INSTRUCTIONS PAGE REGARDING THE PLAN DOCUMENT

This Plan Document bundles all of your health and welfare plans into a single plan. This document is an excellent tool to improve legal compliance and simplify administration of your health and welfare benefit plans.

As a Plan Sponsor, your company is required to have a written Plan Document kept on file for each health & welfare benefit plan. By having this document in place, you have ensured that ERISA compliance regulations are being followed for all of your plans, and have simplified the compliance process by wrapping all your benefits together under one Plan Document which satisfies all of the reporting requirements of the Employee Retirement Income Security Act (ERISA).

There is no mandatory distribution requirement of the ERISA plan document as there is with your Summary Plan Description. Upon a participant's or beneficiary's written request, this written plan document and any attachments are among the documents that must be furnished in response to that request.

The plan administrator may be charged up to $147 per day (indexed for inflation after 2016) if it does not provide the plan document within 30 days after an individual's request. You may impose a reasonable copying charge, not to exceed 25 cents per page, but must charge less if the actual cost to the plan is less in complying with a written request.

The Adoption Agreement, which immediately follows this instruction page, MUST be reviewed by your legal counsel to ensure that it complies with applicable state-law requirements for action by a corporation or other legal entity, and that it is consistent with your own internal governance procedures and corporate structure. It is provided as a sample and should be modified accordingly if it does not accurately reflect your entity.

Adoption Agreement for the

Franklin LTC, LLC Employee Benefits Plan

WHEREAS, Franklin LTC, LLC (the "Corporation") maintains certain employee welfare benefit plans providing the following benefits:

- Medical Programs.

WHEREAS, the Corporation wishes to treat such benefit programs, in effect as of the date of this resolution and as any one of them may be amended from time to time, and any additional benefit program added by duly authorized action of the Corporation or its representatives, as one Employee Welfare Benefit Plan for various purposes including but not limited to required governmental reports and required disclosure to participants and certain beneficiaries, and for COBRA election purposes;

WHEREAS, the Corporation wishes to amend and restate these benefit programs accordingly;

NOW, THEREFORE, IT IS RESOLVED, that the Franklin LTC, LLC Employee Benefits Plan (the "Plan") is hereby adopted to read as set forth in the document entitled "Franklin LTC, LLC Employee Benefits Plan," in substantially the form attached to this resolution; and

RESOLVED, that the Plan may be amended from time to time to update the terms and conditions or change benefits available through the Plan;

RESOLVED, that the officers of the Corporation, or any one of them, is each hereby authorized to execute the Plan and any and all other documents, and to take such other action, which is necessary or convenient to effectuate the foregoing resolutions.

The Corporation hereby adopts the Plan as evidenced on this _____ day of _____, 20_____.

_____	_____
Officer Name, Title	Officer Name, Title
_____	_____
Officer Signature	Officer Signature

Franklin LTC, LLC Employee Benefits Plan
Plan Document
Amended and Restated Effective
October 1, 2016

This document, together with the attached documents, constitutes the written plan document required by ERISA §402 with respect to benefits subject to ERISA.

ARTICLE 1. Definitions

"AD&D" means accidental death and dismemberment insurance.

"Attachments" means the documentation identified in Exhibit A and attached to this document which together with this document constitute the written plan.

"Cafeteria Plan" means the plan, established by the Company under a separate document through which choices of and pre-tax payment for benefits are made in accordance with Code §125.

"COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Code" means the Internal Revenue Code of 1986, as amended.

"Company" means Franklin LTC, LLC, or any successor thereto.

"Covered Person" means any Eligible Employee covered under the Plan, and any individual who is eligible for and covered under the Plan due to the individual's relationship to an Eligible Employee (such as the Employee's spouse, child, or other eligible family member). If a benefit requires enrollment, only an individual who has enrolled is considered a Covered Person with respect to that benefit.

"Effective Date" means, for this amendment and restatement, October 1, 2016. The original effective date of the Plan was May 1, 2016. The Plan has been amended several times since the original effective date.

"Eligible Employee" means an Employee who satisfies the eligibility provisions of Article 3, including the eligibility provisions of the applicable component benefit program.

"Employee" means any common-law employee of the Company. The determination of whether an individual is an Employee, an independent contractor or any other classification of worker or service provider, and the determination of whether an individual is classified as a member of any particular classification of employees shall be made solely in accordance with the classifications used by the Company and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.

"ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

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

"GINA" means the Genetic Information Nondiscrimination Act of 2008.

"Health FSA" means a health flexible spending arrangement established to comply with Code §§ 105 and 125 in order to allow employees to use pre-tax dollars to pay for certain medical expenses not reimbursed or paid under other programs.

"HRA" means a Health Reimbursement Arrangement funded solely by an employer without any salary reduction in order to provide benefits for substantiated medical expenses.

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

"HITECH" means the Health Information Technology for Economic and Clinical Health Act.

"MHPA" means the Mental Health Parity Act of 1996.

"MHPAEA" means the Mental Health Parity and Addiction Equity Act of 2008.

"Michelle's Law" means the law that requires group health plans to allow seriously ill or injured college students who are covered dependents to continue coverage for up to one year while on medically necessary leaves of absence.

"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended.

"Plan" means this Franklin LTC, LLC Employee Benefits Plan.

"Plan Administrator" means Franklin LTC, LLC.

"Plan Sponsor" means Franklin LTC, LLC.
"Plan Year" means the 12-month period beginning each January 1 and ending each December 31, except in the case of a short plan year representing the initial Plan Year or where the Plan Year is being changed, in which case the Plan Year shall be the entire short plan year.
"PPACA" means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010.
"USERRA" means the Uniformed Services Employment and Reemployment Rights Act of 1994.
"WHCRA" means the Women's Health and Cancer Rights Act of 1998.

ARTICLE 2. Introduction

2.1 Introduction

The Company, as Plan Sponsor, established and maintains the Plan for the exclusive benefit of its Employees and certain individuals related to its Employees, such as Employees' spouses and dependents. This document, along with the Attachments, sets forth the terms of the Plan as of the Effective Date. The Plan provides benefits through the component benefit programs identified in Exhibit A.

Each of these component benefit programs is summarized in an insurance contract, a plan document, or another governing document. When the Plan refers to an insurance contract, it also refers to any attachments to such contract, as well as documents incorporated by reference into such contract (such as the application and the certificate of insurance booklet). A copy of each contract (including the booklet), plan document, or other governing document is attached to this document in the Attachments.

2.2 ERISA Status

The Plan provides benefits that are subject to the requirements of ERISA and benefits that are not subject to ERISA. With respect to benefits subject to ERISA, this document and its Attachments constitute the written plan document required by ERISA §402. Component benefit programs included in Exhibit A that are not subject to ERISA as part of this Plan is not intended to subject the component benefit program to ERISA.

The Fiduciary for each ERISA covered benefit is identified in Exhibit A.

ARTICLE 3. Eligibility and Participation Requirements

3.1 Eligibility and Participation

An Eligible Employee with respect to the Plan is any Employee who is eligible to participate in and receive benefits under one or more of the component benefit programs in accordance with the terms and conditions of the Plan (including the terms of the applicable component program). Certain component benefit programs require enrollment (either once or annually) for coverage. Information about enrollment procedures, including when coverage begins and ends for the various component benefit programs, is found in the Attachments. An Eligible Employee begins participating in the Plan upon his or her election to participate in a component benefit program in accordance with the terms and conditions established for that program

or, if earlier, upon meeting the eligibility criteria and becoming covered under a component benefit program that does not require enrollment or an election.

Other individuals, such as an Eligible Employee's spouse, children, or other family members, may be eligible to participate in and receive benefits under one or more of the component benefit programs due to their relationship to an Eligible Employee. Information about such eligibility and coverage is found in the respective Attachments.

3.2 Termination of Participation

When an Eligible Employee's participation in the Plan terminates, benefits under the Plan for the Eligible Employee and Covered Persons covered through that Eligible Employee will cease. When an Eligible Employee's participation in a component benefit program terminates, benefits under that component benefit program for the Eligible Employee and Covered Persons covered through that Eligible Employee will cease. Termination of participation in a component benefit program occurs in accordance with the terms and conditions established for that program.

Benefits under all component programs (for all Covered Persons) will cease upon termination of the Plan.

Other circumstances can result in the termination of benefits. The insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the applicable Attachments provide additional information.

3.3 Qualified Medical Child Support Orders

The Plan will extend medical benefits to an Eligible Employee's non-custodial child as required by any qualified medical child support order (QMCSO) under ERISA §609(a), including a National Medical Support Notice. The Plan has procedures for determining whether an order qualifies as a QMCSO. Covered Persons and beneficiaries can obtain, without charge, a copy of such procedures from the Company’s Human Resources Manager.

3.4 Continuation Coverage Under USERRA

An Employee who is absent from employment for uniformed service has the right to elect to continue his or her group health plan coverage for himself or herself and for any covered dependents for a limited time specified in USERRA. USERRA rights are explained in detail in the summary of continuation coverage rights under USERRA provided in the SPD for the applicable component document.

3.5 Continuation Coverage Under COBRA

If a Covered Person's coverage under a component benefit program that is subject to COBRA (identified in Exhibit A) ceases because of certain “qualifying events” specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of dependent), then the Covered Person may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are explained in detail in the applicable certificate of insurance booklet and the summary of continuation coverage rights under COBRA provided in the SPD for the applicable component document.

ARTICLE 4. Plan Benefits

4.1 Benefits and Contributions

The Plan makes available to Eligible Employees and their eligible family members the benefits identified in Exhibit A. A summary of each component benefit program available under the Plan is provided in the insurance contract (including the certificate of insurance), plan document, or other governing documents, as set forth in the applicable Attachment.

The cost of the benefits provided through the component benefit programs will be funded in part by the Company and in part by employee contributions (which may be pre-tax or after-tax, subject to the terms of the Cafeteria Plan and applicable component benefit program). The Company will determine and periodically communicate the Eligible Employee's share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time.

The Company will make its contributions in an amount that (in the Company's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by employee contributions. The Company will pay its contribution and employee contributions to an insurer or, with respect to benefits that are self-insured, will use these contributions to pay benefits directly to or on behalf of Covered Persons from the Company's general assets. Employee contributions toward the cost of a particular benefit will be used in their entirety prior to using Company contributions to pay for the cost of such benefit.

4.2 Rebates, Refunds, and Similar Payments

Any refund, rebate, dividend, experience adjustment, or other similar payment under a group insurance contract shall be allocated consistent with applicable fiduciary obligations under ERISA.

4.3 No Trust

Nothing in the Plan is intended to require the establishment of a trust. The Company pays its portion of the cost of benefits under the Plan from the Company's general assets.

Unless otherwise required by law, contributions to any self-insured component benefits need not be placed in trust or dedicated to a specific Benefit, but may instead be considered general assets of the Employer. Furthermore, and unless otherwise required by law, nothing herein shall be construed to require the Employer or the Administrator to maintain any fund or segregate any amount for the benefit of any Participant, 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 Employer from which any payment under the Plan may be made.

4.4 Right to Recover Benefit Overpayments and Other Erroneous Payments

If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Covered Person, the Covered Person shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, according to the terms of the Plan, should not have been made, the Plan Administrator, the Company (or designee), or the applicable

insurance company may recover that incorrect payment, whether or not it resulted from the insurance company's or Plan Administrator's (or its designee's) own error, from the person to whom it was made or from any other appropriate party. As may be permitted in the sole discretion of the Plan Administrator, the refund or repayment may be made in one or a combination of the following methods: (a) in the form of a single lump-sum payment, (b) as a reduction of the amount of future benefits otherwise payable under the Plan, (c) as automatic deductions from pay or (d) any other method as may be required or permitted in the sole discretion of the Plan Administrator or the applicable insurance company. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party to the fullest extent permitted by applicable law.

With respect to component benefit programs provided through insurance, the contract language may contain information regarding the Plan's right to subrogate or seek reimbursement of erroneously paid benefits (including payments in excess of the amount appropriately payable). With respect to self-insured component benefit programs, subrogation or reimbursement rights may be set forth in the plan document or other governing documentation.

4.5 Covered Person's Responsibilities

Each Eligible Employee shall be responsible for providing the Plan Administrator and the Company and, if required by an insurance company with respect to a fully insured benefit, the insurance company with his or her current address and, if required, with the address of any individual covered through the Eligible Employee. Any notices required or permitted to be given to a Covered Person hereunder shall be deemed given if directed to the address most recently provided by the Eligible Employee and mailed by first-class United States mail. The insurance companies, the Plan Administrator, and the Company shall have no obligation or duty to locate a Covered Person.

4.6 Right to Information and Fraudulent Claims

Any person claiming benefits under the Plan shall furnish the Plan Administrator or, with respect to a fully insured benefit, the insurance company with such information and documentation as may be necessary to verify eligibility for or entitlement to benefits under the Plan.

The Plan Administrator (and, with respect to a fully insured benefit, the insurance company) shall have the right and opportunity to have a Covered Person examined when benefits are claimed, and when and as often as it may be required during the pendency of any claim under the Plan. The Plan Administrator and, with respect to a fully insured benefit, the insurance company also shall have the right and opportunity to have an autopsy done in the case of death, where it is not forbidden by law.

If a person is found to have falsified any document in support of a claim for benefits or coverage under the Plan, or failed to have corrected information which such person knows or should have known to be incorrect, or failed to bring such misinformation to the attention of the Plan Administrator or the insurance company, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the person's Plan coverage, including retroactively. In addition, the insurance company may refuse to honor any claim for benefits under the Plan for the Covered Person related to the

person submitting the falsified information. Such person shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

ARTICLE 5. Plan Administration

5.1 Plan Administration

The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, authorizing benefit payments, and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s), and expressly describes the nature and scope of the delegated responsibility.

The Company will bear its incidental costs of administering the Plan.

Forfeiture of the component plans shall, at the discretion of the Plan Administrator be used to offset any losses experienced by the Employer during the Plan Year as a result of making reimbursements with respect to all Participants in excess of the Contributions paid by such Participants through Salary Reductions; second, to reduce the cost of administering the component benefit plan during the Plan Year or the subsequent Plan Year (all such administrative costs shall be documented by the Plan Administrator); and third, to provide increased benefits or compensation to Participants in subsequent years in any weighted or uniform fashion that the Plan Administrator deems appropriate, consistent with applicable regulations.

5.2 Discretionary Authority

The Plan Administrator, and any other fiduciary with respect to the Plan to the extent that such individual or entity is acting in its fiduciary capacity, shall have full and sole discretionary authority to interpret all plan documents and to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan (including component benefit programs), and to determine all questions arising in connection with the administration, interpretation, and application of the Plan (including component benefit programs), including the eligibility and coverage of individuals and the authorization or denial of payment or reimbursement of benefits. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary or capricious or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review. Accepting any benefits or making

any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator makes, in its sole discretion and, further, constitutes agreement to the limited standard and scope of review described by this section.

5.3 Reliance on Participant, Tables, etc.

The Plan Administrator may rely upon the direction, information, or election of a Participant as being proper under the Plan and shall not be responsible for any act or failure to act because of a direction or lack of direction by a Participant. The Plan Administrator will also be entitled, to the extent permitted by law, to rely conclusively on all tables, valuations, certificates, opinions, and reports that are furnished by accountants, attorneys, or other experts employed or engaged by the Plan Administrator.

5.4 Election Modifications Required by Plan Administrator

The Plan Administrator may, at any time, require any Participant or class of Participants to amend the amount of their Salary Reductions for a Period of Coverage if the Plan Administrator determines that such action is necessary or advisable in order to (a) satisfy any of the Code's nondiscrimination requirements applicable to this Plan or component benefit plans; (b) prevent any Employee or class of Employees from having to recognize more income for federal income tax purposes from the receipt of benefits hereunder than would otherwise be recognized; (c) maintain the qualified status of benefits received under this Plan; or (d) satisfy Code nondiscrimination requirements or other limitations applicable to the Company's qualified plans. In the event that contributions need to be reduced for a class of Participants, the Plan Administrator will reduce the Salary Reduction amounts for each affected Participant in a manner consistent with the Code until the defect is corrected.

5.5 Provision for Third-Party Plan Service Providers

The Plan Administrator, subject to approval of the Company, may employ the services of such persons as it may deem necessary or desirable in connection with the operation of the Plan. Unless otherwise provided in the service agreement, obligations under this Plan shall remain the obligation of the Company.

5.6 Fiduciary Liability

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for their own willful misconduct or willful breach of this Plan.

5.7 Compensation of Plan Administrator

Unless otherwise determined by the Company and permitted by law, any Plan Administrator that is also an Employee of the Employer shall serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of their duties shall be paid by the Company.

5.8 Bonding

The Plan Administrator shall be bonded to the extent required by ERISA.

5.9 Role of Insurance Company

The Company shall have the right (a) to enter into a contract with one or more insurance companies for the purposes of providing any benefits under the Plan; and (b) to replace any of such insurance companies or contracts. Any dividends, retroactive rate adjustments, or other refunds of any type that may become payable under any such insurance contract shall not be assets of the Plan but shall be the property of and be retained by the Company, to the extent that such amounts are less than aggregate Employer contributions toward such insurance.

Insurance premiums for Covered Persons may be paid in part by the Company out of its general assets and in part by Employees (generally through payroll deductions and, if applicable, pursuant to the terms of the Cafeteria Plan). A schedule of the applicable premiums may be provided during the initial and subsequent open enrollment periods and on request for each of the component benefit programs, as applicable.

5.10 Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Participant or other person to whom a payment is due under the Plan because it cannot ascertain the identity or whereabouts of such Participant or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Participant or other person shall be forfeited following a reasonable time after the date any such payment first became due.

5.11 Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, the allocations made to the account of any Participant, or the amount of benefits paid or to be paid to a Participant or other person, the Plan Administrator shall, to the extent that it deems administratively possible and otherwise permissible under ERISA, the Code or the regulations issued thereunder, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Participant or other person the credits to the account or distributions to which he or she is properly entitled under the Plan. Such action by the Plan Administrator may include withholding of any amounts due to the Plan or the Employer from Compensation paid by the Company.

ARTICLE 6. Circumstances That May Affect Benefits

6.1 Denial, Loss, and Recovery of Benefits

Various circumstances can result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits. The applicable insurance contracts (including the certificate of insurance booklets), plans, and other governing documents in the Attachments provide additional information about the termination, denial, or loss of benefits.

6.2 Plan Termination

Benefits will cease upon termination of the Plan.

ARTICLE 7. Amendment or Termination of the Plan

7.1 Amendment or Termination

The Company, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Company or any of its delegates. For this purpose, amending the Plan includes making changes to a component benefit program. Terminating a component benefit program (including terminating an insurance contract through which such benefits are provided) is not a termination of the Plan. Rather, it is an amendment to the Plan.

ARTICLE 8. Claims and Appeals Procedures

8.1 Claims and Appeals for Fully Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the respective insurer is the named fiduciary under that component benefit of the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, the Covered Person must follow the claims procedures under the applicable insurance, which may require the Covered Person to complete, sign, and submit a written claim on the insurer's form.

The insurance company will decide a Covered Person's claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide a claim. If the insurance company denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Covered Person may appeal to the insurance company for a review of the denied claim. The insurance company will decide the appeal in accordance with its reasonable claims procedures, as required by ERISA if applicable. If the Covered Person does not appeal on time, then he or she may lose his or her right to file suit in a state or federal court, as he or she will not have exhausted his or her internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court). To the extent the component benefit program is subject to provisions of PPACA requiring external review, procedures to that effect will be available.

The insurance contract (including the certificate of insurance) in the applicable Attachment provides information about how to file a claim and appeal a denied claim, and details regarding the insurance company's claims procedures.

8.2 Claims and Appeals for Self-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Company's general assets, the Plan Administrator is the named fiduciary

under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-insured arrangement.

To obtain benefits from a self-insured arrangement, the Covered Person must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide a claim.

The Plan Administrator will decide a Covered Person's claim in accordance with reasonable claims procedures, as required by ERISA. If the Plan Administrator denies a claim in whole or in part, then the Covered Person will receive a written notification setting forth the reason(s) for the denial.

If a claim is denied, the Covered Person may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide the appeal in accordance with reasonable claims procedures, as required by ERISA. If the Covered Person does not appeal on time, then the Covered Person may lose his or her right to file suit in a state or federal court, because he or she will not have exhausted the internal administrative appeal rights (which generally is a prerequisite to bringing a suit in state or federal court).

See the summary plan description (SPD) or other governing document among the applicable Attachments for more information about how to file a claim and appeal a denied claim, and for details regarding the claims procedures applicable to a claim.

8.3 Claims Deadline

Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, a claim for benefits under this Plan (including the component benefit programs) must be made within one year after the date the expense was incurred that gives rise to the claim. It is the responsibility of the Covered Person or his or her designee to make sure this requirement is met.

8.4 Limitations Period for Filing Suit

Unless specifically provided otherwise in a component benefit program or pursuant to applicable law, a suit for benefits under this Plan must be brought within one year after the date of a final decision on the claim in accordance with the applicable claims procedures.

ARTICLE 9. HIPAA Privacy and Security

9.1 Applicability

This Article 9 applies to any health plan as defined by applicable provisions of the HIPAA Privacy and Security Rule.

9.2 Use and Disclosure of Protected Health Information

The Plan may disclose participant information to the Sponsor, as permitted under the Standards for Privacy of Individuality Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations").

In addition, the Plan may disclose protected health information ("PHI") to the Sponsor as necessary to allow the Sponsor to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

9.3 Certification

The Plan will disclose protected health information to the Sponsor only upon receipt of a certification by the Sponsor that the Plan documents have been amended to incorporate the provisions of Section 9.4.

9.4 Sponsor Agreement to Restrictions and Certification

The Sponsor agrees to:

(a) Not use or disclose the PHI other than as permitted, as required by law, or as specified above;

(b) Ensure that any agents, including a subcontractor, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) If it becomes aware, report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures permitted, required by law, or as specified above;

(e) Make available PHI in accordance with the HIPAA Privacy Regulations;

(f) Make available PHI for amendment and incorporate any amendments to PHI in accordance with the HIPAA Privacy Regulations;

(g) Make available the information required to provide an accounting of disclosures of PHI in accordance with the HIPAA Privacy Regulations;

(h) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance;

(i) If feasible, return or destroy all PHI received from the Plan that the Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, restrict access and use as required by the HIPAA Privacy Regulations; and

(j) Ensure that the Sponsor and the Plan are adequately separated (as described in Section 9.5).

9.5 Firewall

(a) The following persons under the control of the Sponsor shall have access to the Plan's PHI to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

(i) members of the legal, finance, information system, audit, accounting, and human resources departments to the extent they perform functions with respect to the Plan; and

(ii) such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

(b) The person(s) named in Subsection 9.5(a) shall have access to and use information only to the extent necessary and reasonable to administer the Plan.

(c) In the event of noncompliance with the restrictions of Article 9 by a designated person or other individual receiving PHI on behalf of the Sponsor, the designated person or other individual shall be subject to discipline in accordance with the Sponsor's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Official.

9.6 HIPAA Security Standards

(a) Safeguards. The Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, as required in the HIPAA Security Standards.

(b) Agents. The Sponsor shall ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect such information.

(c) Security Incidents. The Sponsor shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

ARTICLE 10. General Information About the Plan

10.1 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and the Company to the effect that the individual will be employed for any specific period of time.

10.2 Compliance With State and Federal Mandates

This Plan, and component benefit programs, shall be construed, operated, and administered according to all applicable requirements of the Code and ERISA, and in the event of any conflict between any part, clause, or provision of this Plan and the Code and/or ERISA, the provisions of the Code and/or ERISA shall be deemed controlling, and any conflicting part, clause, or provision of this Plan shall be deemed superseded to the extent of the conflict. In addition, the Plan will comply with the requirements of all other applicable state and federal laws, including but not limited to USERRA, COBRA, HIPAA, NMHPA, WHCRA, FMLA, MHPA, MHPAEA, HITECH, Michelle's Law, GINA, and PPACA.

10.3 Coordination with Insurance Contract or Governing Document

To the extent an insurance contract (including the certificate of insurance), plan document, or other document governing a component benefit program contains terms or conditions that conflict or are inconsistent with this document, the terms of the insurance contract (including the certificate of insurance) plan document, or other governing document shall control, rather than this document, unless such terms are prohibited by or inconsistent with applicable law. For this purpose, silence in an insurance contract (including the certificate of insurance), plan document, or other governing document is not necessarily a conflict or inconsistency.

10.4 No Guarantee of Tax Consequences

Neither the Plan Administrator nor the Company makes any commitment or guarantee that any amounts paid to or for the benefit of a Participant under this Plan will be excludable from the Participant's gross income for federal, state, or local income tax purposes. It shall be the obligation of each Participant to determine whether each payment under this Plan is excludable from the Participant's gross income for federal, state, and local income tax purposes and to notify the Plan Administrator if the Participant has any reason to believe that such payment is not so excludable.

10.5 Governing Law

The Plan shall be construed and enforced according to the laws of Alabama, except to the extent required by federal law.

10.6 Plan Provisions Controlling

In the event that the terms or provisions of any summary or description of this Plan are in any construction interpreted as being in conflict with the provisions of this Plan as set forth in this document, the provisions of this Plan shall be controlling.

10.7 Headings

The headings of the various Articles and Sections are inserted for convenience of reference and are not to be regarded as part of this Plan or as indicating or controlling the meaning or construction of any provision.

10.8 Severability

In the event that any provision of this Plan (including the component benefit programs) is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining provisions of this Plan. The provision shall be fully severable. The Plan shall be construed and provisions enforced as if such invalid or illegal provision had never been part of the Plan.

* * * *

IN WITNESS WHEREOF, Company has caused this Plan to be executed, effective as of the Effective Date.

Franklin LTC, LLC

By: _____

Title: _____

Witness

Signature: _____

EXHIBIT A

Benefit Plan List

Benefit Plan	**Subject to ERISA?**	**Subject to COBRA?**	**Fully-or Self-Insured?**	**Controlling Document (e.g., insurance contract)**	**Named Fiduciary**
Group Medical	**Yes**	**Yes**	**Fully**	**BlueCross BlueShield of Alabama Plan Booklet**	**Franklin LTC, LLC**

Participating Employers

_____

_____

_____

***Common Control Group*: The Internal Revenue Code created rules which treat two or more companies as a single employer if there is enough common ownership or a combination of joint ownership and common activity. It is important for you, along with your legal counsel, to determine whether or not you have a controlled group of companies.**

EXHIBIT B

To the

Franklin LTC, LLC Employee Benefits Plan

October 1, 2016

Insurance Companies or Third-Parties Providing Insured Benefits, Claims Processing, Or Other Administrative Services Under The Plan

I. **Group Medical Insurance**

BlueCross BlueShield of Alabama
450 Riverchase Parkway East
Birmingham, Alabama 35244-2858
1-800-292-8868

Attachments

Attachment #1: Medical Benefits Insurance Contracts-

BlueCross BlueShield of Alabama Plan Booklet Blue Access Gold

BlueCross BlueShield of Alabama Plan Booklet Blue Access Bronze