BANK W HOLDINGS, LLC

HEALTH AND WELFARE BENEFITS PLAN

(CONTRACT EMPLOYEES)

CONSOLIDATED PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

RESTATED EFFECTIVE AS OF December 1, 2016

TABLE OF CONTENTS

INTRODUCTION **1**

PART ONE: ELIGIBILITY AND ENROLLMENT **2**

Eligibility *2*
Eligible Dependents and Beneficiaries *2*
Enrollment *2*
Timing of Enrollment and Enrollment Changes *2*
Special Enrollment Rights *2*
Qualified Medical Child Support Orders *3*
Tax Implications *3*
When Coverage Ends *3*

PART TWO: BENEFITS AND CONTRIBUTIONS **4**

General *4*
Benefit and Coverage Options *4*
How Do I Pay for Contributory Coverage Features? *4*
Claims and Appeal Procedure *4*
Special Benefit for Maternity and Infant Coverage *4*
Special Benefit for Women's Health Coverage *4*
Mental Health and Substance Use Disorder Parity *5*
Patient Protections *5*
Michelle's Law *5*

PART THREE: PLAN ADMINISTRATION **7**

The Plan Administrator *7*
Duties of the Plan Administrator *7*
Plan Administrator Compensation *7*
The Named Fiduciary *7*
Fiduciary Duties *7*
Examination of Records *7*
Reliance on Tables *7*
Indemnification of Administrator *7*
HIPAA Privacy Provisions *7*
Medical Loss Ratio Rebates *8*

PART FOUR: COBRA CONTINUATION COVERAGE **9**

Introduction *9*
COBRA Continuation Coverage *9*
When Is COBRA Coverage Available? *9*
COBRA Coverage and FMLA Leave. *10*
How Is COBRA Coverage Provided? *10*
Early Termination of COBRA Coverage *10*
How Can You Elect Continuation Coverage? *11*
How Much Does Continuation Coverage Cost? *11*
When and How Must Payment for Continuation Coverage Be Made? *11*
If You Have Questions *12*
Keep Your Plan Informed of Address Changes *12*

PART FIVE: RECOVERY PROVISIONS **13**

Refund of Overpayments *13*
Misrepresentation *13*

PART SIX: GENERAL INFORMATION ABOUT THE PLAN **14**

The Company reserves the right to amend this Plan at any time or from time to time without the consent of any Eligible Employee, Participant, dependent, or beneficiary. Although the Company expects to continue the Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Plan or any Plan Coverage Feature at any time without liability.

General Plan Information 14
Company Information 14
Plan Administrator Information 14
COBRA Administrator Information 14
Service of Legal Process 14
Type of Welfare Plan 14
Type of Administration 14
Amendment of the Plan 14
Termination of the Plan 14

PART SEVEN: YOUR ADDITIONAL RIGHTS 15

Your Rights Under ERISA 15
Rights for Participants Who Are Absent on Military Leave: USERRA 15
Rights for Participants on Family Leave Under the FMLA 16
Availability of Health Insurance Marketplace Under the ACA 16

PART EIGHT: MISCELLANEOUS PROVISIONS 17

PART NINE: GLOSSARY OF TERMS 18

PART TEN: SUMMARY OF WELFARE BENEFITS 21

INTRODUCTION

This document sets forth and describes the BANK W Holdings, LLC Health and Welfare Benefits Plan (Contract Employees) (the "Plan"). Some of the terms in the Plan are capitalized. These terms are defined in the Glossary. The purpose of this Plan is to provide certain health and welfare benefits to you and your eligible dependents under one or more Welfare Benefit Contract Documents, as more fully described herein. Each health and welfare benefit offered under the Plan is referred to as a "Coverage Feature" of the Plan. The Coverage Features offered under the Plan are either "Non-Contributory Coverage Features," which are provided to you at the Company's expense, or "Contributory Coverage Features," which require you to pay all or part of the costs of the Coverage Feature.

The Coverage Features are as follows:

- Group Medical

The following Coverage Features offer more than one plan option (e.g., PPO vs HMO or high vs. low) as described in more detail in Part Ten: Summary of Welfare Benefits:

- Group Medical

Each Coverage Feature has its own requirements for eligibility and enrollment. These requirements are set forth more fully in this Plan and in the Welfare Benefit Contract Documents, which are incorporated by reference into the Plan.

Each Coverage Feature provides benefits as set forth in the Welfare Benefits Contract Documents. To the extent the Welfare Benefits Contract Documents include detailed benefits schedules, those benefit schedules will be provided to you, free of charge, upon request made to the Plan Administrator.

This document, together with the Welfare Benefit Contract Documents, constitute both the written plan and the summary plan description as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended, ("ERISA") and US Department of Labor Regulation Sections 2520.102-2 and 2520.102-3 for the Plan. The provisions of the Welfare Benefit Contract Documents are incorporated by reference into this Plan document. If there is any conflict between this document and the Welfare Benefit Contract Documents, the Welfare Benefit Contract Documents will control.

This document contains a summary in English of your Plan rights and benefits. If you have difficulty understanding any part of this document, contact the Plan Administrator identified in Part Six during regular office hours: 8am-5pm.

PART ONE: ELIGIBILITY AND ENROLLMENT

Eligibility

You are eligible to participate under the Plan if you are an Eligible Employee.

Eligible Dependents and Beneficiaries

The Welfare Benefit Contract Documents identify which Coverage Features may cover your Eligible Dependents or beneficiaries, as well as any requirements for their coverage. Upon request, you must provide proof of your dependents' eligibility for coverage.

Enrollment

If you are an Eligible Employee, you and your Eligible Dependents may enroll in a Coverage Feature once you meet the requirements for enrollment for such Coverage Feature set forth in Part Ten: Summary of Welfare Benefits. The Plan Administrator may establish enrollment procedures for each Coverage Feature in accordance with the Welfare Benefit Contract Documents for you and your Eligible Dependents under the Plan. The Plan Administrator may prescribe enrollment forms that must be completed by a prescribed deadline prior to commencement of coverage under the Plan. As a requirement of enrollment in one or more of the Coverage Features, the Plan Administrator may require that you and your Eligible Dependents provide certain personal information, including without limitation addresses and Social Security numbers.

Timing of Enrollment and Enrollment Changes

With respect to the following Coverage Features, once you have met the requirements for enrollment (if any) set forth in Part Ten: Summary of Welfare Benefits and in the respective Welfare Benefit Contract Documents, you will be automatically enrolled and will remain enrolled so long as you are an Eligible Employee:

- None of the Coverage Features have automatic enrollment

With respect to all other Coverage Features, your opportunities to enroll, as well as to change or cancel your enrollment, are limited to the following:

- You (and your Eligible Dependents) may enroll at the time you first meet the requirements for enrollment set forth in Part Ten: Summary of Welfare Benefits and in the respective Welfare Benefit Contract Documents;
- You (and your Eligible Dependents) may enroll, or change or cancel your enrollment, during the Annual Enrollment Period; or
- You (and your Eligible Dependents) may enroll, or change your enrollment, if you become eligible for a "special enrollment right" as described below.

Special Enrollment Rights

If you do not enroll yourself and your Eligible Dependents in any Coverage Feature that is a "group health plan" under Section 701 of ERISA after you first become eligible or during the Annual Enrollment Period, you may be able to enroll under the special enrollment rules under HIPAA that apply when an individual initially declines coverage and later wishes to elect it. Generally, special enrollment is available if (i) you or your Eligible Dependent initially declined coverage because you had other health care coverage and you (or your Eligible Dependent) have lost eligibility for that other health care coverage through no fault of your (or his or her) own; or (ii) since declining coverage initially, you have acquired a new dependent (through marriage or the birth or adoption or placement for adoption of a child) and wish to cover that person. In the former case, you must have given (in writing if a written statement was required at the time by the Plan Administrator and you were provided with a notice of that requirement and its consequences at that time) the alternative coverage as your reason for waiving coverage under the group health plan when you declined to participate. In either case, as long as you (and/or your Eligible Dependents) meet the necessary requirements under the group health plan (including eligibility requirements), you can enroll both yourself and all Eligible Dependents in the group health plan within 30 days after you lose your alternative coverage or the date of your marriage or the birth, adoption, or placement for adoption of your child. Enrollment of your Eligible Dependents is generally conditioned upon your enrollment.

You may also be able to enroll yourself and your dependent in a group health plan pursuant to a special enrollment right created by the Children's Health Insurance Program Reauthorization Act of 2009. If you or your dependent is eligible for, but not enrolled, for coverage under the terms of a group health plan, you (and/or your dependent) may enroll for coverage under the terms of the group health plan if either of the following conditions is met:

- You or your dependent is covered under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under Title XXI of such Act and your (or your dependent's) coverage under such plan is terminated as a result of loss of eligibility for such coverage and you request coverage under the group health plan not later than 60 days after the termination of such coverage; or

- You or your dependent become eligible for assistance, with respect to coverage under the group health plan under such Medicaid plan or state child health plan (including under any waiver or demonstration project conducted under or in relation to such a plan), if you request coverage under the group health plan not later than 60 days after the date you or your dependent is determined to be eligible for such assistance.

Unless otherwise provided in an applicable Welfare Benefit Contract Document, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits. Please contact the Plan Administrator for details about special enrollment.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order, as defined under Section 609 of ERISA ("QMCSO") is an order by a court for one parent to provide a child or children with health insurance under a group health plan. The Plan Administrator will comply with the terms of any QMCSO it receives, and will:

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

A copy of the Plan's QMCSO procedures is available, without charge, upon request from the Plan Administrator.

Tax Implications

Medical, dental, and vision care are generally treated as non-taxable under federal tax law if they are provided to you, your spouse, your dependents, or your children who have not attained the age of 27 as of the end of a taxable year. Your "spouse" for this purpose includes any individual lawfully married to you in any state, whether the spouse is of the opposite or the same sex as you. Your "children" and "dependents" are as defined under Section 105(b) of the Code. In addition, if the Company has established a "Cafeteria Plan" under Section 125 of the Code, you may have the ability to pay any employee portions of premiums for yourself and such individuals on a pre-tax basis.

If, however, a Coverage Feature makes medical, dental, or vision care available for any individual who is not your spouse, child under age 27, or dependent (each as defined above), the value of the coverage provided to such individual is taxable to you for federal law purposes. Situations where these taxes may arise include domestic partnerships or civil unions (where the domestic partner or civil union partner is not your tax dependent), coverage of non-dependent grandchildren and ex-spouses, and coverage of a child beyond the end of the taxable year in which the child reaches age 26. This additional income, known as "imputed income," will be reported on your pay statement and Form W-2 Wage and Tax Statement for the year in which the coverage was provided. You will be required to pay taxes on this additional income, as required by the IRS and, if applicable, state tax authorities.

This document does not address every tax situation that may apply to every Plan Participant. For example, benefits provided under the Plan to certain individuals who are not common law employees of the Company (such as partners in a partnership) may be subject to unique and complicated federal tax laws rules. In addition, this document does not address state and local tax treatment. For information on how applicable tax law may apply to your personal situation, please consult your tax advisor.

When Coverage Ends

Except in the case of COBRA rights described below, benefits for you and your Eligible Dependents under the Plan will terminate upon the earliest of:

- Except as required by applicable state law, the date you cease to be an Eligible Employee,
- The date when you or your Eligible Dependent(s) no longer meet the eligibility requirements set forth in Part Ten: Summary of Welfare Benefits or in an applicable Welfare Benefit Contract Document,
- The time when you or your Eligible Dependent(s) have exhausted the benefits available under a Coverage Feature, as set forth in the applicable Welfare Benefit Contract Document,
- With respect to any Contributory Coverage Features, the last day for which necessary contributions are made,
- With respect to any fully insured Coverage Feature, the date when the group insurance policy applicable to the Coverage Feature terminates,
- With respect to any Coverage Feature, the date when the Company amends the Plan to eliminate such Coverage Feature, or changes such Coverage Feature to eliminate eligibility for you and/or your Eligible Dependents, or

- The date the Company terminates the Plan.

As noted below, the Company reserves the right to change or eliminate benefits under the Plan and may amend or terminate the Plan at any time.

Certain Coverage Features may provide conversion rights. That is, when you cease to participate in the Coverage Feature, you have the right to convert your group coverage under the Coverage Feature into an individual policy. You will be responsible for all costs associated with such individual policy. See the Welfare Benefit Contract Documents for more details.

PART TWO: BENEFITS AND CONTRIBUTIONS

General

Each Coverage Feature, including any amounts you must contribute toward a Contributory Coverage Feature, is more fully described (and subject to the limitations contained) in the Welfare Benefit Contract Documents and in Part Ten: Summary of Welfare Benefits.

Benefit and Coverage Options

Each Contributory Coverage Feature may offer a selection of benefit and coverage options from which you may choose. In addition, the Coverage Features may contain one or more coverage levels including, without limitation:

- Eligible Employee only
- Eligible Employee plus spouse
- Eligible Employee plus child(ren)
- Eligible Employee plus family
- Certain Coverage Features may also offer coverage of domestic partners, former spouses, or other individuals, either pursuant to state law or per the Plan's design

The cost of your coverage may vary depending on which coverage or benefit option you select. Your options are more fully described (and subject to the limitations contained) in the Welfare Benefit Contract Documents and in Part Ten: Summary of Welfare Benefits.

How Do I Pay for Contributory Coverage Features?

Your contributions for each Contributory Coverage Feature are set forth in Part Ten: Summary of Welfare Benefits. The applicable Participating Employer will pay the remaining costs, if any, for each Contributory Coverage Feature.

The Plan Administrator may require that your contributions be made by payroll deduction. In this case, your contributions will be used in funding the cost of the Plan benefits as soon as practicable after they have been received from you or withheld from your pay through payroll deduction.

Your benefits under the Coverage Features are funded through insurance policies, from the Company's general assets, or from a combination thereof, as set forth in Part Ten: Summary of Welfare Benefits.

Claims and Appeal Procedure

Any claim for benefits under the Plan and any subsequent appeal shall be filed in accordance with the provisions of the applicable Welfare Benefit Contract Document. The claims procedures for each Welfare Benefit Contract are furnished automatically, without charge, as a separate document or as part of the Welfare Benefit Contract Documents. Notice of the decision on such claim and any right to appeal such decision shall be provided by the Plan Administrator or, if delegated, by the insurance Company or third-party administrator issuing the applicable Welfare Benefit Contract Document in accordance with the provisions of such contract, Section 503 of ERISA and the ACA, and any regulations thereunder in effect at the time the claim for benefits is made under the Plan. Despite anything to the contrary in this Plan, the claims procedure to be used by the Plan Administrator with respect to benefits provided under a Non-Grandfathered group health plan subject to the ACA shall comply with the rules relating to internal claims and appeals and external review processes established under the ACA.

Special Benefit for Maternity and Infant Coverage

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the attending provider or physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from a plan or the issuer for prescribing the length of stay not in excess of 48 hours or 96 hours, as the case may be. Unless otherwise provided in an applicable Welfare Benefit Contract Document, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Special Benefit for Women's Health Coverage

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") requires group health plans, insurance issuers, and HMOs that already provide medical and surgical benefits for mastectomy procedures to provide insurance coverage for reconstructive surgery following mastectomies. This expanded coverage will be provided in a manner determined in consultation with the attending physician and the patient, and includes coverage for (i) reconstruction of the breast on which the mastectomy has been performed; (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance; (iii) prostheses; and (iv) physical complications at all stages of mastectomy, including lymphedemas. These procedures may be subject to annual deductibles and coinsurance provisions that are similar to those applying to other

medical or surgical benefits provided under the Group Medical Coverage Feature. For answers to specific questions regarding WHCRA benefits, contact the Plan Administrator. Additional state laws may be applicable as more fully described in other materials detailing your medical benefits. Unless otherwise provided in an applicable Welfare Benefit Contract Document, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Mental Health and Substance Use Disorder Parity

If any Group Medical Coverage Feature (1) provides both medical and surgical and mental health or substance use disorder benefits and (2) is not subject to an Increased Cost Exemption:

- The Group Medical Coverage Feature may not apply annual or lifetime limits for mental health or substance use disorders that are lower than those for medical and surgical benefits.
- The Group Medical Coverage Feature may not apply more restrictive financial requirements or treatment limitations to mental health or substance use disorder benefits in any classification than the predominant limitations applied to substantially all of the medical and surgical benefits in any classification.
- The criteria for medical necessity determinations made under any Group Medical Coverage Feature with respect to mental health or substance use disorder benefits shall be made available by the Plan Administrator (in accordance with the Wellstone Act) to any current or potential Participant upon request.
- The reason for any denial under the Plan of reimbursement or payment for services with respect to mental health or substance use disorder benefits in the case of any Participant shall, on request or as otherwise required under the Wellstone Act, be made available by the Plan Administrator to the Participant in accordance with the claims procedures applicable to the Group Medical Coverage Feature.
- The Plan shall be operated and construed in all respects in compliance with the MHPA and the Wellstone Act.

"Mental health benefits" and "substance use disorder benefits" mean benefits with respect to items or services for mental health conditions and substance use disorders, respectively, and shall be as defined in the Welfare Benefit Contract Document applicable to the Group Medical Coverage Feature, pursuant to applicable state and federal law, and consistent with generally recognized independent standards of current medical practice.

Unless otherwise provided in an applicable Welfare Benefit Contract Document, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Patient Protections

The Group Medical Coverage Feature generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Group Medical Coverage Feature network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator identified in Part Six.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the Group Medical Coverage Feature or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our 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. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator identified in Part Six.

Unless otherwise provided in an applicable Welfare Benefit Contract Document, this provision does not apply to a group health plan or group health insurance coverage in relation to its provision of Excepted Benefits.

Michelle's Law

If an Eligible Dependent is a dependent child on a medically necessary leave of absence, the coverage under a Group Medical Coverage Feature (other than an Excepted Benefit) shall not end until the earlier of (1) the date that is one year following the first day of the medically necessary leave of absence or (2) the date on which coverage under the Group Medical Coverage Feature would otherwise terminate under the terms of the Group Medical Coverage Feature. For purposes of Michelle's Law:

- A "dependent child" means the child of a Participant who is an Eligible Dependent and was enrolled in the Group Medical Coverage Feature, on the basis of being a student at a postsecondary educational institution (including an institution of higher education as described in Section 102 of the Higher Education Act of 1965), immediately before

the first day of a medically necessary leave of absence.

- A “medically necessary leave of absence” means a leave of absence of a dependent child from a postsecondary educational institution (including an institution of higher education as described in Section 102 of the Higher Education Act of 1965), or any other change in enrollment of such child at such an institution, that:
  - Commences while such dependent child is suffering from a serious illness or injury;
  - Is medically necessary; and
  - Causes such dependent child to lose student status for purposes of coverage under the Group Medical Coverage Feature.

No leave of absence (or other change of enrollment) shall be considered a medically necessary leave of absence unless the Plan receives written certification by a treating physician of the dependent child that the dependent child is suffering from a serious illness or injury and that the leave of absence (or other change of enrollment) is medically necessary.

PART THREE: PLAN ADMINISTRATION

The Plan Administrator

The Plan Administrator has sole and absolute discretion and authority (i) to interpret the terms of the Plan, (ii) to determine factual questions that arise in the course of administering the Plan, (iii) to adopt rules and regulations regarding the administration of the Plan, including enrollment procedures, (iv) to determine the conditions under which benefits become payable under the Plan, (v) to make determinations of eligibility under the Plan, (vi) to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, domestic partner, or dependent of an employee, by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence, proof of domestic partnership, or other documentation deemed appropriate by the Plan Administrator, and (vii) to make any other determinations that the Plan Administrator believes are necessary and advisable for the administration of the Plan. Any interpretation or determination made by the Plan Administrator will be final, conclusive, and binding on all parties. The Plan Administrator may delegate all or any portion of its authority to any person or entity. However, under no circumstances can the Plan be modified by oral statements of the Plan Administrator.

Duties of the Plan Administrator

The Plan Administrator (i) administers the Plan in accordance with its terms, (ii) decides disputes which may arise relative to a Plan Participant's rights, (iii) keeps and maintains the Plan documents and all other records pertaining to the Plan, (iv) pays or arranges for the payment of claims, (v) establishes, communicates, and implements procedures to determine whether a medical child support order is a QMCSO, and (vi) performs all necessary reporting and disclosure as required by ERISA.

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan unless paid by the Company.

The Named Fiduciary

The Plan Administrator is a "named fiduciary" with respect to the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary will not be liable for any act or omission of such person unless either (i) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures, or (ii) the named fiduciary has breached its fiduciary responsibility under section 405(a) of ERISA.

Fiduciary Duties

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

Examination of Records

The Plan Administrator will generally make available to each Eligible Employee such of his or her records under the Plan as pertain to him or her for examination at reasonable times during normal business hours, but the Plan Administrator shall have no obligation to disclose any records or information that the Plan Administrator, in its sole discretion, determines to be of a privileged or confidential nature.

Reliance on Tables

In administering the Plan, the Plan Administrator is entitled to the extent permitted by law to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by or in accordance with the instructions or recommendations of accountants, counsel, actuaries, consultants, or other experts employed or engaged by the Plan Administrator.

Indemnification of Administrator

The Company agrees to indemnify and to defend to the fullest extent permitted by law any employee or Participating Employer serving as the Plan Administrator or as a member of a committee designated as Plan Administrator (including any employee or former employee who formerly served as Plan Administrator or as a member of such committee) against all liabilities, damages, costs, and expenses (including attorney's fees and amounts paid in settlement of any claims approved by the Company) occasioned by any act or omission to act in connection with the Plan, if such act or omission is in good faith.

HIPAA Privacy Provisions

HIPAA requires group health plans to protect the confidentiality of your private health information. The Plan and the Company will not use or further disclose information that is protected by HIPAA ("Protected Health Information") except as necessary for treatment, payment, health plan operations, and Plan administration, or as otherwise permitted or required by applicable law. In particular, the Plan will not, without written authorization from you, use or disclose your Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Company. In addition, the Plan requires all of its business associates (that is, service providers who help us administer the Plan) to also observe HIPAA's privacy rules.

Under HIPAA, you have certain rights with respect to your Protected Health Information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the US Department of Health and Human Services if you believe your rights under HIPAA have been violated.

To the extent required by applicable law, the Plan will maintain a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, please contact the Plan Administrator. If you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, you should contact the Company's privacy officer.

Medical Loss Ratio Rebates

To the extent a rebate is paid to the Company under the rules governing medical loss ratio with respect to the Group Medical Coverage Feature, the rebate will be apportioned between the Company and Plan Participants in the discretion of the Plan Administrator in accordance with the principles set out in Department of Labor Technical Release 2011-04 (published December 2, 2011).

PART FOUR: COBRA CONTINUATION COVERAGE

Introduction

If you are participating in any group health plan subject to COBRA, you may be entitled to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, generally, upon your termination of employment with a Participating Employer. Your spouse and other qualified beneficiaries may also be entitled to COBRA continuation coverage in specified circumstances. This section generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This section gives only an overview of your COBRA continuation coverage rights. For more information about your COBRA rights and obligations under the Plan and under federal law, you should ask the COBRA Administrator.

COBRA continuation coverage for the group health plan is administered by the COBRA Administrator identified in Part Six.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

In addition to COBRA, there may be other coverage options available to you and your family. For example, you may be eligible to buy medical insurance coverage through the Health Insurance Marketplace. In the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days of the special enrollment event.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of coverage under any group health plan subject to COBRA when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this Plan. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under a group health plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

If you are the spouse of an Eligible Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

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

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

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

A child who is born or placed for adoption with the covered employee during a period of COBRA continuation coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the COBRA Administrator of the birth or adoption.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA

Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Eligible Employee, or the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Company must notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events.

For all other qualifying events (divorce or legal separation of you and your spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator within 60 days after the qualifying event occurs. You should send this notice, in writing, describing the qualifying event, to the COBRA Administrator. If you do not provide timely notice, you may not be eligible for COBRA coverage.

COBRA Coverage and FMLA Leave.

The taking of leave under FMLA does not constitute a qualifying event under COBRA. However, a qualifying event will generally occur if your FMLA leave ends and you do not return to work. Please contact the COBRA Administrator for more information on your (and your spouse's or dependent children's) COBRA eligibility during and following your FMLA leave.

How Is COBRA Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Eligible Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Eligible Employee, the Eligible Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). When the qualifying event is the end of employment or reduction of the Eligible Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability has to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To obtain the 11-month extension, notice must be sent to the COBRA Administrator before the end of the first 18-month period of COBRA continuation coverage. Further, you (or a covered family member) must make sure that the Plan Administrator is notified of the SSA's determination within 60 days of the later of (a) the date of the SSA determination; (b) the date of the qualifying event; (c) the date you would otherwise lose coverage under the Plan; or (d) the date on which you are informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. Notice should be sent in writing, postmarked within the above time frames, to the COBRA Administrator; however, the COBRA Administrator may, in its discretion, accept oral notice if such oral notice is received within the above time frames and complete written notice follows within one week of such oral notice.

If the SSA determines that you (or a covered family member) are no longer qualified for Social Security disability benefits, notice must be sent to the COBRA Administrator within 30 days of the later of (a) the date of the SSA's determination or (b) the date on which you are informed of both the responsibility to provide such notice and the Plan's procedures for providing such notice. The disability extension coverage will terminate upon such determination. Notice should be sent in writing, postmarked within the above time frames, to the COBRA Administrator; however, the COBRA Administrator may, in its discretion, accept oral notice if such oral notice is received within the above time frames and complete written notice follows within one week of such oral notice.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your

family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Eligible Employee or former Eligible Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In all of these cases, you must notify the COBRA Administrator of the second qualifying event within 60 days of the second qualifying event. You should give this notice prior to the qualifying event, or as soon as possible thereafter (but not more than 60 days after the qualifying event). Once the COBRA Administrator receives your notice, it must in turn notify you, your spouse, and children (individually or jointly) of their right to elect COBRA coverage. This notice must be sent to the COBRA Administrator.

Early Termination of COBRA Coverage

COBRA continuation coverage may terminate early if:

- The required premium payment is not paid when due;
- You and your spouse or dependent child(ren), if any, become covered under another group health plan after the date COBRA coverage is elected;
- You, your spouse or dependent child(ren), if any, become entitled to Medicare benefits (under Part A, Part B, or both) after the date COBRA coverage is elected;
- All of the Company's group health plans are terminated; or

If coverage is extended to 29 months due to disability, a determination that the individual is no longer disabled. Continuation coverage under COBRA is provided subject to your eligibility. The COBRA Administrator reserves the right to terminate your COBRA coverage retroactively, subject to the ACA, if you are determined to be ineligible for coverage.

How Can You Elect Continuation Coverage?

Each qualified beneficiary has 60 days from either (1) the date coverage is lost under the Plan or (2) the date they are notified of their right to elect continuation coverage, whichever is later, to inform the COBRA Administrator that he or she wants to elect continuation coverage. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the Eligible Employee and the Eligible Employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the election notice. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. *There is no extension of the election period.*

If you, your spouse, or dependent chooses continuation coverage and pays the applicable premium within the time period specified in the qualifying event notice, the Company is required to provide coverage which, as of the time coverage is being provided, is identical to the coverage provided under the Plan to similarly situated active employees or family members. If the Company changes or ends group health coverage for similarly situated active employees, your coverage will also change or end.

In considering whether to elect continuation coverage you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Qualified beneficiaries do not have to show that they are insurable in order to choose continuation coverage. But a qualified beneficiary must have been actually covered by the Plan the day before the qualifying event in order to elect COBRA coverage.

How Much Does Continuation Coverage Cost?

Generally, each qualified beneficiary will be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan Participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent).

When and How Must Payment for Continuation Coverage Be Made?

First Payment for Continuation Coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage at the time of your election. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date your election notice is postmarked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the COBRA Administrator to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to the COBRA Administrator.

Periodic Payments for Continuation Coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first of each month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break.

Periodic payments for continuation coverage should be sent to the COBRA Administrator.

Grace Periods for Periodic Payments

Although periodic payments are due on the first of each month, you will be given a grace period of 30 days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which it applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

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

<u>If You Have Questions</u>

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the COBRA Administrator identified in Part Six. For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, visit the US Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call its toll-free number at 1.866.444.3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

<u>Keep Your Plan Informed of Address Changes</u>

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

PART FIVE: RECOVERY PROVISIONS

Refund of Overpayments

Whenever a payment has been made under any Coverage Feature in a total amount, at any time, in excess of the maximum amount payable under the Plan's provision ("Overpayment"), you or any other Covered Person must refund to the Plan the applicable Overpayment and help the Plan obtain the refund of the Overpayment from another person or organization. This includes any Overpayments resulting from retroactive awards received from any source, fraud, or any error made in processing your claim.

In case of a recovery from a source other than the Plan, Overpayment recovery will not be more than the amount of the payment. An Overpayment also occurs when payment is made from the Plan that should have been made under another group plan. In that case, the Plan may recover the payment from one or more of the following: any other insurance Company, any other organization, or any person to or for whom payment was made.

The Plan may, at its option, recover the Overpayment by reducing or offsetting against any future benefits payable to the Covered Person or his/her survivors; stopping future benefit payments that would otherwise be due under the Plan (payments may continue when the Overpayment has been recovered); or demanding an immediate refund of the Overpayment from the Covered Person.

With respect to any Coverage Feature providing disability benefits, the Plan Administrator reserves the right to recover funds related to disability benefits for any Overpayment when a Covered Person receives state benefits, including Workers' Compensation and Social Security benefits.

Misrepresentation

If a Participant or any other person makes any intentional misrepresentation or uses fraudulent means in applying for coverage under the Plan, making a change in his or her existing coverage election under the Plan, or filing a claim for benefits under the Plan, his or her coverage under the Plan will be subject to immediate termination, recoupment by the Plan of erroneously paid expenses based on the misrepresentation or fraud, and other remedies available to the Plan Administrator at law and in equity subject to and in accordance with applicable law.

The Plan Administrator has the sole and absolute discretion and authority to verify the initial and continuing eligibility for participation and benefits under the Plan of any person, including any child, spouse, domestic partner, or dependent of an employee, by requesting proof of such eligibility including, as applicable and without limitation, tax returns, marriage certificates, birth certificates, proof of residence, proof of domestic partnership, or other documentation deemed appropriate by the Plan Administrator. The Plan Administrator has the sole and absolute discretion to refuse enrollment or continuing participation in the Plan to any individual who refuses or otherwise fails to provide such proof of eligibility.

PART SIX: GENERAL INFORMATION ABOUT THE PLAN

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

General Plan Information

BANK W Holdings, LLC Health and Welfare Benefits Plan (Contract Employees) is the name of the Plan.

The Company has assigned Plan Number 501 to your Plan.

The effective date of the Plan is December 1, 2016.

The Plan Year begins on December 1 and ends on November 30.

See also Part Ten: Summary of Welfare Benefits and the Welfare Benefit Contract Documents for more information on each Coverage Feature.

Company Information

The Company's name, address, and identification number are:

BANK W Holdings, LLC
5 Bedford Farms Drive Ste 304
Bedford NH 03110
EIN: 27-4348369

Plan Administrator Information

The Plan Administrator is:

BANK W Holdings, LLC
Attn; Human Resources
5 Bedford Farms Drive Ste 304
Bedford NH 03110
603-637-4500

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan.

COBRA Administrator Information

The COBRA Administrator is:

Combined Services LLC
2 Delta Dr #301
Concord, NH 03301
(603) 227-2000

The COBRA Administrator handles all COBRA matters including notices, payment collection, and participant inquiries on behalf of the Plan.

Service of Legal Process

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

The Rowley Agency
45 Constitution Ave.
Concord, NH 03301

Service of legal process may also be made upon the Plan Administrator.

Type of Welfare Plan

The Plan is intended to be an "employee welfare benefit plan" within the meaning of ERISA Section 3(1).

Type of Administration

While the Plan Administrator administers the Plan generally, Plan administration varies for each Coverage Feature. Some Coverage Features furnished under the Plan are administered by the providers/insurers of the applicable Welfare Benefit Contract Document. Other Coverage Features are administered by the Company. If you have questions about the Plan or any Coverage Feature, you may contact the Plan Administrator or the contact listed for a particular Coverage Feature in Part Ten: Summary of Welfare Benefits.

Amendment of the Plan

The Company reserves the power to amend the provisions of the Plan at any time and to any extent that it may deem advisable, in its sole discretion, including without the consent of any Participant, beneficiary, Eligible Employee or other Company employee. Unless otherwise provided, any such amendment will be effective for all Participants, whether or not employed by the Company or any other Participating Employer.

Termination of the Plan

Although the Company has established the Plan with the intention and expectation that it will be continued indefinitely, neither the Company nor any other Participating Employer has any obligation whatsoever to maintain the Plan for any given length of time. The Company may discontinue or terminate the Plan at any time without liability.

PART SEVEN: YOUR ADDITIONAL RIGHTS

Your Rights Under ERISA

General Rights

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Participants are entitled to the following:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, if any, and a copy of the latest annual report (Form 5500 Series), unless an exemption to filing the 5500 applies, available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain copies of all Plan documents and other Plan information including insurance contracts and collective bargaining agreements, if any, and copies of the latest annual report (Form 5500 Series), unless an exemption to filing the 5500 applies, and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies;
- Receive a summary of the Plan's annual financial report, if any. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report unless an exemption to preparation and distribution of the summary annual report applies; and
- Continue coverage under any group health plan subject to COBRA for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You, your spouse, or your dependents may have to pay for such coverage. See Part Four of the Plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

If you have any questions about this Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, including COBRA, HIPAA, and other laws affecting the Plan, or need assistance in obtaining documents from the Plan Administrator, you should contact the nearest area office of the Employee Benefits Security Administration, US Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue NW, Washington, DC. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1.866.444.EBSA. You may also visit its website at www.dol.gov/ebsa.

Rights for Participants Who Are Absent on Military Leave: USERRA

If you take a military leave of absence — whether for active duty or for training — you are entitled to continue your coverage under certain Coverage Features pursuant to the Uniformed Services Employment and Reemployment Rights Act ("USERRA").

Leave less than 31 days. If you are absent from work due to a period of active duty in the military for less than 31 days, your participation in any applicable Coverage Feature will not be interrupted, subject to your payment during such period of your regular Employee contribution for such coverage.

Leave of 31 Days or Greater

If your absence extends for 31 days or greater, you may continue to maintain your coverage under an applicable Coverage Feature for up to 24 months from the date your absence for the purpose of performing military service began. The Company may require you to pay up to 102% of the full premium under each selected Coverage Features, which represents the Company's share, your share, plus 2% for administrative costs.

Notice of Election

The Plan Administrator may develop reasonable procedures addressing how continuing coverage may be elected, consistent with the terms of the Plan and USERRA. If you think you may be affected by USERRA, contact the Plan Administrator.

Coordination with COBRA

USERRA continuation coverage is considered alternative coverage for purposes of COBRA. Therefore, if you elect USERRA continuation coverage, COBRA coverage will generally not be available. However, you should contact your Plan Administrator for more information, since a continuation of coverage under COBRA may be available to your spouse or dependent children in certain circumstances.

Rights for Participants on Family Leave Under the FMLA

FMLA may entitle you, subject to certain eligibility requirements, to take a job-protected leave for your own serious illness, for the birth or adoption of a child, or to care for a spouse, child, or parent who has a serious health condition. If you are the spouse, son, daughter, parent, or next of kin for a covered service member, extended FMLA leave may be available to care for that service member. If you take a leave of absence that qualifies under the FMLA, you may continue your participation in any Coverage Feature subject to continued coverage under the FMLA so long as you continue to contribute your share of the cost of coverage during the leave. Your monthly contributions during FMLA leave will be made pursuant to procedures established by the Plan Administrator. If you lose any coverage during any FMLA leave because you did not make the required contributions, you may re-enroll when you return from your leave. Your coverage will start again on the first day after you return to work and pay the required contributions. Entitlement to FMLA benefits may depend on a number of factors, including the size of the Company and the length of your service with the Company. Please contact the Plan Administrator to determine if you are eligible for FMLA benefits.

Genetic Nondiscrimination

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of individuals or their family members. To comply with this law, the Plan Sponsor is asking you not to provide any genetic information when responding to any request for medical information under the Plan. "Genetic information" that should not be disclosed pursuant to GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, genetic information of a fetus carried by an individual or an individual's family member, and genetic information of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Availability of Health Insurance Marketplace Under the ACA

Effective beginning in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace . To assist you as you evaluate options for you and your family, this section provides some basic information about the new Health Insurance Marketplace and employment-based health coverage offered by your employer.

What Is the Health Insurance Marketplace?

The Health Insurance Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Health Insurance Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Can I save money on my health insurance premiums in the Health Insurance Marketplace?

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

Does employer health coverage affect eligibility for premium savings through the Health Insurance Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Health Insurance Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction

in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or the coverage your employer provides does not meet the "minimum value" standard set by the ACA, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please contact the Plan Administrator.

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

PART EIGHT: MISCELLANEOUS PROVISIONS

- Nothing contained in the Plan nor any action taken hereunder shall be construed as a contract of employment or as giving any Eligible Employee any right to be retained in the employ of the Company or any Participating Employer.
- A pronoun or adjective in the masculine gender includes the feminine gender, and the singular includes the plural, unless the context clearly indicates otherwise.
- Headings and numbers in this Plan are included for convenience of reference only, and if there shall be any conflict between any of the numbers and headings and the text of the Plan, the text shall control.
- Participants shall provide the Plan Administrator with such information and evidence, and shall sign such documents, as may reasonably be requested from time-to-time for the purpose of administration of the Plan.
- Neither the establishment of the Plan nor any amendment thereof will be construed as giving to any Participant or other person any legal or equitable right against the Plan Administrator, or the Company, or any Participating Employers and in no event will the terms of employment or service of any Eligible Employee be modified or in any way affected hereby.
- The Plan is maintained for the exclusive benefit of the Participants.
- No employee of the Company or any Participating Employer, whether or not a Participant in, or eligible to participate in, the Plan, nor any Eligible Dependent, shall at any time have any vested rights to benefits provided under the Plan or under any Welfare Benefit Contract Document.
- To the extent any Coverage Feature under the Plan is self-insured by any Participating Employer or the Company, the benefits provided hereunder will be paid solely from the general assets of the Participating Employer. Nothing herein will be construed to require the Participating Employers or the Plan Administrator to maintain any fund or segregate any amount for the benefit of any Participant in this Plan, and no Participant or other person shall have any claim against, right to, or security or other interest in, any fund, account, or asset of the Participating Employer from which any self-insured benefit payment under the Plan may be made.
- The Company shall act for and on behalf of any and all Participating Employers in all matters pertaining to the Plan, and every act done by, agreement made with, or notice given to the Company shall be binding on all such Participating Employers. To the extent not preempted by ERISA or any other federal statutes or regulations, this Plan shall be governed by, and construed in accordance with, the laws of New Hampshire.
- The Company does not guarantee and is not responsible for the nature or quality of the goods or services provided through any health care provider or program.
- To verify whether a particular service is covered under a Coverage Feature, please contact the applicable provider or administrator set forth in Part Ten: Summary of Welfare Benefits and seek written verification of the coverage determination.

PART NINE: GLOSSARY OF TERMS

"ACA" means, collectively, the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010, as amended from time to time, and any regulations or guidance issued thereunder.

"Annual Enrollment Period" means with respect to a Plan Year, at least a two-week period in November of the preceding Plan Year.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as described in Part Four and any regulations or guidance issued thereunder.

"COBRA Administrator" is defined in Part Six.

"Code" means the Internal Revenue Code of 1986, as amended from time to time, and any regulations or guidance issued thereunder. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.

The "Company" means BANK W Holdings, LLC and any successor to all or a major portion of its assets or business that assumes the obligations of BANK W Holdings, LLC under the Plan.

"Coverage Feature" means a health and welfare benefit offered under the Plan, and may include "Non-Contributory Coverage Features," which are paid for by the Company, and "Contributory Coverage Features," which require you to contribute toward the cost.

"Covered Person" means a Participant as well as any Eligible Dependent or beneficiary who is or becomes covered under one or more Coverage Features.

Your "Eligible Dependents" must meet all eligibility requirements under an applicable Welfare Benefit Contract Document, and generally are:

- Your spouse (defined as an individual lawfully married to you in any state, in accordance with such state's laws, whether the spouse is of the opposite or the same sex as you); if you are legally separated or divorced, your spouse or former spouse is not an eligible dependent unless either mandated by state law or, with respect to a Coverage Feature, expressly deemed to be an Eligible Dependent under the Welfare Benefit Contract of such Coverage Feature; and/or
- Your eligible domestic partner; as determined pursuant to the Company's domestic partnership policies; and/or
- Your domestic partner's eligible dependents, as determined pursuant to the Company's domestic partnership policies; and/or
- For purposes of coverage under any Coverage Feature that provides for medical care of dependents that is excludable under Code Sections 105(b) and 106, any child of a covered Eligible Employee who has not attained age 26. A "child" of an Eligible Employee includes a biological child, stepchild, legally adopted child, or foster child placed with the eligible employee by judgment, decree, or other order of any court of competent jurisdiction. A "child" does not include the spouse or children of an Eligible Employee's child; and/or
- With respect to a Coverage Feature, any individual expressly deemed to be an Eligible Dependent under state law or under the Welfare Benefit Contract of such Coverage Feature.

You are an "Eligible Employee" if you meet all of the following requirements:

- You meet all eligibility requirements for a Coverage Feature, as set forth in the Summary of Welfare Benefits or in the applicable Welfare Benefit Contract Documents.
- You are legally authorized to work in the United States for a Participating Employer.
- You are working in the United States for the Company or a Participating Employer.
- With respect to the Group Medical Coverage Feature, you are a Full-Time Employee as defined in the BANK W Holdings Medical Plan - Eligibility Policy for Contract Employees.
- You are not engaged under an agreement that states you are not eligible to participate in the Plan or a Coverage Feature.
- You are not a nonresident alien performing services outside the United States.
- You are not classified by the Company as an independent contractor or consultant.
- You are classified by the Company as a "Contract Employee".

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended from time to time, and any regulations or guidance issued thereunder.

"Excepted Benefit" means a benefit described in Section 732(c) of ERISA and the regulations promulgated thereunder.

"FMLA" means the Family and Medical Leave Act of 1993, as amended.

"Grandfathered" means the Plan is "grandfathered" within the meaning of § 1251 of the ACA.

"Group Dental Coverage Feature" is as designated in Part Ten: Summary of Welfare Benefits.

"Group Medical Coverage Feature" is as designated in Part Ten: Summary of Welfare Benefits.

"BANK W Holdings Medical Plan - Eligibility Policy for Contract Employees" means the policy created by the Company to describe the eligibility policies applicable to the Group Medical Coverage Feature and incorporated by reference into the Plan.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time and any regulations or guidance issued thereunder.

"HMO" means a Health Maintenance Organization.

"Increased Cost Exemption" means an exemption from the mental health and substance abuse parity rules set forth in Part Two due to increased costs of providing such coverage, as determined in accordance with Section 712(c)(2) of ERISA.

"Health Insurance Marketplace" is as defined in Part Seven.

"MHPA" means the Mental Health Parity Act of 1996, as amended from time to time and as described in Part Two and any regulations or guidance issued thereunder.

"Non-Grandfathered" means, with respect to a Group Medical Coverage Feature, that such Coverage Feature is not "grandfathered" within the meaning of §1251 of the ACA.

"Overpayment" is defined in Part Five.

"Participant" means an Eligible Employee or Eligible Dependent who is eligible under a Welfare Benefit Contract Document to participate in a Coverage Feature and becomes covered under such Coverage Feature either automatically or through his or her enrollment, as applicable.

Participating Employer" means the Company and the following subsidiaries and affiliates of the Company whose participation (or partial participation) in this Plan have been approved by the Company:

- Kroll, Becker Wing LLC
- The Nagler Group, LLC
- Alexander Group, LLC
- Sales Search Partners, LLC

"PHI" means the "Protected Health Information" as defined in 45 C.F.R § 164.501.

"Plan" means the BANK W Holdings, LLC Health and Welfare Benefits Plan (Contract Employees) (Plan Number 501) as set forth in this plan document and summary plan description (including any and all amendments and supplements hereto) and the Welfare Benefit Contract Documents, which are incorporated by reference into the Plan.

"Plan Administrator" means the Company or such other person or committee as may be appointed from time to time by the Company to supervise the administration of the Plan.

"QMCSO" means a Qualified Medical Child Support Order, as described in Part One.

"SSA" means the United States Social Security Administration.

"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994 and any regulations or guidance issued thereunder.

"Welfare Benefit Contract" means a contractual arrangement maintained by the Company, and described in Part Ten: Summary of Welfare Benefits, under which a Coverage Feature is provided to Eligible Employees and, in some cases, Eligible Dependents.

"Welfare Benefit Contract Document" means the documents that describe the benefits offered under the Welfare Benefit Contract(s) for each Coverage Feature, which may include the description or schedule of benefits, certificate of coverage, summary plan description, evidence of coverage, or other similar materials describing the offered benefits. Different Welfare Benefit Contracts may have different types of Welfare Benefit Contract Documents.

The "Wellstone Act" means the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended from time to time, and any regulations and guidance issued thereunder including, without limitation, 29 CFR §2590.712.

"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as described in Part Two, as amended from time to time, and any guidance and regulations issued thereunder.

IN WITNESS WHEREOF, the Company has caused this Plan to be executed in its name and on its behalf this ___ day of _____, 201_, by its duly authorized officer.

BANK W Holdings, LLC

By ____

Name ____

Title ____

PART TEN: SUMMARY OF WELFARE BENEFITS

BANK W Holdings, LLC Health and Welfare Benefits Plan (Contract Employees)

As of December 1, 2016

Group Medical Coverage Feature

Plan Option	Welfare Benefit Contract Information	Eligibility Requirements	Coverage Options	Employee Premium Weekly Cost	Funding	For More Information
Harvard Pilgrim Best Buy HSA HMO	019968	Eligible Employees classified as a Contract employee and working full time (30 or more hours per week) are eligible to participate on the day following the 90th day of employment.	Eligible Employee only Eligible Employee plus children and/or domestic partner's children Eligible Employee plus spouse or domestic partner Eligible Employee plus family	Pay rate $12.99/hour or under: Eligible Employee only: $31.88 Eligible Employee plus children and/or domestic partner's children: $134.09 Eligible Employee plus spouse or domestic partner: $154.03 Eligible Employee plus family: $236.30 Pay rate $13.00/hour-$17.24/hour: Eligible Employee only: $37.67 Eligible Employee plus children and/or domestic partner's children: $139.89 Eligible Employee plus spouse or domestic partner: $159.83 Eligible Employee plus family: $242.10 Pay rate $17.25/hour and above: Eligible Employee only: $49.99 Eligible Employee plus children and/or domestic partner's children: $152.20 Eligible Employee plus spouse or domestic partner: $172.15 Eligible Employee plus family: $254.42	Fully insured	Harvard Pilgrim Healthcare of New England www.harvardpilgrim.org 888-333-4742

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