JIM ELLIS ATLANTA, INC.
SECTION 125 CAFETERIA PLAN

Plan Document and Summary Plan Description
Effective: November 1, 2016
Restated: January 1, 2021

TABLE OF CONTENTS

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by Jim Ellis Atlanta, Inc. (the "Company" or the "Plan Sponsor") as of January 1, 2021, hereby sets forth the provisions of the Jim Ellis Atlanta, Inc. Section 125 Cafeteria Plan (the "Plan"), which was originally adopted by the Company, effective November 1, 2016. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

Effective Date

The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan pursuant to Code Section 125(d). This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of cafeteria plan coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

Jim Ellis Atlanta, Inc.

By: Brooke Gatlin
7DB00F2201C44BC...

Name: Brooke Gatlin

Title: Vice President of Human Resources

Date: 5/3/2021

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

Introduction and Purpose

The Plan Sponsor has established a "cafeteria plan" within the meaning of Code Section 125 for the benefit of eligible Employees and their eligible Dependents. This Plan is a voluntary employee benefit plan that affords a Participant the opportunity to take advantage of tax savings currently available. With this Plan, Employees can set aside a portion of income prior to it being taxed, as outlined herein. Alternatively, eligible Employees may choose to pay for any of the benefits with after-tax contributions on a payroll-reduction basis.

The Plan is funded out of the general assets of the Employer based on salary reduction elections made by participating Employees.

General Plan Information

Name of Plan:
Jim Ellis Atlanta, Inc. Section 125 Cafeteria Plan

Plan Sponsor:
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
www.jimellis.com

Plan Administrator:
(Named Fiduciary)
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Website: www.jimellis.com

Plan Sponsor ID No. (EIN):
58-1500444

Source of Funding:
Self-Funded

Applicable Law:
The Plan is intended to qualify as a cafeteria plan which meets the requirements of Code Section 125.

The Premium Only Option is not an employee benefit plan under the Employee Retirement Income Security Act of 1974 (ERISA).

Plan Year:
January 1 through December 31

Plan Type:
Premium Only Plan

Participating Employer(s):
Jim Ellis Atlanta, Inc. EIN 58-1500444
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341

Phone: (770) 458-6811
Fax: (770) 624-2839

Jim Ellis Volkswagen, Inc. EIN 58-1098119
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839

Jim Ellis, Inc. EIN 58-1767162
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839

Jim Ellis Motors, Inc. EIN 58-2191425
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839

Jim Ellis Automotive Holdings, Inc. EIN 83-3362951
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839

Jim Ellis Atlanta South, Inc. EIN 83-3371039
144 Hwy. 81
McDonough, GA 30253
Phone: (770) 954-7750

Jim Ellis Ford Sandy Springs, Inc. EIN 58-1767162
7555 Roswell Road
Atlanta, GA 30350
Phone: (470) 888-7466

Agent for Service of Process:
Jimmy Ellis
President
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Website: www.jimellis.com

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

Non-English Language Notice

This Plan Document contains a summary in English of a Participant's plan rights and benefits under the Plan. If a Participant has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

Legal Entity; Service of Process

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Discretionary Authority

To the extent required by law, the Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan. Most terms will be listed in this Definitions section, but some terms are defined within the provision the term is used. Becoming familiar with the terms defined in the Definitions section will help to better understand the provisions of this Plan.

"Actively At Work" or "Active Employment"
An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day, provided the covered Employee was Actively at Work on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions (including any State-mandated leave). An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"Affordable Care Act (ACA)"
The "Affordable Care Act (ACA)" shall mean the health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name "Affordable Care Act" is commonly used to refer to the final, amended version of the law. In this document, the Plan uses the name Affordable Care Act (ACA) to refer to the health care reform law.

"Code"
"Code" shall mean the Internal Revenue Code of 1986, as amended.

"Dependent"
"Dependent" for purposes of the Premium Only Option shall mean a Dependent as defined by the Employer-sponsored health plan(s), but in no circumstance (as required by Code Section 125) shall the meaning exceed the definition of a Dependent within the meaning of Code Section 152, determined without regard to subsections (b)(1), (b)(2) and (d)(1)(B) thereof.

"Eligible Employee"
"Eligible Employee" shall mean any full time active Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an employer-employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered "full time."

"Employee"
"Employee" shall mean an individual whom the Employer compensates for personal services performed on a regular and continuous basis and for whom the Employer pays employment taxes as required by the Code. "Employee" excludes self-employed individuals, independent contractors, partners in a partnership, and 2% shareholders of a Subchapter S corporation.

"Employer"
"Employer" shall mean Jim Ellis Atlanta, Inc.

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

"Incurred"
"Incurred" shall mean the date the service is rendered, or the supply or expense is obtained, and not when the Participant is formally billed, charged for, or pays for the service or care.

“Participant”
“Participant” shall mean an Employee who satisfies the eligibility and participation requirements specified in this document and is enrolled in the Plan.

“Plan Year”
“Plan Year” shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

“Service Waiting Period”
“Service Waiting Period” shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

“Spouse”
“Spouse” shall mean, as of the date of determination, an Employee’s present spouse, thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one whom is divorced from the Employee.

ELIGIBILITY FOR COVERAGE; ENROLLMENT

Eligibility Provisions

Each Employee will become eligible to participate in this Plan with respect to himself or herself on the 1st day of the month following completion of a Service Waiting Period of 60 days, provided the Employee has begun work for his or her Participating Employer and subject to the provisions stated in this section.

Participation

Any Eligible Employee may elect to participate in this Plan. Participation in the Premium Only option is optional and requires completion of an enrollment form. Employees may enroll online or via telephone.

Subsequent elections may be made annually during the election period generally held during the months of November and December each year. Such open enrollment elections will become effective on the first day of the next Plan Year.

If an Employee does not complete the election form (either paper or electronic as applicable) on a timely basis, he or she will be considered to have elected not to participate in the Premium Only option of this Plan.

TERMINATION OF PARTICIPATION; CONTINUATION OF COVERAGE

Termination of Participation

A Participant will cease to be a Participant in this Plan on the earliest to occur of the following dates:

- The date upon which the Plan is terminated, or with respect to any particular benefit, the date the benefit is terminated.

- The expiration of the Plan Year for which the Employee has elected to participate (unless during the open enrollment period for the next Plan Year the Employee elects to continue participating).

- For dental, vision, critical illness, and accident, the last day of the month in which the Employee is no longer eligible (because of retirement, termination of employment, layoff, reduction in hours, death of the Employee, or any other reason) to participate. For medical, life insurance, and disability insurance, the day of the month in which the Employee is no longer eligible (because of retirement, termination of employment, layoff, reduction in hours, death of the Employee, or any other reason) to participate.

- The date the Participant elects to terminate his or her participation pursuant to a permitted election change under the terms of this Plan in accordance with Section 125 and any other governing regulation.

Termination of Employment

If an Employee terminates employment during a Plan Year, all contributions to this Plan will cease as of the date of termination.

ELECTION OF BENEFITS

By accepting coverage under this Plan, an Employee and his or her Dependents agree to supply information about medical conditions and records when requested by the Plan. All private health information will be kept confidential and will be used on a need only basis for purposes of administering Plan benefits.

Contributions

An Eligible Employee will elect, unless he/she chooses to waive coverage, to contribute a portion of his or her salary to pay for eligible costs that will be Incurred during a Plan Year.

Change in Elections

Pursuant to federal regulations an Employee may change his or her participation election during the open enrollment period established by the Employer. Such change may be made for any reason and will become effective on the first day of the next Plan Year.

During the remainder of the Plan Year, an Employee may not change his or her election unless he or she experiences a qualifying change in his or her status that is on account of and consistent with the change, as discussed below.

Change in Status

The following events are changes in status:

- Legal marital status. Events that change an Employee's legal marital status, including the following: marriage; death of Spouse; divorce; legal separation; and annulment.

- Number of Dependents. Events that change an Employee's number of Dependents, including the following: birth; death; adoption; and placement for adoption; and court ordered change in custody or Qualified Medical Child Support Order (QMCSO).

- Employment status. Any of the following events that change the employment status of the Employee, the Employee's Spouse, or the Employee's Dependent: a termination or commencement of employment; a strike or lockout; a commencement of or return from an unpaid leave of absence; and a change in worksite. In addition, if the eligibility conditions of the cafeteria plan or other employee benefit plan of the employer of the Employee, Spouse, or Dependent depend on the employment status of that individual and there is a change in that individual's employment status with the consequence that the individual becomes (or ceases to be) eligible under that plan, then that change constitutes a change in employment (e.g., if a plan only applies to salaried employees and an employee switches from salaried to hourly-paid with the consequence that the employee ceases to be eligible for the plan, then that change constitutes a change in employment status).

- Dependent satisfies or ceases to satisfy eligibility requirements. Events that cause an Employee's Dependent to satisfy or cease to satisfy eligibility requirements for coverage on account of age, student status, or any similar circumstance.

- Residence. A change in the place of residence of the Employee, Spouse, or Dependent.

Medicare or Medicaid Entitlement

If the Employee, the Employee's Spouse or qualified Dependent becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Employee may prospectively reduce or cancel his or her election. Likewise, if the Employee, the Employee's Spouse or qualified Dependent loses eligibility to Medicare or Medicaid coverage, then the Employee may prospectively elect to commence or increase his or her election.

Additional Mid-Year Changes for Non-Calendar Year Plan Due to Conflicting Open Enrollment Periods

In order for election changes to be permitted under this exception, the election change must be on account of, and correspond with, the change in coverage under the plan of the Spouse's, former Spouse's or Dependent's employer. This Plan will permit elections for a period of coverage different from that under the plan of the Spouse's, former Spouses or dependent's employer.

Significant Cost or Coverage Changes

If an Employee's cost for coverage under the Employer-Sponsored health plan changes significantly during a Plan Year, the Employee may choose to revoke his or her election under the Premium Only Option and in its place receive on a prospective basis coverage under another plan providing similar coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether a cost increase is significant and whether a substitute plan provides similar coverage. If the change in cost is deemed to be insignificant, each Employee's election shall be prospectively decreased or increased to reflect the change. Similarly, if a change in cost is significant but the Employee chooses not to revoke his or her election, that Employee's election shall be changed accordingly.

Furthermore, an Employee may revoke his or her election or make a prospective election change during the Plan Year if the change corresponds with an open enrollment period change made by the Employee's Spouse or qualified Dependent, provided that the Employee's election change is consistent with the changes made under the other group benefits plan and the other group benefits plan permits such an election change. Similarly, the Plan Administrator (in its sole discretion) will determine, based upon prevailing IRS guidance, whether the requested change is on account of and corresponds with a change made under the group benefits plan of the Spouse or qualified Dependent.

Furthermore, an Employee may revoke his or her election or make a prospective election change during the Plan Year if the coverage under his or her Employer-sponsored health plan is significantly curtailed or ceases during a period of coverage. The Plan Administrator (in its sole discretion) will decide, in accordance with prevailing IRS guidance, whether coverage has been significantly curtailed.

Finally, an Employee who loses group health coverage under plans of governmental or educational institutions (including state children's health insurance programs, state health benefits risk pools, and health plans sponsored by foreign or Indian tribal governments and organization) may be permitted to enroll in the Employer's health care plan and make a prospective election change during the Plan Year. This applies to the Premium Only Option.

Reduction in Hours of Service

In accordance with Notice 2014-55, an Employee who is enrolled in the Employer's benefit plan and experiences a reduction in hours of service, as defined by ACA, may prospectively revoke coverage if the following conditions are met:

- The Employee has been in an employment status under which the Employee was reasonably expected to average at least 30 hours of service per week and there is a change in that Employee's status so that the Employee will reasonably be expected to average less than 30 hours of service, as defined in the Affordable Care Act, per week after the change, even if that reduction does not result in the Employee ceasing to be eligible under the group health plan; and

- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in another health plan that provides minimum essential coverage, as defined in the Affordable Care Act, with the new coverage effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

An Employee exercising a revocation due to a reduction in hours of service must demonstrate intent or actual enrollment in another health plan. The Employee must certify in writing that the Employee, and his or her spouse and/or dependents whose coverage is being revoked, have enrolled or intend to enroll in

another plan that provides minimum essential coverage, as defined in the Affordable Care Act, and that such coverage will be effective no later than the first day of the second month following the month that includes the date the original coverage under the Employer's group health plan is revoked.

Enrollment in a Qualified Health Plan Through an Exchange
An Exchange is also referred to as the Health Insurance Marketplace, hereinafter referred to as "Exchange."

In accordance with Notice 2014-55, an Employee who is enrolled in the Employer's group health plan may prospectively revoke coverage if the following conditions are met:

- The Employee must be eligible for a Special Enrollment Period to enroll in a qualified health plan through the Exchange pursuant to applicable guidance or the Employee is seeking to enroll in a qualified health plan through the Exchange during the Exchange's applicable annual open enrollment period; and

- The revocation of the election of coverage under the group health plan corresponds to the intended enrollment of the Employee, and any related individuals who cease coverage due to the revocation, in a qualified health plan through the Exchange. Such coverage must be effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

An Employee exercising a revocation due to enrollment in a qualified health plan through the Exchange must demonstrate intent or actual enrollment in the Exchange coverage. The Employee must certify in writing that the Employee, and his or her spouse and/or dependents whose coverage is being revoked, have enrolled or intend to enroll in Exchange coverage and that such coverage will be effective no later than the day immediately following the last day of coverage on the Employer's group health plan.

PREMIUM ONLY OPTION

For an Employee enrolled in certain health care benefit plan(s) sponsored by the Employer, payroll deductions for contributions, including any change in the cost of the benefit during a period of coverage under the terms of the Plan, will be taken automatically before income is taxed for federal, applicable state and Social Security purposes, as allowed by law. The Employee's election for those contributions will continue year after year unless the Employee makes a change during the open enrollment period, or in the case of a qualified status change.

Eligible Expenses

A Premium Only Option allows Employer-sponsored premium payments to be paid by the Employee on a pre-tax basis instead of after-tax. Coverage may include the following:

- Health
- Dental
- Vision
- Employee Group Term Life (up to $ 50,000)

PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator provides certain claims processing and other technical services. The Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

Plan Administrator

The Plan is administered by the Plan Administrator and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms.
2. To determine all questions of eligibility, status and coverage under the Plan.
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms.
4. To make factual findings.
5. To decide disputes that may arise relative to a Participant's rights and/or availability of benefits.
6. To prescribe procedures for filing a claim for reimbursement, to review claim denials and appeals relating to them and to uphold or reverse such denials.
7. To keep and maintain the Plan documents and all other records pertaining to the Plan.
8. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO.

9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.
10. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention that it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for qualified medical expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor.

CLAIMS PROCEDURES; PAYMENT OF CLAIMS

Appeals

Disputed Premium Only Plan Claims

A dispute under this Plan may arise if (a) the wrong amount was withdrawn from the Employee's salary or (b) the benefit cost was not appropriately paid. Should a dispute arise, an Employee must:

- Notify the Plan Administrator within 60 days after the payroll period of such dispute; and
- Identify incorrect amount withdrawn from the Employee's salary.

The Plan Administrator will adjust accordingly when appropriate.

Claims Under the Premium Only Option - Explanation of Denial
If a claim is denied in or whole or in part, the Participant will be provided with a notice, either in writing or electronically, containing the following information:

- The specific reason or reasons for the denial.
- The specific Plan provision or provisions on which the denial is based.
- A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such information is necessary.
- A statement that the Participant, the Participant or duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine relevant Plan Documents and records upon request at no charge and to submit written comments on issues. The Participant also has the right to obtain applicable determination procedures used to ascertain coverage under a Qualified Medical Child Support Order at no charge from the Plan Administrator.
- A statement that the claim and its denial shall be reviewed upon submission of a written request.
- A statement that failure to submit a written request for review within 180 days after the receipt of the written explanation of the claim denial shall make the Plan's decision final.

Decision on Review
A claim and its denial (in whole or in part) shall be reviewed if a written request for appeal is filed within 180 days after receipt of the written explanation of the claim denial by the Participant. Appeals should be sent to the Plan Administrator. Otherwise, the initial decision shall be the final decision of the Plan. The Plan shall review the request for appeal information and comments submitted by the Participant or the Participant's duly authorized representative. The Plan shall furnish the Participant with a written explanation of its decision with respect to the appeal within 60 days following receipt of the written appeal.

The Participant will be provided with a notice of the explanation of the appeal decision, either in writing or electronically, containing the following information:

- The specific reason or reasons for the decision.
- The specific Plan provisions and records, if any, on which the decision is based.
- If applicable, a response to the information and comments submitted by the Participant and his or her duly authorized representative.

- A statement of the Participant's right to review relevant documents and other information (upon request and at no charge).

- If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, then a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request.

Limitation of Action

A Participant cannot bring any legal action against the Plan for a claim of benefits until 90 days after all appeal processes have been exhausted. After 90 days, if the Claimant wants to bring a legal action against the Plan, he or she must do so within three years of the date he or she is notified of the final decision on the final appeal or he or she will lose any rights to bring such an action against the Plan.

A Participant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within three years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

MISCELLANEOUS

Clerical Error/Delay

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

Conformity With Applicable Laws

Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of any applicable law.

Fraud

It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

Headings

The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

Word Usage

Whenever any words are used herein in the singular or plural, they shall be construed as though they were in plural or singular, as the case may be, in all cases where they would so apply.

The Effect of the Plan on Other Benefits

Under present law, an Employee's earnings, for the purpose of determining his or her FICA earnings and his or her eventual Social Security benefits, do not include salary reduction contributions made to the Plan. This means that if an Employee earns less than the Social Security wage base, his or her eventual Social Security benefits will be slightly reduced. The value of the FICA and federal (and state, if applicable) income tax savings to the Employee will normally exceed any reduction in his or her eventual Social Security benefit.

No Guarantee of Tax Consequences

It is the sole obligation of each Participant to determine whether any payment under this Plan is excludable from their gross income for federal, state, or local tax purposes. Although certain tax treatment of Plan benefits is expected and desired, it is not guaranteed that any particular tax consequence result from participation in the Plan or that amounts paid as Plan benefits will be excludable from the Participant's gross income as applicable. Additionally, the Participant must notify the Plan Administrator if he or she has any reason to believe that such payment is not so excludable.

Nondiscrimination

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between similarly situated individuals. The Plan Administrator shall have the authority to adjust contributions to avoid discrimination.

No Waiver or Estoppel

All parts, portions, provisions, and conditions in the Plan, and/or other items addressed in this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no waiver of or

estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

If applicable, whenever payments have been made by this Plan in a total amount, at any time, in excess of the amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made.