS

In the case of post-service claims, the plan will notify the claimant of the plan's benefit determination on review within a reasonable period of time. Such notification will be provided not later than 60 days after receipt by the plan of the claimant's request for review of an adverse benefit determination.

18. REFUNDS, INDEMNIFICATION & SUBROGATION

Any dividends, retroactive rate adjustments or other refunds of any type that may become payable as a benefit shall not be assets of the Plan but the property of the Employer. The Employer will not be liable for the loss or obligation relating to any insurance coverage except as is expressly provided by the Plan.

You must immediately repay any excess or taxable payments or reimbursements, reimburse the Employer for any liability for making such payments, including but not limited to: failure to withhold payroll taxes, withholding taxes from such payments or reimbursements. If you fail to repay an excess amount or make adequate indemnification, the Plan may offset your salary or wages and/or offset other benefits payable under the Plan, to the extent permitted by applicable law.

If you or a covered Dependent have any reason to believe that the Plan has paid benefits that are subject to recovery from any third party or person, you are obligated to notify the Plan. Further, you may not pursue or settle any claim paid by the Plan that is related to a personal injury without the Plan's involvement.

Under the provisions of the Plan, you (or your attorney, if applicable) are required to:

- furnish the information needed to enforce the provision to the appropriate Insurance Company, Trustee or Plan or Claims Administrator
- take action necessary to protect the Plan's interest if you recover any money (whether by settlement or judgment of the court)
- obtain written consent from the Plan to settle your claim.

If you fail to include the Plan in any settlement, you may be required to reimburse the Plan for your medical benefits plus any costs the Plan incurs for legal expenses in the recovery effort. Further the Plan's recovery reimbursements will not be reduced by attorney's fees or any other expenses unless express written authorization from the Plan is obtained.

Rights of Subrogation

The Plan features a subrogation or right of recovery provision. This provision helps control the cost of the Plan by placing the obligation for payment of a claim upon the party or parties who are at fault. Under the subrogation provision, the Plan, Insurance Company, trust or any third party acting on behalf of the Plan has the right to recover any medical expenses it has paid on your behalf for illness or injuries caused by a third party or person. By participating in the Plan, you and/or your covered Dependents consent and agree that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third party or person.

The Plan will be subrogated to any and all rights of recovery that the person, his heirs, guardians, executors, agents, or other representatives (hereafter individually and collectively "injured person") may have as a result of the loss. In no case will the amount subject to subrogation exceed the amount of medical or other benefits paid for the injuries under the Plan and the expenses incurred by the Plan in collecting this amount.

The rights of recovery (from whatever source) to which the Plan will be subrogated include, without limitation, the injured person's rights of recovery against:

- Any person or entity (third party) that caused, contributed to, or is in any way responsible for the injury by act or omission
- Any person, Insurance Company, health care provider or other entity that is in any way responsible for providing

indemnification, coverage, compensation or other payment as a result of the injury

- Any no-fault personal injury protection, financial responsibility, or uninsured or underinsured motorist insurance
- Any motor vehicle medical and wage loss reimbursement insurance
- Any homeowners, renters, premises and owners, landlords, and tenants insurance, including medical reimbursement coverage
- Any group accident and health insurance, athletic team, sporting event, school, club, and other specific risk insurance coverage or accident benefit plans
- Any third party, any plan, or any fund liable as a result of a judgment or settlement.

The Plan's right of subrogation applies not only to those expenses of which the Plan Sponsor or Plan Administrator is aware at the point of the initial claim, but also to any and all eligible expenses which are or may be compensable by a third party as a result of the loss.

By accepting Plan coverage for injuries or other charges, the injured person acknowledges the Plan's right to subrogation. The Plan may require a written acknowledgment of the Plan's right to subrogation. By accepting Plan coverage, the injured person acknowledges and agrees that this Plan will recover in full before any amounts (including attorney fees incurred by the injured person) are deducted from the policy, proceeds, judgment or settlement. The amount of the Plan's subrogation interest shall be deducted first from any recovery by or on behalf of the injured person. Such recovery shall be regardless of whether a settlement or judgment is allocated as to the injured person's actual medical expenses, pain and suffering, loss of wages, etc.; or received by the injured person, even though the amount of settlement or judgment does not provide full satisfaction for any damages suffered by the injured person.

The Plan reserves the right to reduce the amount of its recoverable subrogation interest where, in the discretion of its fiduciaries, a reduction is in the best interests of the Plan and its participants and warranted by the circumstances.

In addition, this Plan will be subrogated for attorney's fees incurred in enforcing its subrogation rights under this section. The Plan may, if the Plan agrees in writing, pay for some or all of the expenses or attorney fees incurred by the injured person in connection with any recovery. The Plan also reserves the right to initiate an action in the name of the Plan or in the name of the injured person to recover its subrogation interest.

The injured person specifically agrees to do nothing to prejudice or prevent this Plan's rights to subrogation. In addition, the injured person agrees to cooperate fully with the Plan and the Plan Administrator in asserting and protecting the Plan's subrogation rights. The injured person agrees to execute and deliver all instruments and papers (in their original form) and do whatever else is necessary to fully protect this Plan's subrogation rights.

The injured person shall notify the Plan in writing when there is a proposed settlement; further, the injured person must obtain the Plan's written consent before signing any release or agreeing to any settlement.

The injured person specifically agrees to notify the Plan Administrator, in writing, of whatever benefits are paid under this Plan that arise out of any injury or illness that provides or may provide the Plan subrogation rights under this section. Also, the Plan may provide a notice of lien regarding a subrogation claim to any person, insurer, attorney or other responsible party; this document provides sufficient notice to protect the Plan's subrogation rights and, except as required by ERISA, the Plan may not be compelled to initiate or to intervene in any legal action in order to establish or maintain its right of subrogation.

Failure to comply with the requirements and Plan provisions surrounding rights of recovery and subrogation by the injured person may, at the Plan Administrator's discretion, result in a forfeiture of benefits under this Plan.

A covered Participant or Beneficiary specifically agrees that:

- At the option of the Plan, the injured party shall sign a Subrogation Agreement (provided by the Plan) acknowledging and agreeing to the rights of subrogation before any benefits are paid under the Plan
- The covered person shall notify the plan and complete any necessary documentation of such injury as requried by the Plan, prior to the payment of claims
- The covered person shall, at all times, cooperate with the Plan and provide further information as requested
- The covered person acknowledges that failure to comply with any terms and conditions of the Plan may, at the sole discretion of the Plan Administrator, result in one or more of the following:

- Denial of payment of claims
- Termination of coverage under the Plan.

If a court shall, at any time, find any part of this section unenforceable, the remaining terms and conditions shall remain in full force and effect.

If there is a conflict between this document and the Component Benefit Plan's related Plan Documents, the Component Benefit Plan's Plan Documents will control.

19. CESSATION OF BENEFITS

The Employer intends for the Plan to continue indefinitely; however, the Employer reserves the right to alter, amend or terminate this Plan at any time and for any reason, in whole or in part, provided that no amendment shall authorize or permit any part of the trust fund (if such a Fund exists) to be used or diverted to any purpose other than to the exclusive benefit of the Participants.

Notwithstanding the foregoing, the Plan may be amended at any time to conform its provisions to the requirements of ERISA, the Internal Revenue Code and other applicable laws.

Your benefits will terminate (end) if you no longer meet the Component Benefit Plan's eligibility requirements, when you fail to make the necessary contributions or when you stop participating in the Plan.

Benefits will also end upon termination of the Plan.

Other circumstances can result in the limitation, reduction, recovery (through subrogation or reimbursement), denial or termination of benefits.

You may also lose all or part of any benefit due to you if you cannot be located at the time of your claim and/or when the benefit becomes payable to you.

20. ANTI-ALIENATION CLAUSE

You may not anticipate, exchange, pledge, encumber or assign any benefit or payments under the Plan except that you may designate a Beneficiary, when applicable.

21. AMENDMENT OR TERMINATION

As the Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time for any reason. You have no vested or permanent rights or benefits under the Plan.

Plan benefits will typically change from year-to-year. Examine each Component Benefit Plan's related Plan Documents made available and/or provided to you to determine the benefits of the Plan.

A number of decisions that are not governed by ERISA may be made to establish a Component Benefit Plan, to determine the benefit package, to include certain features in a plan, to amend a plan, and to terminate a plan. When making these decisions, an Employer is acting on behalf of its business, not the Plan, and, therefore, is not a Fiduciary. However, when an Employer (or someone hired by the Employer) takes steps to *implement* these decisions, that person is acting on behalf of the Plan and, in carrying out these actions, may be a Fiduciary.

If the Plan is terminated, Plan Participants and Beneficiaries will have no further rights other than payment of benefits for eligible covered expenses incurred before the Plan was terminated. The amount and form of any final benefit will depend on any contract provisions affecting the Plan.

Plan assets, if any, will be considered general assets of the Employer unless such assets constitute Employee funds. If such assets constitute Employee funds, reasonable means, as per ERISA or other governing guidelines, of determining payment to said Employees will be made to ensure that no part of the trust fund shall be used or diverted to any purpose other than to the exclusive benefit of the Participants, unless otherwise permitted by law.

22.
YOUR ERISA RIGHTS

A Participant of the plan is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan Participants shall be entitled to:

- Receive information about the Plan and benefits
- Obtain copies of the Plan Documents
- Receive a summary of the Plan's Annual Financial Report
- Continue group health plan coverage
- Prudent action by plan Fiduciaries
- Enforce your rights
- Obtain Assistance with Your Questions

Receive Information about the Plan and Benefits

You have the right 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, as applicable: each Component Benefit Plan's Plan Documents, collective bargaining agreements and copies of the latest annual report (IRS Form 5500 Series), if any, filed by the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain Copies of Plan Documents

Upon written request to the Plan Administrator, you have the right to receive copies of documents governing the operation of the Plan and each Component Benefit Plan's related Plan Documents.

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 to furnish each Participant with a summary of the Plan's Summary Annual (financial) Report, when required by law.

Continue Group Health Plan Coverage

You or your covered Dependents may be eligible to continue group health plan coverage when coverage would otherwise end if there is a loss of coverage under a COBRA eligible Component Benefit Plan as a result of a qualifying event as described below:

Termination of your **employment** for any reason except gross misconduct. Coverage may continue for you and/or your eligible Dependents.
A **reduction in your hours**. Coverage may continue for you and/or your eligible Dependents.
Your **death**. Coverage may continue for your eligible Dependents.
Your **divorce or legal separation**. Coverage may continue for your eligible Dependents.
You becoming **entitled to Medicare**. Coverage may continue for your eligible Dependents.
Your covered Dependent child's **ceasing to be a Dependent child** under the Plan. Coverage may continue for that Dependent.

A Participant or Dependent may have to pay to continue his/her coverage.

Review this document and each Component Benefit Plan's related Plan Documents that govern your COBRA continuation coverage rights for each respective COBRA-eligible Component Benefit Plan.

If eligible for COBRA, an election notice describing continuation options is provided in the event you or your Dependents become eligible for COBRA coverage.

If ineligible for COBRA due to Employer or Plan size, you may be eligible to continue your group health plan through state continuation law. State continuation coverage is similar to COBRA but, in most circumstances, it doesn't last as long and typically only applies to group health plans.

If you or your covered Dependents become eligible for state continuation, conversion or portability you will not receive any further correspondence regarding your rights other than what is provided herein or within each Component Benefit Plan's related Plan Documents. It is the Participant's or Beneficiary's responsibility to request, in a timely fashion, conversion or portability in any instance of loss of benefits eligibility, when applicable.

Continuation coverage may terminate the earlier of:

- your Dependent(s) is/are no longer eligible due to age or failure to meet other eligibility requirements,
- you or your Dependents become eligible for, or insured by, any other group health plan or government assistance health plan,
- the date you no longer reside in the service area as defined by the group health plan,
- the date you fail to pay a required premium,
- termination of the group health plan by the Employer, or
- exhaustion of any COBRA or other state continuation benefits.

To determine and protect your conversion, portability or continuation options, if any, review each Component Benefit Plan's related Plan Documents or contact the Component Benefit Plan or Plan Administrator within **30 days** of you or your Dependent's loss of eligibility.

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 the Plan. The people who operate your Plan, called ``fiduciaries'' of the Plan, have a duty to act prudently and in the interest of you and other plan Participants and Beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension or welfare) benefit or exercising your rights under ERISA.

Enforce Your Rights

Under ERISA there are steps you can take to enforce your rights in the grievance and appeals process. If your claim is denied, in whole or in part, by the Insurance Company, Plan Administrator or Third-Party Administrator, you will receive a written notification setting forth the reason(s) for the denial. If your claim is denied, you may, within certain time frames:

- have the right to know why the claim was denied
- obtain copies of documents relating to the decisions without charge
- appeal any denial of the claim to the Plan Administrator, Insurance Company, Trustee or related Third-Party Administrator for a review of the denied claim
- have the right to obtain an external or independent review of your claim, in certain circumstances.

If you have a claim for welfare (Component Benefit Plan) benefits which is denied or ignored, in whole or in part, you have a right to know why such occurred, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules. You also have a right to file suit in a state or federal court if a claim is denied or ignored, in whole or in part. If you do not appeal the denial in a timely manner, you will lose your right to file suit in a state or federal court because you will not have exercised certain appeal rights (which generally is a prerequisite to bringing suit in state or federal court). In addition to the claims procedures described, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a qualified medical child support order, you may file suit in a federal court. Should a plan Fiduciary misuse the Plan's assets or monies, or if you are discriminated against for asserting your rights under the Plan, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees.

Finally, if you request a copy of any Plan document or any Component Benefit Plan related Plan Documents or the latest Summary Annual (financial) Report (Form 5500), if such is required by law to be filed, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such instance, the court may require the Plan Administrator to provide the materials to you 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.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the plan or Third-Party Administrator (Component Benefit Plan contact details provided in **Addendum A**) or contact the Plan Administrator. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, 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 at 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 at (202) 693-8673.

When does ERISA not apply?

In general, ERISA does ***not*** cover group health plans established or maintained by:

- governmental entities
- churches for their Employees
- plans which are maintained solely to comply with applicable workers compensation, unemployment or disability laws.

ERISA also does not cover plans maintained outside the United States primarily for the benefit of nonresident aliens or unfunded excess benefit plans.

As well, voluntary plans are generally Employee-paid benefits that are not sponsored or endorsed by an Employer. Voluntary plans are insured, completely optional for election, and paid for by Employees. To be considered exempt under ERISA's voluntary plan safe harbor, several requirements must be met. These require the plan to:

- be completely voluntary
- not allow Employer contribution
- not allow the Employer to endorse the plan
- not allow the Employer to receive consideration for collecting and remitting premiums (other than reasonable compensation)

23. NOTICE OF RIGHT TO FILE A SUIT

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.

If you do not file an appeal in a timely manner for any denial, you will lose your right to file suit in a state or federal court, because you will not have exercised certain appeal rights (which generally is a prerequisite to bringing suit in state or federal court).

24. PLAN EXCLUSIONS

Each Component Benefit Plan's related Plan Documents set forth eligibility requirements, benefit limitations and exclusions. The availability of benefits is subject to meeting and maintaining eligibility or other requirements, following claims procedures and making all applicable contributions or deferrals in a timely fashion.

Charges in connection with any illness or injury of the covered person resulting from or occurring during commission or attempted commission of a criminal battery or felony by the covered person are excluded. With respect to the Plan's exclusion of coverage for injuries or illness that result from a crime, please review the terms of each Component Benefit Plan's related Plan documents.

If a group health plan provides benefits for any type of injury, it may not deny or exclude coverage for illnesses that result from an act of domestic violence or as a result of a mental or physical health condition.

25. NETWORK BENEFITS

Some Component Benefit Plans may use a 'provider network.' A provider network is a list of the doctors, other health care providers, pharmacies, hospitals, etc., that the plan has contracted with to provide care to Participants and Beneficiaries. These providers are called 'network providers' or 'in-network providers.' Some benefits may be excluded if not provided by a network provider.

In the event a Component Benefit Plan uses a 'provider network,' you will receive a copy of such listing by one or more separate documents or such listing will be made available electronically via the internet.

26. NON-DISCRIMINATION STATEMENT

Axiom Staffing Group, Inc. complies with applicable Federal civil rights laws and does not discriminate, exclude or treat individuals differently on the basis race, age, religion, sex, national origin, socioeconomic status, sexual orientation, gender identity or expression, disability, veteran status or source of payment. Additionally, in compliance with Code Section 105(h), any self-insured group health Component Benefit Plan(s), if applicable, shall not discriminate in favor of "highly compensated Employees" or "key Employees" as defined by the IRS and does not discriminate against non-highly compensated or key-Employees as to eligibility to participate and as to benefits available under any self-funded Welfare Benefit Plan. In order to avoid nondiscriminatory actions, Axiom Staffing Group, Inc. may limit or deny pre-tax deferrals/elections (salary reductions) agreement to the extent necessary to avoid such discrimination in compliance with federal law.

27. ACA & GROUP HEALTH PLAN PREVENTATIVE CARE

The Patient Protection and Affordable Care Act (the "Affordable Care Act" or "ACA") governs group health plans that are not HIPAA-excepted benefits in a number of ways. One such way is to require coverage of certain minimum preventive care services.

The U.S. Preventive Services Task Force (USPSTF) is an independent, volunteer panel of national experts in prevention and evidence-based medicine. The Task Force works to improve the health of all Americans by making evidence-based recommendations about clinical preventive services such as screenings, counseling services and preventive medications. All recommendations are published on the Task Force's web site at:
www.uspreventiveservicestaskforce.org/Page/Name/home.

The Task Force assigns each recommendation a letter grade based on the strength of the evidence and the balance of benefits and harms of a preventive service. The Task Force does not consider the costs of a preventive service when determining a recommendation letter grade. The recommendations apply only to people who have no signs or symptoms of the specific disease or condition under evaluation, and the recommendations address only services offered in the primary care setting or services referred by a primary care clinician. As such, coverage of minimum preventative care services that have in effect a current rating of "A" or "B" must be provided without cost sharing for the covered group health plan Participant. For more information regarding USPSTF's list of "A" and "B" recommendations, please visit:
www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations-by-date/.

Preventive care includes screenings, certain immunizations and other services for adults and children. All recommended preventive services will be covered as required by the Affordable Care Act and state law, as applicable. Preventive care services are covered at no cost meaning no deductible, copayments or coinsurance is applied when you use an 'in-network' provider.

Certain benefits for Members who have current symptoms or a diagnosed health problem may be covered under the 'diagnostic services' benefit, instead of this benefit, if the coverage does not fall within the state or ACA-recommended preventive services. For more information about preventative care as it related to the ACA mandates, please contact the Plan or the Plan Administrator or refer to:
www.healthcare.gov/coverage/preventive-care-benefits/.

28. EMPLOYEE RIGHTS & RESPONSIBILITIES UNDER (FMLA)

The Family and Medical Leave Act (FMLA) provides a means for covered Employees to balance their work and family responsibilities by taking unpaid leave for certain reasons.

FMLA applies to any Employer in the private sector who engages in commerce, or in any industry or activity affecting commerce, and who has 50 or more Employees each working day during at least 20 calendar weeks in the current or preceding calendar year. The law covers all public agencies (state and local governments) and local education agencies (schools, whether public or private). Federal Employers do not need to meet the "50 Employee" test as Title II of FMLA covers most federal Employees, who are subject to regulations (http://www.opm.gov/oca/leave/HTML/fmlafac2.asp) issued by the Office of Personnel Management.

FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

- the birth of a child or placement of a child for adoption or foster care
- to bond with a child (leave must be taken within 1 year of the child's birth or placement)
- to care for the Employee's spouse, child or parent who has a qualifying serious health condition
- for the Employee's own qualifying serious health condition that makes the Employee unable to perform the employee's job
- for qualifying exigencies related to the foreign deployment of a military member who is the Employee's spouse, child or parent.

An eligible Employee who is a covered servicemember's spouse, child, parent or next of kin may also take up to 26 weeks of FMLA leave in a single 12-month period to care for the servicemember with a serious injury or illness.

An Employee does not need to use leave in one block. When it is medically necessary or otherwise permitted, Employees may take leave intermittently or on a reduced schedule.

Employees may choose, or an Employer may require, use of accrued paid leave while taking FMLA leave. If an Employee substitutes accrued paid leave for FMLA leave, the Employee must comply with the Employer's normal paid leave policies.

While Employees are on FMLA leave, Employers must continue their group health plan coverage as if the Employees were not on leave. While Employees are on FMLA leave, plan eligibility may continue for the duration of the leave if the required Employee contributions necessary to maintain coverage are paid for cost of the coverage of the Component Welfare Benefit Plan(s). The Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible Dependents will be automatically reinstated on the date you return to employment if you and your Dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

Upon return from FMLA leave, most Employees must be restored to the same job or one nearly identical to it with equivalent pay, benefits, and other employment terms and conditions.

Subject to certain exceptions, if you fail to return to work after the leave of absence, the Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA. You may be entitled to elect Continuation Coverage, even if you were not covered under the Plan during the leave. Coverage continued under this provision is in addition to coverage described below under the section entitled "General Notice of COBRA Continuation Coverage Rights."

An Employer may not interfere with an individual's FMLA rights or retaliate against someone for using or trying to use FMLA leave, opposing any practice made unlawful by the FMLA, or being involved in any proceeding under or related to the FMLA.

In general, to be eligible for FMLA leave, an Employee must meet the following criteria:

- be employed by a covered Employer and work at an Employer's worksite within 75 miles of which that Employer (location) employs at least 50 people
- have worked at least 12 months (which do not have to be consecutive) for the Employer
- have worked at least 1,250 hours during the 12 months immediately before the date FMLA leave begins.

Generally, Employees must give 30-days' advance notice of the need for FMLA leave. If it is not possible to give 30-days' notice, an Employee must notify the Employer as soon as possible and, generally, follow the Employer's usual procedures.

Employees do not have to share a medical diagnosis, but must provide enough information to the Employer so it can determine if the leave qualifies for FMLA protection. Sufficient information could include informing an Employer that the Employee is or will be unable to perform his or her job functions, that a family member cannot perform daily activities, or that hospitalization or continuing medical treatment is necessary. Employees must

inform the employer if the need for leave is for a reason for which FMLA leave was previously taken or certified.

Employers can require a completed certification or periodic recertification supporting the need for leave to be provided on a timely basis. If the employer determines that the certification is incomplete, it must provide a written notice indicating what additional information is required.

Once an Employer becomes aware that an Employee's need for leave is for a reason that may qualify under the FMLA, the Employer must notify the Employee if he or she is eligible for FMLA leave and, if eligible, must also provide a notice of rights and responsibilities under the FMLA. If the Employee is not eligible, the Employer must provide a reason for ineligibility.

Employers must notify their Employees if leave will be designated as FMLA leave, and if so, how much leave will be designated as FMLA leave.

Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer.

The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

The Plan intends to comply with all Family and Medical Leave Act regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

29. RIGHTS UNDER USERRA

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that Employers must meet for certain Employees who are involved in the uniformed services. USERRA protects the job rights of individuals who voluntarily or involuntarily leave employment positions to undertake military service or certain types of service in the National Disaster Medical System. USERRA also prohibits employers from discriminating against past and present members of the uniformed services and applicants to the uniformed services.

Reemployed Rights

You have the right to be reemployed in your civilian job if you leave that job to perform service in the uniformed service and:

- you ensure that your Employer receives advance written or verbal notice of your service
- you have five years or less of cumulative service in the uniformed services while with that particular Employer
- you return to work or apply for reemployment in a timely manner after conclusion of service
- you have not been separated from service with a disqualifying discharge or under other than honorable conditions.

If you are eligible to be reemployed, you must be restored to the job and benefits you would have attained if you had not been absent due to military service or, in some cases, a comparable job.

Right to be Free from Discrimination and Retaliation

If you:

- are a past or present member of the uniformed service
- have applied for membership in the uniformed service
- are obligated to serve in the uniformed service

Then an Employer may not deny you:

- initial employment
- reemployment
- retention in employment
- promotion
- any benefit of employment

because of this status.

In addition, an Employer may not retaliate against anyone assisting in the enforcement of USERRA rights, including testifying or making a statement in connection with a proceeding under USERRA, even if that person has no service connection.

Health Insurance Protection

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based group health plan coverage for you and your Dependents for up to 24 months while in the military (from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave).

Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your Employer's Group health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months.

If the leave is 30 days or less, your contribution amount will be the same as for active Employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

Enforcement

The U.S. Department of Labor, Veterans Employment and Training Service (VETS) is authorized to investigate and resolve complaints of USERRA violations.

For assistance in filing a complaint, or for any other information on USERRA, contact VETS at **1-866-4-USA-DOL** or visit its website http://www.dol.gov/vets. An interactive online USERRA Advisor can be viewed at http://www.dol.gov/elaws/userra.htm.

If you file a complaint with VETS and VETS is unable to resolve it, you may request that your case be referred to the Department of Justice or the Office of Special Counsel, as applicable, for representation.

You may also bypass the VETS process and bring a civil action against an employer for violations of USERRA.

Terms

As used in this provision, "Uniformed Services" means the:

- the Armed Forces
- the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or Full-Time National Guard duty (pursuant to orders issued under federal law)
- the commissioned corps of the Public Health Service
- any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- active duty
- active duty for training
- initial active duty training
- inactive duty training
- full-time National Guard duty
- a period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties
- a period for which you are absent from your job for the purpose of performing certain funeral honors duties
- certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

When USERRA Continuation Coverage Ends

This USERRA continuation coverage will end earlier if one of the following events takes place when you:

- fail to make a premium payment within the required time
- fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service
- lose your rights under USERRA, for example, as a result of a dishonorable discharge.

Intent to Comply

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the plan in accordance with such actual regulations.

30. GROUP HEALTH PLAN MEDICAL LOSS RATIO (MLR) REBATES

A Medical Loss Ratio (MLR) is the amount of (***fully insured***) group health plan premiums that an insurer spends on health care and activities to improve health care quality. The Medical Loss Ratio is expressed as a percentage. **For example**, an MLR of 90% means 9 out of 10 of all premium dollars the insurer receives are spent on health care and quality improvement, with the other dollars spent on overhead, profits, and administrative costs.

Starting in 2012, an insurer that does not spend enough of its premium dollars on health care must provide a rebate to the insured individual or to the policyholder, which may be the Employer that purchased the insurance.

Under Health Care Reform, an insurer that offers health care coverage to individuals or small groups (usually less than 50 Employees) generally must meet an 80% MLR. This means that these insurers must spend at least 80% of annual premiums paid on health care costs (or activities that improve health care quality) as opposed to profits and administrative costs, including executive salaries, overhead, and marketing. An insurer that offers coverage in the large group market (usually over 50 Employees) must meet at least an 85% MLR. It must spend at least 85% of premiums on health care costs or quality improvement.

Individual states can require a higher MLR for insurers operating within their state.

An insurance issuer that does not meet its MLR for the year is required to issue rebates to policyholders. Rebates are based upon aggregated market data in each state and not upon a particular group health plan's experience.

In order to reduce the burden on issuers and minimize the tax impacts on Participants in and sponsors of group health plans, the rules provide that issuers must pay any rebates owed to persons covered under a group health plan to the policyholder (typically the Employer that sponsors the plan), who is then responsible for distributing the rebate to eligible plan policyholders.

Each year's rebates must be provided to policyholders by **September 30**.

Notice of Rebate — To Be Provided by Issuer

Under the rules, issuers are required to provide information in the form of a rebate notice to enrollees who are owed rebates.

Employer Responsibilities for Distribution

The U.S. Employee Benefits Security Administration has released technical guidance for Employers and group health plans on how to handle the distribution of rebates paid pursuant to the MLR requirements. To the extent that premium rebates are considered to be plan assets, they become subject to ERISA (including ERISA's requirements related to standards of fiduciary conduct). According to the guidance:

- If the plan or its trust is the policyholder, in the absence of specific plan or policy language to the contrary, the entire rebate would constitute plan assets, and the policyholder would be required to comply with ERISA's fiduciary provisions in the handling of rebates that it receives.
- If the Employer is the policyholder, determining the Plan's portion, if any, may depend on provisions in the Plan, the policy or on the manner in which the Plan Sponsor and the Plan Participants have shared in the cost of the policy.

There are several methods by which an Employer may distribute rebates to plan enrollees, including a rebate check in the mail, a lump-sum reimbursement to the same account that was used to pay the premium if it was paid by credit card or debit card, or a direct reduction in future premiums.

Decisions on how to apply or expend the Plan's portion of a rebate are subject to ERISA's general standards of Fiduciary conduct:

- Under ERISA, the responsible Fiduciaries must act prudently, solely in the interest of Plan Participants and Beneficiaries, and in accordance with the terms of the plan to the extent consistent with the provisions of ERISA.
- With respect to these duties, the technical guidance notes that a Fiduciary also has a duty of impartiality to the Plan's Participants. A selection of an allocation method that benefits the Fiduciary, as a Participant in the plan, at the expense of other Participants in the plan would be inconsistent with this duty.
- An allocation does not fail to be impartial or "solely in the interest of Participants," for purposes of ERISA, merely because it does not exactly reflect the premium activity of policy subscribers. In deciding on an allocation method, the Fiduciary may properly weigh the costs to the plan and the ultimate plan benefit as well as the competing interests of Participants or classes of Participants provided such method is reasonable, fair and objective. **For example,** if a Fiduciary finds that the cost of distributing shares of a rebate to former Participants approximates the amount of the proceeds, the Fiduciary may properly decide to allocate the proceeds to current Participants based upon a reasonable, fair and objective allocation method.
- Similarly, if distributing payments to any Participants is not cost-effective (e.g., payments to Participants are of *de Minimis* amounts, or would give rise to tax consequences to Participants or the plan), the Fiduciary may utilize the rebate for other permissible plan purposes including applying the rebate toward future Participant premium payments or toward benefit enhancements.

Potential Tax Consequences

In addition to requirements under ERISA that may apply to the distribution of rebates by Employers, there may also be tax implications that need to be considered.

Generally, the immediate consequence of a premium rebate triggers a corresponding increase in taxable income when such premiums were paid on a pre-tax basis.

31. GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

Introduction

Please note, generally, COBRA continuation is only available to participants covered under a group health plan sponsored by an Employer (or controlled, affiliated or aggregated service group) which employs 20 or more Employees in the preceding calendar year.

If you are or become covered under an eligible group health plan (a group health plan sponsored by an eligible employer), this notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. In this instance the term "group health plans" include those plans that provide comprehensive medical, dental and vision benefits. Certain supplemental plans are not COBRA eligible. The Certificate or Component Benefit Plan's Summary Plan Description will the member's right to continue coverage, if any, by means of COBRA (or other continuation privileges). Please refer to these documents or contact the Plan to understand your rights to continue coverage, if any, once you fail to meet actively at work eligibility requirements.

PAPERWORK REDUCTION ACT STATEMENT

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately four minutes per respondent. Interested parties are encouraged to send

comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0123.

OMB Control Number 1210-0123 (expires 12/31/2019)

Continuation Coverage Rights Under COBRA

If you are covered under a group health plan (the Plan), you and/or covered Dependents may be eligible for COBRA in the future. This notice has important information about your right to COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. COBRA is a temporary extension of coverage under the Plan.

If/when you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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 other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

For the purpose of this notice, group health coverage *may* include:

- Health plans
- Dental plans
- Vision plans
- Healthcare Flexible Spending Account Benefits
- Health Reimbursement Account Benefits

COBRA may also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For more information about your rights and obligations under the Plan and under federal law, you should review each Component Benefit Plan's documents, Certificate of Insurance and related plan documents or contact the Plan or Plan Administrator.

For more details regarding general COBRA rights and responsibilities, you can also visit:
https://www.dol.gov/general/topic/health-plans/cobra

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace.

By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs.

Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA Continuation Coverage?

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

If you are a covered **Employee**, **child or spouse**, you will become a qualified Beneficiary if you lose your coverage under the Plan because of the following events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're a covered **spouse** of an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse's hours of employment are reduced to the point they are no longer meeting the hours or "actively at work" requirements
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies
- The parent-employee's hours of employment are reduced
- The parent-employee's employment ends for any reason other than their gross misconduct
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both)
- The parents become divorced or legally separated
- The child stops being eligible for coverage under the Plan as a "Dependent child."

The chart below explains, in general, the events that can trigger eligibility for COBRA and who is eligible for COBRA.

EVENT	COVERED INDIVIDUAL
Termination (for reason other than gross misconduct) or reduction in hours of employment	• Employee • Spouse • Dependent child
Employee enrollment in Medicare *(Part A, B or both)*	• Spouse • Dependent child
Divorce or legal separation	• Spouse • Dependent child
Death of Employee	• Spouse • Dependent child
Loss of 'Dependent child' status under the plan	• Dependent child

When is COBRA continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

Examples of qualifying events and of the documentation that may be requested from you include:

Divorce or Annulment

- Finalized Divorce Decree or Certificate of Annulment
- Proof of Legal seperation, if recognized

You Gain a Dependent

- Marriage, adoption, legal custody, death or birth certificate

Loss of Employee's Eligibility

- The end of employment or reduction of hours of employment below the hours required to maintain eligibility status

Loss of Dependent's Eligibility

- Proof of Full-Time student status or physical impairment
- Proof of the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)
- Employee's death certificate

Loss of Other Qualified Coverage

- HIPAA Certificate of Credible Coverage (COC) showing that the individual had an involuntary loss of coverage

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified

beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months.

The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

You must provide this notice to the COBRA Administrator for Axiom Staffing Group, Inc.

Admin America
COBRA Administrator
1720 Windward Concourse, Suite 290
Alpharetta, Georgia 30005
Phone: (770) 992-5959

It is also recommended to advise your Plan Administrator of any such Dependent change impacting eligibility.

Axiom Staffing Group, Inc.
Plan Administrator
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event.

This extension may be available to the spouse and any Dependent children getting COBRA continuation coverage if the employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child.

This extension is only available if the second qualifying event would have caused the **spouse** or **Dependent child** to lose coverage under the Plan had the first qualifying event not occurred.

Are There other Coverage Options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's

website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep the Plan Informed

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

For all qualifying events related to Dependent coverage (such as divorce or legal separation of the employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Plan Administrator within 30 days after the qualifying event occurs. You must provide this to the COBRA Administrator.

Admin America
COBRA Administrator
1720 Windward Concourse, Suite 290
Alpharetta, Georgia 30005
(770) 992-5959

It is also recommended to advise your Plan Administrator of any such Dependent change impacting eligibility.

Axiom Staffing Group, Inc.
Plan Administrator
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

Plan Contact Information (Plan Administrator)

The contact information from whom information about the Plan and COBRA continuation coverage can be obtained upon request is as follows:

Axiom Staffing Group, Inc.
Plan Administrator
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

It is also recommended to advise your COBRA Administrator of any such Dependent change impacting eligibility.

Admin America
COBRA Administrator
1720 Windward Concourse, Suite 290
Alpharetta, Georgia 30005
Phone: (770) 992-5959

OMB Control Number 1210-0123 (expires 12/31/2019)

You can also get more information about COBRA by visiting: https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/an-Employees-guide-to-health-benefits-under-cobra.pdf

32. THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits discrimination in group health plan coverage based on genetic information. GINA is effective for plan years beginning after May 21, 2009 (June 1, 2010 for calendar year plans). GINA expands the genetic information protections included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA prevents a plan or issuer from imposing a preexisting-condition exclusion provision based solely on genetic information, and prohibits discrimination in individual eligibility, benefits or premiums based on any health factor (including genetic information).

GINA provides that group health plans and issuers cannot base premiums for an Employer or a group of similarly situated individuals on genetic information. (However, premiums may be increased for the group based upon the manifestation of a disease or disorder of an individual enrolled in the plan.)

GINA also generally prohibits plans and issuers from requesting or requiring an individual to undergo a genetic test. However, a health care professional providing health care services to an individual is permitted to request a genetic test. Additionally, genetic testing information may be requested to determine payment of a claim for benefits, although the regulations make clear that the plan or issuer may request only the minimum amount of information necessary in order to determine payment. There is also a research exception that permits a plan or issuer to request (but not require) that a Participant or Beneficiary undergo a genetic test.

GINA also prohibits a plan from collecting genetic information (including family medical history) prior to or in connection with enrollment, or for underwriting purposes. Thus, under GINA, plans and issuers are generally prohibited from offering rewards in return for collection of genetic information, including family medical history information collected as part of a Health Risk Assessment (HRA). The regulations provide several examples illustrating GINA's application to HRAs.

If you enroll in our group health plan, you may be asked to provide certain medical information about yourself and/or your Dependents. In this instance, the following information is important for you to know. The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits Employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law.

To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

33. MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) generally applies to Employers that employ 50 or more Employees and its health plan if it provides for mental health and substance abuse benefits. (Thus, if your Plan does not currently offer any mental health or substance abuse benefits, then MHPAEA does not apply.)

Under Health Care Reform, most non-grandfathered *small* group health plans are required to cover mental health and substance use disorder services (as one category of "essential health benefits"), at parity with medical and surgical benefits, for plan years starting in 2014.

Federal Mental Health Parity does not require plan sponsors to offer mental health or substance abuse coverage. However, if a plan sponsor chooses to offer mental health or substance abuse benefits, the law prohibits imposing substantially more restrictive financial requirements (such as copays, deductibles or out of pocket limits) or treatment limitations (including quantitative treatment limitations, such as day or visit limits, scope, or duration of treatment and non-quantitative treatment limitations on mental health or substance abuse benefits) than those applied to medical or surgical benefits.

For example, a plan may not apply separate deductibles for treatment related to mental health or substance use disorders and medical or surgical benefits—they must be calculated as one limit.

Additionally, if a plan provides mental health or substance abuse disorder benefits in any classification of benefits, mental health or substance abuse disorder benefits must be provided in every classification in which medical/surgical benefits are provided. For example, if a plan covers inpatient, in-network mental health benefits, the plan must provide mental health benefits in every classification in which medical/surgical benefits are provided.

The law defines mental health and substance abuse disorder benefits as those "defined under the terms of the plan and in accordance with applicable federal and state law." This means that the law defers to group health plans to define mental and substance use disorders and their coverage. Definitions must be consistent with "generally recognized independent standards of current medical practice" which include the Diagnostic and Statistical Manual of Mental Disorders, the International Classification of Diseases and State guidelines. As previously noted herein, where state law either defines or mandates coverage of specific mental illnesses or services, those definitions will continue to apply to plans subject to state regulation. Further, the definitions for "medical surgical benefits" and "substance use disorder benefits" include benefits for items as well as services.

Federal Mental Health Parity establishes a floor for benefits but specifically allows states to continue to enforce any parity requirement deemed stronger than federal law (as long as state law does not compromise the federal law). For plans not subject to state laws (self- funded ERISA plans), the federal law sets both the floor and the ceiling.

Or you can get more information by visiting:

- https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity
- https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/mhpaea_factsheet.html

34. NEWBORNS AND MOTHER'S PROTECTION ACT DISCLOSURE

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

You may also find helpful information by visiting:

- https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/publications/protections-for-newborns

Plans subject to state law requirements may prepare Plan Document statements describing any applicable State law.

35. QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROCEDURES & OBLIGATIONS

A 1993 amendment to the Employee Retirement Income Security Act (ERISA) requires employment-based group health plans to extend health care coverage to the children of a parent-Employee who is divorced, separated, or never married when ordered to do so by state authorities.

Generally, a state court or agency may require an ERISA-covered group health plan to provide health benefits coverage to children by issuing a medical child support order. The group health plan must determine whether the medical child support order is "qualified." Such an order is referred to as a Qualified Medical Child Support Order (QMCSO). In addition, a State child support enforcement agency may obtain group health coverage for a child by issuing a National Medical Support Notice that the group health plan determines to be qualified.

QMCSOs Coverage Requirements

The QMCSO provisions apply to "group health plans" subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). For this purpose, a "group health plan" generally is a plan that both:

- Is sponsored by an Employer or Employee organization (or both)
- Provides "medical care" to Employees, former Employees or their families.

"Medical care" for the purpose of this notice means amounts paid for the diagnosis, cure, mitigation, treatment or prevention of a disease; for the purpose of affecting any structure or function of the body; transportation primarily for or essential to such care or services; or for insurance covering such care or services.

As used in this booklet, the term "group health plan" refers to that term as defined in section 607(1) of ERISA and means generally any welfare plan established or maintained by an Employer or Employee organization (or both) that provides medical care to Employees or their Dependents directly or through insurance, reimbursement or otherwise.

ERISA does not generally apply to plans maintained by Federal, State or local governments; churches; and Employers solely for purposes of complying with applicable workers' compensation or disability laws. However, provisions of the Child Support Performance and Incentive Act (CSPIA) of 1998 require church plans to comply with QMCSOs and National Medical Support Notices, and State and local government plans to comply with National Medical Support Notices.

For more information, please visit:
https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/publications/qualified-medical-child-support-orders.pdf

[ERISA §§ 4(b), 609(a), and 607(1), Internal Revenue Code § 213(d), CSPIA § 401(f)].

QMCSO Procedures

Ordinarily, an Employer may receive a Notice when a child support enforcement agency initially enforces an Employee's medical support obligation, or when an Employee with a previously established medical support obligation is newly hired.

The Notice is comprised of:

- Part A, Notice to Withhold for Health Care Coverage (which includes an Employer Response), and
- Part B, Medical Support Notice to Plan Administrator (which includes a Plan Administrator Response).

If the Employee named in the Notice is not an Employee of the Employer, if the Employer does not maintain or contribute to a plan that provides Dependent coverage, or if the named Employee is among a class of Employees (e.g. part-time or non-union) not eligible for enrollment in a plan that provides Dependent coverage, the Employer must check the appropriate box on the Employer Response and return it to the issuing agency within 20 business days after the date of the Notice (or sooner if reasonable). Otherwise, the Employer must transfer Part B of the Notice to the group health plan (or plans) for which the child may be eligible for enrollment not later than 20 business days after the date of the Notice.

For these purposes, the "date of the Notice" means the date that is indicated as such on the Notice.

If the Employer offers a number of different types of benefits (e.g., dental, prescription) through separate plans, and the issuing agency has not specified which or all are covered by the Notice, the Employer should assume all plans are covered by the Notice, and send copies of Part B of the Notice to each Plan Administrator.

The application of a waiting period (such as one requiring that a new Employee must be employed for a certain amount of time or work a certain number of hours) before an Employee may enroll in the group health plan does not affect the Employer's obligation to transfer Part B to the Plan Administrator(s).

When transferring Part B of the Notice, the Employer retains Part A. An Employer that transfers Part B of the Notice to a Plan Administrator(s) may later need to use the Employer Response after it has been notified of the qualification of the Notice and has determined that necessary Employee contributions cannot be withheld from wages.

[Social Security Act § 466(a) (19), 45 CFR § 303.32(c)]

Obligations of the Plan

A Plan Administrator who receives a National Medical Support Notice must review the Notice and determine whether it is appropriately completed. The administrator must complete the Plan Administrator Response (included with Part B of the Notice), indicating whether the Notice is a QMCSO, and return it to the State agency that issued the Notice within 40 business days after the date of the Notice.

If the Plan Administrator determines that the Notice is appropriately completed, the administrator is required to treat the Notice as a QMCSO. The Plan Administrator must in that case inform the State agency that issued the Notice when coverage under the plan of the child named in the Notice will begin and must provide the custodial parent of the child (or, in some cases, a named State Officer) with information about the child's coverage under the plan, such as the plan's summary plan description, any forms or documents necessary to make claims under the plan, etc.

If the Participant is not enrolled and there is more than one option available under the plan for coverage of the child, the Plan Administrator must also use the Plan Administrator Response to notify the agency of that fact, and inform them of the available options for coverage. If the agency does not then respond within 20 business days and the plan has a "default option," the Plan Administrator may enroll the child in the default option.

The Department of Labor has issued a regulation, 29 CFR 2590.609-2, that provides guidance on how administrators of group health plans must deal with Notices they receive.
[ERISA § 609(a) (5) (C), 29 CFR § 2590.609-2]

Additional Information

An "appropriately completed" Notice satisfies the informational requirements of the QMCSO provisions by:

- Providing the name and last known mailing address (if any) of the Participant and the name and mailing address of each child covered by the order
- Having the child support enforcement agency identify either the specific type of coverage or all available group health coverage
- Instructing the Plan Administrator that if a Notice does not designate either specific type(s) of coverage or all available coverage, it should assume that all are designated, and further instructing the Plan Administrator that if a group health plan has multiple options and the Participant is not enrolled, the agency will make a selection after the Notice is qualified and, if the agency does not respond within 20 business days, the child will be enrolled under the plan's default option if there is one
- Specifying that the period of coverage may end for the named child only when similarly situated Dependents are no longer eligible for coverage under the terms of the plan, or upon the occurrence of events specified in the Notice.

A Notice also requires the plan to provide to a named child *only* those benefits that the plan provides to any Dependent of a Participant who is enrolled in the plan, and any other benefits that are necessary to meet the requirements of the State laws relating to medical child support.

The following information about ERISA and other laws may be useful sources of information about obtaining health care coverage and medical care for children. Two agencies in the Department of Health and Human Services play significant roles in the provision of health care coverage to children. The Office of Child Support Enforcement is responsible for establishing standards and providing guidance for the Child Support Enforcement Program under Title IV-D of the Social Security Act.

- Centers for Medicare and Medicaid Services
  The Centers for Medicare and Medicaid Services administers Medicaid and the State Children's Health Insurance Program (also known as SCHIP) and provides additional guidance under HIPAA and other recently enacted health-related laws.
- National Child Support Enforcement Association
  The National Child Support Enforcement Association (NCSEA) is a nonprofit membership organization comprised primarily of State and local child support enforcement agencies, as well as staff and management of State child support enforcement agencies.
- Eastern Regional Interstate Child Support Association (ERICSA) and the Western Interstate Child Support Enforcement Council (WICSEC) are child support enforcement professional organizations focusing on issues of interstate child support enforcement.

Each State has a child support enforcement agency. Sometimes this agency is located in the state Attorney General's office, but it is frequently found as part of the state's Department of Social or Human Services.

Other Related Information

- National Medical Support Notice - Notice to Withhold for Health Care Coverage, OMB No. 0970-0222 - This Notice is issued under section 466(a)(19) of the Social Security Act, section 609(a)(5)(C) of the Employee Retirement Income.
- Employee Income and Security Act of 1974 (ERISA), and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998.
- National Medical Support Notice - Medical Support Notice to Plan Administrator, OMB No. 1210-0113 - This Notice is issued under section 466(a) (19) of the Social Security Act, section 609(a) (5)(C) of the Employee Retirement Income Security Act of 1974, and for State and local government and church plans, sections 401(e) and (f) of the Child Support Performance and Incentive Act of 1998. Receipt of this Notice from the Issuing Agency constitutes receipt of a Medical Child Support Order under applicable law. The rights of the parties and the duties of the Plan Administrator under this Notice are in addition to the existing rights and duties established under such law.

36. WOMEN'S HEALTH & CANCER RIGHTS ACT ENROLLMENT NOTICE

If you are covered under our group health plan and have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA).

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed

- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. The deductible amount and co-insurance applied is based on your health plan enrollment. Please review your health plan Summary of Benefits and Coverage (SBC) for more details.

If you would like more information on WHCRA benefits, call your Plan Administrator at (678) 762-0285.

37. WOMEN'S HEALTH & CANCER RIGHTS ACT ANNUAL NOTICE

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA which amends ERISA, requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. Because one or more group health plan(s) offers coverage for mastectomies, WHCRA applies to Axiom Staffing Group, Inc.'s Cigna group health plan(s). The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for reconstruction of the breast on which the mastectomy has been performed:

- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions and limitations or exclusions otherwise applicable under the policy/plan.

To obtain more information, contact the group health plan (plan contact details can be found in **Addendum A**) or the Plan Administrator for more information. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

38. WELLNESS PROGRAM DISCLOSURE

Your health plan is committed to helping you achieve your best health.

Rewards for participating in a wellness program may be available to all Employees participating in the Axiom Staffing Group, Inc. Group Health Plan. If it is unreasonably difficult due to a medical condition for you to achieve the standards for the reward under this program, or if it is medically inadvisable for you to attempt to achieve the standards for the reward under this program, call us at (678) 762-0285 and we will work with you to develop another way to qualify for the reward.

Call the Plan Administrator for more information. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

39. HIPPA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your Dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in this Plan if you or your Dependents lose

eligibility for that other coverage (or if the Employer stops contributing toward your or your Dependents' other coverage). However, you must request enrollment within **30 days** after your Dependents' other coverage ends (or after the Employer stops contributing toward the other coverage).

In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. You must take such action within **30 days** after the marriage, birth, adoption or placement for adoption.

Events that may trigger Special Enrollment Rights

- **Divorce or** legal separation
- **Death** of the Employee covered by the plan
- **Termination** of other coverage (including exhaustion of COBRA benefits)
- **Reduction** in the number of **hours** of employment
- The plan decides to **no longer offer any benefits** to a class of similarly situated individuals
- **Employer contributions** toward group health plan coverage **ceases**
- A covered individual **no longer resides**, lives or works in the covered service **area.**

Special Enrollment Effective Dates

In the case of birth, adoption, placement for adoption or placement in foster care, the Plan must ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption or placement in foster care, or it may permit the qualified individual or enrollee to elect an effective coverage date of the first of the month following the date of birth, adoption, placement for adoption or placement in foster care. If the Plan permits the qualified individual or enrollee to elect a coverage effective date of either the first of the month following the date of birth, adoption, placement for adoption or placement in foster care, the Plan must ensure coverage is effective on the date duly selected by the qualified individual or enrollee.

In the case of marriage, the Plan must ensure that coverage is effective for a qualified individual or enrollee no later than the first day of the month following plan selection.

In the case of a qualified individual or enrollee eligible for a special enrollment period, the Plan must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

If a qualified individual loses coverage, becomes newly eligible for enrollment or becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move and if the plan selection is made on or before the day of the triggering event, the Plan must ensure that the coverage effective date is on the first day of the month following the date of the triggering event. If the Plan selection is made after the date of the triggering event, the Plan must ensure that coverage is effective on the first day of the following month, at the option of the Plan.

In the case of a court order, the Plan must ensure that coverage is effective for a qualified individual or enrollee on the date the court order is effective, or it may permit the qualified individual or enrollee to elect a coverage effective date in accordance with Plan. If the Plan permits the qualified individual or enrollee to elect a coverage effective date, the Plan must ensure coverage is effective on the date duly selected by the qualified individual or enrollee.

If a Participant or Dependent deceases, the Plan must ensure that coverage is effective on the first day of the month following the Plan selection, or it may permit the enrollee or Dependent to elect a coverage effective date. If the Plan permits the enrollee or his or her Dependent to elect a coverage effective date, the Plan must ensure coverage is effective on the date duly selected by the enrollee or his or her Dependent.

The Plan may require documentation of proof that an event has occurred that triggers a special enrollment.

Examples of special enrollment and the corresponding documentation that may be requested from you include but may not be limited to:

Divorce or Annulment

- Finalized Divorce Decree or Certificate of Annulment
- Proof of Legal seperation, if recognized

You Gain a Dependent

- Marriage, adoption, legal custody, death or birth certificate

Loss of Employee's Eligibility

- The end of employment or reduction of hours of employment below the hours required to maintain eligibility status

Loss of Dependent's Eligibility

- Proof of full-time student status or physical impairment
- Proof of the Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both)
- Employee's death certificate

Loss of Other Qualified Coverage

- HIPAA Certificate of Credible Coverage (COC) showing that the individual had an involuntary loss of coverage

Please note, special enrollment rights do *not, under the definition of the law,* apply to excepted benefits (such as stand-alone dental or vision plans) and non-health plans. However, such plans may extend special enrollment rights as disclosed herein. Refer to each Component Benefit Plan's Certificate of Insurance, contracts, agreements, amendments, riders, Summary of Benefits and Coverage and/or Summary Plan Description and any other documents making up the Component Benefit Plan or contact the Component Benefit Plan (contact information is provided in Addendum A) or the Plan Administrator for additional details or clarity regarding this provision.

Other Special Enrollment Provisions

Under the Children's Health Insurance Program Reauthorization Act of 2009, two additional Special Enrollment Rights exist under HIPAA:

- **Termination of Medicaid or CHIP Coverage.** You or your Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health insurance plan (CHIP) under Title XXI of such Act and such coverage is terminated as a result of loss of eligibility.

You must request enrollment no later than 60 days after coverage is terminated.

- **Eligibility for Assistance under Medicaid or CHIP.** You or your Dependent becomes eligible for Medicaid or CHIP assistance with respect to group health plan coverage. This includes any waiver or demonstration project under Medicaid or CHIP.

You must request a change in enrollment no later than **60 days** after the date eligibility for such assistance begins.

To Request Special Enrollment or Additional Information

To request special enrollment or obtain more information, contact the plan (contact details can be found in Addendum A) or your Plan Administrator. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

The impacted individual must notify the Plan in writing or otherwise comply with the enrollment procedures (supplying any required documentation) timely.

40.
PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: http://flmedicaidtplrecovery.com/hipp/ Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131
CALIFORNIA – Medicaid	**INDIANA – Medicaid**
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-800-541-5555	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864

IOWA – Medicaid and CHIP (Hawki)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – Medicaid

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – Medicaid

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – Medicaid

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – Medicaid

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – Medicaid and CHIP

Website: http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – Medicaid

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – Medicaid and CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING – Medicaid**
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565 .

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

41.
HEALTH SAVINGS ACCOUNT FINANCIAL INSTITUTION INFO

Health Savings Accounts (HSAs) are savings accounts that allow individuals to pay for qualified out-of-pocket medical expenses using pre-tax dollars. Unlike more traditional health care (spending) accounts, the funds in an HSA belong to the individual, not the Employer, Health Plan, Financial Institution or the Insurance Company, and travel with the individual. A Health Savings Account is not a plan covered under ERISA. However, Employees may make pre-taxed deferrals if pre-tax plan eligibility requirements are met. It is for courtesy that a summary of the Health Savings Account Contact information is provided below.

Admin America

Health Savings Account Financial Institution

1720 Windward Concourse, Suite 290 Alpharetta, Georgia 30005

Address

770-992-5959

Phone

Additionally, Admin America may charge account fees to account holders. For more details about account holder rights and responsibilities, fees and/or any account options, contact the HSA Financial Institution listed above.

To request enrollment, when eligible, or obtain more information about when you can and cannot make new HSA payroll related deductions, please contact the Health Savings Account Financial Institution (contact details above) or the Plan Administrator.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

SOURCE OF ACCOUNT CONTRIBUTIONS

Employees

TAX STATUS OF EMPLOYEE CONTRIBUTIONS

Pre-Taxed

EMPLOYEES ELIGIBLE TO DEFER

In order to defer pre-tax monies into a Health Savings Account (H.S.A.), an Employee must:

- be actively employed
- be eligible to make deferrals into an H.S.A. at the time the deferral is made
- be eligible for and elect a Qualified High Deductible (H.S.A. eligible) Health Plan option offered by Axiom Staffing Group, Inc.
- have an 'open' Health Savings Account (the banking requirements for the individual have been met)
- meet any additional IRS guidelines regarding HSA eligibility.

CHANGING HSA DEFERRAL AMOUNTS

An Employee can stop, on a prospective basis, Health Savings Account deferrals at any time without any reason.

However, the ability to start or change deferrals during the Plan Year, if any, is subject to the Employer's payroll practices. Please contact the Plan Administrator for more details.

WHEN EMPLOYEE PARTICIPATION ENDS

Date the Employee becomes ineligible to contribute towards a Health Savings Account.

For more information regarding Health Savings Accounts, contact the Health Savings Account financial institution or visit:
https://www.irs.gov/publications/p969/ar02.html

ADDENDUM A

Component Benefit Plans Offered in the Plan

Eligibility and participation requirements are summarized in the tables below for each Component Benefit Plan offered in the Plan. With respect to any waiting period for initial enrollment under any Welfare Plan the Plan Administrator may provide for the crediting of prior service for Employees of participating employers involved in an acquisition, merger or similar transaction with the Employer. Contact the Plan Administrator for details if you believe this may apply to you.

Availability of benefits is subject to the Employee, Dependent and/or Plan Participant or Beneficiary fulfilling any enrollment requirements, maintaining eligibility and making all payments and/or contributions to the plan, as required. Additional eligibility rules, rights, plan restrictions and/or limitations may apply as defined in each Component Benefit Plan's related Plan documents. To determine eligibility, please review the sections below and each Component Benefit Plan's related Plan Documents to ensure your understanding of the benefits, limitations, exclusions, rights, responsibilities and general terms applicable to each Component Benefit Plan. Related Plan Documents include but are not limited to documents such as: Certificate of Insurance, contracts, agreements, amendments, riders, Summary of Benefits and Coverage and/or Summary Plan Description, and any other documents making up the Component Benefit Plan. In the event a Component Benefit Plan utilizes a network of providers, such a listing of providers is provided and/or made available without charge by requesting such, in writing, from the Plan or the Plan Administrator. Each Component Benefit Plan's related Plan Documents and listings are provided in one or more separate documents and/or made available by means of electronic access via the Internet. These documents will also provide the provisions that govern the use, benefit and/or requirement to access care. A copy of this document and each Component Benefit Plan's related Plan Documents are provided/made available at no charge by requesting such, in writing, from the Plan or the Plan Administrator. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

In order to participate in each Component Benefit Plan, Employees must satisfy and maintain eligibility and contribution requirements as described in summary in the tables below and must comply with the enrollment requirements, as set forth by the Plan. "**When Employee Participation Begins"** (in the tables below) indicates when Eligible Employees can enroll or apply for (initial) entry into the Plan. Likewise, **"When Employee Participation Ends"** (in the tables below) generally provides the date coverage will end due to instances in which a loss of eligible Employee (or Dependent) status occurs. Other situations in which Participation would otherwise end include but are not limited to: Plan termination or in the event of a Plan Participant's failure to make timely contributions or enrollment elections, as defined by the Plan, when required. An individual also ceases to be a Participant or Beneficiary in any Component Benefit Plan on the earliest date in which such individual: becomes ineligible to receive any plan benefit, even if the contingency for which the benefit is provided occurs, and such individual is not designated by the Plan as an eligible Participant or Beneficiary. Unless otherwise noted in the Component Benefit Plan documents, an Eligible Employee must participate in the Plan in order for Dependents to participate/be eligible for the Plan.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	GROUP HEALTH PLAN(S)
NAME OF COMPONENT BENEFIT PLAN(S)	CIGNA OPEN ACCESS PLAN - LOW CIGNA OPEN ACCESS PLAN- HIGH CIGNA HSA OPEN ACCESS PLAN
PLAN CLAIMS CONTACT INFORMATION	Medical Claims at P.O. Box 188061, Chattanooga TN 37422-8061 or (800) 997-1654
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer & Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Full- time employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	End of month in which Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

ATTENTION:
If you speak a non-English language, language assistance services, free of charge, are available to you. Call (800) 997-1654.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	MINIMUM ESSENTIAL COVERAGE GROUP HEALTH PLAN(S)
NAME OF COMPONENT BENEFIT PLAN(S)	MECPLANNAME
PLAN CLAIMS CONTACT INFORMATION	MECCaprock at 4401 82nd Street, Suite 1200, Lubbox, TX 79424 or 1-800-747-9446
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer & Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Seasonal/ Temporary Employees
WHEN EMPLOYEE PARTICIPATION BEGINS	1st of month following the end of a 60 day Administrative Period for Variable hour Employees and after the applicable testing period for any Variable Hour Employee as described in **Addendum B**
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	End of month in which Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not Seasonal/ Temporary
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

ATTENTION:
If you speak a non-English language, language assistance services, free of charge, are available to you. Call 1-800-747-9446.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	HOSPITAL INDEMNITY BENEFITS
NAME OF COMPONENT BENEFIT PLAN(S)	HOSPITAL INDEMNITY(HIP) PLAN
PLAN CLAIMS CONTACT INFORMATION	WEB-TPA at PO Box 310 Grapevine, TX 76099-0067 or 1-866-441-3433
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer & Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Seasonal/ Temporary Employees
WHEN EMPLOYEE PARTICIPATION BEGINS	1st of month following a 60 day waiting period for Seasonal/ Temporary Employees.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	End of month in which Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Seasonal/ Temporary Employees.
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

COMPONENT BENEFIT PLAN(S) DESCRIPTION	DENTAL PLAN(S)
NAME OF COMPONENT BENEFIT PLAN(S)	METLIFE DENTAL PLAN
PLAN CLAIMS CONTACT INFORMATION	Metlife Dental Claims at PO BOX 981282 El Paso, TX 79998-1282 or 800-275-4638
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Full- time Employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	End of month in which Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

COMPONENT BENEFIT PLAN(S) DESCRIPTION	DENTAL PLAN(S)
NAME OF COMPONENT BENEFIT PLAN(S)	WEB-TPA DENTAL PLAN
PLAN CLAIMS CONTACT INFORMATION	WEB-TPA at PO Box 310 Grapevine, TX 76099-0067 or 866-441-3433
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer & Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Seasonal/ Temporary Employees
WHEN EMPLOYEE PARTICIPATION BEGINS	1st of month following a 60 day waiting period
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	End of month in which Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Seasonal/ Temporary Employees
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

COMPONENT BENEFIT PLAN(S) DESCRIPTION	VISION PLAN(S)
NAME OF COMPONENT BENEFIT PLAN(S)	VSP VISION
PLAN CLAIMS CONTACT INFORMATION	VSP at PO Box 385018 Birmingham, AL 35238-5018 or 1-800-877-7195
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Full- time Employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	End of month in which Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

COMPONENT BENEFIT PLAN(S) DESCRIPTION	BASE LIFE AND AD&D
NAME OF COMPONENT BENEFIT PLAN(S)	METLIFE BASIC TERM LIFE/AD&D
PLAN CLAIMS CONTACT INFORMATION	MetLife Group Life Claims at P.O. Box 6100, Scranton, PA 18505-6100 or 1-800-638-6420
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	N/A
ELIGIBLE EMPLOYEE DESCRIBED	Full- time Employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	Date Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	N/A
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

Please note, employer provided (paid) base life benefits may be taxable. For more details, please visit: https://www.irs.gov/help-resources/tools-faqs/faqs-for-individuals/frequently-asked-tax-questions-answers/interest-dividends-other-types-of-income/life-insurance-disability-insurance-proceeds/life-insurance-disability-insurance-proceeds-1.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	SUPPLEMENTAL/VOLUNTARY LIFE AND AD&D
NAME OF COMPONENT BENEFIT PLAN(S)	METLIFE VOLUNTARY LIFE
PLAN CLAIMS CONTACT INFORMATION	MetLife Group Life Claims at P.O. Box 6100, Scranton, PA 18505-6100 or 1-800-638-6420
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Full- time Employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	Date Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

Please note: AD&D coverage, if offered to the employee, may not extend to Dependents covered under the Plan. For more details, please review the Insurance Certificate or related Plan Documents or contact the Plan Administrator. And, Employee (paid) life benefits may be taxable when funded by pre-taxed contributions. For more details, please visit *https://www.irs.gov/government-entities/federal-state-local-governments/group-term-life-insurance.*

COMPONENT BENEFIT PLAN(S) DESCRIPTION	BASE LIFE AND AD&D
NAME OF COMPONENT BENEFIT PLAN(S)	WEB-TPA BASIC TERM LIFE/AD&D
PLAN CLAIMS CONTACT INFORMATION	WEB-TPA at PO Box 310 Grapevine, TX 76099-0067 or 866-441-3433
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	N/A
ELIGIBLE EMPLOYEE DESCRIBED	Seasonal/ Temporary Employees
WHEN EMPLOYEE PARTICIPATION BEGINS	1st of month following a 60 day waiting period for Seasonal/ Temporary Employees.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	Date Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Seasonal/ Temporary Employees
ELIGIBLE DEPENDENTS	N/A
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

Please note, employer provided (paid) base life benefits may be taxable. For more details, please visit: https://www.irs.gov/help-resources/tools-faqs/faqs-for-individuals/frequently-asked-tax-questions-answers/interest-dividends-other-types-of-income/life-insurance-disability-insurance-proceeds/life-insurance-disability-insurance-proceeds-1.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	VOLUNTARY LONG-TERM DISABILITY
NAME OF COMPONENT BENEFIT PLAN(S)	METLIFE LONG TERM DISABILITY PLAN
PLAN CLAIMS CONTACT INFORMATION	Metlife at P.O. Box 14590, Lexington, KY 40512 or 1-888-444-1433
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	N/A
ELIGIBLE EMPLOYEE DESCRIBED	Full- time Employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	Date Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	N/A
WHEN DEPENDENT PARTICIPATION ENDS	N/A

Please note: disability benefits that are a) employer provided (paid – in whole or in part), or b) purchased with pre-taxed employee contributions, if applicable, may be taxable. For more details, please visit: https://www.irs.gov/help-resources/tools-faqs/faqs-for-individuals/frequently-asked-tax-questions-answers/interest-dividends-other-types-of-income/life-insurance-disability-insurance-proceeds/life-insurance-disability-insurance-proceeds-1.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	VOLUNTARY SHORT TERM DISABILITY
NAME OF COMPONENT BENEFIT PLAN(S)	METLIFE SHORT TERM DISABILITY PLAN
PLAN CLAIMS CONTACT INFORMATION	Metlife Short Term Disability Plan at P.O. Box 14590, Lexington, KY 40512 or 1-800-230-9531
PLAN BENEFITS FUNDED BY	Insurer (Insurance Company)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Insurer (Insurance Company)
SOURCE OF PLAN CONTRIBUTIONS	Employer
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	N/A
ELIGIBLE EMPLOYEE DESCRIBED	Full- time employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	Date Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	N/A
WHEN DEPENDENT PARTICIPATION ENDS	N/A

Please note: disability benefits that are a) employer provided (paid – in whole or in part), or b) purchased with pre-taxed employee contributions, if applicable, may be taxable. For more details, please visit: https://www.irs.gov/help-resources/tools-faqs/faqs-for-individuals/frequently-asked-tax-questions-answers/interest-dividends-other-types-of-income/life-insurance-disability-insurance-proceeds/life-insurance-disability-insurance-proceeds-1.

COMPONENT BENEFIT PLAN(S) DESCRIPTION	CAFETERIA PLAN: HEALTH CARE FLEXIBLE SPENDING ACCT
NAME OF COMPONENT BENEFIT PLAN(S)	AXIOM STAFFING GROUP, INC. HEALTHCARE FLEXIBLE SPENDING ACCOUNT
PLAN CLAIMS CONTACT INFORMATION	United Healthcare at PO Box 30506, Salt Lake City, UT 84130
PLAN BENEFITS FUNDED BY	Plan Sponsor (Employer)
PLAN (CLAIMS PAYMENT) SERVICES PROVIDED BY	Administrative Contract (Third Party Administrator)
SOURCE OF PLAN CONTRIBUTIONS	Employer & Employees
TAX STATUS OF EMPLOYEE CONTRIBUTIONS	Pre-Taxed
ELIGIBLE EMPLOYEE DESCRIBED	Full- time employees working 30+ hours/week.
WHEN EMPLOYEE PARTICIPATION BEGINS	First of month following date of hire for Full- Time Employees working 30+ hours/week.
DEFAULT ENROLLMENT APPLIES IN THE EVENT OF	N/A, default enrollment does not apply in the event you fail to make a formal election it is presumed that you have intended to decline coverage due to other coverage
WHEN EMPLOYEE PARTICIPATION ENDS	Date Employee becomes ineligible
INELIGIBLE EMPLOYEES	Employees who are not considered Full-Time (such as Part-Time Employees), Employees who are considered Seasonal/ Temporary and Variable Hour Employees who do not work at least the specified hours during the testing period as described in **Addendum B**
ELIGIBLE DEPENDENTS	Dependent children and legal Spouse, including a bona fide domestic partner
WHEN DEPENDENT PARTICIPATION ENDS	Refer to the related Plan Documents for specific details regarding age limitations or restrictions, if dependent benefits are offered

Any healthcare Flexible Spending Account is deemed as a health and welfare benefit Plan and is therefore subject to ERISA and a Component Benefit Plan under this Plan. However, salary deferrals, if any, associated with a Cafeteria Plan for non-health and welfare plans (such as Dependent care, transit and parking, etc.) are not subject to the provisions of ERISA and therefore are not considered to be a part of this Plan though funding for such non-health and welfare plans may be administered under the Cafeteria Plan. For more information about Flexible Spending Accounts, visit: https://www.irs.gov/pub/irs-pdf/p969.pdf or https://www.irs.gov/publications/p15b/ar02.html.

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ADDENDUM B

Explanation of Hours of Service Requirement for Employees

The Affordable Care Act (ACA) imposes rules governing offers of group health plan coverage by Employers. An offer of group health plan coverage is based upon an expectation of full-time status.

However, in the case of a Variable Hour Employee, an offer of group Health plan coverage is based upon the result of the measurement period. Therefore, some Employees may be considered full-time as per the 'look-back measurement method' described below. The look-back measurement method applies to both newly hired and other (ongoing) part-time, hourly and/or seasonal Employees as applicable.

These rules are important, since they determine the circumstances under which Employees qualify for coverage and when.

CLASSIFICATION OF EMPLOYEES

Upon hire an Employee will be classified as full-time, part-time, variable hour, or seasonal as follows as noted in **Addendum A**.

- **Full-Time Employee** is a Employee who is expected to work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A.**
- **Hourly Employee** is an Employee who is paid an hourly wage for their services, as opposed to a fixed salary. This Employee may or may not work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A.**
- **Non-resident Alien** is an Employee who is assigned a classification by the Internal Revenue Service as a non-U.S. citizen, or foreign national status or an individual who doesn't pass the green card test or the substantial presence test. This Employee may or may not work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A.**
- **Part-Time Employee** is an Employee who is not expected to work the required average number of hours per week during each calendar month as expressed for plan eligibility for each Component Benefit Plan in **Addendum A**.
- **Salaried Employee** is an Employee who is paid a fixed amount of money or compensation (also known as a salary).
- **Seasonal Employee** is an Employee who performs labor or services on a seasonal basis and who is hired into a position for which the customary annual employment is six months or less. Generally, this employee is not eligible for some or all of the Component Benefit Plans offered in the Plan.
- **Variable Hour Employee** is an Employee for whom, based on the facts and circumstances at the start date, it cannot be determined that such Variable Hour Employee is reasonably expected to work, on average, the required number of hours per week during the testing period as described in Addendum B and as expressed for plan eligibility for each Component Benefit Plan in **Addendum A**.

Employees who are *not regularly* scheduled to work the hours necessary to be considered benefit eligible (such as Part-Time, Seasonal and Variable Hour Employees), must first complete a **12-month initial measurement period** (that starts on the **first day of employment**) during which they are *not* eligible to participate in the plan. At the completion of the initial measurement period, an Employee who has worked, on average, at least 30 hours of service per week during that period will be eligible for coverage on the **first day of the month following a 60 day Administrative Period** (i.e., 13-and-a-fraction months after his or her hire date). Employees who qualify for coverage under this rule will remain eligible for a **12-month period** (called the 'stability period') irrespective of their hours, provided they remain employed. An Employee who fails to work on average at least 30 hours per week during his or her initial measurement period is not eligible for coverage during the corresponding stability period. Employees, who have been employed for some time are subject to similar rules, except that the testing period is a fixed, **12-month** period that runs from **November 1 to the following October 31**. This period is called the 'standard measurement period.'

Once an Employee has worked through a full standard measurement period, he or she is considered to be an 'ongoing Employee.' An ongoing Employee who works on average at least 30 hours of service per week during any standard measurement period will qualify for coverage during a stability period, which is the **immediately following calendar year**. An ongoing Employee who fails to work on average at least 30 hours per week during

any standard measurement period is not eligible for coverage during the corresponding stability period.

There are rules that govern the transition from newly hired to ongoing Employee that will affect when coverage might be available. In addition, where an Employee experiences a break-in-service of at least 13 weeks (26 weeks for educational institutions), they may be treated as newly hired upon their return. A similar result occurs under a 'rule of parity' where a rehired Employee may be treated as a new Employee following a break of at least four weeks if the Employee's break in service is longer than the Employee's period of service immediately preceding the break in service.

Summary of Axiom Staffing Group, Inc.'s Hours Requirement for Eligibility

The tables below are designed to summarize the method and manner in which Axiom Staffing Group, Inc. determines variable hour Employees' eligibility in our health plan.

New Hire (Initial) Eligibility

TYPE OF MEASUREMENT STANDARD	Look Back Measurement Method
MEASUREMENT PERIOD	10 Months
MEASUREMENT PERIOD BEGINS	1st day of Employment
ADMINISTRATIVE PERIOD	60 Days After Close of Measurement Period
WHEN COVERAGE BECOMES EFFECTIVE	1st of Month Following End of Administrative Period
STABILITY PERIOD	12 Months

Once a variable hour Employee has completed initial eligibility as described above, they will be considered an Ongoing Employee subject to a Standard Measurement Period Testing as described below.

Ongoing Employee Eligibility

TYPE OF MEASUREMENT STANDARD	Look Back Measurement Method
MEASUREMENT PERIOD	10 Months
MEASUREMENT PERIOD BEGINS	June through April
ADMINISTRATIVE PERIOD	60 Days
WHEN COVERAGE BECOMES EFFECTIVE	1st of Month Following End of Administrative Period
STABILITY PERIOD	12 Months

Need Help or Additional Information?

If you need additional information, need help and/or believe *your or your* Dependent(s) eligibility has been calculated incorrectly, please contact the Plan Administrator immediately for more information or assistance. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

44. SUMMARY ANNUAL REPORT (SAR) DISCLOSURE NOTICE

A Summary Annual Report is a summary of certain information contained in a plan's annual report on Form 5500, along with notification to Participants of their rights under ERISA to receive additional information. ERISA requires that a Summary Annual Report be given to each Participant covered under an ERISA Welfare Benefit Plan. While most plans that are required to Form 5500 are also required to provide Summary Annual Report, a plan is exempt from this requirement if it is a totally unfunded Welfare Benefit Plan under which benefits are paid solely from the general assets of the Employer or Employee organization maintaining the plan.

The Summary Annual Report must be furnished to plan Participants within nine months after the end of each Plan Year.

If, however, an extension of time to file Form 5500 is granted, the time to provide the Summary Annual Report is also extended. In such case, the Summary Annual Report must be furnished within two months after the extended deadline for filing the Form 5500.

SARs may be distributed in any manner that would satisfy the DOL rules for distribution of Summary Plan Descriptions.

45. SUMMARY OF BENEFITS & COVERAGE (SBC) NOTICE

The Summary of Benefits and Coverage (SBC) is designed to help you better understand and evaluate your group health insurance choices. The SBC contains the same standard language used by all insurance companies and group health plans to make it easier for you to compare health plans.

The information contained in an SBC includes:

- A short plain language summary about benefits & coverage
- A uniform glossary of health insurance terms

The SBC also includes details, called 'coverage examples,' which are comparison tools that allow you to see what the plan would generally cover in two common medical situations.

You may also request a copy of the glossary of terms from your Health Plan Sponsor, Insurer or Administrator.

Also, if you don't speak English, you may be entitled to receive the SBC and uniform glossary in your native language upon request to your health Insurance Company or group health plan.

In an effort to comply with the Affordable Care Act (Healthcare Reform), a copy of the Summary of Benefits & Coverage (SBC) for the plan is enclosed/included.

The SBC is always available by contacting the (underlying Component Benefit Plan contract) health plan (see **Addendum A**), the Plan Administrator or Third-Party Administrator (see **Addendum A**). The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

46. MODEL MARKETPLACE NOTICE DISCLOSURE

If your company is covered by the Fair Labor Standards Act, it should provide a written notice to you about the Health Insurance Marketplace by October 1, 2013.

Employers must provide the notice to each Employee (automatically and free of charge) regardless of plan enrollment status (if applicable) or of part-time or full-time status.

The notice may be provided by first-class mail or, alternatively, it may be provided electronically if certain requirements are met.

Employers are not required to provide a separate notice to Dependents or other individuals who are or may become eligible for coverage under the plan but who are not Employees.

Employers are required to provide a written notice to each current Employee not later than October 1, 2013, and to each new Employee at the time of hiring beginning October 1, 2013 (a notice will generally be considered provided at the time of hiring' if it is provided within 14 days of an Employee's start date).

The Marketplace Notice is intended to inform Employees:

- About the Health Insurance Marketplace (www.healthcare.gov)
- That, depending on their income and what coverage may be offered by the Employer, they may be able to get lower cost private insurance in the Marketplace
- That, if they buy insurance through the Marketplace, they may lose the Employer contribution (if any) to their health benefits.

Which Marketplace Notice Applies to You?

Because Employees' situation can change from time to time, we have provided all Marketplace notices that may apply to you. The chart below will help you determine which notice applies to you.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

(NOT OFFERED COVERAGE)

- For Employees who are not eligible for our health plan benefits (part-time Employees, for example)

(QUALIFIED COVERAGE)

- for Employees who are eligible to participate in the Cigna health plans whose annual income is equal to or more than: $20,830.67

(NON-QUALIFIED COVERAGE)

- for Employees in the Cigna plans whose annual income is less than: $20,830.67
- for Employees who are offered Minimum Essential (only) Health Plan Coverage

If you have questions about the notice, you can also ask your Employer.

These notices apply to the following Employers participating in the Plan:

Controlling Employer of the Plan

Axiom Staffing Group, Inc.
FEIN: 58-2449544
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

New Health Insurance Marketplace Coverage Options and Your Health Coverage

(EMPLOYEE IS NOT OFFERED COVERAGE)

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as June 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Axiom Staffing Group, Inc.		58-2449544
5. Employer address		6. Employer phone number
2475 Northwinds Parkway, Suite 575		(678) 762-0285
7. City	8. State	7. Zip Code
Alpharetta	GA	30009
10. Who can we contact about Employee health coverage at this job? Human Resources at Axiom Staffing Group, Inc.		
11. Phone number (if different from above)	12. Email address	
(678) 762-0285	insurance@axiomstaffing.com	

You are not eligible for health insurance coverage through this employer. You and your family may be able to obtain health coverage through the Marketplace, with a new kind of tax credit that lowers your monthly premiums and with assistance for out-of-pocket costs.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

(EMPLOYEE IS OFFERED QUALIFIED COVERAGE)

Form Approved
OMB No. 1210-149
(expires 5-31-2020)

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as June 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact your Employer at (678) 762-0285.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Axiom Staffing Group, Inc.		4. Employer Identification Number (EIN) 58-2449544
5. Employer address 2475 Northwinds Parkway, Suite 575		6. Employer phone number (678) 762-0285
7. City Alpharetta	8. State GA	7. Zip Code 30009
10. Who can we contact about Employee health coverage at this job? Human Resources at Axiom Staffing Group, Inc.		
11. Phone number (if different from above) (678) 762-0285	12. Email address insurance@axiomstaffing.com	

Here is some basic information about health coverage offered by this Employer:

- As your Employer, we offer a health plan to:
  - ☐ All Employees. Eligible Employees are:
    considered **Full-Time** benefit eligible Employees who remain actively at work.

  - ☒ Some Employees. Eligible Employees are:
    considered **Full-Time** or **Variable Hour** benefit eligible Employees who remain actively at work.

- With respect to Dependents:
  - ☒ We do offer coverage. Eligible Dependents are:
    dependent children and legal spouse, including a bona fide domestic partner. Benefit eligibility is based upon a variety of issues, including Employee participation and eligibility and Dependent status.

  - ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable based on employee wages.

** Even if your employer *intends* for your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

(EMPLOYEE IS OFFERED NON-QUALIFIED COVERAGE)

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: GENERAL INFORMATION

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

WHAT IS THE HEALTH INSURANCE MARKETPLACE?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as June 1, 2014.

CAN I SAVE MONEY ON MY HEALTH INSURANCE PREMIUMS IN THE MARKETPLACE?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

DOES EMPLOYER HEALTH COVERAGE AFFECT ELIGIBILITY FOR PREMIUM SAVINGS THROUGH THE MARKETPLACE?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

HOW CAN I GET MORE INFORMATION?

For more information about your coverage offered by your employer, please check your summary plan description or contact the Plan Administrator at (678) 762-0285.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name		4. Employer Identification Number (EIN)
Axiom Staffing Group, Inc.		58-2449544
5. Employer address		6. Employer phone number
2475 Northwinds Parkway, Suite 575		(678) 762-0285
7. City	8. State	7. Zip Code
Alpharetta	GA	30009
10. Who can we contact about Employee health coverage at this job?		
Human Resources		
11. Phone number (if different from above)	12. Email address	
(678) 762-0285	insurance@axiomstaffing.com	

Here is some basic information about health coverage offered by this Employer:

- As your Employer, we offer a health plan to:
  - ☐ All Employees. Eligible Employees are:
    considered **Full-Time** benefit eligible Employees who remain actively at work.

  - ☒ Some Employees. Eligible Employees are:
    considered **Full-Time** or **Variable Hour** benefit eligible Employees who remain actively at work.

- With respect to Dependents:
  - ☒ We do offer coverage. Eligible Dependents are:
    Dependent children and legal spouse, including a bona fide domestic partner. Benefit eligibility is based upon a variety of issues, including Employee participation and eligibility and Dependent status.

  - ☐ We do not offer coverage.

  - ☐ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable based on employee wages.

  ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

47.
IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE (**CREDITABLE** COVERAGE)

CMS Form 10182-CC Updated April 1, 2011
OMB 0938-0990

Important Supplemental Information to this notice

This notice applies to the following group health plans offered by the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan:

- Cigna Open Access Plan - Low;
- Cigna Open Access Plan- High; and
- Cigna HSA Open Access Plan;

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Axiom Staffing Group, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- Axiom Staffing Group, Inc. has determined that the prescription drug coverage offered by the Cigna Open Access Plan - Low, Cigna Open Access Plan- High and Cigna HSA Open Access Plan, is, on average for all plan Participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

In order to determine eligibility, you may need to compare the credibility status of your previously elected Axiom Staffing Group, Inc. health plan to your current plan election, if any. Refer to the information under the section entitled **"Optional Information to Help You"** or contact your Plan Administrator at Axiom Staffing Group, Inc. or the health plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Axiom Staffing Group, Inc. coverage may be affected. You may be able to keep this coverage if you elect part D and this plan may coordinate with Part D coverage. Please refer to your Component Benefit Plan's related Plan Documents or contact the health plan for more details regarding coordination of coverage.

If you do decide to join a Medicare drug plan and drop your current Axiom Staffing Group, Inc. coverage be aware that you and your Dependents may be able to get this coverage back.

When Will You Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Axiom Staffing Group, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base Beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base Beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the Plan Administrator or the Health Plan listed below for further information.

Axiom Staffing Group, Inc.
Plan Administrator
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Axiom Staffing Group, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf ("Medicare & You") handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf ("Medicare & You") handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (**1-800-633-4227**). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Optional Information to Help You

The charts below may help ensure you understand the credibility (or non-credibility) status of Axiom Staffing Group, Inc.'s prescription drug plan(s). It may be helpful to you to consider the credibility status when making coverage selections and to identify a possible status change (affording you a Special Enrollment Period under Medicare *or not*).

2018-2019 (Prior) Plan Year Group Health Plans	**Prescription Plan Status Per CMS/ Medicare**
Cigna Open Access Plan - Low	Creditable
Cigna Open Access Plan- High	Creditable
MEC Plan	Non-Creditable

2019-2020 (Current) Plan Year Group Health Plans	**Prescription Plan Status Per CMS/ Medicare**
Cigna Open Access Plan - Low	Creditable
Cigna Open Access Plan- High	Creditable
Cigna HSA Open Access Plan	Creditable

MEC Plan	Non-Creditable

Contact & Notice Information

Date: Not less than annually, prior to 10/15
Entity: Axiom Staffing Group, Inc.
Contact: **Plan Administrator**
Address: 2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone Number: (678) 762-0285

OMB 0938-0990 CMS Form 10182-NC Updated April 1, 2011

48. IMPORTANT NOTICE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE (**NON-CREDITABLE** COVERAGE)

CMS Form 10182-NC Updated April 1, 2011
OMB 0938-0990

Important Supplemental Information to this notice:

This notice applies to the following group health plans offered by the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan:

- MEC Plan

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Axiom Staffing Group, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are three important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Axiom Staffing Group, Inc. has determined that the prescription drug coverage offered by the MEC Plan;, on average for all plan Participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered Non-Creditable Coverage. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the MEC Plan,. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.
- You can keep your current coverage from MEC Plan,. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully—it explains your options.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

When Will You Pay A Higher Premium (Penalty) To Join a Medicare Drug?

Since the coverage under MEC Plan is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, your monthly premium may go up by at least 1% of the Medicare base Beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your

premium may consistently be at least 19% higher than the Medicare base Beneficiary premium. You may have to pay this higher premium (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Axiom Staffing Group, Inc. coverage may not be affected.
You may be able to keep this coverage if you elect part D and this plan may coordinate with Part D coverage

If you do decide to join a Medicare drug plan and drop your current Axiom Staffing Group, Inc. coverage, be aware that you and your Dependents may be able to get this coverage back.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the Plan Administrator or the Health Plan listed below for further information.

Axiom Staffing Group, Inc.
Plan Administrator
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan and if this coverage through Axiom Staffing Group, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf ("Medicare & You") handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the https://www.medicare.gov/pubs/pdf/10050-Medicare-and-You.pdf ("Medicare & You") handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

OMB 0938-0990 CMS Form 10182-NC Updated April 1, 2011

Optional Information to Help You

The charts below may help ensure you understand the credibility (or non-credibility) status of Axiom Staffing Group, Inc.'s prescription drug plan(s). It may be helpful to you to consider the credibility status when making coverage selections and to identify a possible status change (affording you a Special Enrollment Period under Medicare *or not*).

2018-2019 (Prior) Plan Year Group Health Plans	**Prescription Plan Status Per CMS/ Medicare**
Cigna Open Access Plan - Low	Creditable
Cigna Open Access Plan- High	Creditable
MEC Plan	Non-Creditable

2019-2020 (Current) Plan Year Group Health Plans	**Prescription Plan Status Per CMS/ Medicare**
Cigna Open Access Plan - Low	Creditable
Cigna Open Access Plan- High	Creditable
Cigna HSA Open Access Plan	Creditable
MEC Plan	Non-Creditable

Contact & Notice Information

Date: Not less than annually, prior to 10/15

Entity:	Axiom Staffing Group, Inc.
Contact:	**Plan Administrator**
Address:	2475 Northwinds Parkway, Suite 575 Alpharetta, GA 30009
Phone Number:	(678) 762-0285

The valid OMB control number for this information collection is 0938-0990.

49. GROUP HEALTH PLAN PRIVACY NOTICE BASICS

Overview

The federal law Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandates strict privacy and security standards to protect Protected Health Information (PHI) and Electronic Protected Health Information (ePHI) as defined below. The Plan intends to affect the necessary measures to protect such information pertaining to covered persons to ensure such information remains confidential. This notice sets forth the guidelines the Plan Sponsor must follow when using and disclosing PHI.

The federal law Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all parties involved to take sufficient steps to protect any individually identifiable health information to the extent that such information must be kept confidential.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Terms

COVERED ENTITIES

Group health plans that provide or pay the cost of medical care are covered entities under the federal privacy law known as the Health Insurance Privacy and Accountability Act (HIPAA). For the purposes of HIPAA, the term "group health plans" include:

- health*
- dental
- vision
- prescription drug insurers
- health maintenance organizations ("HMOs")
- Medicare
- Medicaid
- Medicare+Choice and Medicare supplement insurers
- long-term care insurers (excluding nursing home fixed-indemnity policies)

*Health may include a Healthcare Reimbursement Arrangement and/or a Healthcare Flexible Spending Account

For the purposes of HIPAA, the term "group health plans" include:

- Employer-sponsored group health plans
- government and church-sponsored health plans
- multi-employer health plans

There are exceptions. A group health plan with less than 50 participants that is administered solely by the employer that established and maintains the plan is not a covered entity.

Two types of government-funded programs are not health plans:

- those whose principal purpose is not providing or paying the cost of health care, such as the food stamps program;
- those programs whose principal activity is directly providing health care, such as a community health center, or the making of grants to fund the direct provision of health care. Certain types of insurance entities are also not health plans, including entities providing only workers' compensation, automobile insurance, and property and casualty insurance. If an insurance entity has separable lines of business, one of which is a health plan, the HIPAA regulations apply to the entity with respect to the health plan line of business.

INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Health information that either actually identifies an individual or creates a reasonable basis to believe that the information would identify the individual.

Protected Health Information (PHI) means health information that:

- Is created or received by health care providers, health plans, or health care clearinghouses;
- Relates to an individual's past, present or future physical or mental health condition, the provision of health care to an individual or the past, present or future payment for the provision of health care to an individual;

- Identifies the individual or creates a reasonable basis to believe that the information, including demographic information, can be used to identify the individual.

Electronic Protected Health Information (ePHI) refers to PHI that is transmitted by maintained in electronic media, as defined in 45 C.F.R. § 160.103. For the purposes of this Document, ePHI and PHI are used synonymously herein.

Learn About Your Privacy Rights

An Insurance Company that provides group health coverage is a covered entity. The insurer of the group health plan is responsible to provide a copy of the privacy notice (to describe how medical information about you can be used and disclosed and how you can get access to this information).

The Plan Sponsor (Employer) is the covered entity if the health plan is self-insured (such as a partially self -funded health plan, a health care Flexible Spending Account or Health Reimbursement Account). If the group health plan is self-insured, the Plan Administrator or Third-Party Administrator will provide a copy of the group health plan's privacy notice.

If you have any questions about this Notice or about our privacy practices, please contact the plan (contact details can be found in **Addendum A**) or your Plan Administrator.

The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan is:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

50.
NOTICE OF HIPAA PRIVACY PRACTICES

Self-Insured/Funded Component Benefit Plan(s) Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This Notice of Privacy Practices describes the legal obligations of the following plans of Axiom Staffing Group, Inc. Employee Welfare Benefit Plan:

- health
- dental
- vision
- The Axiom Staffing Group, Inc. Cafeteria Plan (Health Care Flexible Spending Account)

This Notice of Privacy Practices also describes your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH). This Notice has been drafted in accordance with the HIPAA Privacy Rule, contained the in the Code of Federal Regulations at 45 CFR Parts 160 and 164. Terms not defined in this Notice have the same meaning as they have in the HIPAA Privacy Rule.

Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, health care operations or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices (the "Notice") to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan or your employer on behalf of a group health plan that relates to:

- Your past, present or future physical or mental health or condition;
- The provision of health care to you;
- The past, present or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please contact: HR Manager at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009 or by phone at (678) 775-3944. Or, you may contact the **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at: Axiom Staffing Group, Inc., 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009 or by phone at (678) 762-0285.

Effective Date

This Notice is effective January 1, 2015.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your protected health information;
- Inform you promptly if a breach occurs that may have compromised the privacy or security of your information;
- Provide you with certain rights with respect to your protected health information;
- Provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information;
- Follow the terms of the Notice that is currently in effect;
- Not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can share information, you may change your mind at any time and advise us in writing of such change.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail to their last-known address on file.

How We May Use and Disclose Medical Your Protected Health Information

We will disclose your protected health information when required to do so by federal, state or local law, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

FOR TREATMENT

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students or other hospital personnel who are involved in taking care of you. **For example**, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

FOR PAYMENT

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan or to coordinate Plan coverage. **For example**, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, medically necessary or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or pre-certification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

FOR HEALTH CARE OPERATIONS

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services and fraud & abuse detection programs; business planning and development such as cost management; and business management and general

administrative Plan activities. If use or disclosure of protected health information is made for underwriting purposes, any such protected health information that is genetic information of an individual is prohibited from being used or disclosed.

TO BUSINESS ASSOCIATES

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. **For example**, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

AS REQUIRED BY LAW

We may disclose your protected health information when required by national security laws or public health disclosure laws.

Additional permitted uses may also include:

TO ASSIST WITH PUBLIC HEALTH AND SAFETY ISSUES

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

TO PLAN SPONSORS

For the purpose of administering the plan, we may disclose to certain Employees of the Employer protected health information. However, those Employees will only use or disclose that information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

SPECIAL SITUATIONS

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

ORGAN AND TISSUE DONATION

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary to facilitate organ or tissue donation and transplantation.

MILITARY AND VETERANS

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

WORKERS' COMPENSATION

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS

We may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

HEALTH OVERSIGHT ACTIVITIES

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

LAW ENFORCEMENT

We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct;
- about criminal conduct;
- in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

NATIONAL SECURITY AND INTELLIGENCE ACTIVITIES

We may release your protected health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

INMATES

If you are an inmate of a correctional institution or are under the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

RESEARCH

We may disclose your protected health information to researchers when:

- The individual identifiers have been removed;
- When an institutional review board or privacy board (a) has reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

GOVERNMENT AUDITS

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

DISCLOSURES TO YOU

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information where the disclosure was for reasons other than for payment, treatment or health care operations, and where the protected health information not disclosed pursuant to your individual authorization.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care;
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

PERSONAL (AUTHORIZED) REPRESENTATIVES

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney).

Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- You have been, or may be, subjected to domestic violence, abuse or neglect by such person
- Treating such person as your personal representative could endanger you
- In the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

FUNDRAISING AND MARKETING

Prior to disclosing your protected health information in the case of any fundraising efforts, you will be notified prior to receiving such fundraising communications. Such communication will provide you with the option of opting-out of receiving such communications. Additionally, uses and disclosures of PHI for marketing purposes and disclosures that constitute a sale of PHI will require authorization.

SPOUSES AND OTHER FAMILY MEMBERS

With only limited exceptions, we will send all mail to the Employee. This includes mail relating to the Employee's Dependents who are covered under the Plans and includes mail with information on the use of Plan benefits by the Employee's Dependents and information on the denial of any Plan benefits to the Employee's Dependents.

If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

AUTHORIZATIONS

Other uses or disclosures of your protected health information not described above will only be made with your written authorization. Most uses and disclosures of psychotherapy notes (when appropriate) will require your authorization.

You may revoke written authorization at any time, so long as the revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Access

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to HR Manager at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. Or, you may contact the **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at: Axiom Staffing Group, Inc., 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing or other supplies associated with your request.

Additionally, you have the right to request electronic copies of certain protected health information in a designated record set. We will provide such information in the electronic form and format requested by you, provided it is readily producible. If the requested form and format are not readily producible, we will provide the information in a readable electronic form and format that is mutually agreed upon with you. If you request a copy of the electronic information, we may charge a reasonable fee for the labor costs and supplies involved in creating the information.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to HR Manager.

Right to Amend

If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to HR Manager. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the information that you would be permitted to inspect and copy
- Is already accurate and complete.

If we deny your request, we will notify you in writing within 60 days with an explanation as to why the request was denied. You then have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include:

- disclosures for purposes of treatment, payment or health care operations
- disclosures made to you
- disclosures made pursuant to your authorization
- disclosures made to friends or family in your presence or because of an emergency
- disclosures for national security purposes
- disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to HR Manager in c/o Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. Your request must state a time period of no longer than six years prior to the date you ask for the accounting.

Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

If you request a restriction, it is your responsibility to notify any other entity that may be impacted by the requested restriction.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if:

- except as otherwise required by law, the disclosure is to the health plan for purposes of carrying out payment or health care operations (and is not for purposes of carrying out treatment);
- the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid out-of-pocket in full.

To request restrictions, you must make your request in writing to HR Manager in c/o Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. In your request, you must tell us:

- what information you want to limit;
- whether you want to limit our use, disclosure, or both;
- to whom you want the limits to apply—**for example**, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to HR Manager in c/o Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information. Notice of a breach will be provided to you within 60 days of the breach being identified.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain a copy of this notice at our website, https://www.axiomstaffing.com/.

You may also obtain a paper copy of this notice by making a requesting in writing to the HR Manager in c/o Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. Or, you may contact the **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at: Axiom Staffing Group, Inc., 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009 or by phone at: (678) 762-0285

Right to Choose Someone to Act for You

You have the right to appoint a personal representative (also known as an "Authorized Representative") to act on your behalf with respect to your protected health information, such as if you have given someone medical power of attorney or if someone is your legal guardian.

To appoint a personal representative to act on your behalf, you must make your request in writing to HR Manager in c/o Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. Your request must specify who the individual is that you are appointing, that individual's contact information and in which matters the appointed individual may act on your behalf.

Right to File Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights. To file a complaint with the Plan, contact HR Manager in c/o Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009. Or, you may contact the **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at: Axiom Staffing Group, Inc., 2475 Northwinds Parkway, Suite 575, Alpharetta, GA 30009 or by phone at (678) 762-0285.

All complaints must be submitted in writing. A complaint to the Office of Civil Rights should be sent to the appropriate OCR

contact address for the region or by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights.

General Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Permitted Uses and Disclosures

The Plan Sponsor can use or disclose PHI without prior Participant authorization or consent in the following situations when the PHI is used or disclosed:

- to the Participant who is the subject of the PHI
- for treatment, payment or health care operations
- incident to a use or disclosure otherwise permitted or required under the privacy rules set forth in this Article, and such disclosure occurs despite reasonable Plan safeguards which are in place
- pursuant to and in compliance with a valid authorization
- pursuant to an agreement with the Participant in situations where the Participant is given the choice to agree to or object to such use or disclosure.

Adequate Separation

The following designated Employee(s) of the Plan Sponsor (and any delegates or successors to their current job titles/positions) may be given access to PHI and ePHI because such access is essential for them to perform their Plan administration duties:

- HR Manager (Ex. Human Resources or Privacy Officer)

The Employees identified above as having access to PHI shall have access to PHI that is restricted to Plan Administration functions necessary and essential for the ongoing functioning of the Plan.

The Plan's Privacy Officer has responsibility for facilitating and ensuring compliance with all privacy rules and procedures. All Employees and contractors of the Plan Sponsor who handle PHI will be subject to enforcement sanctions administered in a manner that is consistent with the Plan Sponsor's human resources policies and procedures. Sanctions will be determined based on the nature of the violation, its severity, whether or not the violation was intentional and whether or not the offending individual has engaged in previous violations. Sanctions may include verbal warnings, written warnings, probationary periods, suspension or termination. Sanctions will be consistently applied in a nondiscriminatory manner.

Other Questions about Your Plan?

To obtain more information, contact the **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

HIPAA PRIVACY AUTHORIZATION FORM

(Use this form if you want to authorize an adult or entity to receive protected health information about you.)

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. Authorization

I, _____, authorize (healthcare provider or health plan) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare

☐ from: _____ to _____

☐ All past, present, and future periods.

3. Extent of Authorization

☐ I authorize the release of my complete health record (including records relating to mental healthcare, and treatment of alcohol or drug abuse).

☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Alcohol/drug abuse treatment

☐ Other (please specify):

_____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

X_____

Signature of patient or personal representative

_____

Date

X_____

Printed name of patient or personal representative

X_____

Relationship to patient

51. WORKPLACE POSTERS

Some of the statutes and regulations enforced by the U.S. Department of Labor (DOL) and other state and federal agencies require that certain notices be provided to Employees and/or posted in the workplace.

Please note, some of these notices/posters may only apply in specific conditions or circumstances, if any. Please review them carefully to determine what information might apply to you. For questions, refer to the contact information provided on each notice in the following pages or Contact Human Resources for more information.

This information and other important Employee related information may be available in a (your) non-English language. Contact Human Resources, your Employer or the Plan Administrator for more information. The Plan Administrator for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at:

Axiom Staffing Group, Inc.
2475 Northwinds Parkway, Suite 575
Alpharetta, GA 30009
Phone: (678) 762-0285

52. DOCUMENT DISCLOSURE

This **Summary Plan Description,** or SPD, is the main vehicle for communicating plan rights and obligations to participants and beneficiaries. As the name suggests, it is a summary of the material provisions of the plan document and is intended to be understandable to the average participant or beneficiary of the employer. Previous to and following this page, you may find additional pieces of important information such as the Health Plan Summary of Benefits & Coverage for all group health plans offered.

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- Intended for informational purposes and does not replace any state or federal law, Certificate of Insurance or other Component Benefit Plan governing documents. Refer to the "Terms of the Plan" for more details.
- Not intended to provide tax or legal advice.
- Related Plan Document/Component Benefit Plan Information.

Please review all of the information carefully. At any time, you may request a copy of plan information, by making such request, from your Plan Administrator, in writing.

53. SUGGESTIONS OR QUESTIONS

We've got the resources to help! You're encouraged to ask questions and take an interest to understand your rights and responsibilities as an Axiom Staffing Group, Inc. eligible Employee, plan Participant or Beneficiary.

Call your Plan Administrator for more information. The **Plan Administrator** for the Axiom Staffing Group, Inc. Employee Welfare Benefit Plan at:

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Phone: (678) 762-0285

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