ARIEL CLINICAL SERVICES WRAP BENEFIT PLAN
PLAN DOCUMENT

As Amended and Restated
Effective as of December 1, 2022

This document together with the Master Contracts, the Employer Participation Agreements or the Certificates of Coverage identified in this document constitutes the Plan.

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INTRODUCTION

Ariel Clinical Services (the "Controlling Employer") hereby amends and restates in its entirety the ARIEL CLINICAL SERVICES WRAP BENEFIT PLAN (the "Plan"), formerly known as Ariel Clinical Services Employee Benefits Plan. The purpose of the Plan is to consolidate in one Plan document certain welfare benefit plans (the "Component Benefit Plans") sponsored by Ariel Clinical Services so as to provide uniform administration of such welfare benefits. The Component Benefit Plans are listed in **Exhibit A** to this Plan. This Plan is effective December 1, 2022 and supersedes any prior Plan document.

The insurance contracts, policies and procedures, and any other documents making up the Component Benefit Plans are hereby incorporated by reference into this document. (References in this document to insurance contracts, insurance policies and insurance generally will include HMO contracts, if any, or similar arrangements.) These documents in the aggregate serve as a written Plan document for purposes of compliance with the applicable requirements of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where a conflict of language exists between the Component Benefit Plan and this Plan or its Summary Plan Description ("SPD"), the Component Benefit Plan will control to the extent such Component Benefit Plan is not inconsistent with Federal law and regulations or unless the Plan specifically provides otherwise.

ARTICLE ONE: Definitions and Interpretation

Section 1.1 Definitions.
Where the following words and phrases appear in the Plan, they shall have the respective meanings set out below, unless their context clearly indicates otherwise. Capitalized terms not defined in this Plan will have the meaning given to them in the applicable documents describing the particular Component Benefit Plan.

(a) Affiliated Employer means any corporation, limited liability company, or other business entity that is under common control with Ariel Clinical Services (as determined under Code Section 414(b) or (c)); a member of an affiliated service group with Ariel Clinical Services (as determined under Code Section 414(m)); an entity required to be aggregated with Ariel Clinical Services pursuant to Code Section 414(o); or any other entity that the Controlling Employer permits participation in the Plan. Affiliated Employers that have adopted the Plan are listed in **Exhibit C**.

(b) Affordable Care Act means Patient Protection and Affordable Care Act ("ACA"), as amended by the Health Care and Education Reconciliation Act of 2010.

(c) Applicable Large Employer means, with respect to a calendar year, an employer that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. In making the Applicable Large Employer determination, all persons/entities treated as a single employer under Code Section 414(b), (c), (m) or (o) are treated as one employer.

(d) Certificate of Coverage means a document given to an insured that describes the benefits, limitations and exclusions of coverage provided by an insurance company.

(e) Code means the Internal Revenue Code of 1986, as amended.

(f) Component Benefit Plan means the specific benefit arrangement identified in **Exhibit A** by which the Plan provides welfare benefits. A Component Benefit Plan includes any applicable insurance policies and Certificates of Coverage relating thereto and may be amended from time to time by the Controlling Employer.

(g) Controlling Employer is Ariel Clinical Services. If the Controlling Employer merges or is otherwise consolidated with any Affiliated Employer, the surviving Employer, as to the group of Employees covered by the Plan immediately before such merger or consolidation and to the group of Employees of Affiliated Employers thereafter adopting the Plan, shall become the Controlling Employer, unless the Controlling Employer that will be merged out of existence specifies in writing to the contrary.

(h) Dependent means, unless otherwise specifically provided in the Plan or in a Component Benefit Plan (to the extent such provisions are in compliance with Federal law), a natural or adopted child, step-child, foster child, child for whom the Employee and/or the Employee's Spouse are the legal guardian or for whom the Employee or Employee's Spouse has legal custody, or any other person specified as such in **Exhibit A**.

(i) Effective Date of the Plan is December 1, 2022, superseding any prior versions of all Plans providing similar benefits as of such date.

(j) Employee means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (i)(A) any leased

employee (including but not limited to those individuals defined as leased employees in Code Section 414(n)) or an individual classified by the Employer as a contract worker or independent contractor for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll; (i)(B) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not in either (i)(A) or (i)(B) herein, such individual is determined by the Internal Revenue Service ("IRS"), any governmental agency or authority, or a court or agency (including any reclassification by an Employer or in settlement of any claim or action relating to such individual's employment status) to be a common-law employee of the Employer; (ii) any individual who is a former Employee; and (iii) any individual who is a non-resident alien. Notwithstanding the above, any of the individuals listed in the categories (i) through (iii) above, may be included if so specified in **Exhibit A** or are required to be included pursuant to the terms of **Exhibit B** attached hereto. Any Employee subject to a collective bargaining agreement may be included as an Employee under **Exhibit A** or **Exhibit B** attached hereto.

(k) Employer is the Controlling Employer and any Affiliated Employer that adopts the Plan in part or in its whole in accordance with the provisions of Article Eight.

(l) ERISA means the Employee Retirement Income Security Act of 1974, as amended.

(m) Group Health Plan is an employee welfare benefit plan within the meaning of ERISA Section 3(1) to the extent that such plan provides "medical care" within the meaning of ERISA Section 733(a)(2).

(n) HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

(o) HIPAA-Excepted Coverage is any benefit that is not subject to the HIPAA portability provisions, as set forth at 26 CFR 54.9831-1(c), including, but not limited to, accident-only coverage, disability income coverage, liability insurance, worker's compensation, automobile medical payment insurance, credit-only insurance, coverage for on-site medical clinics, and retiree-only health plans. HIPAA-Excepted Coverage also includes, under certain circumstances, limited-scope dental or vision benefits as well as long-term care, nursing home care, home health care, or community-based care benefits provided that they are: (i) under a separate policy, certificate or contract of

insurance or (ii) otherwise not an integral part of the Group Health Plan; (i.e., Participants may decline coverage if claims for the benefits are administered under a contract separate from claims administration for any other benefits under the Group Health Plan). In addition, benefits under a health care flexible spending account and/or health reimbursement arrangement are HIPAA-Excepted Coverage if: (i) the Employer offers other Group Health Plan coverage (not limited to excepted benefits) to Employees; and (ii) the maximum benefit payable to any Participant cannot exceed either two times the Participant's salary reduction election for the year or, if greater, $500 plus the amount of the Participant's salary reduction election. HIPAA-Excepted Coverage also includes “noncoordinated excepted benefits” such as coverage for only a specified disease or illness and hospital indemnity or other fixed indemnity insurance if: (i) the benefits are provided under a separate policy, certificate or contract of insurance; (ii) there is no coordination between the provision of such benefits and any exclusion of benefits under any Group Health Plan maintained by the same plan sponsor; and (iii) the benefits are provided under any Group Health Plan maintained by the same plan sponsor.

(p) Hour of Service means (i) *Hour of Service.* The term *Hour of Service* means each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer; and each hour for which an employee is paid, or entitled to payment by the employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of absence (as defined in 29 CFR 2530.200b–2(a)). For rules determining an employee’s hours of service, see Code Section 4980H and CFR 54.4980H-3. (ii) *Excluded hours.* (A) *Bona fide volunteers.* The term *Hour of Service* does not include any hour for services performed as a bona fide volunteer. (B) *Work-study program.* The term *Hour of Service* does not include any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a *substantially* similar program of a State or political subdivision thereof. (C) *Services outside the United States.* The term *Hour of Service* does not include any hour for services to the extent the compensation for those services constitutes income from sources outside the United States (within the meaning of Code Sections 861 through 863 and the regulations thereunder). (iii) *Service for other Applicable Large Employer members.* In determining Hours of Service and status as a full-time employee for all purposes under Code Section 4980H, an Hour of Service for one Applicable Large Employer member is treated as an Hour of Service for all other Applicable Large Employer

members for all periods during which the Applicable Large Employer members are part of the same group of employers forming an Applicable Large Employer.

(q) Insured Benefit Program is a fully-insured benefit plan where the Employer pays a fixed premium to a third-party commercial insurance carrier that covers the claims.

(r) Participant is any individual who has properly enrolled in, and who participates in, a Component Benefit Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate in the Plan. Participation requirements are described in **Exhibit A** and may be further described in the individual Component Benefit Plans.

(s) Plan means ARIEL CLINICAL SERVICES WRAP BENEFIT PLAN, as amended from time to time.

(t) Plan Administrator is the party identified that will perform the duties and responsibilities as detailed in this document and, if applicable the documents of a Component Benefit Plan.

(u) Plan Year For recordkeeping purposes, the Plan Year for the Plan is the 12 month period beginning on December 1 and ending November 30. For this purpose, the Plan Year identified herein shall override any ERISA Plan Year reference in any other documents incorporated by reference and inconsistent herewith.

(v) Premium(s) means the actual premium charge by the insurance carrier with respect to an insured product or the "premium equivalent" amount (i.e., the cost of coverage for the applicable Component Benefit Plan) for non-insured benefits.

(w) Self-Funded Benefit Program is a benefit plan in which the Employer assumes the financial risk for providing benefits to its Employees.

(x) Spouse means an individual who is legally married to an employee.

All other defined terms in the Plan shall have the meanings specified in the various Articles of the Plan in which they appear.

Section 1.2 Number and Gender.

Whenever a noun or pronoun is used in this Plan in plural form and there is only one person within the scope of the word so used, or in singular form and there be more than one person within the scope of the word so used, such noun or pronoun shall have a plural or singular meaning as the case may be. Likewise, pronouns of one gender shall include the other gender. The words "herein," "hereof," and "hereunder" shall refer to this Plan. Headings are given to the Articles and Sections of the Plan only for the purpose

of convenience and to make the document easier to read. Headings, numbering, and paragraphing shall not in any case be deemed material or relevant to the interpretation of the Plan or its contents.

Section 1.3 Statutory and Regulatory References.
Any reference herein to any statutory provision (e.g., of the Code, ERISA, etc.) shall include any corresponding or succeeding provision(s) of any applicable legislation that amends, supplements, or replaces such provision, and for which compliance by or with respect to the Plan is required. Furthermore, any such reference shall include the regulations promulgated, and any other interpretive guidance issued, and effective thereunder and in effect with respect to the Plan. Any reference herein to a section of the Code of Federal Regulations ("CFR") shall mean the cited section as in effect or such may be amended or replaced from time to time, and for which compliance by or with respect to the Plan is required.

ARTICLE TWO: Eligibility, Participation and Contributions

Section 2.1 Eligibility.
The eligibility requirements for Participant benefits under the Plan are identified in **Exhibit A** and may be set forth in each Component Benefit Plan.

Section 2.2 Enrollment
Each eligible Employee who has satisfied the requirements of Section 2.1, where enrollment is required by the Employer to participate, may become a Participant for a Plan Year by enrolling in the Plan in accordance with procedures established by the Plan Administrator for that purpose. For purposes of the Plan, references to enrollment shall include telephone enrollment, electronic enrollment, or any other form of enrollment, if and to the extent permitted by the Plan Administrator. Enrollment shall be made at such time and in such manner as the Plan Administrator shall prescribe and shall remain in effect until the first day of the next following plan year. The plan year for each Component Benefit Plan should be set forth in that plan and may be different than the Plan Year for this Plan. As part of such enrollment, the eligible Employee shall agree to make any required contributions towards the cost of such coverage.

An eligible Employee may elect and enroll, where enrollment is required by the Employer to participate, in some or all of the benefits available under a Component Benefit Plan. An eligible Employee may also elect not to participate in a Component Benefit Plan for which annual elections are then being made. Once an eligible Employee is a participant in the Plan, the Employee will be given an opportunity to elect and enroll in the benefits for which such Employee has become newly eligible.

If a newly eligible Employee fails to enroll in a Plan which requires enrollment when first eligible, or within 30 days (or, for some employers, 31 days) (or within 60 days in the event of a Medicaid- or CHIP-related special enrollment event) of the occurrence of a Change in Status (defined in Section 2.4 below) or other event entitling the eligible Employee to an election change under this Article Two, the eligible Employee may not enroll in the Plan until the next following annual open enrollment period. Once made, an enrollment (and the elections made therein) may be revoked or modified during a Plan

Year only on account of the eligible Employee's termination of employment or the occurrence of an event entitling the eligible Employee to an election change in accordance with this Article Two.

Section 2.3 Participation.
Any individual who is eligible to participate in any Component Benefit Plan and who is properly enrolled in a Component Benefit Plan shall be a Participant in this Plan. The participation requirements under the Plan are identified in **Exhibit A** and may be set forth in each Component Benefit Plan.

If an Employee previously participated in the Plan and is rehired, such Employee will be eligible to become a Participant on the same terms as if such Employee were a newly hired Employee. Notwithstanding the above, if the Group Health Plan is one offered by an Applicable Large Employer subject to Section 4980H of the Code, an Employee who resumes providing service to such Applicable Large Employer after a period during which Employee was not credited with any Hours of Service may be treated as having terminated employment and been rehired as a new Employee only if the following conditions apply: (i) such Employee had no Hours of Service for a period of at least 13 consecutive weeks (26 for educational organization employers); or (ii) such Employee had a break in service of a shorter period of at least four consecutive weeks with no credited hours of service, and that period exceeded the number of weeks of Employee's period of employment. These provisions are intended to comply with Section 4980H of the Code and are not intended to expand the rights or benefits of employees for any other purpose and should be so construed.

As to any Component Benefit Plan that is a Group Health Plan (other than one offering only HIPAA-Excepted Coverage), any otherwise eligible Employee must wait no longer than ninety (90) days to begin coverage under such Component Benefit Plan.

With respect to insured benefits, participation may be delayed or otherwise affected as provided under the applicable Certificate of Coverage due to an insurance carrier's imposition of an "actively at work" requirement for certain types of insurance, which provisions may also apply in the case of a rehired Employee. This "actively at work'' requirement is not permitted for Group Health Plans (other than ones offering only HIPAA-Excepted Coverage) unless there is an exception for individuals who are absent from work due to a health factor (e.g., individual is out on sick leave on the day coverage would otherwise become effective).

Section 2.4 Election Changes
A Participant may change or revoke his or her elections during a Plan Year on account of the Participant's termination of employment and upon a Change in Status to the extent permitted under the Employer's Code Section 125 cafeteria plan and the applicable Component Benefit Plan, or as required by applicable law. For the purposes of this Section 2.4, the term "Change in Status" means a change in status or other event that permits a mid-year election change, as determined under the Employer's cafeteria plan and the applicable Component Benefit Plan. If the Plan is a Group Health Plan, a Change in Status shall also include the occurrence of a special enrollment event under HIPAA or CHIPRA.

Section 2.5 Termination of Participation.
Participation in the Plan will terminate on the date an Employee is no longer eligible to participate in every Component Benefit Plan. An Employee may become ineligible for any benefit under the Plan if such Employee fails to pay the applicable premiums or meet other requirements of a particular Component Benefit Plan. The provisions for the termination of Participant benefits under the Plan are identified in **Exhibit A** and may be set forth in each Component Benefit Plan.

Section 2.6 Contributions.
The cost of the benefits provided through the Component Benefit Plans may be funded in part by Employer contributions and in part by Employee contributions, which may be pre-tax through a cafeteria plan under Code Section 125. In some instances, a Component Benefit Plan may require only the Employer or the Employee to contribute. Ariel Clinical Services will determine and periodically communicate the Employee's share of the cost of the benefits provided through each Component Benefit Plan, and it may change that determination at any time. The Employer will make its contributions in an amount that in Ariel Clinical Services's sole discretion determines is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Employee contributions. The Employer will pay its contribution and Employee contributions to an insurance company or, with respect to benefits that are self-funded, will use these contributions to pay benefits directly on behalf of Employees or their eligible family members from the Employer's general assets. Employee contributions will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

Section 2.7 Look-Back Measurement Provisions.
If the Employer has elected to include the optional look-back measurement provisions under the ACA, such provisions may be reflected in **Exhibit B** attached hereto.

Section 2.8 No Eligibility Discrimination Due to Health Status.
To the extent required by HIPAA, the Plan shall not establish rules for eligibility (including continued eligibility) for health benefits for any Employee under the Plan that are based on one or more health status-related factors (including health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability) of the Employee or his or her Dependent.

Section 2.9 No Premium Discrimination Due to Health Status.
The Plan shall not require an Employee (as a condition of enrollment or continued enrollment in the health benefits offered under this Plan) to pay a premium or otherwise contribute an amount which exceeds the amount paid by a similarly situated Employee solely due to a health status-related factor (including health status, medical condition (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability) of the Employee; provided, however, that the rules regarding health status-related factors do not restrict the amount an Employer may charge for coverage or prevent premium discounts or rebates or modified deductibles and co-payments in return for adherence to programs of health promotion and disease prevention.

ARTICLE THREE: Incorporation by Reference; Benefits

Section 3.1 Incorporated Documents.
The Plan incorporates the documents, including without limitation any insurance contracts and related Certificates of Coverage, containing the substantive provisions governing the Component Benefit Plans provided under this Plan and further identified in **Exhibit A.** If the Component Benefit Plan documents are amended or superseded, the amended or successor documents will automatically become incorporated documents. If there is no provision in an incorporated document corresponding to a provision of this Plan, to the extent applicable, the Plan provisions will apply to the incorporated document. Where a conflict of language exists between the Component Benefit Plan and this Plan, the Component Benefit Plan will control to the extent not inconsistent with Federal law and regulations thereunder or unless the Plan specifically provides otherwise.

Section 3.2 Benefits Available.
The benefits available under the Plan shall consist of the benefits available under the Component Benefit Plans, including all limitations and exclusions with respect to each Component Benefit Plan's benefits. The benefits available under each Component Benefit Plan are set forth in the Component Benefit Plan documents. The availability of benefits is subject to payment by the Participant of all applicable contributions and satisfaction of any eligibility or other requirements of a particular Component Benefit Plan. If the Employer provides for a cafeteria plan under Code Section 125, certain benefits thereunder may be paid for by an Employee on a pre-tax basis. If such a cafeteria plan is provided, it will be identified as a funding source in **Exhibit A**. Nonetheless, such cafeteria plan which is a premium-only plan ("POP") (and any dependent care assistance plan that may be offered thereunder) will not be subject to the requirements of ERISA, even though the POP cafeteria plan (and any dependent care assistance plan that may be offered thereunder) may be considered part of the Plan.

Section 3.3 Termination of Rights to Benefits.
Any termination of a Participant's coverage under a Component Benefit Plan shall be considered a termination of that same coverage under this Plan. An Employee's benefits (and the benefits of his or her eligible family members including Dependents) will cease when the Employee's participation in the Plan terminates. Benefits will also cease upon termination of the Plan and certain benefits may cease upon termination of a Component Benefit Plan. Other circumstances can result in the termination of benefits. The insurance contracts (including the Certificates of Coverage), plans, and other governing documents in the applicable Exhibits provide additional information.

ARTICLE FOUR: Administration of the Plan

Section 4.1 Named Fiduciary.
The Plan Administrator is the "Named Fiduciary" of the Plan for purposes of ERISA. With respect to the determination of the amount of, and entitlement to, benefits under any insured Component Benefit Plan, however, the respective insurance company is also a Named Fiduciary under the Component Benefit Plan, with the full power to interpret and apply the terms of the Component Benefit Plan as they relate to the benefits provided

under the applicable insurance policy. The insurance companies providing insured benefits under the Component Benefit Plans are identified in **Exhibit A**. In addition, where any other party has accepted status as a Named Fiduciary, with respect to the determination of the amount of, and entitlement to, benefits under any uninsured Component Benefit Plan, such Named Fiduciary (also referred to as a "Claim Fiduciary") with respect to the applicable Component Benefit Plan is identified in **Exhibit A.**

Section 4.2 Delegation.
The Plan Administrator may delegate to any committee, person, or Employee, officer or agent of Ariel Clinical Services or an Affiliated Employer 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 at any time by written notice from one party to the other. Unless the Controlling Employer has delegated such responsibility to another party, the Controlling Employer shall be the Plan Administrator. The provisions of this Section 4.2 control over any inconsistent provisions of any Component Benefit Plan.

Section 4.3 General.
Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan or may hold settlor and fiduciary positions with the Plan. A Named Fiduciary may designate persons other than the Named Fiduciaries to carry out its fiduciary responsibilities under the Plan.

Section 4.4 Interpretation and Findings of Fact.
The Plan Administrator shall have the sole and absolute discretion to interpret the provisions of the Plan. Each insurance company providing insured benefits under a Component Benefit Plan, to the extent necessary to pay or adjudicate claims with respect to any Component Benefit Plan for which it provides benefits, shall have sole and absolute discretion to interpret the provisions of the Component Benefit Plan. This includes, without limitation, supplying omissions from, correcting deficiencies in, or resolving inconsistencies or ambiguities in, the language of the Plan or the Component Benefit Plan, determining the rights and status under the Plan or the Component Benefit Plan of Participants and other persons, to decide disputes arising under the Plan or the Component Benefit Plan, to make factual determinations, and to make any determinations and findings with respect to the benefits payable and the persons entitled to benefits as may be required for the purposes of the Plan or the Component Benefit Plan.

Section 4.5 Assistance.
The Plan Administrator may employ such clerical, legal, actuarial, accounting, or other assistance or services that it believes are reasonable and necessary or advisable in connection with the performance of its duties.

Section 4.6 Indemnification.
To the extent permitted by law, the Employer shall indemnify and hold harmless any person serving as the Plan Administrator or partner, manager, officer, or Employee, as the case may be, of Ariel Clinical Services or an Affiliated Employer, whether such person is acting as a member of a committee or individual who has received delegated authority from the Plan Administrator, from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in

connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, or lack of good faith. Notwithstanding the above, the indemnification provisions of this section shall not apply to any person (or entity) compensated for providing a fiduciary service (such as an insurance company or third-party administrator who has accepted fiduciary responsibility for claims). The provisions of this Section 4.6 control over any inconsistent provisions of any Component Benefit Plan.

Section 4.7 Insuring and Funding Benefits.

Funding for the Plan shall consist of the sum of the funding for all Component Benefit Plans and may include funding through a cafeteria plan which, if available, is identified as a funding source in **Exhibit A.** Ariel Clinical Services shall have the right to pay benefits from its general assets, insure any benefits under the Plan, and establish any fund or trust for the holding of contributions or payment of benefits under the Plan, either as mandated by law or as Ariel Clinical Services deems advisable in its sole discretion. In addition, Ariel Clinical Services shall have the right in its sole discretion to alter, 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. If any benefit is funded by the purchase of insurance, the benefit shall be payable solely by the insurance carrier.

With respect to any insurance company refunds/rebates received by Ariel Clinical Services including those that are subject to the Medical Loss Ratio ("MLR") provisions of the ACA, such refunds/rebates must be treated consistent with the provisions of ERISA and the applicable guidance thereunder, including the Department of Labor Technical Release 2011-04. The allocation of insurance refunds that are not "Plan assets" are to be used, allocated, and/or distributed among one or more of the Employer(s) as the Controlling Employer in its sole discretion determines appropriate. As to any other amounts, fiduciary decisions by the Plan Administrator are required based on the facts and circumstances relating to such refund. Generally, the following rules will apply with respect to MLR (note that these rules do not apply to self-funded plans):

(a) If the Employer pays the entire premium applicable to the Component Benefit Plan, the entire refund amount will be retained by the Employer;

(b) If the Participants pay the entire premium applicable to the Component Benefit Plan, the entire refund amount will be used to benefit the Participants;

(c) If the Employer and Participants shared premiums based on a fixed percentage, the rebate is divided based on percentage;

(d) If the Employer paid a fixed amount of premiums and Participants paid the rest, the rebate is a Plan asset (and must be used for the benefit of the Participants) to the extent it does not exceed total Participant contributions in the relevant MLR period;

(e) If the Participants paid a fixed amount and the Employer paid the rest, the rebate belongs to the Employer to the extent it does not exceed the total Employer contributions in the relevant MLR period;

(f) Allocation among Participants of their portion of any refund need not be pro rata and may not include all Participants (e.g., former participants may be excluded where based on a cost-benefit analysis (provided however in all cases the allocation must be based on a reasonable, fair and objective method)); and

(g) If the rebate is applied toward a benefit enhancement or as an offset to Participants' share of future premiums, verification of the additional benefit or how the premium offset will be applied (e.g., will there be a one-time premium holiday, or will the Participants' share of premiums be reduced over a period of months) should be provided in a written policy.

Despite the general rules previously discussed, the following conditions apply with respect to Plan assets:

(a) A "Plan Fiduciary" (as defined in ERISA Sections 3(16), 3(21) or 3(38)) in all cases must act prudently, solely in the interest of the Plan Participants and beneficiaries, and in accordance with the terms of the Plan to the extent consistent with the provisions of ERISA and is prohibited by ERISA from receiving a rebate amount greater than the total amount of premiums and other Plan expenses paid by the Employer; and

(b) The use of any refunds for expenses should be limited to those necessary and reasonable expenses (1) paid to a third-party or (2) for reimbursing in-house expenses, but in such case, only upon the advice of outside counsel.

With respect to refunds to Participants of a Group Health Plan, premiums must be allocated among Participants in the same policy.

The following rules will generally apply unless extraordinary circumstances determined by the fiduciary dictate otherwise:

(a) First, refunds will be used within 90 days of receipt by the Plan to reduce future premiums; and

(b) Second, refunds will be used within 90 days of receipt by the Plan to enhance benefits, pay expenses, or make distributions to Participants as determined by the fiduciary after considering all of the facts and circumstances.

In addition, with respect to any other insurance company rebate or similar refund not subject to the MLR rules, the Employer may apply similar rules or any other rules it determines in its sole discretion are advisable under the circumstances, subject to ERISA (including any fiduciary duties it may have thereunder).

Section 4.8 Subrogation and Right of Reimbursement.
To the extent not inconsistent with the provisions of any underlying documents incorporated by reference in the Plan, the following provisions shall control as to any Component Benefit Plan.

The Plan does not provide primary coverage for expenses associated with an injury or illness caused or worsened by the action of any third party which gives rise to a claim against that party, nor does it provide primary coverage for such expenses to the extent that there is other applicable coverage from a source other than the Plan (including, but not limited to, medical benefits under an automobile insurance policy). If an Employee, Spouse, Dependent, or any other person specified as an "Eligible Non-Employee" in **Exhibit A** (a "Covered Individual") incurs expenses and receives benefits from the Plan or its carrier (s) as a result of an injury or accident caused by the action of a third party, immediately upon payment of any benefits under the Plan, the Plan shall be subrogated (substituted) to all rights of recovery against any person or organization whose conduct or action caused or contributed to the loss for which payment was made by the Plan.

As a condition to participation in or the receipt of benefits under the Plan, a Covered Individual agrees that if such person receives or is entitled to any reimbursement or any other financial recovery from any source, including such Covered Individual's own insurance carrier or another welfare benefit plan (such as a disability plan, if any) sponsored by the Controlling Employer, whether by judgment, settlement, award, government or worker's compensation benefits, or otherwise, on account of such injury or illness, the Plan has the right to recover the amounts the Plan has paid or will pay as a result of that injury, and the Plan has a lien on any such recovery. Similarly, if any person, including any natural person or entity, or a Covered Individual has possession of funds recovered from a third party as to which any Covered Individuals have or had a claim, then the Plan shall be subrogated to that claim and will have a right to recover directly from the person that is holding the funds. By participating in and accepting benefits under the Plan in connection with such an injury or illness, a Covered Individual agrees and is bound to assist the Plan in its attempt to recover from that person, assigns any recovery to the Plan and authorizes such Covered Individual's attorney, personal representative, or insurance company to reimburse the Plan. In the event that a Covered Individual is deceased, the Plan has a right to recover funds from such Covered Individual's estate pursuant to this reimbursement provision. The Plan will not pay attorney fees or costs associated with the Covered Individual without prior express written authorization by the Plan, which the Plan may grant or withhold in its sole discretion. In this regard, the Plan will not be subject to any "make whole" or other subrogation rule that may otherwise apply by law that reduces its right to recover the full amount of its loss unless the Plan has expressly agreed to do so in writing. Rather, the Plan is entitled to full reimbursement:

(a) before the Covered Individual is entitled to retain any part of such financial recovery, regardless of the stated reason for the financial recovery or whether the Covered Individual has other costs or suffered other injuries not paid for or compensated by the Plan (notwithstanding any "make whole doctrine" by whatever name called);

(b) without regard to any claim of fault on the part of the Covered Individual, whether under comparative negligence or otherwise;

(c) without reduction for attorneys' fees and other costs incurred by the Covered Individual in making a recovery without the prior express written

consent of the Plan (notwithstanding any "fund doctrine," "common fund doctrine," or "attorneys' fund doctrine" by whatever name called); and

(d) notwithstanding that the recovery to which the Plan is subrogated is paid to a decedent, a minor, a decedent's estate, or an incompetent or disabled person.

A Covered Individual (and individuals acting on such Covered Individual's behalf, including without limitation attorneys) shall do nothing to prejudice the Plan's subrogation and reimbursement rights and shall, when requested, provide the Plan with information and cooperate with the Plan in the enforcement of its subrogation and reimbursement rights. It is the Employee's duty, and the duty of individuals acting on the Employee's behalf, to notify the Plan Administrator within 45 days of the date of the injury or the date when the Employee gives notice to any other party, including an attorney, of the intention to pursue or investigate a claim to recover damages on behalf of a Covered Individual. The payment of benefits under the Plan on account of an injury or illness as a result of an action of a third party is contingent on the Covered Individual:

(a) informing the Plan Administrator of the action to be taken by the Covered Individual;

(b) agreeing (in such form and to such documents as the Plan may require) to the Plan being reimbursed from any recovery from a third party and subrogated to any right of recovery the Covered Individual has against a third party;

(c) refraining from action which would prejudice the Plan's subrogation rights (including, but not limited to, making a settlement which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan); and

(d) cooperating in doing what is reasonably necessary to assist the Plan in any recovery.

If the Covered Individual should fail or refuse to comply with this Section, the Covered Individual is not entitled to benefits under the Plan and must reimburse the Plan for any and all costs and expenses, including attorneys' fees, incurred by the Plan in enforcing its rights hereunder. The Plan may determine not to exercise all of the reimbursement and/or subrogation rights described in this Section in certain types of cases, with respect to certain covered groups, or with respect to certain geographic areas, without waiving its right to enforce its rights in the future as to other groups or in other geographic areas.

For purposes of this section, "reimbursement" includes all direct and indirect payments to a Covered Individual for injury or illness from any source, by way of settlement, judgment, or any other means, including but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, no-fault automobile insurance coverage, and homeowner's insurance.

ARTICLE FIVE: Amendments, Terminations and Mergers

Section 5.1 Right to Amend.
Ariel Clinical Services reserves the right to amend the Plan and any Component Benefit Plan from time to time in its sole discretion, including amendments that are retroactive in effect to the extent permitted by law.

Section 5.2 Plan Merger.
Ariel Clinical Services reserves the right to merge the Plan or any Component Benefit Plan at any time in its sole discretion.

Section 5.3 Right to Terminate.
Ariel Clinical Services may terminate the Plan and any Component Benefit Plan in whole or in part at any time in its sole discretion. In addition, any amounts remaining in the Plan at termination shall be distributed as if they were insurance company refunds/rebates and subject to the procedures provided in Section 4.7.

Section 5.4 Payment of Claims Upon Termination.
Upon termination of the Plan, the Plan shall continue until all pending claims for benefits outstanding as of the date of termination have been paid or otherwise resolved.

ARTICLE SIX: Guarantees and Liabilities

Section 6.1 No Guarantee of Employment.
Nothing contained in the Plan shall be construed as a contract of employment between an Employer and an Employee or Participant, or any other individual, or as a right of any Employee or Participant, or any other individual, to continue in the employment of an Employer, or as a limitation of the right of an Employer to discharge any of the Employees or Participants, or any other individuals, with or without cause, or change the terms and conditions of employment of the Employees or Participants.

Section 6.2 No Guarantee of Non-Taxability.
Neither the Plan Administrator nor the Employer makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for Federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to any Participant. It shall be the obligation of each Participant to determine whether each payment under the Plan is excludable from the Participant's gross income for Federal and state income tax purposes, and to notify the Employer if the Participant has reason to believe that any such payment is not so excludable.

Section 6.3 Withholding Taxes.
To the extent an Employer is required to withhold Federal, state, local or foreign taxes in connection with any payment made to a Participant under a Component Benefit Plan, the Employer shall withhold the amount from the payment as determined by the Employer in its sole discretion.

Section 6.4 Incapacity to Receive Payment.
If the Plan Administrator finds that any Participant entitled to receive benefits under the Plan is, at the time such benefits are payable, unable to care for his or her affairs because of a physical, mental, or legal incompetence, the Plan Administrator may, in its sole discretion, pay the benefits to which the Participant was entitled to one or more persons chosen by the Plan Administrator from among the following: the institution maintaining or responsible for the maintenance of such Participant, his or her Spouse, his or her children, or other relative by blood or marriage. Any payment made under these circumstances shall be a complete discharge of all liability under the Plan with respect of such payment.

Section 6.5 Severability Provision.
If any provision of the Plan or the application of a provision to any circumstance or person is invalid, the remainder of the Plan and its application to other circumstances or persons shall not be affected thereby.

Section 6.6 Right of Recovery.
The Plan Administrator shall have the right to recover any payment it made but should not have made or made to an individual or organization not entitled to payment, from the individual or organization or anyone else benefiting from the improper payment, including from any monies then payable, or which may become payable, in the form of salary, wages, or benefits payable under the applicable Employer-sponsored benefit program to the extent permitted by applicable law.

ARTICLE SEVEN: Claims Procedures

Section 7.1 Benefits Administered by Insurers or TPAs.
Claims for benefits that are insured or administered by a third party administrator shall be filed in accordance with the specific procedures contained in the insurance policies, Component Benefit Plans or the third party administrative services agreement. These procedures will be followed unless inconsistent with the requirements of ERISA, in which case the ERISA procedures specified below will be followed. The address of the individual insurance company providing benefits and/or third party administrator (if any) that reviews claims made under a Component Benefit Plan is set forth in **Exhibit A** to the extent required by law or provided by the Plan Administrator. All other general claims or requests, including claims for eligibility to participate in the Plan, should be directed to the Plan Administrator (and determinations thereon will be made in accordance with the Plan Administrator's reasonable procedures).

Section 7.2 Personal Representative.
A Participant may exercise his or her rights directly or through an authorized personal representative. A Participant may have only one representative at a time to assist in submitting an individual claim or appealing an unfavorable claim determination.

A personal representative will be required to produce evidence of his or her authority to act on the Participant's behalf and the Plan may require such Participant to execute a form relating to such representative's authority before that person will be given access to the Participant's protected health information or allowed to take any action for the Participant.

(An assignment or attempted assignment of a Participant's benefits does not constitute a designation of an authorized personal representative. Such a delegation must be clearly stated in a form acceptable to the Plan Administrator.) This authority may be proved by one of the following:

(a) A power of attorney for health care purposes, notarized by a Notary Public;

(b) A court order appointing the person as the conservator or guardian of the individual; or

(c) Evidence that an individual is the parent of a minor child.

The Plan retains discretion to deny to a personal representative access to any Participant's protected health information to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This provision also applies to personal representatives of minors.

Section 7.3 General Claims Procedure.

Subject to Section 7.4 governing claims made under a Component Benefit Plan that is a Group Health Plan, and Section 7.5, governing claims made under a Component Benefit Plan providing disability benefits, the following procedures will be followed if a claim under a Component Benefit Plan is denied, in whole or in part. These claims procedures do not apply to any cafeteria plan which is a premium-only plan ("POP") (or any dependent care assistance plan offered thereunder).

(a) If a claim is denied, the claimant will receive written notification within 90 days after the claim was submitted. Under special circumstances, the Claim Fiduciary may take up to an additional 90 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial 90-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The written notification of a denied claim will include the reasons for the denial, with reference to the specific provisions of the Component Benefit Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If written notification is not delivered within 90 days, the claim shall be treated as denied.

(b) Within 60 days after notification of a claim denial (or the date of a deemed denial), a claimant may appeal the denial by submitting a written request for reconsideration of the claim to the Plan Administrator, which includes the reasons why the claimant feels the claim is valid and the reasons why the claimant thinks the claim should not be denied. Before submitting an appeal request, the claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. If the claimant fails to file an appeal for review within 60 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it under these

procedures or in a court or any other venue. Documents, records, written comments, and other information in support of the appeal should accompany any appeal request. The Plan Administrator will consider such information in reviewing the claim and provide, within 60 days, a written response to the appeal. This 60-day period may be extended an additional 60 days under special circumstances, as determined by the Plan Administrator due to matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial 60-day period of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. The Plan Administrator's response will explain the reason for the decision with specific reference to the provisions of the Plan on which the decision is based, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits and a statement about the claimant's right to bring a civil action under ERISA Section 502 (a).

(c) The Plan Administrator has the sole discretion to interpret the appropriate Plan provisions, and such decisions are conclusive and binding. For purposes of the provisions in this Article Seven, the term "Plan Administrator" will include the applicable insurance company or other party that has accepted its fiduciary responsibility to make claim determinations (consistent with Section 4.1 above as a Claim Fiduciary) with respect to the applicable Component Benefit Plan.

(d) To the extent not inconsistent with the provisions of the applicable Component Benefit Plan, with respect to any civil actions brought under the Plan, a claimant will be barred from bringing such civil action after one year from the date of exhausting the Plan's claims procedures relating to the denial of such claim. In the case of a Group Health Plan claim discussed below, this includes not only exhausting the Plan's internal claims procedure but also exhausting the Plan's external claims procedure, where applicable.

Section 7.4 Special Rules for Group Health Plan Claims.

For purposes of ERISA, there are four categories of claims under a Component Benefit Plan that is a Group Health Plan and each one has a specific timetable for approval, request for additional information, or denial of the claim. The four categories of claims are:

Urgent Care Claim is a claim where failing to make a determination quickly could seriously jeopardize a claimant's life, health, or ability to regain maximum function, or could subject the claimant to severe pain that could not be managed without the requested treatment. A licensed physician with knowledge of the claimant's medical condition may determine if a claim is an Urgent Care claim.

Pre-Service Claim is a claim for which the claimant is required to get advance approval or pre-certification before obtaining service or treatment for a medical condition.

Post-Service Claim is a request for payment for covered services the claimant has already received.

Concurrent Care Claim is a request to extend an ongoing course of treatment beyond the period of time or number of treatments that has previously been approved under the Plan.

(a) Time for Decision on a Claim. The time deadline for making decisions on claims under a Group Health Plan depends on the urgency of the claim. (See Time Limit Chart below for maximum time limits.) A claimant will be notified of any determination on a claim (whether favorable or unfavorable) as soon as possible. If an Urgent Care Claim is denied, the claimant will be notified orally, and written notice will be provided within three days.

If additional information is needed because necessary information is missing from the initial claim request, a notice requesting the missing information from the claimant will be sent within the timeframes shown in the chart below and will specify what information is needed. The claimant must provide the specified information to the Claim Fiduciary within 45 days after receiving the notice. The determination period will be suspended on the date the Claim Fiduciary sends a notice of missing information and the determination period will resume on the date the claimant responds to the notice.

Under special circumstances with respect to pre-service and post-service claims, the Claim Fiduciary may take up to an additional 15 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial claim determination time period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The notice of extension that the claimant receives will include (i) an explanation of the standards on which entitlement to benefits is based; (ii) the unresolved issues that prevent a decision on the claim; and (iii) any additional information needed to resolve those issues.

Note that fully-insured Group Health Plan claims (if any) may be subject to even more accelerated response time for the insurers. See Certificates of Coverage for details.

Time Limit (Group Health Plan Claims)	Urgent Care*	Pre-Service*	Post-Service*
To make initial claim determination	72 hours	15 days	30 days
Extension (with proper notice and if delay is due to matters beyond Plan's control)	None	15 days	15 days
To request missing information from claimant	24 hours	5 days	30 days
For claimant to provide missing information	48 hours	45 days	45 days

* The Claim Fiduciary will decide the appeal of Concurrent Care Claims within the time frame set forth in the chart depending on whether such claim is also an Urgent Care Claim and the request to extend care is not made at least 24 hours prior to the scheduled expiration of treatment, a Pre-Service Claim, or a Post-Service Claim and before the expiration of any previously approved course of treatment. For an Urgent Care Claim that is a Concurrent Care Claim, if the request to extend care is made at least 24 hours prior to the scheduled expiration of the treatment, the initial claim determination will be made no later than 24 hours after such claim is filed with the Claim Fiduciary.

(b) Notification of Denial. Except for Urgent Care Claims, when notification may be oral followed by written notice within three days, the claimant will receive written notice if the claim is denied. The notice will contain the following information:

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific Plan provisions on which the determination was made;

(iii) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502 if the claim is denied on review;

(v) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

(vi) If an adverse determination is based on an internal rule, guidance, protocol, or other similar criteria, an explanation of those criteria or a statement that the criteria will be provided free of charge upon request; and

(vii) If the adverse determination is based on a medical necessity or experimental treatment limit or exclusion, an explanation of the scientific or clinical judgment on which such

decision is based, or a statement that such explanation will be provided free of charge upon request of such person or persons who conducted the initial claim determination. The Plan fiduciary will provide an independent full and fair review of the claimant's claim and will not give any deference or weight to the initial adverse determination. The claimant will receive a written notice of the decision on review.

(c) How to Appeal a Denied Group Health Plan Claim. If a claim is denied, the claimant (or the claimant's attorney or other person authorized to act on the claimant's behalf) will have 180 days following the date the claimant receives written notice of the denial in which to appeal the claim. If the claimant fails to file an appeal for review within 180 days of the denial notification, the claim will be deemed permanently waived and abandoned, and the claimant will be precluded from reasserting it under these procedures or in a court or any other venue. Unless the claimant is appealing the denial of an Urgent Care Claim, a request for review must be made in writing. If the claimant is requesting review of an Urgent Care Claim, the claimant may request review orally or by facsimile. A request for review should contain the claimant's name and address, the date the claimant received notice the claim was denied, and the reason(s) for disputing the denial. The claimant may submit written comments, documents, records, and other information relating to the claim. If requested, the claimant will be provided, free of charge, reasonable access to, or copies of, all documents, records, and other information relevant to the claim.

The period of time for the Plan to review the appeal request and to notify the claimant of its decision depends on the type of claim as follows:

Urgent Care Claim – 72 hours; the claimant will be notified orally and written notice will be provided within three days.

Pre-Service Claim – 30 days if the Component Benefit Plan provides for only one mandatory appeal; 15 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

Post-Service Claim – 60 days if the Component Benefit Plan provides for only one mandatory appeal; 30 days for each appeal if the Component Benefit Plan provides for two mandatory appeals.

The review will take into account all comments, documents, records, and other information submitted relating to a Participant's claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will be conducted by a Plan fiduciary other than the person or persons (or subordinate of such person or persons) who conducted the initial claim determination. In addition, if the denial of the claim was based, in whole or in part, on a medical

judgment in reviewing the claim, the Claim Fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment in reviewing the claim. This person will not be a person or a subordinate of a person consulted by the Claim Fiduciary in deciding the initial claim. The Plan fiduciary will provide an independent full and fair review of a Participant's claim and shall not give any deference or weight to the initial adverse determination. The Employee will receive a written notice of the decision on review. The notice will contain the following information:

(i) The specific reason or reasons for the adverse determination;

(ii) Specific references to the pertinent plan provisions on which the denial is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Whether a document, record or other information is relevant to a claim for benefits shall be determined by reference to Section 503-1(m)(8) of ERISA;

(iv) A statement describing any voluntary appeal procedures offered by the plan and the claimant's right to obtain information about such procedures described in Section 503-1(c)(3)(iv) of ERISA, and a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following any final adverse benefit determination;

(v) A statement that a copy of any internal rule, guideline, protocol or other similar criteria relied upon in making the adverse benefit determination is available free of charge upon request;

(vi) A statement that if a denial of the claim is based on medical necessity or experimental treatment, or a similar exclusion or limit, the Claim Fiduciary will, upon request, provide the claimant, free of charge, an explanation of the scientific or clinical judgment, applying the terms of the plan to the claimant's medical circumstances; and

(vii) The following statement, if and to the extent applicable: "You and your plan may have other voluntary alternative

dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Also, upon request, the Claim Fiduciary will provide the claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

(d) Additional Internal Claims Provisions Requirements for Health Plans Under the ACA. Unless otherwise provided below, the following internal claims provisions relating to an "Adverse Benefit Determination" generally apply (subject to any grace period extensions by the Department of Labor ("DOL")) to Group Health Plans (other than ones offering only HIPAA-Excepted Coverage). For purposes of this Section 7.4(d), "Adverse Benefit Determination" means a claim denial (including a final internal adverse benefit determination) *neither involving a Grandfathered Plan nor HIPAA-Excepted Coverage* by the Plan Administrator or a Claim Fiduciary (as identified in Section 4.1 above) that involves any medical claim or any claim involving rescission of coverage. This determination may be appealed by the claimant and may be subject to external review under certain circumstances provided below.

(i) With respect to any rescission, such rescission shall be permissible only upon a finding of fraud or intentional misrepresentation of a material fact;

(ii) The claimant must be provided by the Plan (free of charge) as soon as possible with any new or additional evidence considered, relied upon, or generated by the Plan or Claim Fiduciary in connection with the claim as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the claimant to respond to such new evidence or rationale, both in the case of an initial determination or a final internal Adverse Benefit Determination;

(iii) To avoid conflicts of interest and to assure independence and impartiality, decisions regarding hiring, compensation, termination, promotion or other similar matters involving an individual claims reviewer (such as a claim adjudicator or a medical expert) must not be made based on the likelihood that such individual will support the denial of benefits;

(iv) Notices to claimants by the Plan or Claim Fiduciary must also include additional content as follows:

a. Any notice of Adverse Benefit Determination or final internal Adverse Benefit Determination must include information sufficient to identify the claim involved, including the date of the service, the health care provider, the claim amount (if applicable) and state that, upon request by the claimant, the diagnosis code and treatment code and their corresponding meanings will be provided and, upon any such request by a claimant, any such code and meaning must be provided as soon as practicable.

b. Any notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination must include the denial code and corresponding meaning as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision.

c. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

d. The availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Services Act to assist the claimant.

e. Notices in a culturally and linguistically appropriate manner, consistent with the DOL regulations, to a claimant in the health plan who reside in a county in which ten (10) percent or more of the population is literate only in the same non-English language as determined by guidance published by the DOL (a "10 Percent Non-English County"). For a health plan that has a claimant in a 10 Percent Non-English County, notices regarding the internal and external claims review must appear in both English and in such other relevant non-

English language and, once a request has been made by a claimant, all subsequent notices to such person must be in the applicable non-English language as well. Also, the Plan or Claim Fiduciary must maintain oral language services in the non-English language (such as a telephone customer assistance hotline) to answer questions or provide assistance with filing claims and appeals.

(v) Failure to adhere to all the requirements, described previously relating to the ACA, will allow the claimant to deem the internal claims and appeals process non-compliant (and exhausted), and the claimant may proceed to pursue any external review process or remedies (including court action) available under ERISA or under state law, if applicable. Notwithstanding the above, action or inaction relating to the above rules that is (i) de minimis, (ii) non-prejudicial to the claimant, (iii) attributable to good cause or matters beyond the Plan's or Claim Fiduciary's control, (iv) in the context of an ongoing good-faith exchange of information, and (v) not reflective of a pattern or practice of non-compliance, will not be considered non-compliant.

(e) Additional External Claims Provisions Requirements for Health Plans Under the ACA. With respect to any Adverse Benefit Determination (defined in Section 7.4(d)) that involves medical judgment (including, but not limited to, a determination regarding 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) or any claim involving a rescission of coverage (whether or not the rescission has an adverse effect on any particular benefit at that time), an external review is to be provided to a claimant either under the State external appeals process or the Federal external appeals process as described in the following paragraphs of this section.

(i) For ***"State Review Plans"*** (i.e., plans with insurance contracts approved by a state that has an external review process that the DOL has determined includes acceptable minimal protections to claimants), the DOL provides that the state's external review process shall apply to the applicable fully-insured arrangement (and to certain self-funded arrangements that have been allowed by State law to be subject to the State's review rules). These safe harbor rules shall continue to apply to states meeting the "strict standards" but shall only apply to states meeting the

"similar standards" until January 1, 2018, as more fully described below. (Please refer to the table identified here: https://www.cms.gov/CCIIO/Resources/Files/external_appeals.html.)

a. A state may meet the "strict standards" included in the DOL rules, which set forth 16 minimum consumer protections based on the National Association of Insurance Commissioners ("NAIC")'s Uniform Health Carrier External Review Model Act (the "NAIC Model Act") in place on July 23, 2010.

b. A state may operate an external review process under "similar standards" to those outlined in the NAIC Model Act subject to certain requirements by the DOL and other governmental authorities (These "similar standards" apply until January 1, 2018).

c. ***State Review Plans*** are subject to the external review procedures reflected in the underlying Certificates of Coverage or to a separate claims document to be provided to claimants by the insurance company or the Plan.

(ii) For ***"Federal Review Plans"*** (i.e., plans that are (i) self-funded or (ii) have not elected or are not eligible to be State Review Plans), the DOL provides that the following basic requirements apply under its safe harbor rules (which are based in significant part on the NAIC Model Act). The external review rules may be provided in more detail in an underlying document (which may also contain provisions for the Plan's benefits) that is made part of the Plan.

a. A claimant shall have four months after the day you receive notice or are deemed notified of the final internal Adverse Benefit Determination to request an external review of any final internal Adverse Benefit Determination;

b. The Plan or Claim Fiduciary shall have five business days from the date the claim is made to complete a preliminary review to determine if the claim is eligible for external review (determining whether the claimant

was covered (eligible) at the time the service was provided), whether the appeal relates to a medical judgment, and whether the internal appeals process has been exhausted (e.g., all relevant information requested from the claimant was provided) and, therefore, considered fully;

c. Within one business day after the preliminary review, the Plan or Claim Fiduciary shall notify in writing the claimant of its decision. If the claim is complete but not eligible for external review, the reason for its ineligibility and contact information for the Employee Benefits Security Administration must be provided to the claimant. If the claim is incomplete, an explanation of what is necessary to complete the claim must be requested of the claimant and the Plan or Claim Fiduciary must permit the claimant a reasonable time to perfect the claim (i.e., the remainder of the four month appeal period or, if later, 48 hours after the notice of incompletion);

d. If the claimant appeals an appealable final internal adverse benefits determination (or challenges whether or not it is appealable), the claim must be referred (i) to an Independent Review Organization (IRO) accredited by URAC (formerly known as the Utilization Review Accreditation Commission) or (ii) by a similar nationally-recognized accrediting organization to conduct external reviews, on a random basis among two IROs in both cases contracted with by the Plan Administrator or Claim Fiduciary (which may be done through global contracts obtained by a third party administrator) and which provide in such existing contract for a rotating or other unbiased (e.g., random) method of selection and without financial incentives tending toward denial of benefits. However, where these conditions are not strictly met, the DOL will make a determination on a case-by-case basis of the Plan's compliance with

the external claims review requirements of the ACA;

e. Once assigned to the IRO, the IRO must make a determination on a *non-urgent care claim* within forty-five days after the IRO receives the assignment;

f. If the IRO reverses the decision of the Plan or Claim Fiduciary, payments or coverage must begin immediately, even if the Plan or Claim Fiduciary expects to appeal it to a court of law;

g. The claimant must have a right to expedited review for an Urgent Care claim. The standards for an Urgent Care claim under external review are the same as those under the internal review (e.g., upon request for expedited treatment by the claimant, delay would (i) seriously jeopardize the life or health of the claimant or (ii) jeopardize the claimant's ability to regain maximum function). Once assigned to the IRO, the IRO must make a determination on an Urgent Care as expeditiously as possible but in no event more than seventy-two hours (or forty-eight hours if the request was not in writing) after its receipt of the request. If the IRO's notice of its determination is not provided in writing within 48 hours after the date of providing that notice it must provide written confirmation to the Employee and the Plan; and

h. The contracts with the IROs must include the requirements contained in DOL Technical Releases 2010-01 and 2011-02, and the IROs must agree, among other things, to the following: de novo review of all information and documents timely received (including the Plan document, claims records, health care professional recommendations, and clinical review criteria used, if any), retaining its records for six years and making them available to the applicable claimant (or to state and Federal government agencies, to the extent not in violation of any privacy laws) for

examination upon request, and inclusion of certain information in notices to claimants.

(iii) Pursuant to DOL pronouncements, if the Plan complies with either the State or Federal interim compliance methods described previously, no excise tax liability should be reported on IRS Form 8928 with respect to Section 2719(b) of the Public Health Service Act. Further, the DOL will not take enforcement action against a plan that has voluntarily complied with a State external review process (where available to a plan in the applicable state) that meets the strict standard or the similar standard of the NAIC Model Act described previously. The Plan intends and is taking steps in good faith to comply with the claims and appeals rules under the ACA, and the provisions herein should be interpreted accordingly.

(iv) The No Surprises Act (the "Act"), part of the broader Consolidated Appropriations Act of 2021, effective January 1, 2022, extended these external claims provision requirements to any Adverse Benefit Determination that involves consideration of whether a plan or insurer is complying with the Act for both grandfathered and non-grandfathered plans.

a. On December 30, 2021, the Centers for Medicare and Medicaid Services ("CMS") issued guidance on state-law external review procedures that cannot accommodate external reviews of Adverse Benefit Determinations involving surprise medical billing requirements, which outlined two alternatives:

1. The state may refer the matter to the federal external review procedure, which is administered by the Department of Health and Human Services ("HHS"); or

2. Plans or insurers may request external review of Act-related issues using an accredited independent review organization that conducts external review for Act-related issues only under the federal process, if

applicable requirements are met.

These alternatives may be used until the state review procedure is changed to accommodate external review of Act-related surprise billing issues.

b. Reviews under the federal external review process are performed by a contractor called MAXIMUS Federal Services, Inc. ("MAXIMUS").

States will generally have four months from the receipt date of an Adverse Benefit Determination to refer the matter to MAXIMUS. MAXIMUS must provide its determination within 45 days of receiving the request for review.

Section 7.5 Disability Claims.

A disability claim is a claim that requires the Plan to determine if the claimant is disabled for purposes of eligibility for disability benefits under a Component Benefit Plan. Except as provided in this Section 7.5, the general claims procedures in Section 7.3 apply, including but not limited to the provisions relating to any Plan fiduciary's rights and responsibilities as provided in Section 7.3(c) and the claims limitation period identified in Section 7.3(d). An adverse benefit determination made with respect to disability benefits includes a rescission of disability coverage, as provided under 29 CFR 2560.503-1(m)(4)(ii), that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(a) Time for a Decision on a Disability Claim. The Plan will notify the claimant of its determination within 45 days after its receipt of the claim. This period can be extended for two additional 30-day periods (up to a total of 105 days) if a decision cannot be made because of circumstances beyond the control of the Plan Administrator. If an extension of time is required, the claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. If, prior to the end of the first 30-day extension period, the Claim Fiduciary determines that an additional extension is necessary due to matters beyond its control, the Claim Fiduciary may take up to an additional 30 days to review the claim. If an additional extension of time is required, the claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. If the Claim Fiduciary extends its period for reviewing a claim due to special circumstances, the notice of extension the claimant receives will include an explanation of the standards on which entitlement to

benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The claimant has at least 45 days to provide the specified information.

(b) Notification of Denial. If a claim for disability benefits is denied, the claimant will receive written notice of denial that sets out the information below in a culturally and linguistically appropriate manner in accordance with 29 CFR 2560.503-1(m)(4)(ii):

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific Plan provisions on which the determination was made;

(iii) A description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the Plan's review procedures and the time limits that apply to such procedures, including a statement of the claimant's right to bring a civil action under ERISA Section 502(a) if the claim is denied on review;

(v) Where the determination is adverse, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

a. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational-professionals who evaluated the claimant;

b. The views 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; and

c. A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(vi) If the adverse 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 of

such person or persons who conducted the initial claim determination;

(vii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist; and

(viii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim.

(c) How to Appeal a Denied Disability Claim. The claimant may appeal the Plan's determination within 180 days following receipt of an adverse determination in accordance with the procedures set forth in Section 7.4(c). The Plan will notify the claimant of its determination on review within 45 days. Under special circumstances, the Claim Fiduciary may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the Claim Fiduciary expects to render a decision. The claimant has at least 45 days to provide the specified information.

(d) Notification of Benefit Determination on Review. The claimant will receive written notice of the Plan's benefit determination on review that sets out the information below in a culturally and linguistically appropriate manner in accordance with 29 CFR 2560.503-1(m)(4)(ii):

(i) The specific reason or reasons for the adverse determination;

(ii) Reference to the specific Plan provisions on which the benefit determination is based;

(iii) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;

(iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under ERISA Section 502(a), including any applicable contractual limitations period that applies to the claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim;

(v) Where the determination is adverse, a discussion of the decision, including an explanation of the basis for disagreeing with or not following:

a. The views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

b. The views 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; and

c. A disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

(vi) 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; and

(vii) Either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist.

(e) Additional Requirements for Disability Claims. All claims and appeals for disability benefits must be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision; thus, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical or vocational expert) must not be made based upon the likelihood that the individual will support a denial of benefits. Before a decision on review of a denied claim for disability benefits may be made, the Plan Administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which a notice of

adverse benefit determination on review is required to be provided under applicable DOL regulations to give the claimant a reasonable opportunity to respond prior to that date. In addition, before a decision on review of a denied claim for disability benefits may be made based on a new or additional rationale, the Plan Administrator shall provide the claimant, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under applicable DOL regulations to give the claimant a reasonable opportunity to respond prior to that date.

(f) Failure to Establish and Follow Reasonable Claims Procedures. Failure to adhere to the requirements described in this Section 7.5 will allow the claimant to deem the claims and appeals process non-compliant (and exhausted), and the claimant may proceed to pursue any remedies (including court action) available under ERISA. Notwithstanding the preceding sentence, action or inaction relating to the above rules that is (i) de minimis, (ii) non-prejudicial to the claimant, (iii) attributable to good cause or matters beyond the Plan's or Claim Fiduciary's control, (iv) in the context of an ongoing good-faith exchange of information, and (v) not reflective of a pattern or practice of non-compliance, will not be considered non-compliant. This paragraph will be interpreted and administered in accordance with 29 CFR 2560.503-1(1)(2).

ARTICLE EIGHT: Adoption by Affiliated Employers

Section 8.1 Adoption Procedure.
Any Affiliated Employer may adopt the Plan and become an Employer thereunder provided Ariel Clinical Services approves the adoption of the Plan by the Affiliated Employer and designates the Affiliated Employer as an Employer. Any Affiliated Employer agrees to be bound by the terms of the Plan and any other terms and conditions that may be required by Ariel Clinical Services or its delegate, provided that such terms and conditions are not inconsistent with the purposes of the Plan.

Section 8.2 Adoption Agreement.
If Ariel Clinical Services should so require, the adoption of the Plan by any Affiliated Employer may be made subject to a written Adoption Agreement.

Section 8.3 Employer Reimbursement.
Each Affiliated Employer shall, upon demand from Ariel Clinical Services, reimburse Ariel Clinical Services for the Affiliated Employer's appropriate share of any expenses, insurance premiums or funding necessary to provide benefits under the Plan. The amount of such reimbursement shall be the sole discretion of Ariel Clinical Services and binding on any adopting Affiliated Employer.

Section 8.4 Withdrawal as Employer.
Any Affiliated Employer that adopts the Plan may withdraw from the Plan, but only with the express written approval, and within the sole discretion, of Ariel Clinical Services, and such withdrawal shall constitute a termination of the Plan as to such Affiliated Employer. Any such withdrawal and termination must be in writing and filed with Ariel Clinical Services or its delegate, and shall become effective when received by Ariel Clinical Services unless there is a written agreement between Ariel Clinical Services and the Affiliated Employer as to another effective date. Unless waived by Ariel Clinical Services, an Affiliated Employer shall be responsible as to Participants and covered Dependents for any such person's claims incurred but not presented for payment as of the date of withdrawal.

Section 8.5 Controlling Employer's Right to Terminate Adoption.
Ariel Clinical Services has the right to terminate any Affiliated Employer's adoption of or participation in the Plan at any time.

ARTICLE NINE: Miscellaneous

Section 9.1 Governing Law.
This Plan shall be construed, enforced, and administered in accordance with the laws of Colorado, except to the extent that those laws are superseded by the Federal law of the United States of America, in which case such Federal law shall apply. If any provision of the Plan or the application thereof to any circumstance or person is invalid, the remainder of the Plan and the application of such provision to other circumstances or persons shall not be affected thereby.

In addition, certain Federal laws only apply based on factors such as the number of employees or Participants relating to an Employer's control group or for other reasons. In this regard, the following laws may be applicable (the provisions specified below are intended to reflect the requirements of such laws and are not intended to grant additional rights beyond such laws to any individual, and such language should be interpreted accordingly):

(a) CHIPRA. The Children's Health Insurance Program ("CHIP") and Medicaid were expanded under the Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") to include the special enrollment rights of Employees and Dependents beyond acquiring a Dependent by birth, marriage, or adoption or losing other medical coverage that was in place at the time of the original coverage. Employees and Dependents who are eligible but not enrolled in a health plan must also be given the opportunity to do so where (i) the Employee's or Dependent's Medicaid or CHIP coverage is terminated due to a loss of eligibility, or (ii) the Employee or Dependent becomes eligible for a subsidy with respect to this Plan under Medicaid or CHIP. An Employee must request this special enrollment within 60 days of the loss of coverage in the first scenario, and within 60 days of when eligibility is determined in the second scenario if enrollment is desired. Employees have the option

to keep their children covered under the state's health program or enroll them in the employer's health plan.

To be "qualified employer-sponsored coverage" under the law, (i) the Group Health Plan or health insurance coverage must be creditable coverage for HIPAA purposes; (ii) the Employer contribution toward the cost of any premium for the coverage must be at least 40%; and (iii) the coverage must be available to individuals in a manner that would be considered to be a nondiscriminatory group for eligibility purposes under Section 105(h) of the Code. CHIPRA specifically excludes coverage under health care flexible spending accounts and high deductible health plans ("HDHP"s).

Each state in which an Employee resides will choose whether or not it will implement this optional subsidy. It will then decide whether the subsidy will be paid: (i) directly to Employees as a reimbursement of their portion of the Group Health Plan premium and other out-of-pocket expenditures; or (ii) directly to employers on behalf of the Employees. In this latter instance, an employer may opt-out of receiving the premium assistance subsidy so that the subsidy would be paid directly to the Employee. This opt-out will permit the employer to continue to withhold the Employee's full premium obligation and avoid direct involvement with the subsidy program.

The amount of premium assistance available is the incremental premium cost difference between coverage for the Employee only and coverage for the Employee plus the eligible child or children.

Employers must notify all Employees about the new CHIPRA special enrollment rights regardless of enrollment status. The enrollment notice may be given to Employees together with the Group Health Plan's eligibility and enrollment information, open enrollment packets, or summary plan description.

An Employer must also provide an annual notice to all Employees residing in impacted states regarding the assistance available and how to apply for such assistance, regardless of enrollment status. Each Employer sponsoring a Group Health Plan must provide the Employer Medicaid/CHIP Notice to applicable Employees.

In addition, CHIPRA requires plan sponsors to provide disclosure information to state agencies regarding when a plan Participant or beneficiary is covered under the company's Group Health Plan and Medicaid or CHIP. This disclosure is designed to assist states in determining the cost-effectiveness of providing the premium assistance subsidies. The law directs the Department of Health and Human Services and the Department of Labor to develop a model disclosure form for this purpose. States may not request this information until the first plan year that begins after the date on which the model form is first issued.

(b) Continuation Coverage Under COBRA. Where the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA") applies to a Component Benefit Plan, such Plan shall be operated in accordance with such law. Generally, if the Group Health Plan coverage for a Participant or his or her eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of Dependent), then the Participant and his or her eligible family members may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are generally explained in detail in the Certificate of Coverage issued by an insurance company or in the Group Health Plan. Consistent with law, the Plan Administrator (or third-party COBRA administrator, if any) will provide qualified beneficiaries with a COBRA election form. Qualified beneficiaries must elect to continue participation within 60 days after participation ends or from the date of receipt of the form, whichever is later. The Plan will offer COBRA continuation coverage only after the Plan Administrator (or third-party COBRA administrator, if any) has been notified that a qualifying event has occurred. COBRA rights are generally explained in detail in the Certificate of Coverage issued by an insurance company or in the Group Health Plan. In the event any provision of this document, including the applicable Exhibits, fails to comply with the requirements of applicable law or fails to determine the rights or liability of any party, the provisions of COBRA shall prevail. In no event shall the rights granted by this Plan be greater than those required to be provided by COBRA.

To continue group health coverage under COBRA, the Employer may elect to charge the qualified beneficiary up to 102% of the full cost of the coverage (or 150% in the case of an 11-month extension due to disability if the disabled qualified beneficiary's coverage is continued during the extension period). These payments are to be made during the 18, 29 or 36-month period of continuation coverage according to the COBRA rules. The first premium payment must be received by the COBRA administrator within 45 days after the date of the COBRA election and must include COBRA payment for the entire period from the date coverage ended through the month of the payment. Subsequent premiums must be received by the COBRA administrator within 30 days after the premium due date.

If health care FSA coverage is offered under the Plan, COBRA continuation for such coverage ends on the last day of the health care FSA plan year in which the qualifying event occurs, unless the Employer allows the optional carryover feature. A COBRA qualifying beneficiary must be provided the health care FSA carryover option if it is provided to active health care FSA Participants. The health care FSA carryover cannot last beyond the end of the applicable maximum COBRA coverage period (e.g., 18 months from the date of the COBRA qualifying event). However, COBRA will not be provided under the health care FSA if, as of

the date of the qualifying event, the Participant would not receive (during the remainder of the plan year) a benefit under the health care FSA that is more than the amount such Participant would pay for COBRA for the remainder of that plan year. Any carryover permitted by the Employer must be included in determining whether the health care FSA is underspent. As an additional benefit, the Employer may in its sole discretion extend to civil union partners, and qualified same-sex domestic partners the rights which may parallel the Federal laws of COBRA ("COBRA-like rights"). Where such extension has been made, the applicable Certificate of Coverage (or its equivalent) will address the details. Any COBRA-like rights offered under the Plan to such persons presently do not enjoy the same income tax benefits at the Federal level as regular COBRA benefits and may not at the state level. This document does not address Federal, state and local tax treatment in detail, and is not intended to provide tax advice.

(c) Family and Medical Leave Act Coverage. The Family and Medical Leave Act of 1993 ("FMLA") generally applies to employers with 50 or more employees within a 75 mile radius. FMLA also requires an employee to have worked a certain number of hours and months in order to be eligible. Where applicable this law provides certain rights and options relating to Group Health Plan coverage. It requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees. Such family leave is allowed for the following reasons: incapacity due to pregnancy, prenatal medical care, or child birth; care for the employee's child after birth or placement for adoption or foster care; care for the employee's Spouse, child, or parent who has a serious health condition; or a serious health condition that makes the employee unable to perform his or her job.

In 2008 the FMLA was expanded regarding an eligible employee's parents or immediate family members being called to active military duty status or in active military duty: first, the events for triggering family leave now include "qualifying exigencies" of covered service members. Second, with respect to care for covered service members with a serious injury or illness, eligible employees can take up to 26 weeks of job-protected leave in a single 12-month period.

While an employee is on FMLA leave, the employer must maintain the employee's health coverage, including family coverage, under any Group Health Plan on the same terms as if the employee had continued to work. Any changes to the Group Health Plan during the time an employee is on FMLA leave apply to that Employee's health benefits. Notice of any opportunity to change plans or benefits must also be given to an employee on FMLA leave.

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and

responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

However, an employee may choose not to retain health coverage during FMLA leave. When the employee returns from FMLA leave, the employee is entitled to be reinstated on the same terms as prior to taking the leave. Upon return from FMLA leave, most employees will be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms to the extent required by the law. Use of FMLA leave cannot result in the loss of any employment benefits that accrued prior to the start of an employee's leave.

The employer's obligation to maintain health benefits under FMLA stops if the employee's premium payment is more than 30 days late and the employer has given the employee written notice at least 15 days in advance advising that coverage will cease if payment is not received. If an employee's coverage lapses because he or she failed to make his or her premium payments, the Employer must restore the employee's coverage upon return from FMLA leave; the employee cannot be required to meet any qualification requirements imposed by the plan, including new waiting periods or passing a medical exam to be reinstated.

An employer's obligation to maintain health benefits under FMLA also stops if and when an employee informs the employer of intent not to return to work at the end of the leave period, or if the employee fails to return to work when the FMLA leave entitlement is exhausted for a reason other than medical necessity. Generally, if the employee does not return from leave, the employer has the right to request reimbursement for any payments made for the employee's coverage during leave.

Coverage provided under the FMLA is not COBRA coverage, and FMLA leave is not a qualifying event under COBRA. A COBRA qualifying event may occur, however, when an employer's obligation to maintain health benefits under FMLA ceases, such as when an employee notifies an employer of his or her intent not to return to work or fails to return to work at the end of the FMLA leave.

(d) GINA. The Genetic Information Nondiscrimination Act ("GINA") applies to certain health plans (generally those that are not HIPAA-excepted). GINA states that health benefit plans may not discriminate on the basis of genetic information with respect to eligibility, premiums and contributions. In this regard, GINA generally prohibits private employers with more than 15 employees from the collection or use of genetic information (including family medical history information) by a "covered entity" or "business associate" as defined under HIPAA. One exception to this rule is that a

minimum amount of genetic testing results may be used if necessary to make a determination regarding a claims payment.

Where GINA applies, genetic information is treated as protected health information under HIPAA. Under GINA, the plan must provide that an employer cannot request or require that the individual reveal whether genetic testing has or has not occurred relating to that individual, nor can an employer require an individual to undergo a genetic test. An employer cannot use genetic information to set contribution rates or premiums. Covered entities and business associates may not use genetic information for restricted underwriting purposes. "Restricted underwriting purposes" include underwriting activities involving eligibility determinations, premium computations, and any other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits.

GINA allows an additional exception to the general prohibition described above. This exception applies where an employer offers an incentive for an employee's spouse to provide information about the spouse's current or past health status as part of a voluntary wellness program.

(e) HIPAA Compliance Requirements. Where HIPAA applies to a Component Benefit Plan, such Plan shall be operated in accordance with such law. Where GINA applies, genetic information is treated as protected health information under HIPAA.

In addition, a Group Health Plan that is subject to HIPAA (i.e., not HIPAA-Excepted Coverage) must comply with the following:

(i) If a Group Health Plan provides benefits for a type of injury, it may not deny benefits otherwise provided for the treatment of injury if the injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions);

(ii) A Group Health Plan may not apply a "Preexisting Condition Exclusion" (as defined under HIPAA);

(iii) A Group Health Plan must provide for special enrollment opportunities. These rules are explained in more detail in the Certificate of Coverage relating to the applicable Group Health Plan;

(iv) Where a wellness program that is a health-contingent program subject to HIPAA is offered under the Plan, the Plan will provide a reasonable alternative standard for participation in all Plan materials describing the program. This may include tailoring the standards for each individual on a case-by-case basis in order to comply with the HIPAA wellness rules; and

(v) Where extension of benefits has been made to civil union partners, and qualified same-sex domestic partners, the HIPAA privacy rights shall apply.

(f) Medicare Part D – Creditable Coverage. Before October 15 of each year, employers must inform Medicare-eligible participants as to whether the group plan's prescription drug coverage is creditable, meaning that the coverage is expected to pay, on average, as much as the standard Medicare prescription drug coverage. Individuals who do not maintain creditable coverage for 63 days or longer following their initial enrollment period for Medicare Part D may be required to pay a late enrollment penalty.

(g) Mental Health Parity. The Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (collectively "MHPAEA"), generally requires that, where the employer employs more than 50 employees and its health plan provides for mental health and substance use disorder benefits, parity is required between mental health/substance use disorder benefits and medical/surgical benefits offered under a Group Health Plan. Therefore, financial and treatment limits for mental health/substance use disorder, such as deductibles, co-payments, co-insurance and out-of-pocket expenses, days of coverage, limited networks for services, and other similar limits on dollars or scope or duration of treatment may not be substantially more limited than for medical/surgical benefits provided.

An exemption under MHPAEA exists in which a Group Health Plan sponsor is able to demonstrate that compliance with MHPAEA results in increased claims of at least 2% in the first year the plan is subject to MHPAEA or 1% in subsequent years. If a Group Health Plan obtains a certified actuarial report demonstrating the increase in actual costs, then the plan qualifies for exemption from the parity requirements for one year. Under MHPAEA, plans that comply with the parity requirements for one full plan year and that satisfy the conditions for the increased cost exemption are exempt from the parity requirements for the following plan year, and the exemption lasts for one year. Thus, the increased cost exemption may only be claimed for alternating plan years.

The Consolidated Appropriations Act of 2021 ("CAA") further amended the MHPAEA to require Group Health Plans to perform and document comparative analyses of the design and application of non-quantitative treatment limitations ("NQTLs") e.g., limits that Group Health Plans place on benefits that are not tied to specific monetary or visit limits). Such comparative analyses must be made available, upon request, to the secretaries of the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury. In addition to the requested analyses, the following information must also be submitted:

(i) The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all mental health/substance use disorder benefits;

(ii) The factors used to determine that the NQTLs will apply to mental health/substance use disorder benefits and medical or surgical benefits and the evidentiary standards used for these factors;

(iii) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health/substance use disorder benefits, as written and in operation, are comparable to, and are applied to no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification; and

(iv) The specific findings and conclusions reached by the Group Health Plan or health insurance carrier with respect to the health insurance coverage, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA.

(h) Michelle's Law. Michelle's Law applies to Group Health Plans in limited circumstances. Michelle's Law states that health benefit plans must provide extended coverage to a Participant's Dependent, who as a full-time student in a postsecondary educational institution would otherwise lose coverage because of taking medically-necessary leave due to a serious illness or injury. This extension is required for up to twelve (12) months or, if earlier, the date the coverage would otherwise end under such component benefit plan.

This extended coverage may be conditioned on the Plan's receipt of a certification from a physician who has examined the Dependent and represents the need for the Dependent's leave or change in enrollment status due to the serious illness or injury. The Plan must furnish information about Michelle's Law in any notice regarding a certification of student status required for continued coverage under the health plan component of the Plan. Such notice must describe rights to continued coverage during a medically necessary leave of absence. The Plan intends to be in good faith compliance with the law and, therefore, any language in the Plan or a Component Benefit Plan to the contrary is to be superseded by the requirements of Michelle's Law.

(i) Newborns' and Mothers' Health Protection Act. Group Health Plans and health insurance insurers offering group insurance coverage 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 normal 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 the previously discussed periods. In any case, such plans and insurers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance insurer for prescribing a length of stay not in excess of such periods.

(j) No Surprises Act. Effective January 1, 2022, the No Surprises Act (the "Act") is a key component of the CAA. It seeks to protect patients from surprise medical bills when they receive unanticipated out-of-network care from providers and facilities delivering emergency care or from out-of-network providers delivering emergency and non-emergency care at in-network facilities. The Act also protects patients from surprise bills from out-of-network air ambulance services.

The Act applies to grandfathered and non-grandfathered plans but does not apply to retiree-only plans, health reimbursement arrangements, excepted benefits, or short-term limited-duration insurance plans.

(i) Emergency Services. The CAA prohibits providers and plans from balance billing patients for emergency services, regardless of the in-network or out-of-network status of the facility or provider treating the patient. Emergency services can include items and services provided to patients after they are stabilized and as part of outpatient observation, or as part of an inpatient or outpatient stay that is connected to the original emergency visit, unless certain conditions are met. The patient is only responsible for the cost-sharing amount (i.e., copayments and deductibles) that would apply if the services had been provided at in-network facility and in-network provider.

Patient cost-sharing cannot be greater than the recognized amount and will count toward any in-network deductible or out-of-pocket maximums. The recognized amount may be either: (i) determined by existing state law or regulation, or (ii) if no state law is in place, the qualifying payment amount (defined by the CAA as the median contracted rate recognized by the plan as the total maximum payment provided on January 31, 2019, for the same or similar item or service, by a similar provider, in the same geographic region). The qualifying payment amount will be increased annually by the consumer price index.

(ii) Non-Emergency Services. The CAA generally prohibits balance billing for non-emergency services performed by

out-of-network providers at in-network facilities. The non-emergency provisions allow for some exceptions to the surprise billing protections if the patient receives specific notice and provides consent. Providers who are eligible to request a consent waiver must include a written notice to the patient not later than 72 hours before the date on which the items or services are provided. This notice must include the following information:

a. notification that the provider or facility is out-of-network;

b. clear statement that consent is optional and the patient can seek care from an in-network provider;

c. good faith estimate of the amount the patient may be charged;

d. if the service is to be furnished by an out-of-network provider in an in-network facility, a list of in-network providers who are able to provide the service; and

e. information on whether prior authorization is needed.

Once the patient receives the notice, he or she has the option to consent. The notice must be signed by the patient where the patient acknowledges that he or she was provided with written notice and informed about the payment and how it may affect cost-sharing. The consent must include the date on which the patient received the notice and the date on which the patient signed the consent. The plan must retain the consent for seven years.

If the notice and consent requirements are not met, the cost sharing for the item or service cannot be greater than if the service was provided in-network.

(iii) Ancillary Services. If the out-of-network provider meets certain notice and consent requirements, the patient may be balanced billed. This opportunity is not available for specified ancillary services. Ancillary services that may not balance bill include the following:

a. services provided at an in-network facility related to emergency medicine, anesthesiology, pathology, radiology, laboratory and neonatology, regardless of

whether they are provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists and intensivists;

b. diagnostic services (including radiology and laboratory services);

c. items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at the facility; and

d. other items and services provided by other specialty practitioners as HHS specifies through rulemaking.

(iv) Air Ambulance Services. The Act also addresses balance billing for patients for air ambulance services (the legislation does not address ground ambulance services). If an insured patient receives air ambulance services by an out-of-network provider, and those services otherwise would have been covered if the air ambulance was in-network, the patient may only be responsible for the same cost sharing that would apply if the provider was in-network. The cost sharing amounts can count toward the patient's in-network deductible and out-of-network maximums.

(v) Independent Dispute Resolution. The No Surprises Act directed federal officials to establish a federal independent dispute resolution ("IDR") system to resolve disputes between payers and out-of-network providers.

Upon receipt of initial payment or notice of denial of payment, disputing parties have 30 business days to initiate, in writing (electronic is acceptable), an open negotiation period to negotiate a payment rate. A full 30 business days from the initial date of notice must run out before either party can initiate the federal IDR process.

The IDR process applies to plans and services for which balance billing was prohibited. Within four business days of the 30-day patient-provider dispute resolution process ending, either party may initiate the federal IDR process by sending a notice to the other party and federal government through the federal IDR portal. The notice must contain certain information, including a preferred certified IDR entity candidate. The receiving party has three business days to respond. If they disagree with the initiating party's

selection of a certified IDR entity, they must propose their own.

If the two parties agree, they must inform the Departments of Health and Human Services, Labor and Treasury and the Office of Personnel Management (the "Departments") of their selection including the name, entity number and an attestation from both parties that neither has a conflict of interest. If the parties cannot agree on an IDR entity within three business days, they must notify the Departments the following day, and the Departments will select one at random (within six business days). The chosen certified IDR entity must attest through the IDR portal within three business days that they meet all requirements, including no conflicts of interest with either party. In the event that they are ineligible for any reason, the selection process starts over.

Within 10 business days of a certified IDR entity being selected, both parties must submit: (i) their respective offers; (ii) relevant supporting information and documentation; (iii) the IDR process administrative fee; and (iv) the certified IDR entity fee. Administrative fees are nonrefundable, including in cases where a resolution is reached by the parties before the IDR entity renders a decision or where the IDR process is not applicable because of a preempting state law or applicable All-Payer Model Agreement. Both parties must also provide additional information to the IDR entity upon request and may choose to provide supplemental, relevant information.

The certified IDR entity must consider the qualified payment amount ("QPA") for the applicable year for the qualified IDR item or service and additional credible information relating to the offer submitted by the parties that relates to the circumstances. Certified IDR entities are prohibited from considering usual and customary charges or rates of other plans or payers or beneficiaries, including public payers. Additionally, it is not the IDR entity's role to determine whether the QPA was calculated correctly, make determinations of medical necessity or review coverage denials. However, if either the certified IDR entity or one of the parties believes the QPA has not been calculated in accordance with the requirements set forth, they are encouraged to notify the applicable state or federal authority, or submit a complaint against the plan or issuer. The certified IDR entity must render a written decision within 30 business days informing both parties of which

offer was selected as the final payment amount along with the underlying rationale. This decision is binding, unless fraud or misrepresentation of material facts is involved.

To streamline, multiple claims for similar qualified IDR items and services may be submitted and considered jointly (i.e., "batched") if the following conditions are met:

a. They are billed by the same provider, group or facility (i.e., the same national provider identifier (NPI) or taxpayer identification number (TIN));

b. Payment would be made by same plan/issuer;

c. They involve the same or similar items/services; and

d. Items/services were furnished within the same 30 business day period.

Batched items and services may have different QPAs, such as when it involves the same service but two different types of plans. When this is the case, the parties should provide relevant information for each QPA, and the IDR entity will consider QPAs for each item or service separately. The IDR entity may make different payment determinations for each item or service. In these cases, the party with fewest determinations in its favor is considered the non-prevailing party and is responsible for paying the certified IDR entity fee. If equal, the fee will be split evenly between the parties.

(k) The Affordable Care Act. The ACA requires the modification of Group Health Plans in a number of ways. Below are significant changes (which may also be reflected in the applicable Certificates of Coverage) that affect Group Health Plans *that are neither a grandfathered plan nor HIPAA-Excepted Coverage*:

(i) If a Participant or Dependent receives emergency services in the emergency department of a hospital, such Participant or Dependent is not required to obtain prior authorization, and such Participant's or Dependent's cost-sharing obligations (including co-payments and co-insurance) will be the same as would be applied to care received by preferred providers; however, such Participant or Dependent may be responsible for the allowed amount under the Group Health Plan and the amount billed by a non-network provider, to the extent permitted by the ACA;

(ii) Coverage of minimum preventive care services that have in effect a rating of "A" or "B" in the current recommendations of the U.S. Preventive Services Task Force must be provided without cost-sharing by the covered person and which also include special provisions for first dollar coverage of certain immunizations, preventive care and screening for infants, children, adolescents, and women, except as otherwise provided by applicable law and guidance;

(iii) If the Group Health Plan requires or allows a Participant to select a primary care physician ("PCP"), the Participant can designate any participating PCP (who participates in the network and who is accepting new patients) as the designated PCP; additionally, a participating physician specializing in pediatrics may be selected as the PCP for a covered Dependent child; if the Group Health Plan designates a PCP automatically, until a Participant makes this designation, the Group Health Plan or health insurer will designate one for the Participant;

(iv) A female covered person is permitted to receive services for OB/GYN care without referral by a PCP. That is, prior authorization from a health plan or insurer or from any other person (including a primary care provider) is not necessary in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals; and

(v) Internal appeal and external review claim procedures are revised as provided in Section 7.4 of this Plan Document.

Significant changes (which may also be reflected in the applicable Certificates of Coverage) include the following for *both Grandfathered Plans and non-grandfathered Group Health Plans that are not HIPAA-Excepted Coverage*:

(i) Any lifetime and annual maximum no longer applies to essential health benefits (to the extent covered under the Group Health Plan), which include the following: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services (including behavioral health treatment); prescription drugs; rehabilitative and habilitative services and devices; laboratory services;

preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (collectively, "Essential Health Benefits"). For purposes of determining whether a benefit or service is an essential health benefit relating to permissible annual or lifetime limits and cost sharing limits under the ACA, the Plan must choose a benchmark state;

(ii) No rescissions in health plan coverage will be allowed except for fraud or an intentional misrepresentation of a material fact and will require 30 calendar days' advance notice to an individual before coverage is rescinded;

(iii) If a health plan includes coverage for Dependents, a Participant's child (including step-child, legally adopted child, a child placed for adoption and a child under a Qualified Medical Child Support Order or National Support Notice described in more detail in Section 9.1(k) below) is covered until the end of the calendar month in which such child turns age 26 regardless of such child's tax dependent status;

(iv) Discrimination is prohibited against health care providers acting within the scope of their professional license and applicable state laws;

(v) It is prohibited for a health plan to drop coverage because an individual (who requires treatment for cancer or another life-threatening condition) chooses to participate in a clinical trial or deny coverage for routine care that would otherwise be provided because an individual is enrolled in a clinical trial; and

(vi) The annual limitation (for other than HSA-compatible high-deductible health plans, which limits are less) on the out-of-pocket maximum on essential health benefits, for plan years beginning in 2022, is $8,700 for self-only coverage and $17,400 for coverage other than self-only coverage (increased in both cases in future years by the premium adjustment percentage described under ACA Section 1302(c)(4)).

(l) Qualified Medical Child Support Orders. The Employer's group health plans (including, but not limited to, medical, vision, dental and employee assistance plans) will provide benefits as required by any Qualified Medical Child Support Order ("QMCSO") as defined in Section 609(a) of ERISA and will provide benefits to Dependent children placed with Participants for adoption under the same terms and conditions as apply in the case of Dependent children who are natural children of Participants, in

accordance with ERISA Section 609(c). The Employer has established detailed procedures for determining whether an order qualifies as a QMCSO. Participants' Spouses and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

(m) Uniformed Services Employment and Reemployment Rights Act Coverage. Any Participant covered under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), shall continue to participate and be eligible to receive benefits under the Plan in accordance with USERRA rules and regulations. Any continuation coverage provided pursuant to USERRA will run concurrently with COBRA continuation coverage, to the extent permitted by law.

(n) Women's Health and Cancer Rights Act. The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires that health plans offering medical and surgical benefits in connection with a mastectomy also provide coverage for (i) reconstruction of the breast on which the mastectomy was performed; (ii) surgery and reconstruction of the other breast to provide symmetrical appearance; and (iii) prostheses and treatment of physical complications during all stages of the mastectomy, including lymphedema.

Section 9.2 Communication to Employees.
The Employer will notify all Employees of the availability and terms of the Plan at such time and in such manner as the Controlling Employer may determine.

Section 9.3 Limitation of Rights.
Neither the establishment of the Plan nor any Plan amendment will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator, Ariel Clinical Services, or any Affiliated Employer, except as expressly provided in this Plan document or under applicable law, and in no event will the terms of employment or service of any Participant be modified or in any way be affected hereby.

Section 9.4 Benefits Solely from General Assets.
The Employer intends that in most instances the benefits provided under this Plan will be paid solely from the general assets of the Employer or through insurance. Where benefits are provided by insurance, the Employer has no obligation for the payment of such benefits, except as expressly provided by the Plan.

Section 9.5 Errors.
Any administrative or clerical error when determining eligibility or benefits or maintaining Plan records shall not place in force any coverage or benefits not provided under the Plan, void any valid coverage or benefits provided under the Plan, or extend any coverage or benefits that have otherwise terminated. When an administrative or clerical error becomes known (including an error relating to mistaken contributions), the Plan Administrator shall cause all proper and equitable adjustments to be made, including any adjustment to any required contributions as necessary to correct the error (to the extent permitted by law). In no event shall the Controlling Employer or any Employer or

the Plan Administrator, or other fiduciary of the Plan be liable in any manner for any administrative or clerical error, or for any other determination of fact, made in good faith.

Section 9.6 Non-Alienation of Benefits or Other Rights and Obligations.
Except as expressly provided in the Plan (including in an applicable Component Benefit Plan), benefits available or provided under the Plan: (i) are not in any way subject to debts or other obligations of a Participant (or beneficiary) entitled thereto; (ii) may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered; and (iii) shall not be subject to being taken by his or her creditors by any process whatsoever; and any attempt to cause such benefits to be so subjected will not be recognized, except to the extent required by law (e.g., as required by the tax withholding provisions of applicable law).

Also, except as expressly provided in the Plan (including in applicable Component Benefit Plan), any other rights and/or obligations under the Plan to or with respect to a Participant (or beneficiary) may not be voluntarily or involuntarily sold, transferred, alienated, assigned, or encumbered, and any attempt to cause such right or obligation to be so subjected will not be recognized except to the extent required by law (e.g., by the designation of an authorized representative pursuant to the Claims Procedures of ARTICLE SEVEN of the Plan and ERISA).

Section 9.7 Nondiscrimination Requirements.
All rules, decisions, interpretations and designations by the Plan Administrator under the Plan shall be made in a nondiscriminatory manner, and persons similarly situated shall be treated alike. Further, this Plan shall not in operation discriminate in favor of "highly compensated individuals" (as defined under Code Section 414(q)) as to eligibility to participate or in favor of "highly compensated individuals" as to contributions and benefits as required by any applicable provisions of the Code, including, but not limited to, Sections 79 and 105(h) and 125. If the Plan Administrator determines during any Plan Year that the Plan may fail to satisfy any nondiscrimination requirement imposed on the Plan by the Code or may exceed any limitation on benefits provided to "highly compensated individuals," "key employees" or such other Employees or classification of Employees for whom benefits may not be discriminatory under the Code, the Plan Administrator shall have the discretion and authority to take such action as it deems necessary to assure compliance with such nondiscrimination requirement limitation.

****

IN WITNESS WHEREOF, and as conclusive evidence of the adoption of the foregoing, Ariel Clinical Services has caused the Plan to be duly executed in its name and on its behalf, to be effective as of December 1, 2022.

Ariel Clinical Services

By: _____

Title: _____

Date: _____

EXHIBIT A: COMPONENT BENEFIT PLANS

ARIEL CLINICAL SERVICES WRAP BENEFIT PLAN

The information in this Exhibit is effective December 1, 2022 unless otherwise indicated below.

Component Benefit Plans Offered Under the Plan

Below is a list of each Component Benefit Plan and the eligibility and participation requirements of those plans. Also listed may be the name of the Insurance Company or Administrator that processes claims, the address for filing claims and the telephone number to call for questions regarding claims procedures and forms.

Generally, unless otherwise indicated below or as provided in **Exhibit B**, an eligible Employee under the Plan is any regular common-law employee of Ariel Clinical Services who is not a leased employee, contract worker or independent contractor, seasonal employee, variable hour employee, or former employee, and such regular common-law employee is eligible to participate in and receive benefits under one or more of the Component Benefit Plans. Non-resident aliens are also not eligible unless specifically included under "Eligible Employees" below. To determine whether an Employee is eligible to participate in a Component Benefit Plan, please read the eligibility information below for the applicable Component Benefit Plan.

Medical HDHP (BBAX) Plan	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	UnitedHealthcare Insurance Company; 185 Asylum Street; Hartford, CT 06103-0450; 860-702-5000
Grandfathered Health Plan	No
Look-Back Provisions	Yes; See Exhibit B
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Medical PPO (CHCX) Plan	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	UnitedHealthcare Insurance Company; 185 Asylum Street; Hartford, CT 06103; 860-702-5000
Grandfathered Health Plan	No
Look-Back Provisions	Yes; See Exhibit B
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Dental Plan	
Eligible Employees *	Part time employees who work at least 20 hours per week and full time employees working 30 hours or more per week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Delta Dental of Colorado; 6465 Greenwood Plaza Blvd. Ste. 900; Centennial, CO 80111; 800-610-0201
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Vision Plan	
Eligible Employees *	Part time employees who work at least 20 hours per week and full time employees working 30 hours or more per week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employer and Employee
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Ameritas Insurance Group; 5900 O Street; Lincoln, NE 68501; 800-311-7871
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Life and AD&D Plan	
Eligible Employees *	Part time employees who work at least 20 hours per week and full time employees working 30 hours or more per week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	None
Contribution Source(s)	Employer Only
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Mutual of Omaha; 3300 Mutual of Omaha Plaza; Omaha, NE 68175; 800-228-9999
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Voluntary Life and AD&D Plan	
Eligible Employees *	Part time employees who work at least 20 hours per week and full time employees working 30 hours or more per week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Metlife, Inc.; 200 Park Avenue; New York, NY 10166; 212-578-2211
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Flexible Spending Account (FSA) Plan	
Eligible Employees *	All Full-Time Employees Who Work a Minimum of 30.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	Yes, subject to Employer's Section 125 Cafeteria/POP Plan Document. A domestic partner who is not a dependent is post-tax for Federal tax purposes.
Funding Arrangements	Self-funded
Plan Administered By	ThrivePass; 3801 Franklin Street; Denver, CO 80205; 866-855-2844
Claim Fiduciary	Plan Administrator/Employer
Trustee	None
Grandfathered Health Plan	No
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Employee Assistance Program (EAP) Plan	
Eligible Employees *	All full-time and part-time employees
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employer Only
Funding Arrangements	Self-funded
Plan Administered By	Triad Inc America; 9800 Pyramid Ct #400; Englewood, CO 80112; 720-470-3915
Claim Fiduciary	Plan Administrator/Employer
Trustee	None
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Accident Plan	
Eligible Employees *	All Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Aflac; 1932 Wynnton Road; Columbus, GA 31999; 800-992-3522
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Critical Illness Plan	
Eligible Employees *	All Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Aflac; 1932 Wynnton Road; Columbus, GA 31999; 800-992-3522
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

Hospital Indemnity Plan	
Eligible Employees *	All Employees Who Work a Minimum of 20.0 Hours per Week
Participation Begins *	On 1st of Month Following Satisfaction of 30 Day Waiting Period
Participation Ends *	Last Day of Month in Which Employment with Eligible Status Ends
Excluded Employees	None
Eligible Non-Employees (e.g. Spouses, Dependents)	Spouses, Dependents/Children, Domestic Partners
Contribution Source(s)	Employee Only
Contributions Pre-Taxed?	No
Funding Arrangements	Insured Benefit Program
Insurance Carrier	Aflac; 1932 Wynnton Road; Columbus, GA 31999; 800-992-3522
* Additional rules may apply per insurance documents and/or benefit program descriptions.	

EXHIBIT B: LOOK-BACK PROVISIONS

ARIEL CLINICAL SERVICES WRAP BENEFIT PLAN

PART ONE: Definitions to Look-Back Provisions

Where the following words and phrases appear in the Exhibit, they shall have the respective meanings set out below, unless their context clearly indicates otherwise.

(a) **Applicable Large Employer** means, with respect to a calendar year, an Employer that employed an average of at least 50 **Full-Time Employees** (including full-time equivalent Employees) on business days during the preceding calendar year. In making the **Applicable Large Employer** determination, all persons treated as a single Employer under Code Section 414 (b), (c), (m) or (o) are treated as one Employer.

(b) **Continuing Employee** means an Employee whose break in service was shorter than one resulting in treatment as a **New Employee** under the Rehire Rules.

(c) **Dependent** means as to Look-Back Provisions, unless otherwise specifically provided in a Component Benefit Plan (to the extent such provisions are in compliance with Federal law), a natural or adopted child and a child for whom the Employee and/or the Employee's Spouse are the legal guardian or for whom the Employee or Employee's Spouse has legal custody or any other person specified as such in **Exhibit A** as to Look-Back Provisions.

(d) **Employment Break Period** means a period of at least four consecutive weeks (disregarding **Special Unpaid Leave**), measured in weeks, during which an Employee is not credited with **Hours of Service**. This applies only to educational organizations using the look-back measurement method.

(e) **Full-Time Employee** means, with respect to a calendar month, an Employee who is employed an average of at least 30 **Hours of Service** per week with an Employer.

(f) **Hours of Service**

(i) *In general.* The term ***Hour of Service*** means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty or leave of

absence (as defined in 29 CFR 2530.200b–2(a)). For the rules for determining an Employee's hours of service, see Code Reg. Section 54.4980H–3 (generally, Employers calculate **Hours of Service** for Employees paid on an hourly basis from records of hours worked and hours for which payment is made or due). Employees paid on a non-hourly basis (such as salaried Employees) may have their **Hours of Service** calculated using the same method as for hourly Employees or may choose a "days-worked" or a "weeks-worked" equivalency so long as such an approach would not result in a substantial understatement of a non-hourly Employee's **Hours of Service**.)

(ii) *Excluded hours*

(A) *Bona fide volunteers.* The term ***Hour of Service*** does not include any hour for services performed as a bona fide volunteer.

(B) *Work-study program.* The term ***Hour of Service*** does not include any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a substantially similar program of a State or political subdivision thereof.

(C) *Services outside the United States.* The term ***Hour of Service*** does not include any hour for services to the extent the compensation for those services constitutes income from sources without the United States (within the meaning of Sections 861 through 863 and the regulations thereunder).

(iii) *Service for other **Applicable Large Employer** members.* In determining **Hours of Service** and status as a **Full-Time Employee** for all purposes under Section 4980H, an **Hour of Service** for one **Applicable Large Employer** member is treated as an **Hour of Service** for all other **Applicable Large Employer** members for all periods during which the **Applicable Large Employer** members are part of the same group of Employers forming an **Applicable Large Employer**.

(g) **Initial Administrative Period** means an optional period, selected by an **Applicable Large Employer** member, of no longer than 90 days beginning immediately following the end of an **Initial Measurement Period** and ending immediately before the start of the associated **Initial Stability Period**. The **Initial Administrative Period** also includes the period between a **New Employee**'s start date and the beginning of the **Initial Measurement Period**, if the **Initial Measurement Period** does not begin

on the Employee's start date. The **Initial Measurement Period** and **Initial Administrative Period** together cannot extend beyond the last day of the first calendar month beginning on or after the first anniversary of the Employee's start date.

(h) **Initial Measurement Period** means a period selected by an **Applicable Large Employer** of at least three consecutive months but not more than 12 consecutive months used by the **Applicable Large Employer** as part of the look-back measurement method in § 54.4980H-3(d).

(i) **Initial Stability Period** means a period selected by an **Applicable Large Employer** member that immediately follows, and is associated with, an **Initial Measurement Period** (and, if elected by the Employer, the **Initial Administrative Period** associated with that **Initial Measurement Period**), and is used by the **Applicable Large Employer** member as part of the look-back measurement method in § 54.4980H–3(d).

(j) **Look-Back Measurement Method** means that an **Applicable Large Employer** determines each **New Employee's** or **Ongoing Employee's Full-Time Employee** status by looking back at the **Initial** or **Standard Measurement Period**.

(k) **Monthly Measurement Method** means that an **Applicable Large Employer** determines each Employee's status as a **Full-Time Employee** by counting the Employee's **Hours of Service** for each calendar month.

(l) **New Employee** means an Employee who has been employed by an **Applicable Large Employer** for less than one complete **Standard Measurement Period**.

(m) **Ongoing Employee** means an Employee who has been employed by an **Applicable Large Employer** member for at least one complete **Standard Measurement Period**.

(n) **Seasonal Employee** means an Employee who is hired into a position for which the customary annual employment is six months or less.

(o) **Special Unpaid Leave** means unpaid leave subject to the Family and Medical Leave Act of 1993 (FMLA), 103, 29 U.S.C. 2601 et seq., or to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), 103, 38 U.S.C. 4301 et seq., or on account of jury duty.

(p) **Standard Administrative Period** means an optional period, selected by an **Applicable Large Employer** member, of no longer than 90 days beginning immediately following the end of a **Standard Measurement Period** and ending immediately before the start of the associated **Standard Stability Period**.

(q) **Standard Measurement Period** means a period of at least three but not more than 12 consecutive months that is used by an **Applicable Large Employer** member as part of the look-back measurement method in § 54.4980H–3(d).

(r) **Standard Stability Period** means a period selected by an **Applicable Large Employer** member that immediately follows, and is associated with, a **Standard Measurement Period** (and, if elected by the Employer, the **Standard Administrative Period** associated with that **Standard Measurement Period**), and is used by the **Applicable Large Employer** member as part of the look-back measurement method in § 54.4980H–3(d).

(s) **Variable Hour Employee**

(i) In general, means an Employee if, based on the facts and circumstances at the Employee's start date, the **Applicable Large Employer** member cannot determine whether the Employee is reasonably expected to be employed on average at least 30 **Hours of Service** per week during the **Initial Measurement Period** because the Employee's hours are variable or otherwise uncertain.

(ii) Factors

(A) In general. Factors to consider in determining whether the Employee is reasonably expected to be (or reasonably expected not to be) employed on average at least 30 **Hours of Service** per week during the **Initial Measurement Period** include, but are not limited to, whether the Employee is replacing an Employee who was a **Full-Time Employee** or a **Variable Hour Employee**, the extent to which the **Hours of Service** of Employees in the same or comparable positions have actually varied above and below an average of 30 **Hours of Service** per week during recent measurement periods, and whether the job was advertised, or otherwise communicated to the **New Employee** or otherwise documented (for example, through a contract or job description) as requiring **Hours of Service** that would average at least 30 **Hours of Service** per week, less than 30 **Hours of Service** per week, or may vary above and below

an average of 30 **Hours of Service** per week. These factors are only relevant for a particular **New Employee** if the Employer has no reason to anticipate that the facts and circumstances related to that **New Employee** will be different. In all cases, no single factor is determinative. For purposes of determining whether an Employee is a **Variable Hour Employee**, the **Applicable Large Employer** member may not take into account the likelihood that the Employee may terminate employment with the **Applicable Large Employer** (including any member of the **Applicable Large Employer**) before the end of the **Initial Measurement Period**.

(B) Additional factors for an Employee hired by an Employer for temporary placement at an unrelated entity. In the case of an individual who, under all the facts and circumstances, is the Employee of an entity (referred to solely for purposes of this paragraph as a ‘‘temporary staffing firm’’) that hired such individual for temporary placement at an unrelated entity that is not the common law Employer, additional factors to consider in determining whether the Employee is reasonably expected to be (or reasonably expected not to be) employed by the temporary staffing firm on average at least 30 **Hours of Service** per week during the **Initial Measurement Period** include, but are not limited to, whether other Employees in the same position of employment with the temporary staffing firm, as part of their continuing employment, retain the right to reject temporary placements that the temporary staffing firm offers the Employee; typically have periods during which no offer of temporary placement is made; typically are offered temporary placements for differing periods of time; and typically are offered temporary placements that do not extend beyond 13 weeks.

(C) Educational organizations. An Employer that is an educational organization cannot take into account the potential for, or likelihood of, an **Employment Break Period** in determining its expectation of future **Hours of Service**.

(iii) Application only for look-back measurement method. The term **Variable Hour Employee** is used as a category of employees under the **Look-Back Measurement Method** and is not relevant to the **Monthly Measurement Method**.

PART TWO: Look-Back Provisions

Notwithstanding anything herein to the contrary, for any component benefit plan that is a health plan maintained by an **Applicable Large Employer** subject to the ACA's assessable penalty payments under Section 4980H of the Internal Revenue Code, the following rules apply in determining eligibility for and coverage of **New Employees** and **Ongoing Employees**, as well as their **Dependents**:

- **New Employees** will have their **Hours of Service** counted during an **Initial Measurement Period** of 12 months to determine whether they have worked an average of at least 30 hours per week ("the 30-Hour Weekly Average") if, based on the facts and circumstances at Employee's start date, an Employer cannot determine whether Employee is reasonably expected to be employed for the 30-Hour Weekly Average (such as **Variable Hour Employees**, **Seasonal Employees**, and employees of educational organizations). If Employee is found to have met the 30-Hour Weekly Average, Employee will then be offered health coverage for an **Initial Stability Period** of 12 months.

    - The 12-month **Initial Measurement Period** will begin on the first of the month coinciding with or following the date of hire.
    - The one (1) month minus one (1) day **Initial Administrative Period** will immediately follow the **Initial Measurement Period**.
    - The 12-month **Initial Stability Period** will begin immediately following the **Initial Administrative Period**.

- **New Employees** reasonably expected to be **Full-Time Employees** at their start date will have their **Hours of Service** counted using the **Monthly Measurement Method** from their date of hire until they have completed one full **Standard Measurement Period** and become **Ongoing Employees**. Once they have completed one **Standard Measurement Period** and become **Ongoing Employees**, they will be measured using the **Look-Back Measurement Method**.

    - **New Employees** reasonably expected to be **Full-Time Employees** at their start date must be offered coverage by the first day of the month immediately following the conclusion of the Employee's initial three full calendar months of employment.

- **Ongoing Employees** will have their **Hours of Service** counted during a **Standard Measurement Period** of 12 months to determine whether they have worked the 30-Hour Weekly Average. If Employee is found to have met the 30-Hour Weekly Average, Employee will then be offered health coverage for a **Standard Stability Period** of 12 months.

- The 12-month **Standard Measurement Period** will begin on October 1, 2021 and end on September 30, 2022, and will begin on October 1 and end on September 30 of each succeeding year thereafter.
- The two (2) month **Standard Administrative Period** will begin on October 1, 2022 and end on November 30, 2022, and will begin on October 1 and end on November 30 of each succeeding year thereafter.
- The 12-month **Standard Stability Period** will begin on December 1, 2022 and end on November 30, 2023, and will begin on December 1 and end on November 30 of each succeeding year thereafter.

- **Transition from a New Employee to an Ongoing Employee:** A **New Employee** must be measured for the first **Standard Measurement Period** for which Employee is employed. This means that a **New Employee** may have **Hours of Service** counted during the **Initial Measurement Period** and, at the same time, may have **Hours of Service** counted during an overlapping **Standard Measurement Period**. A **New Employee** becomes an **Ongoing Employee** if Employee remains employed for an entire **Standard Measurement Period**.

- **New Employee (Variable Hour, Seasonal, etc.) Change in Employment Status:** For a **New Employee** who experiences a "change in employment status" during his or her **Initial Measurement Period** such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be full-time, an Employer is not subject to an assessable payment for that employee until (i) the first day of the fourth full calendar month following the change in employment status, or (ii) if earlier and the employee is a **Full-Time Employee** based on the **Initial Measurement Period**, the first day of the first month following the end of the **Initial Measurement Period** (including any **Initial Administrative Period**).

- **Ongoing Employee Change in Employment Status:** An **Ongoing Employee** who experiences a "change in employment status" before the end of the **Standard Stability Period** will not have any change in classification as a **Full-Time** or non **Full-Time Employee** for the remaining portion of the stability period; however, the Employer may choose to make use of the special rule, as permitted by the ACA. Under this rule, if an Employee experiences a "change in employment status" to a position where the Employee will be working consistently under 30 hours per week, and the Employee was offered minimum value from the first day of the calendar month following three months of employment through the "change in employment status," the Employer may follow the steps below to determine continued eligibility for health coverage:

- For first three months following the "change in employment status," Employee remains covered under the **Standard Stability Period**;
- On the first of the fourth calendar month, the Employer may use the **Monthly Measurement Method** to determine eligibility;
- The **Monthly Measurement Method** may be used until the end of the first full **Standard Measurement Period** and **Standard Administrative Period**; and
- After that, the **Look-Back Measurement Method** must be used to determine eligibility.

- **Rehire Rules:** An employee who resumes providing service to an **Applicable Large Employer** after a period during which the employee was not credited with any **Hours of Service** may be treated as having terminated employment and been rehired as a **New Employee** only if the following conditions apply: (i) such employee had no **Hours of Service** for a period of at least 13 consecutive weeks (26 for educational organization Employers); and (ii) such employee had a break in service of a shorter period of at least four consecutive weeks with no credited **Hours of Service**, and that period exceeded the number of weeks of the employee's period of employment.

  - **Break-in-Service Rules for Continuing Employees:** For purposes of applying the look-back measurement method to a returning Employee not treated as a **New Employee**, the Employer would determine the Employee's average **Hours of Service** for a measurement period by computing the average after excluding any **Special Unpaid Leave** (and in the case of an educational organization, also excluding any **Employment Break Period**) during that measurement period and by using that average as the average for the entire measurement period. Alternatively, the Employer could treat the Employee as credited with **Hours of Service** for any periods of **Special Unpaid Leave** (and, in the case of an educational organization, any **Employment Break Period**) during that measurement period at a rate equal to the average weekly rate at which the Employee was credited with **Hours of Service** during the weeks in the measurement period that are not part of a period of **Special Unpaid Leave** (or, in the case of an educational organization, an **Employment Break Period**). In no case, however, as it relates to educational organizations, would the Employer be required to exclude (or credit) more than 501 **Hours of Service** during **Employment Break Periods** in a calendar year (however no such limit applies for **Special Unpaid Leave**).

- **Treatment of Continuing Employees:** Under the look-back measurement method, an Employee treated as a **Continuing Employee** retains, upon resumption of services, the status that the Employee had with respect to the application of any stability period. For example, if the **Continuing Employee** returns during a stability period in which the Employee had previously been treated as a **Full-Time Employee**, the Employee remains full-time upon return and through the end of the applicable stability period. A **Continuing Employee** treated as a **Full-Time Employee** will have been offered coverage upon resumption of services if such coverage is offered as of the first day that the Employee is credited with an **Hour of Service**, or, if later, as soon as administratively practicable (no later than the first day of the calendar month following resumption of services).

- **COBRA:** A qualifying event for purposes of reduction in hours of employment will be based off the loss of coverage date, assuming the loss of coverage occurs within 18 months of the reduction in hours.

These provisions are intended to comply with the look-back safe harbor options permitted under governmental regulations relating to the ACA and are not intended to expand rights relating to coverage or benefits of employees for any other purpose and should be so construed. As such, the primary purpose of these provisions is to avoid the penalties under Section 4980H of the Internal Revenue Code. For this purpose, no employee who would be otherwise excluded from the Plan shall be included under these provisions except to avoid such penalties.

EXHIBIT C: AFFILIATED EMPLOYERS ADOPTING PLAN

ARIEL CLINICAL SERVICES WRAP BENEFIT PLAN

The information in this Exhibit is effective December 1, 2022.

Affiliated Employers Adopting Plan

None