LAFAYETTE VENETIAN BLIND, INC.
HEALTH AND WELFARE PLAN

(As Amended and Restated Effective as of January 1, 2021)

ABV Advisors
Carmel, Indiana

ADOPTION OF THE
LAFAYETTE VENETIAN BLIND, INC.
HEALTH AND WELFARE PLAN

(As Amended and Restated Effective as of January 1, 2021)

Pursuant to resolutions adopted by the Authorized Officer of Lafayette Venetian Blind, Inc. (the "Company"), the undersigned officer of the Company hereby adopts the LAFAYETTE VENETIAN BLIND, INC. HEALTH AND WELFARE PLAN (As Amended and Restated Effective as of January 1, 2021) on behalf of the Company, in the form attached hereto.

Dated this _____ day of _________________________, 2021.

LAFAYETTE VENETIAN BLIND, INC.

By: ____

Its: ____

ATTEST/WITNESS:

By: ________________________________

Its: _________________________________

LAFAYETTE VENETIAN BLIND, INC.
HEALTH AND WELFARE PLAN

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ARTICLE I

Introduction

Section 1.1 Purpose of Plan. Lafayette Venetian Blind, Inc. (the "Company") maintains the LAFAYETTE VENETIAN BLIND, INC. HEALTH AND WELFARE PLAN (the "Plan") for the purpose of providing welfare benefits to its eligible employees.

Section 1.2 Effective Date; Plan Year. The Plan was originally established by the Company effective January 1, 2017 (the "Original Effective Date"). The "Effective Date" of the Plan, as amended and restated as set forth herein, is January 1, 2021. The provisions of the Plan only apply to an individual employed by the Company on or after the Effective Date. The rights and benefits, if any, of an employee whose employment with the Company terminated before the Effective Date will be determined in accordance with the terms of the Plan as of the date of his termination. The Plan is administered on the basis of a "Plan Year," which is the twelve-month period commencing on each January 1 and ending on the next following December 31.

Section 1.3 Plan Administration. The Plan will be administered by the Company or by a committee appointed by the Company (the "Administrator"). Except as provided in Article V, the Administrator will be the "plan administrator" and "named fiduciary" of the Plan. The Administrator may engage one or more third-party administrators to process benefit claims and to assist in the overall administration of the Plan. The Administrator, from time to time, may adopt any rules and procedures it deems necessary or desirable for the proper and efficient administration of the Plan. Any notice or document required to be given to or filed with the Company or the Administrator will be properly given or filed if delivered or mailed by registered mail, postage paid, to Lafayette Venetian Blind, Inc., P.O. Box 2838, 3000 Klondike Road, West Lafayette, IN 47996-2838.

Section 1.4 Plan Benefit Arrangements and Policies. The Plan is funded by the Company through self-funded benefit arrangements (an "arrangement" or the "arrangements") and fully-insured group policies (a "policy" or the "policies") as described in Appendix A. An authorized officer can add, delete, or otherwise modify an arrangement or policy by amending the Appendix and any of the Supplements related to the Plan without a requirement to formally amend this Plan.

The terms and provisions of each arrangement and policy are attached hereto as supplements to the Plan and are hereby incorporated by reference into the Plan as provided in Section 1.5.

Section 1.5 Supplements. The provisions of the Plan may be modified by supplements to the Plan. The terms and provisions of each supplement are a part of the Plan and, unless prohibited by law, supersede any other provisions of the Plan to the extent necessary to eliminate any inconsistencies between the supplement and any other Plan provision.

Section 1.6 Employers and Affiliates. Any Affiliate may adopt the Plan for the benefit of its employees with the Company's consent in accordance with Section 8.1. For purposes of this Plan, the term "Affiliate" means the Company and any other corporation or trade or business within the same control group (as defined in ERISA Section 3(40)(B)). The Company and each other Affiliate that adopts the Plan are referred to as the "Employers" and sometimes individually as an "Employer."

ARTICLE II

Participation

Section 2.1 Commencement of Participation. Subject to the conditions and limitations of the Plan, an employee of the Company who is eligible for coverage under an arrangement or policy will be eligible to participate in the Plan. An employee will become a "Participant" in the self-funded benefit arrangements described in Section 1.4 in accordance with the terms and conditions of the applicable arrangement. An employee will become a "Participant" in the fully-insured benefit policies described in Section 1.4 in accordance with the terms and conditions specified in the applicable policy. A spouse or dependent of a Participant will become covered under the self-funded benefit arrangements described in Section 1.4 in accordance with the terms and conditions of the applicable arrangement. A spouse or dependent of a Participant will become covered under the fully-insured benefit policies described in Section 1.4 in accordance with the terms and conditions specified in the applicable policy. An employee and any dependent will become covered and will remain covered under an arrangement or policy at the time, for the periods and under the conditions specified in the applicable arrangement or policy.

Section 2.2 Cessation of Participation. Except as provided in Article IV, a Participant will cease to be a Participant, and a dependent will cease to be a covered dependent, eligible for benefits under this Plan on (and no benefits will be payable under the Plan after) the earliest of (i) the date he is no longer eligible for coverage under the terms of any arrangement or policy, as provided in the arrangement or policy (ii) the date the Plan is terminated or (iii) the date he ceases to make a contribution towards the cost of an arrangement or policy as required by the Administrator.

Section 2.3 Reinstatement of Former Participant. A former Participant whose employment with the Company terminates will be treated as a new employee on his rehire and will again become a Participant in accordance with Section 2.1. Notwithstanding the foregoing, a former Participant who has a break in service of less than 13 weeks will become eligible for coverage under the medical arrangement in accordance with Section 2.1, without regard to his break in service.

Section 2.4 Notice of Participation. The Administrator will notify each employee of the date on which he becomes eligible to participate in the Plan, and will furnish each Participant and dependent receiving benefits under the Plan with a copy of a summary plan description.

Section 2.5 COBRA Continuation Provisions. A Participant, his spouse and his dependents will be eligible to continue their medical, dental and vision coverage (the "medical coverages") under the Plan to the extent provided by terms of Internal Revenue Code Section 4980B and Article IV.

ARTICLE III

Plan Benefits

Section 3.1 Benefit Amounts. A Participant and dependent will be covered under the arrangements and policies described in Section 1.4 as provided in Article II and, therefore, will be eligible for benefits only as set forth in the applicable arrangements and policies.

Section 3.2 Benefit Payments. To receive a benefit under this Plan, a Participant, or other person eligible for a benefit by reason of his relationship to a Participant, must submit a claim to the applicable third-party claims administrator or insurer under the terms of the applicable arrangement or policy. Benefit payments will be made by the third-party claims administrator or insurer as soon as practicable after a properly completed claim has been submitted and approved by the third-party claims administrator or insurer, consistent with applicable law. To be eligible for a benefit, the claim required by this Section must contain the information and materials required under the applicable arrangement or policy and must be filed with the third-party claims administrator or insurer within the period described in that arrangement or policy.

Section 3.3 Coordination of Benefits. Benefits payable under the Plan will be coordinated with benefits payable under other insurance, plan or HMO coverages in accordance with the terms of that arrangement or policy.

Section 3.4 Subrogation. Subject to applicable law and the provisions of the arrangement or policy described in Section 1.4, if benefits are paid or payable under the Plan to or on behalf of a Participant or a person eligible for a benefit by reason of his relationship to the Participant (a “dependent”) and if the Participant or dependent (or the Participant’s or dependent’s guardian or estate) has, may have, or asserts a claim or right to recovery against any other party or parties (including insurance companies and carriers), the Plan will be subrogated to all claims and rights of recovery of the Participant or dependent and will be entitled to reimbursement from any judgment, settlement or payment resulting from the individual’s claim or right. The Plan will be reimbursed in full for any benefits paid or payable by the Plan before any amounts (including legal fees incurred by the Participant or dependent or guardian or estate) are deducted from the judgment, settlement or payment or are paid to any other person (including the Participant or dependent). If a suit is filed, the Plan may record a notice of payment of benefits which will constitute a lien against any judgment recovered.

The Participant or dependent (including his or her guardian or estate) must take any action the Plan may reasonably require to secure the Plan’s rights under this Section and avoid any action that would prejudice the Plan’s rights. If the dependent is a minor, or under any other legal disability, the parent or guardian of the dependent may act on behalf of, and consequently bind, the dependent for purposes of this Section.

If the Participant or dependent (including his or her guardian or estate) fails to promptly bring suit against the third-party, the Plan may take any legal action it deems necessary or desirable against the third-party in its own name or in the name of the Participant or dependent to secure recovery. The Plan may retain benefits paid or to be paid and its court costs (including attorney fees) from any judgment, settlement or payment, with the balance, if any, to be paid to the Participant or dependent.

Section 3.5 Reimbursement. If the Plan pays any amount to any individual (including a Participant or dependent) or entity in excess of the amount it is required to pay, the Plan will be entitled to be reimbursed for the excess from that individual or entity. If a Participant or dependent has received a payment from a third-party for any benefit, the Plan may reduce its required payment by that amount.

ARTICLE IV

Continuation Coverage Rights

Section 4.1 Purpose. The purpose of this Article is to describe provisions relating to the rights of certain Participants and their dependents to elect to continue coverage under the Plan's medical coverages if, but for such election, a qualifying event (as defined in Section 4.2) would result in a Participant's or dependent's loss of coverage under the arrangements or policies.

Section 4.2 Qualifying Event. The term "qualifying event" means any of the following events which would result in the loss of coverage under the medical coverages (or for purposes of subsection (f), a substantial elimination of coverage within one year before or after the commencement of the proceeding) for a qualified beneficiary:

(a) The death of the Participant;

(b) The termination (other than by reason of gross misconduct) or retirement of the Participant, or a reduction of the Participant's hours of employment;

(c) The divorce or legal separation from the Participant;

(d) The Participant's becoming entitled to benefits under Title XVIII of the Social Security Act;

(e) A dependent child ceasing to be classified as a dependent of a Participant; or

(f) A proceeding in a case under Title 11, United States Code, involving the Company as the debtor in bankruptcy, but only if the Participant retired from the Company and continued as a Participant.

The term "qualified beneficiary" means a spouse or dependent child of a Participant who was a beneficiary under the medical coverages on the day before the qualifying event and a dependent child who is born to or placed for adoption with the Participant (before the dependent attained age 18) during the Participant's period of coverage under this Article IV. For purposes of subsection (b) above, that term also includes the Participant. For purposes of subsection (f), a loss of coverage will be deemed to have occurred in the event of a substantial elimination of coverage for the Participant who retired on or before the date of the substantial elimination or for the spouse (including a surviving spouse) or a dependent child of that Participant who was a covered dependent on the day before the substantial elimination.

Section 4.3 Notice of Right to Elect Continuation Coverage. Within 30 days of the occurrence of an event described in Section 4.2(a), (b) or (d), the Company will provide the Administrator written notice of that event. Within 14 days of its receipt of the Company's notice, or the receipt by the Administrator of a timely notice from a Participant, the Administrator will provide the Participant's dependents covered under the medical coverages at the time of such event and, if applicable, the Participant, with written notice of such person's

right to continuation of coverage pursuant to the terms of this Article. Notification made to the spouse or former spouse of a Participant will be treated as notification to all other qualified beneficiaries residing with such spouse at the time notification is made. For purposes of this Section, "timely notice from a Participant" will mean the receipt by the Administrator from the Participant or dependent of written notification of the occurrence of an event described in subsection 4.2(c) or (e) within 60 days of the occurrence of such event.

Section 4.4 Election of Continuation Coverage. Subject to the conditions and limitations of this Article, a qualified beneficiary may make a written election of continuation of coverage under the medical coverages at any time during the 60-day period that begins on the later of (i) the date coverage would otherwise terminate under the medical coverages by reason of a qualifying event, or (ii) the date written notice of the right to continuation of coverage is provided to the qualified beneficiary; provided, however, that timely notice (as defined in Section 4.3) was received by the Administrator if continuation coverage is available as a result of a qualifying event described in subsection 4.2(c) or (e). For a qualifying event under subsection 4.2(b) or (f), the election of coverage may be made by the Participant, or may be made by the Participant's spouse. Such election will be deemed an election made on behalf of any other qualified beneficiary who would lose coverage as a result of that qualifying event. For a qualifying event under subsection 4.2(a), (c), (d) or (e), the election of coverage may be made solely by the spouse or former spouse of the Participant and such election will be deemed an election on behalf of any other qualified beneficiary who would lose coverage as a result of such death, divorce or legal separation; provided that, if one or more dependent children are the sole qualified beneficiaries under the medical coverages, the election may be made by (or on behalf of) such dependent children.

Section 4.5 Duration of Coverage. If continuation of coverage is elected within the election period described in Section 4.4, the coverage will be effective retroactively to the date coverage under the medical coverages would otherwise have terminated but for such election. Subject to the conditions and limitations of this Section, the maximum period for which coverage under the medical coverages may be continued following the occurrence of a qualifying event is as follows:

(a) In the case of a qualifying event under subsection 4.2(b), 18 calendar months following the date on which the qualifying event occurred; provided that, if (i) a subsequent qualifying event occurs during that 18 calendar month period of continuation coverage, the maximum period, for a qualified beneficiary other than the Participant, will not exceed a period of 36 calendar months measured from the date of the initial qualifying event or (ii) the Participant became entitled to benefits under Title XVIII of the Social Security Act within the 18-month period preceding the qualifying event under subsection 4.2(b), the maximum period, for a qualified beneficiary other than the Participant, will not exceed a period of 36 months measured from the date the Participant became entitled to that coverage. Notwithstanding the foregoing, in no event will a Participant's becoming entitled to benefits under Title XVIII of the Social Security Act be treated as a "subsequent qualifying event" under clause (i) of the preceding sentence.

(b) In the case of a qualifying event under subsection 4.2(b) for a qualified beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the qualifying event or during the first 60 days of coverage under this Article IV, 29 calendar months following the date of the qualifying event; provided that the qualified beneficiary has notified the Administrator within 60 days of the determination and prior to the end of the 18-month period described in (a) above.

(c) In the case of a qualifying event under subsection 4.2(f), the lifetime of the Participant for that Participant and 36 months following the death of the Participant for the surviving Dependents of that Participant.

(d) In all other cases, 36 calendar months following the date of the qualifying event.

Notwithstanding the foregoing, continuation of coverage pursuant to the provisions of this Article as to any qualified beneficiary will terminate upon the first to occur of the following events:

(1) Failure to make timely payment of the premium required under Section 4.7 of the Plan;

(2) Termination of the medical coverages (and all other group health plans maintained by the Company);

(3) Coverage under any other group health plan (as an employee or otherwise) obtained after the qualified beneficiary has elected continuation coverage, provided that the coverage does not contain any exclusion or limitation with respect to any preexisting condition, other than an exclusion or limitation that does not apply to (or is satisfied by) the qualified beneficiary;

(4) Entitlement to Medicare benefits under Title XVIII of the Social Security Act (other than for a qualified beneficiary described in the last sentence of Section 4.2); or

(5) The first day of the month beginning more than 30 days after the date a qualified beneficiary who was disabled and receiving coverage under subsection 4.5(b) is finally determined to no longer be disabled under Title II or XVI of the Social Security Act.

In the event a former Participant becomes entitled to Medicare benefits under Title XVIII of the Social Security Act during the 18-month period described in subsection 4.5(a), the maximum continuation for all the qualified beneficiaries other than the former Participant will be extended to 36 calendar months from the date of the initial qualifying event.

Section 4.6 Continuation Coverage. For purposes of this Article, "continuation coverage" means the coverage provided for under the medical coverages.

Section 4.7 Premium Requirement. As a condition of eligibility for continuation of coverage under this Article, a qualified beneficiary who elects to continue coverage (or on whose behalf such election is made) must make premium payments not less frequently than monthly in the amounts and at the times specified by the Administrator. The amount of such premium payments will be determined by the Administrator from time to time in accordance with the provisions of Section 4980B(f)(4) of the Internal Revenue Code. With respect to a qualified beneficiary whose election of continuation of coverage is made after the date of the qualifying event, the initial premium amount will take into account the period of coverage that precedes the date of election and must be paid in full no later than 45 days following the date of election. Subsequent premium payments will be considered timely made only if received by the Administrator no later than 30 days following the premium due date otherwise established by the Administrator and communicated to the qualified beneficiary; provided that no premium may be required prior to the expiration of the 45-day period described in the preceding sentence. Notwithstanding the foregoing, if the Participant's termination of employment was the result of a military leave covered by USERRA, the Participant's premium payment under this Section cannot be more than the normal premium amount for a similarly situated employee if the military leave was for 30 or fewer days.

Section 4.8 USERRA. An employee who is absent from work for more than 31 days in order to fulfill a period of duty in the "uniformed services" of the United States (as determined under the USERRA) will be treated as experiencing a qualifying event under Section 4.2(b) as of the first day of his absence for that duty. However, the maximum period of coverage under Section 4.5 will be the lesser of (i) 24 months following the date the qualifying event was deemed to occur or (ii) the period ending on the day after the date the employee fails to timely apply for or return to active employment with the Company following his discharge from active military duty.

Section 4.9 Waiver of Continuation Coverage. If the medical coverages so allow, a qualified beneficiary may waive his rights to continuation coverage under this Article at the time specified in Section 4.4 in a manner determined by the Administrator. The qualified beneficiary may revoke that waiver by electing continuation coverage at any time during the 60-day continuation coverage election period described in Section 4.4. The continuation coverage so elected will include any period before the election is made and after the date any of the events described in Section 4.2 have occurred. Coverage otherwise provided under this Article will not be made available effective as of the date such coverage would have been provided had the waiver been made and not revoked.

ARTICLE V

General Provisions

Section 5.1 Information Required by Administrator. Each person entitled to benefits under the Plan must furnish the Administrator or the applicable third-party claims administrator or insurer with any document, evidence, data or information the Administrator or applicable third-party claims administrator or insurer considers necessary or desirable for the purpose of administering the Plan or determining benefits. The records of the Company as to an employee's or Participant's period of employment, termination of employment and the reason therefore, reemployment and earnings will be conclusive on all persons unless determined to the Administrator's satisfaction to be incorrect.

Section 5.2 Uniform Rules. The Administrator will administer the Plan on a reasonable and nondiscriminatory basis and will apply uniform rules to all persons similarly situated.

Section 5.3 Benefit Determinations for Self-Funded Benefits . Benefits under a self-funded arrangement described in Section 1.4 will only be paid to the extent the third-party claims administrator for that arrangement determines benefits are payable. The third-party claims administrator for an arrangement will determine the timing and amount of payments, if any, to be made under the arrangement. A Participant or beneficiary may request a review of any determination made by a third-party claims administrator upon written request to that third-party claims administrator, who will be the named appeals fiduciary with respect to the arrangement. The claimant will be afforded a full and fair review of such a request. The review of that claim will be made in accordance with the procedures established by the third-party claims administrator for that purpose and in accordance with the regulations promulgated by the Department of Labor under the Employee Retirement Income Security Act of 1974 ("ERISA"), in accordance with regulations promulgated under the Patient Protection and Affordable Care Act ("PPACA"), if applicable. The procedures for review of a denied claim are fully set forth in the applicable arrangement, to the extent required by law. Furthermore, to the extent applicable, a third-party claims administrator of a disability arrangement is responsible for adjudicating and reviewing claims in accordance with the disability claims regulations outlined in 29 CFR § 2540.502. To the extent that the disability administrator's benefit summary or booklet is inconsistent or incomplete, the Plan will comply with the disability claims regulations outlined in 29 CFR 2560.503.

Section 5.4 Review of Insured Benefit Determinations. Because the benefits under the group insurance policies described in Section 1.4 are only paid to the extent that the applicable insurer determines benefits are payable under a policy, the insurer will be the Plan's claims administrator and named appeals fiduciary with respect to the benefits provided under the policy it issued for the Plan. Consequently, the insurer will determine the timing and amount of payments, if any, to be made under the policy it issued and will afford a claimant a full and fair review of its determination in accordance with the claims and review procedures set by the insurer for the policy and any claims procedures applicable to the policy under regulations promulgated by the Department of Labor under ERISA, and in accordance with regulations promulgated under the PPACA, if applicable. The procedures for review of a denied claim are

fully set forth in the applicable policy or certificate, to the extent required by law. For the fully-insured disability policies, the insurer is responsible for adjudicating and reviewing claims in accordance with the disability claims regulations outlined in 29 CFR § 2540.502. To the extent that the disability insurer's policy or certificate is inconsistent or incomplete, the Plan will comply with the disability claims regulations outlined in 29 CFR 2560.503.

Section 5.5 Administrator Decision Final. The Administrator is empowered to, and will, interpret the Plan and decide all questions concerning the Plan and the eligibility of any person to participate in or benefit under the Plan, other than benefit claims determined by a claims administrator, appeals fiduciary (if someone other than the Administrator) under Section 5.3 or benefit claims determined by an insurer under Section 5.4. Any interpretation of the provisions of the Plan and any decisions on any matter made by the Administrator, a claims administrator, appeals fiduciary or insurer in good faith will be final and binding on all persons. Consequently, benefits under the Plan will be paid only if the Administrator or the applicable claims administrator, appeals fiduciary or insurer decides in its discretion that the applicant is entitled to them. When making a determination, the Administrator may rely upon information furnished by the Company, an employee, a claims administrator or the Company's legal counsel. A misstatement or other mistake of fact will be corrected when it becomes known and the Administrator will make such adjustment on account thereof as it considers equitable and practicable.

Section 5.6 Action by Company. Any action required or permitted to be taken by the Company under the Plan will be by resolution of its Board of Directors, Board of Managers or similar governing body, by resolution of a duly authorized committee of its Board of Directors, Board of Managers or similar governing body, or by a person or persons authorized by resolution of its Board of Directors, Board of Managers, similar governing body or such committee.

Section 5.7 Waiver of Notice. Any notice required under the Plan may be waived by the person entitled to such notice.

Section 5.8 Gender and Number. Where the context admits, words in the masculine gender will include the feminine and neuter genders, the singular will include the plural, and the plural will include the singular.

Section 5.9 Controlling Law. Except to the extent superseded by laws of the United States or as specifically provided otherwise in a policy or assignment, the laws of the State of Indiana will be controlling in all matters relating to the Plan.

Section 5.10 Employment Rights. The Plan does not constitute a contract of employment, and the participation in the Plan will not give any employee the right to be retained in the employ of the Company, or any right or claim to any benefit under the Plan, unless such right or claim has specifically accrued under the terms of the Plan.

Section 5.11 Interests Not Transferable. The interests of persons entitled to benefits under the Plan are not subject to their debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.

Section 5.12 Facility of Payment. When a person entitled to a benefit under the Plan is under a legal disability, or, in the Administrator's opinion is in any way incapacitated so as to be unable to manage his financial affairs, the Administrator may direct benefit payments to be made to such person's legal representative, or to a relative or friend of such person for such person's benefit, or the Administrator may direct the application of such benefits for the benefit of such person. Any payment made under this Section will be a full and complete discharge of any liability of such a Participant under the Plan.

Section 5.13 Indemnification. To the extent permitted by law, the Company will indemnify any current or former employee or director of the Company against any and all liability or claim of liability (to the extent not indemnified under any liability insurance contract or other indemnification agreement) which the person incurs on account of any act or failure to act in connection with the good faith administration of the Plan, including all expenses incurred in the person's defense if the Company fails to provide a defense after having been requested to do so in writing. The right to indemnification under this Section is conditioned upon the person notifying the Company of any claim of liability within 30 days of the person's notice of that claim and granting the Company the right to participate in and control the settlement and defense of that claim.

Section 5.14 Misrepresentation or Fraud. A person who receives a benefit under an arrangement or policy as a result of providing false, misleading or fraudulent information shall repay all amounts paid by the Plan and shall be liable for all costs of collection, including reasonable attorney fees. Coverage received under an arrangement or policy that is subject to the PPACA shall only be rescinded retroactively if false, misleading or fraudulent information was provided intentionally by the Participant, his spouse or dependent, subject to the Participant's right to notice and appeal as required under the PPACA and regulations promulgated thereunder.

Section 5.15 HIPAA Compliance. The Plan will comply with the "privacy regulations" and the "security regulations" found at 45 CFR Parts 160 and 164, as they may be amended from time to time, issued under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the provisions of the Health Information Technology for Economic and Clinical Health Act ("HITECH") and the Omnibus Final Rule (as issued on January 23, 2013), governing the use and disclosure of protected health information ("PHI") and electronic protected health information ("ePHI") (as those terms are defined under HIPAA and its regulations) to the extent they apply to the Plan. Consequently, the Plan, through the Administrator, will establish and maintain a privacy and security plan that will describe the policies, practices and procedures that will be maintained and followed by the Plan to comply with the requirements of HIPAA and its regulations. The privacy and security plan will include a description of the permitted and required uses and disclosures by the Plan of any PHI created or obtained by the Plan, including disclosures to the Company and will require the Company to reasonably and appropriately safeguard ePHI created, received, maintained or transmitted to or by the Company on behalf of the Plan. The privacy and security plan will be maintained for so long as it is required by the HIPAA regulations. The privacy and security plan will:

(a) Describe the rules and procedures for maintaining adequate separation between the Plan and the Company with respect to any PHI in the Plan's possession. This will include:

(1) A description of the individuals under the Company's control who will be given access to PHI, including those who may receive the PHI in the Plan's ordinary course of business.

(2) Rules and procedures for restricting access to and use of PHI as required by HIPAA and the privacy regulations.

(3) An effective mechanism for resolving any issues of noncompliance by any individuals described in paragraph (1) above.

(b) Describe specific rules for limiting disclosures of PHI to the Company. The rules will require, before the Plan will disclose any PHI to the Company, that the Company provides a certificate that the Plan has been amended to incorporate items (1) through (10) below and the Company to agree:

(1) Not to use or further disclose PHI other than as permitted or required by the Plan and the privacy plan or as required by applicable law;

(2) To ensure that any agents or subcontractors to whom it provides PHI that it receives from the Plan will similarly abide by the same restrictions that apply to it;

(3) Not to use or disclose any PHI for employment related actions or decisions, or in connection with any other benefit or employee benefit plan;

(4) To report to the Plan any use or disclosure of information that is inconsistent with the permitted uses or disclosures of which the Company becomes aware;

(5) To make PHI available only to the extent consistent with the Plan's privacy plan;

(6) To make PHI available to the extent required to fulfill the requirements related to Plan's policy regarding the right to request an account of disclosures;

(7) To make its internal practices, books, and records relating to the use or disclosure of PHI that it receives from the Plan available to the Secretary of the Department of Health and Human Services for audit purposes;

(8) If feasible, to return or destroy all PHI received from the Plan that the Company retains, in any form, when no longer needed for the purpose for which the disclosure was made;

(9) To ensure that adequate separation between the Plan and the Company exists to assure the confidentiality of all PHI; and

(10) To adopt a risk assessment and breach notification procedure in the event that the Plan becomes aware of a breach of unsecured PHI for which notification could be required under the HITECH Act.

(c) Designate the Plan's "privacy officer" and "security officer."

(d) The security provisions of the plan will require the Company to:

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

(2) Ensure that adequate separation between the Company and the Plan is supported by reasonable and appropriate security measures;

(3) Ensure that any agent to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect the ePHI; and

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

Section 5.16 PPACA Compliance. The medical arrangement shall comply with all mandates applicable to that arrangement under the PPACA (as amended and modified by the Health Care and Education Affordability and Reconciliation Act), and all regulations promulgated thereunder by the Departments of Health and Human Services, Labor and Treasury. Any disclosures required by PPACA and its implementing regulations to be made to Participants shall be included in the summary Plan description distributed to Participants.

ARTICLE VI

Funding

The Company will pay all costs of providing the benefits available under the Plan. The Company will pay the cost for any self-funded benefits from its own general assets and from withholdings or payments from employees as determined by the Administrator from time to time. The premiums and other charges for the policies provided under this Plan will also be paid by the Company and, to the extent determined by the Administrator, by withholdings or payments from employees. The Administrator may set different Participant contribution rates and charges from time to time in its sole and absolute discretion for each arrangement and policy and for different Participants or groups of Participants.

ARTICLE VII

Amendment and Termination

Any part or all of the Plan (including an arrangement or policy) may be amended by the Company at any time in its sole discretion. While the Company expects and intends to continue the Plan, it also reserves the right to terminate the Plan, in whole or in part, at any time in its sole discretion. In the event of the dissolution, merger, consolidation or reorganization of the Company, the Plan will terminate unless the Plan is continued by resolution of the board of directors of a successor to the Company.

ARTICLE VIII

Participation By Affiliates

Section 8.1 Affiliate Participation. Any Affiliate may adopt the Plan and become an Employer under the Plan by:

(a) filing a certified copy of a resolution of its Board of Directors, Board of Managers or similar governing body to that effect with the Company; and

(b) obtaining the Company's consent to that action.

Section 8.2 Company Action Binding on Other Employers. As long as the Company is an Employer under the Plan, it is empowered to act for any other Employer in all matters relating to the Plan.