Jim Ellis Atlanta, Inc. Health and Welfare Plan

Plan Document and Summary Plan Description

Effective Date: November 1, 2016
Amended and Restated: January 1, 2024

Jim Ellis Atlanta, Inc.

January 1, 2024

Jim Ellis Atlanta, Inc. Health and Welfare Plan
Plan Document and Summary Plan Description

This document incorporates by reference one or more specific contracts or documents that describe in more detail certain provisions governing the Employer Welfare Benefits Plan Document and Summary Plan Description.

PREAMBLE AND EXECUTION

WHEREAS, Jim Ellis Atlanta, Inc. ("the Company") maintains the Jim Ellis Atlanta, Inc. Health and Welfare Plan, Plan Document and Summary Plan Description; and

WHEREAS, the Company desires to amend and restate the Plan;

NOW, THEREFORE by virtue and in exercise of the amending power reserved to the Company, Jim Ellis Atlanta, Inc. Health and Welfare Plan ("the Plan") is hereby amended and restated as one Employee Benefit Plan Document and Summary Plan Description, which amendment and restatement shall be effective January 1, 2024.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 1st day of April, 2024.

By:

DocuSigned by:
Brooke Gatlin
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Brooke Gatlin
Vice President of Human Resources
Jim Ellis Atlanta, Inc.

TABLE OF CONTENTS

ESTABLISHMENT OF PLAN; GENERAL PLAN INFORMATION

Effective Date

The Effective Date (as defined herein) of the Jim Ellis Atlanta, Inc. Health and Welfare Plan ("the Plan") is January 1, 2024.

Purpose

Jim Ellis Atlanta, Inc. (the "Company") maintains the Plan for the exclusive benefits of its eligible employees and their eligible Dependents. The purpose of the Plan is to consolidate in one plan document certain provisions of the welfare benefit plans (the "Component Benefit Plans") sponsored by the Company and to provide uniform administration of such welfare benefits. The Component Benefit Plans are listed in Appendix A to this Plan.

The insurance contracts, summary plan descriptions, policies and procedures, and any other documents making up the Component Benefit Plans are hereby incorporated by reference into this document. Eligible employees may obtain an additional copy upon written request at no charge. These documents in the aggregate serve as a written plan document for the purposes of compliance with Section 402 and the Summary Plan Description as required by Section 102 of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Including Component Benefit Plans that are not subject to ERISA as part of this Plan is not intended to subject the Component Benefit Plans to ERISA.

Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined within the Definitions Section, in its sole discretion and in accordance with the provisions herein may amend or terminate the Plan or any provision of the Plan including, but not limited to, the existence and duration of coverage for Employees and/or Dependents of Employees, eligibility and requirements for coverage, the availability, nature and extent of benefits, and the conditions for and method of payment of benefits.

General Information about the Plan

Name of Plan:
Jim Ellis Atlanta, Inc. Health and Welfare Plan

Plan Sponsor:
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Boulevard
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839
Website: www.jimellis.com

Plan Administrator:
(Named Fiduciary)
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Boulevard
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839
Website: www.jimellis.com

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

Plan Year:
January 1 through December 31

Effective Date:
November 1, 2016
Amended and Restated January 1, 2024

Plan Number:
501

Type of Plan:
Employee benefits plan providing group
Medical and Prescription Drugs
Dental
Vision
Group Term Life Insurance and AD&D
Group Disability Insurance
Critical Illness Coverage
Accident Coverage
Cafeteria Plan

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

Funding Medium and Type of Plan Administration:
Benefits are provided through group insurance policies or group health plans issued to the Company.

The Medical and Prescription Drug benefits are self-insured. The Medical benefits are administered by Nova Healthcare Administrators, Inc., and the Prescription Drug benefits are administered by Independent Health's Pharmacy Benefit Dimensions, Inc. Both the Company and the participating Employees contribute to the Medical and Prescription Drug benefits.

The Dental benefits are fully insured and administered by Anthem. Both the Company and the participating Employees contribute to the premiums.

The Vision benefits are fully insured and administered by Anthem. The participating Employees contribute to the premiums.

The Group Term Life Insurance and Accidental Death and Dismemberment benefits are fully insured and administered by Greater Georgia Life/Anthem. The Company contributes to the premiums.

The Group Disability insurance benefits are fully insured and administered by Greater Georgia Life. The participating Employees contribute to the premiums.

The Critical Illness Coverage insurance benefits are fully insured and administered by Voya Financial. The participating Employees contribute to the premiums.

The Accident Coverage insurance benefits are fully insured and administered by Voya Financial. The participating Employees contribute to the premiums.

The Cafeteria Plan benefits are administered by the Company. The Cafeteria Plan is intended to qualify under Section 125 of the Internal Revenue Code of 1986, as amended. Participating Employees contribute to these benefits as provided in this Plan, in the applicable Component Benefit Plan, and as permissible by law.

The Company administers the Plan and the availability of group insurance and health plans to fund the benefits. The Company shares some responsibility with the insurance companies and third party administrators for administering group insurance policies and health plans as described in the Administration Section. Premiums and contributions paid for by the Company come out of its general assets. Premiums and contributions paid by eligible participating employees are paid in part by pre-tax or post-tax payroll deductions. The Plan Administrator provides the employees a schedule of the applicable premiums and contributions during the initial and subsequent open enrollment periods and on written request for each Component Benefit Plan as applicable.

Insurance Companies and/or Administrators:
Please refer to Appendix A for a list of all carriers and/or administrators.

Participating Employer(s):
Please refer to Appendix C for a list of all Participating Employers.

Agent *(for service of process)*:
Brooke Gatlin
Vice President of Human Resources
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.

Important Disclaimer: All benefits under the Plan are provided through group insurance policies and/or self-insured benefit plans. If the terms of this document conflict with the terms of such insurance policies and/or self-insured benefit plans, the terms of the group insurance policies and/or self-insured benefit plans will control, unless otherwise required by law.

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings. Words and phrases not defined in this Section shall have the meaning set forth in an applicable Component Benefit Plan, and if not defined in an applicable Component Benefit Plan, then such words and phrases shall have the meaning customarily given them by the applicable insurance company, third party administrator, or other service provider, as the case may be.

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

Affordable Care Act (ACA)
The "Affordable Care Act (ACA)" means 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.

Cafeteria Plan
A Cafeteria Plan is a type of tax-advantaged employee benefits program created under Code Section 125 that allows Employees to pay certain qualified expenses on a pre-tax basis.

Claimants
A Covered Person (or his or her duly authorized representative) may file a claim for benefits to which such Claimant believes he or she is entitled.

COBRA
COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder. COBRA applies only to the following benefits provided under this Plan:

Medical/Prescription Drug Benefits
Dental
Vision

Code
Code means the Internal Revenue Code of 1986, as amended, and its regulations.

Company
Company means Jim Ellis Atlanta, Inc., and any successor, by merger or otherwise.

Component Benefit Plan
Component Benefit Plan means an insurance policy, administrative services agreement, plan, trust, certificate of coverage, evidence of coverage, summary plan description or other document incorporated by reference in the General Plan Information Section, Governing Instrument Section, or in other sections of the Plan, together with any exhibits, supplements, addendums or amendments thereto. The Component Benefit Plans are listed in Appendix A.

Covered Person
Covered Person means an individual who has properly enrolled in, and who participates in a Component Benefit Plan in accordance with the terms and conditions established for that benefit plan, and who has not for any reason become ineligible to participate further in that benefit plan. Participation requirements are described in the individual Component Benefit Plans.

Dependent
Dependent means a spouse or dependent child of an Employee who is a Covered Person who is eligible to participate in the Plan pursuant to the terms of one or more Component Benefit Plans, and who is a "dependent" within the meaning of Section 152, as modified for purposes of Code Sections 105(b) and 106.

A Dependent may be eligible for coverage with respect to certain benefits, but not all benefits, as hereinafter described in the Plan.

Effective Date
Effective Date means the date this amended and restated Plan becomes operative; the Effective Date is January 1, 2021. The effective date of each Component Benefit Plan is set forth in the applicable Component Benefit Plan.

Employee
Employee means a common law employee of an Employer. The term Employee does not mean any of the following persons:

1. A self-employed individual, as defined in Code Section 401(c)(1)(A),
2. A member of the board of directors of the Company who is not otherwise an Employee,
3. A person the Plan Administrator determines is an Employer's independent contractor, or
4. A person the Plan Administrator determines an Employer engages as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an "Employee" as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters.

Employer
Employer means the Company and any subsidiary and any successor which, with the approval of the Plan Administrator, and subject to such conditions as the Plan Administrator may impose, adopts the Plan.

ERISA
ERISA means the Employee Retirement Income Security Act of 1974, as amended, and its regulations.

HIPAA
HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and regulations issued pursuant thereto.

Patient Protection and Affordable Care Act (PPACA)
The "Patient Protection and Affordable Care Act (PPACA)" means the health care reform law enacted in March 2010, Public Law 111-148; PPACA, together with the Health Care and Education Reconciliation Act, is commonly referred to as Affordable Care Act (ACA). (See "Affordable Care Act").

Plan
Plan means the Jim Ellis Atlanta, Inc. Health and Welfare Plan as herein set forth and as amended from time to time.

Plan Administrator
Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

Plan Year
Plan Year means the 12-month period beginning January 1 and ending December 31. The Plan Year for each Component Benefit Plan is set forth in the applicable Component Benefit Plan document.

ELIGIBILITY, PARTICIPATION, AND COVERAGE

Eligibility

Employees shall be eligible for Plan participation on the later of the Effective Date or the date they meet the eligibility requirements set forth in the applicable Component Benefit Plan; however, the following Employees shall not be eligible for Plan participation unless required by law:

1. Any Employee who is regularly scheduled to work less than 30 hours per week.

Specific eligibility requirements for certain benefits shall be set forth in the Benefits Section or in the applicable Component Benefit Plans. Note that certain Component Benefits Plans may require that you make an annual election to enroll for coverage. Information relative to enrollment procedures was distributed upon your eligibility to participate. An individual may request a copy of the Component Benefit Plan at no charge.

Participation

The provisions and requirements describing how and when Employees become Covered Persons in the Plan and any conditions and limitations to participation in the Plan shall be as set forth in the applicable Component Benefit Plan(s).

Coverage

The provisions and requirements describing when and how Employees and Dependents become Covered Persons, the conditions and limitations to coverage, and the circumstances under which coverage terminates shall be as set forth in the applicable Component Benefit Plan(s).

Termination

Your participation and the participation of your eligible family members in the Plan will terminate on the day described by each Component Benefit Plan. Your employment ends when you cease active work with the Company. Coverage may also terminate if you fail to pay your share of an applicable premium, if your hours drop below any required hourly threshold, if you submit false claims or for any other reason set forth in the insurance booklets, benefit summaries or other governing documents for the Component Benefit Plans.

Coverage under Family and Medical Leave Act and Section 609 of ERISA

Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Person who is an Employee solely to the extent necessary to comply with the Family and Medical Leave Act of 1993 (“FMLA”), and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

Section 609 of ERISA

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order under Section 609(a) of ERISA or to an adoptive child or child placed for adoption solely to the extent required by Section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder.

Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section shall be conditioned upon payment of applicable contributions by the Employee.

Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereinafter the “Uniformed Services Act”), a Covered Person who is an Employee who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the

Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of any required premiums.

This Section shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

Health Insurance Portability and Accountability Act of 1996

HIPAA Title I

Solely to the extent required by the Health Insurance Portability and Accountability Act of 1996 (hereinafter "HIPAA"), an Employee shall be a Covered Person under the Plan no later than such time as required under HIPAA, and the Plan shall be subject to the special enrollment, pre-existing condition limitations (if applicable) and nondiscrimination in health status provisions of HIPAA. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under HIPAA and the rulings and regulations issued thereunder.

HIPAA Title II

The Plan shall comply with the privacy and security regulations of HIPAA, in accordance with the provisions set forth in HIPAA Privacy and HIPAA Security Sections. This Section shall be interpreted and applied to give an Employee only those rights as prescribed under the Health Insurance Portability and Accountability Act of 1996, and the rulings and regulations issued thereunder.

If you have additional questions, please contact:

Vice President of Human Resources
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Blvd.
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Phone: (770) 458-6811
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The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA). Please see the applicable Component Benefit Plan for information regarding disclosures of Electronic Protected Health Information ("Electronic PHI") to the insurance company and/or Plan Sponsor for policy and/or plan administration functions and the applicable procedures related to the security of this information.

Coordination with State Medicaid Programs

The fact that a Covered Person is eligible for coverage by, or is covered by, a State Medicaid program shall not affect the Covered Person's eligibility to participate in the Plan or to receive benefits. The payment of benefits under the Plan with respect to any Covered Person shall be made in accordance with any assignment of rights made by or on behalf of the Covered Person of a beneficiary of the Covered Person as required by any State Medicaid program, as provided in Section 609(b) of ERISA. To the extent a payment has been made to or with respect to a Covered Person pursuant to a State Medicaid program and the amount so paid is for a medical expense that the Plan has a legal liability to pay, the Plan will pay such expense in accordance with any State law that provides that the State has acquired the right with respect to the Covered Person to receive payment for such expense.

This Section shall be interpreted and applied to give an Employee only those rights as prescribed under State Medicaid Programs, and the rulings and regulations issued thereunder.

Mental Health Parity Act and Mental Health Parity and Addiction Equity Act

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations to the extent required. For further details, please contact the Plan Administrator.

Women's Health and Cancer Rights Act

Solely to the extent required under the law of the Women's Health and Cancer Rights Act (hereinafter "WHCRA"), the Plan shall provide certain benefits related to benefits received in connection with a mastectomy.

In the case of a Covered Person who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the coverage shall be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Such reconstructive benefits are subject to annual plan deductibles and coinsurance provisions such as other medical and surgical benefits covered under the Plan.

This Section shall be interpreted and applied to give an Employee only those rights as prescribed under WHCRA, and the rulings and regulations issued thereunder.

Newborns' and Mothers' Health Protection Act

Solely to the extent required by the Newborns' and Mothers' Health Protection Act (hereinafter "NMHPA"), the Plan shall provide that coverage for childbirth may not be limited to a hospital stay of less than 48 hours for normal delivery, or less than 96 hours for cesarean section, or require the provider to obtain approval for shorter hospital stays. The requirement shall not apply if the attending provider, in consultation with the mother, decides to discharge the mother or newborn earlier than the time prescribed by the NMHPA.

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under the NMHPA, and the rulings and regulations issued thereunder.

Genetic Information Nondiscrimination Act of 2008

The Plan shall also comply with the Genetic Information Nondiscrimination Act of 2008 (hereinafter "GINA").

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under GINA, and the rulings and regulations issued thereunder.

Children's Health Insurance Program Reauthorization Act of 2009

The Plan shall also comply with the Children's Health Insurance Program Reauthorization Act of 2009 (hereinafter "CHIP").

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under CHIP, and the rulings and regulations issued thereunder.

Michelle's Law

The Plan shall also comply with Michelle's Law (P.L. 110-381).

This Section shall be interpreted and applied to give Covered Persons only those rights as prescribed under Michelle's Law, and the rulings and regulations issued thereunder.

BENEFITS

Medical and Prescription Drug Benefits

Covered Persons shall have the right to the medical benefits and prescription drug benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Dental Benefits

Covered Persons shall have the right to the dental benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Vision Benefits

Covered Persons shall have the right to the vision benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such applicable Component Benefit Plan. A description of such benefits, including the amount payable, required deductibles, co-payments, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Group Term Life Insurance Benefits and Accidental Death and Dismemberment Benefits

Covered Persons who are Employees shall have the right to the group term life insurance benefits and accidental death and dismemberment insurance benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions, and limitations set forth in such Component Benefit Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions, the procedure for naming beneficiaries and consequences for failure to name a beneficiary, shall be as set forth in the applicable Component Benefit Plan.

Group Disability Insurance

Covered Persons who are Employees shall have the right to the disability insurance benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Critical Illness Coverage

Covered Persons who are Employees shall have the right to the critical illness insurance benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan.

Accident Coverage

Covered Persons who are Employees shall have the right to the accident insurance benefits described in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan. \

Cafeteria Plan Benefits

Covered Persons shall have the right to the benefits described below and in the applicable Component Benefit Plan. Such benefits shall be subject to the terms, conditions and limitations set forth in such Component Benefit Plan. A description of such benefits, including the amount payable, maximums, conditions precedent to payment, limitations and exclusions shall be as set forth in the applicable Component Benefit Plan. The Plan participates in the Jim Ellis Atlanta, Inc. Section 125 Cafeteria Plan, which is intended to qualify under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"), and which is incorporated as if fully set forth herein.

The following benefits are available under the Jim Ellis Atlanta, Inc. Section 125 Cafeteria Plan:

- Medical and Prescription Drug Benefits
- Health Flexible Spending Account
- Dental Benefits
- Vision Benefits

HEALTH FLEXIBLE SPENDING ACCOUNT

General. If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $3,200 per Plan Year (as may be adjusted for cost-of-living increases), credited to your health care flexible spending account ("Health FSA"). You can receive amounts from this account, in cash, as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the Plan Year and while you are a participant in the Health FSA. You may request Claim Forms from the Claims Administrator to file your claim and receive reimbursement for eligible medical expenses.

Generally, eligible medical expenses are expenses that you, your spouse or your Dependent (determined as described in the next paragraph) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses, and that have not been taken as a deduction in any tax year. Eligible medical expenses include over-the-counter (OTC) drugs without a prescription, menstrual products, and personal protective equipment (PPE) (such as masks, hand sanitizer and sanitizing wipes) as defined by the IRS for the prevention of COVID-19.

Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services for which you are required to make advance payment can be reimbursed at the time the advance payment is made.

For purposes of Health FSA reimbursements, "Dependent" includes anyone who is your Dependent for federal income tax purposes, as well as your biological, adopted or step-child or your eligible foster child if the child will be younger than 27 on the last day of the calendar year, even if the child is not a Dependent for federal income tax purposes.

To be reimbursed from your Health FSA or limited purpose Health FSA, you must submit to the Claims Administrator a request for reimbursement on a form provided by the Claims Administrator. You also must provide evidence of the amount, nature and payment of the underlying medical expense for which reimbursement is sought, as required by the Claims Administrator. Unless a later date is designated by the Plan Administrator, you must submit your requests by no later than 60 days following the end of the Plan Year in which the expenses were incurred if you were an active employee on the last day of the Plan Year.

Health FSA Carry Over. Generally, any amounts held in your Health FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited. However, if you have at least $25 remaining in your health FSA at the end of the Plan Year, and you re-enroll in the health FSA for the upcoming Plan Year, you may carry over an unused amount equal to 20% of the maximum salary reduction contribution under IRS Code Section §125(i) for that plan year. The maximum unused amount from 2024 that you may roll over to a health FSA for the plan year beginning in 2025 is $640.

Termination. If your employment terminates during the Plan Year, you must submit your request for reimbursement of expenses incurred while you were an active employee, within 30 days following your employment termination date, unless you elect to continue Health FSA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). *See the "COBRA Continuation Rights" section for more details.*

COORDINATION OF BENEFITS

Coordination of Benefits Provisions

Coordination of benefits provisions are set forth in Component Benefit Plans where applicable. For more information regarding coordination of benefits, see the applicable Component Benefit Plan.

CONTINUATION COVERAGE

Eligibility for Continuation Coverage

The provisions contained in this Section apply only to the following benefits provided under the Plan:

Medical/Prescription Drug Benefits
Health Flexible Spending Account
Dental
Vision

The provisions of this Section do not govern to the extent provided herein.

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

COBRA rights are explained in detail in applicable Component Benefit Plans (insurance booklet, certificate of coverage/policy, or plan document). If you have any questions about your COBRA rights, please contact the Plan Administrator for a copy of your COBRA rights.

Below is a brief summary of COBRA benefits, but if any applicable Component Benefit Plan (as indicated above) coverage for you or your eligible family ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child ceasing to meet the definition of "dependent"), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. Please see the applicable Component Benefit Plan for details.

Continuation Coverage Definitions

For purposes of this Section, the following terms have the following meanings:

A. "Employee" means a person who is (or was) covered under the Plan by virtue of the person's performing services for the Employer on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage.

B. "Dependent" means, with respect to an Employee as defined in this Section, any individual who, on the day before the occurrence of the event giving rise to the right to elect COBRA continuation coverage, is covered under the Plan as (1) the Dependent spouse of such Employee or (2) the Dependent child of such Employee. The term Dependent shall include any child born to or placed for adoption with the Employee during the continuation period.

C. "Qualified Beneficiary" means an Employee or Dependent as defined in this Section but shall not mean Dependents defined in the Election Rules, except that the term Qualified Beneficiary shall include Dependents born to or placed for adoption with the Employee during the continuation period.

D. "Qualifying Event" means any of the following, the occurrence of which would result in loss of coverage under the Plan were it not for the right to purchase COBRA continuation coverage:

1. For Employees, termination of employment for any reason other than gross misconduct, or loss of eligibility due to reduction in hours worked by the Employee.
2. For Dependents:

    a. Death of the Employee.
    b. Divorce of the Employee and spouse.
    c. Legal separation of the Employee and spouse.
    d. Reduction in hours worked by the Employee or termination of employment by the

Employee for any reason other than gross misconduct.

e. Entitlement of the Employee to benefits under Title XVIII of the Social Security Act (relating to Medicare).
f. Ceasing to qualify as a Dependent child under the Plan.

The Qualifying Event shall be deemed to occur on the date of the Qualifying Event, not on the date coverage ends because of the Qualifying Event.

Loss of Eligibility for Continuation Coverage

A Qualified Beneficiary shall not be eligible for COBRA continuation coverage unless both A and B occur:

A. The Company or Plan Administrator is notified of the election of COBRA continuation coverage, on a form provided for that purpose, within 60 days of the later of:

1. The date the Qualified Beneficiary's coverage under the Plan would otherwise terminate by reason of an event described in this Section.
2. The date notice of eligibility is sent to the individual in accordance with the Notice Requirements.

B. The Qualified Beneficiary pays the initial required premium, as set forth in the Required Premium Section below, no later than the date 45 days after the date on which COBRA continuation coverage was elected.

Until expiration of the election period, a Qualified Beneficiary may change or revoke any election. Failure to elect COBRA continuation coverage within the prescribed election period shall result in a waiver of the right to COBRA continuation coverage.

Termination of COBRA Continuation Coverage

COBRA continuation coverage shall terminate on the date on which the earliest of the following occurs:

1. The last day of the month preceding the date the Qualified Beneficiary fails to pay a subsequent required premium within 30 days of the date it is due.
2. The date the Qualified Beneficiary first becomes, after the date of making a COBRA election, entitled to Medicare.
3. The date the Qualified Beneficiary first becomes, after the date of making a COBRA election, covered under another group health plan, as defined in Code Section 5000(b)(1), not containing a limitation or exclusion as to any preexisting condition of such individual (other than such an exclusion or limitation which does not apply to, or is satisfied by, such beneficiary by reason of the Health Insurance Portability and Accountability Act of 1996).
4. 36 months from the date on which a Qualifying Event described in Continuation Coverage Definitions Sections (D)(2)(a), (D)(2)(b), (D)(2)(c), (D)(2)(e), or (D)(2)(f) occurs.
5. 18 months from the date on which a Qualifying Event described in Continuation Coverage Definitions Sections (D)(1) or (D)(2)(d) occurs. If a Qualifying Event described in Continuation Coverage Definitions Sections (D)(2)(a), (D)(2)(b), (D)(2)(c), or (D)(2)(f) occurs subsequent to a Qualifying Event described in Continuation Coverage Definitions Section (D)(2)(d), an additional period of coverage shall be allowed for Dependents who have properly and timely elected and paid for COBRA continuation coverage; but, in no event shall the sum of the first and second periods of coverage exceed 36 months from the date of the first Qualifying Event giving rise to the Qualified Beneficiary's eligibility for COBRA continuation coverage.
6. The date the Company terminates all group health plans.
7. In the case of a Qualified Beneficiary who is determined under Title II or XVI of the Social Security Act to have been disabled (i) at the time of the Qualifying Event or (ii) at any time during the first 60 days of continuation coverage, the 18-month period set forth in #5 above shall be extended to 29 months; provided that such individual notifies the Plan Administrator of such determination in accordance with the Notice Requirements provision before the end of such 18-month period; and provided further that if the Qualified Beneficiary does not remain disabled during the extended

period, coverage shall cease with the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the Qualified Beneficiary is no longer disabled.

8. In the case of a Qualifying Event described in Continuation Coverage Definitions Section (D)(2)(d) that occurs less than 18 months after the date the Employee becomes entitled to Medicare, 36 months from the date the Employee becomes entitled to Medicare.
9. For the Health FSA or Limited-Purpose Health FSA, if COBRA is required to be provided, the last day of the Plan Year in which the Qualifying Event occurs.

Notice Requirements

1. The Employer shall notify the Plan Administrator of the occurrence of an event described in Continuation Coverage Definitions Sections (D)(1), (D)(2)(a), (D)(2)(d), and (D)(2)(e), within 30 days of the date of the described event.
2. The Qualified Beneficiary shall be responsible for notifying the Plan Administrator of the occurrence of an event described in Continuation Coverage Definitions Sections (D)(2)(b), (D)(2)(c), or (D)(2)(f) within 60 days of the date of the described event.
3. The Plan Administrator shall provide notice to Qualified Beneficiaries of their COBRA continuation coverage rights within 14 days of the date it receives the notice described in #1 and #2 above.
4. A Qualified Beneficiary, who is determined under Title II or XVI of the Social Security Act to have been disabled at any time within the first 60 days of the continuation period, shall be responsible for notifying the Plan Administrator of such determination within 60 days after the date of such determination, but in no event later than the end of the 18-month period set forth in Termination of COBRA Continuation Coverage Section above, in provision #5. Such Qualified Beneficiary further shall be responsible for notifying the Plan Administrator of any final determination under such Title(s) that he or she is no longer disabled, within 30 days of the date of such determination.
5. At the commencement of coverage under the Plan, the Plan Administrator shall provide each Employee or spouse who is a Covered Person with notice of their rights under COBRA.
6. The Plan Administrator shall provide notice to each Qualified Beneficiary of any termination of COBRA continuation coverage that takes effect earlier than the end of the maximum period of COBRA continuation coverage applicable to the Qualified Beneficiary.
7. The Plan Administrator shall provide notice to each Employee, spouse or Dependent of the unavailability of COBRA continuation coverage if the Plan Administrator determines after receiving notice of a Qualifying Event that the Employee, spouse or Dependent is not entitled to COBRA continuation coverage.

Coverage Available for Continuation

A Qualified Beneficiary may elect to continue receiving the health care coverage (as defined in COBRA regulations) he or she was receiving immediately before the event giving rise to the right to elect COBRA continuation coverage. If coverage provided to similarly situated active Employees is changed or eliminated, COBRA continuation coverage also shall be changed or eliminated. If the Company terminates the Plan but continues to maintain one or more other group health plans, as defined in Code Section 5000(b)(l), COBRA continuation coverage recipients may elect coverage under one of those other group health plans. A Qualified Beneficiary may be able to elect to continue to receive coverage for the level of reimbursement, if any, that the individual had in effect under his or her Health FSA or Limited-Purpose Health FSA immediately before the Qualifying Event after reflecting debits for health care reimbursements made up to the Qualifying Event.

Election Rules

Scope of Election

Each affected Qualified Beneficiary generally shall have an independent right to elect or reject COBRA continuation coverage under this Section; provided, however, that in the event an Employee or his or her spouse makes an election to continue coverage on behalf of the other or on behalf of any other Qualified Beneficiary, such election shall be binding on such other party; and provided further, that in the event the Qualified Beneficiary is a minor or an incapacitated person, the parent or legal guardian of such minor or the

legal representative of such incapacitated person shall have the right to elect or reject continuation coverage on behalf of such minor or incapacitated person, and any such election or rejection of coverage shall be binding on such minor or incapacitated person. Each Qualified Beneficiary is entitled to a separate election with respect to any choice of coverages available under the Plan.

After Acquired Dependents
A Qualified Beneficiary eligible for COBRA continuation coverage may elect to cover Dependents (as defined in this Section) acquired after the date of eligibility described under the Loss of Eligibility of Continuation Coverage Section to the same extent as Covered Persons, provided the Company or Plan Administrator is notified of the election to cover such Dependent(s) in the manner and within the time set forth in an applicable document incorporated by reference under the Plan, except that in no event shall notice be required within a period of less than 30 days. Such newly acquired Dependent(s), other than Qualified Beneficiaries defined in this Section, shall have no independent right to COBRA continuation coverage. Failure to notify the Company or Plan Administrator within the prescribed time shall result in a waiver of the right to elect COBRA continuation coverage for such newly acquired Dependent(s).

Open Enrollment Periods
During an open enrollment period occurring during the COBRA coverage period, a Qualified Beneficiary may elect to cover Dependents not previously covered, subject to the terms and conditions set forth in the applicable document incorporated by reference under the Plan. This subsection shall not apply to Health FSA or Limited-Purpose Health FSA benefits.

Required Premium

In order to receive COBRA continuation coverage, Qualified Beneficiaries shall agree, on forms furnished by the Plan Administrator, to pay any required premiums to the Plan and shall make such premium payments when and as required. All premiums other than the initial premium shall be due on the first day of the calendar month. The amount of the premium shall be no more than 102 percent of the cost of coverage. In the case of a Qualified Beneficiary who is determined under Title I or XVI of the Social Security Act to have been disabled at any time within the first 60 days of continuation coverage, the cost of coverage for the 19th month through the 29th month of coverage shall be no more than 150 percent of the cost of coverage. Notwithstanding the foregoing, the cost of coverage shall not exceed the maximum, nor be changed more frequently than, permitted by law.

Special Rules for Health Flexible Spending Accounts
For a health flexible spending account ("health FSA"), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the Plan Year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the Plan Year in which the qualifying event occurs. COBRA continuation coverage for the health FSA cannot be extended beyond that time for any reason.

> *EXAMPLE: Assume that an employee elected to contribute a total of $1,200 to her health FSA account for a Plan Year and then her employment terminates six months after the start of that Plan Year. By that time, she has contributed $600 to her FSA account through payroll deductions. Assume that she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the Plan Year is $400. However, if she were permitted to continue to participate in the FSA for the rest of the Plan Year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the FSA. On the other hand, if she had incurred expenses of $588 or less before her employment terminated, she would be offered the opportunity to elect COBRA continuation coverage under the FSA for the remainder of the Plan Year because her maximum benefit under the Plan for the rest of the Plan Year would be more than the amount she would be required to pay ($612).*

Any filing deadlines or other rules for filing a request for reimbursement under the health FSA, as described earlier in this SPD, will continue to apply if you elect continuation coverage under the health FSA.

Governing Provisions

When the provisions for COBRA continuation coverage are set forth in an applicable Component Benefit Plan, such applicable Component Benefit Plan shall govern except to the extent such language fails to comply with requirements of applicable law or fails to determine the right or liability of the party, in which case the provisions of this Section shall govern.

CONTRIBUTIONS, FUNDING AND PLAN ASSETS

Contributions

Employer Contributions

The Employer shall pay, as contributions to the Plan, all or a portion, as determined by the Company, of the cost of the benefits provided under the Plan. The Employer reserves the right to cease payments under the Plan at any time and shall be under no obligation to make any contributions to the Plan after the Plan is terminated.

Employee Contributions

1. **Amount:** From time to time, the Company shall determine, on a fixed dollar or percentage basis, the amount, if any, of contributions required from Covered Persons who are Employees to entitle them and their Dependents, if applicable, to be covered by and receive benefits under the Plan. The amount of such contribution shall be as set forth in any election or enrollment materials, whether paper or electronic as part of a web-based enrollment process, issued or posted in conjunction with the Plan or the Company's Cafeteria Plan (if applicable), as such materials may be changed from time to time. Any such election or enrollment materials are hereby incorporated by reference into the Plan as if set forth in full herein. Employee contributions under the Company's Cafeteria Plan (if applicable) are subject to maximum contribution limits as established by the Company and in compliance with Internal Revenue Service contribution limitations.
2. **Payment:** As a condition of receiving benefits under the Plan, eligible Employees shall agree, on forms or materials furnished by the Company or through a telephone or web-based enrollment process, to make contributions under the Plan in the amount determined as described above and shall make such contributions when and as required. If so provided under the terms of the Company's Cafeteria Plan contributions by Employees shall be made by salary reduction in accordance with the terms of such plan and a corresponding contribution by the Employer.

Priority of Contributions

Benefits shall be deemed to come first from amounts contributed by eligible Employees and then from amounts contributed by the Employer.

Funding

Funding Policy

The Company shall establish and carry out, and may revise from time to time, the funding policy for the Plan.

Funding Mechanism

Contributions from the Employer and/or eligible Employees may be held under or paid to one or more of the following vehicles: insurance policies or arrangements, Health Maintenance Organizations or dedicated trust funds established by the Employer. In addition, benefits may be paid directly from the general assets of the Employer.

Plan Assets

Subject, in all cases, to the right of the Employer to terminate its obligation hereunder, the Employer shall pay benefit(s) provided for herein, to the extent not:

1. Provided for by Employee contributions.
2. Payable from an insurance policy held under the Plan.
3. Paid by a dedicated trust fund established by the Employer.

Where an insurance policy provides for payment of premiums directly from the Company, unless the insurance policy states otherwise, payable dividends, retroactive rate adjustments, or experience refunds are not Plan Assets. These dividends, retroactive rate adjustments, or experience refunds are Company property, which the Company may retain to the extent they do not exceed the Company's aggregate contributions to Plan cost made from its own funds.

ADMINISTRATION

Plan Administrator

The Company shall appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Company shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of ERISA.

Plan Administrator's Duties

Except as to those functions reserved within the Plan to the Board of Directors, the Company, or an Employer, the Plan Administrator shall have the duty to manage the operation and administration of the Plan. The Plan Administrator shall cause to be maintained such records as may be reasonably necessary or desirable for the proper management and administration of the Plan. The Plan Administrator shall also cause to be maintained for inspection by any individual who participates or is eligible to participate in the Plan, a copy of the document governing the Plan; the latest annual report, summary annual report, and summary plan description; and any amendments or changes to these documents. Upon written request, the Plan Administrator shall provide to such participating or eligible individuals a copy of these documents and may impose a reasonable charge, as permitted by law, for such copies.

Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Board of Directors, the Company or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

1. Require any person to furnish such information as Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan.
2. Make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan.
3. Interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
4. Determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan.
5. Determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof.
6. Delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan.
7. Engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan.
8. Make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Company, including changing the funding arrangement or any other amendments as may be required or appropriate to satisfy the requirements of the Code and ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies.
9. Pay all reasonable and appropriate expenses in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Persons and all other interested parties.

Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid by the Employer. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

Reserved Powers

The Company reserves the powers, among others:

1. To adopt the Plan.
2. To amend and terminate the Plan according to the Amendment, Termination, or Merger of Plan provisions contained herein.
3. To appoint and remove any claim administrator, Plan Administrator, third party administrator, or insurance company.

Power and Authority Insurance Company(ies) or Third Party Administrator(s)

Benefits under the Plan are provided through the following group policies:

Please refer to Appendix A for a list of all carriers and Component Benefit Plans.

In addition to the provisions outlined above, the insurance companies and/or Plan Administrator are responsible for determining eligibility for and the amount of any benefits payable under their respective Component Benefit Plans and prescribing claims procedures to be followed and the claims forms to be used by employees pursuant to their respective Component Benefit Plans.

Please contact the Plan Administrator or the appropriate claim administrator, third party administrator, or insurance company if you have any questions regarding the Plan, your eligibility, or the amount of any benefit payable under a Component Benefit Plan.

PROCEDURES

General Claims Procedures

Except as hereinafter provided, the provisions of this Section shall apply to every claim for a benefit under the Plan regardless of the basis asserted for the claim and regardless of when the act or omission upon which the claim is based occurred.

These provisions shall not apply to the extent that claims and appeals procedures are set forth differently in a Component Benefit Plan. In addition, the provisions of this Section shall not be interpreted so as to override applicable state laws that are more protective of Covered Persons' rights with respect to claims and appeals under ERISA plans, to the extent such state laws are not preempted by ERISA.

Claims Procedure for Fully Insured and Self-Insured Benefits

For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Plans provided under an insurance policy or through a self-insured benefit plan, the respective insurer or Plan Administrator is the named fiduciary under the Component Benefit Plan, with the full power to make factual determinations and to interpret and apply the terms of the Component Benefit Plan as they relate to the benefits provided under an insurance policy or through a self-insured benefit plan.

To obtain benefits of a Component Benefit Plan from the insurer or from the self-insured benefit plan, you must follow the claims procedures under the applicable insurance contract or self-insured benefit plan, which may require you to complete, sign and submit a written claim on a form obtained from the respective insurer or Plan Administrator for a self-insured benefit plan.

The insurance company or Plan Administrator, if a self-insured benefit plan, will decide your claim in accordance with its reasonable claims procedure, as required by ERISA. The insurance company or Plan Administrator, if a self-insured benefit plan, has the right to secure independent medical advice and to require such other evidence, as it deems necessary, in order to decide your claim. If the insurance company or Plan Administrator denies your claim, in whole or part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company or Plan Administrator, if a self-insured benefit plan, for a review of the denied claim. The insurance company or Plan Administrator, if a self-insured benefit plan, will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

You should refer to the documentation with respect to the applicable Component Benefit Plan among the applicable Attachments for more information about how to file a claim and for details regarding the insurance company's or Plan Administrator's, if a self-insured benefit plan, claims procedures.

Claims Deadline

Unless specifically provided otherwise in a Component Benefit Plan or pursuant to applicable law, a claim for benefits under this Plan (including the Component Benefit Plans) 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.

Legal Remedy

Before pursuing a legal remedy, a Claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

Other Party Liability Claims

Term Used in this Section:

"Incurred"
A covered expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, covered expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, covered expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Other Party Liability
This Section shall govern with respect to Plan benefits for injuries or illnesses of Covered Persons related to another party's actions or inactions. To the extent that conflicting subrogation or recovery provisions exist in an insurance contract or plan document which is a Component Benefit Plan, such provisions in the insurance contract or plan document shall govern.

Payment Condition
The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, illness or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this Section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Participant(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation
As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the illness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

If the Participant(s) fails to file a claim or pursue damages against any entity the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement
The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Participant(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, made whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

Participant is a Trustee Over Plan Assets
Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.

4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved. No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability
The Plan's right to reimbursement extends to any incident related care that is received by the Participant(s) ("Incurred") prior to the liable party being released from liability. The Participant's/Participants' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Participant has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death
In the event that the Participant(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations
It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the illness, disability, or injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
7. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
8. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

9. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
10. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
11. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid, to be paid, Incurred, or that will be Incurred, prior to the date of the release of liability from the relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Payment Procedures

Payment of Claim

Subject to the No Assignment of Benefits provision, benefits shall be payable to the Claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a Claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Plan Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such Claimant as the Plan Administrator deems appropriate.

Facility of Payment

If a Claimant dies before all amounts payable under the Plan have been paid, or if the Plan Administrator determines that the Claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the Claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the Claimant may be paid to any other person or institution reasonably determined by the Plan Administrator to be entitled equitably thereto and without prejudice therefor. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by a claim administrator, third party administrator, or insurance company for a self-insured Component Benefit Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to the applicable Component Benefit Plan and applied to the payment of current benefits and administrative fees under the Component Benefit Plan. In the event a

Covered Person subsequently requests payment with respect to the voided check, the Plan Sponsor for the self-insured Component Benefit Plan shall make such payment under the terms and provisions of the Component Benefit Plan as in effect when the claim was originally processed. Unclaimed self-insured Component Benefit Plan funds may be applied only to the payment of benefits (including administrative fees) under the Component Benefit Plan pursuant to ERISA (if applicable) and any other applicable State law(s).

MISCELLANEOUS

No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company, or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested.

No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

No Assignment of Benefits

Except as provided in the Procedures Section, benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may direct, in writing, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized, to a provider of medical or dental services or supplies furnished or to be furnished to him or her, or to a person or entity that has provided or paid for, or agreed to provide or pay for, any benefits payable under the Plan. The Plan reserves the right to make payment directly to the Covered Person. No payment by the Plan pursuant to such direction and assignment shall be considered as recognition by the Plan of a duty or obligation to pay a provider of medical or dental services or supplies except to the extent the Plan actually chooses to do so.

Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

Misrepresentation or Fraud

A Covered Person who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis.

Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in the Procedures Section, nor shall an action be brought at all unless within three years after the date a claim is incurred under the Plan.

Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable federal law and, to the extent not preempted, the laws of the State of Georgia.

Governing Instrument

This document, together with the documentation incorporated by reference into it, is the legal instrument governing the Plan.

Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

Captions and Headings

The captions and headings of a Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

Pronouns

Unless the context otherwise demands, words importing any gender shall be interpreted to mean any or all genders.

Word Usage

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

Notices

No notice or communication in connection with the Plan made by a Claimant, an Employee, or a Covered Person shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

Parties' Reliance

The Company, the Employer, a claim administrator, the Plan Administrator, a third party administrator(s), an insurance company(ies), and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

Disclaimer

The Company makes no assertion or warranty about:

1. Health care services and supplies that Covered Persons obtain reimbursement for as Plan benefits, or
2. Whether Plan benefits will be excludable from a covered Person's gross income for federal or state income tax purposes.

Expenses

All expenses of the Plan shall be paid from Employee contributions or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

Indemnification

The Employer, to the extent permitted by law, shall indemnify and hold harmless any employee, officer, or shareholder of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

AMENDMENT, TERMINATION OR MERGER OF PLAN

Right to Amend the Plan

Except as provided in this Section, the Company reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by the Company in accordance with its normal procedures. However, the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulation or to reflect the Company's intent.

Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Company reserves the unlimited right to terminate or merge the Plan. Any decision to terminate or merge the Plan shall be in writing and shall be adopted by the Company in accordance with its normal procedures.

Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine except that no amendment, termination or merger shall reduce benefits payable for covered expenses incurred prior to the later of the date the amendment, termination or merger is effective or adopted, except as required or permitted by law.

Change in Funding Mechanism

The Company reserves the unlimited right to change, modify, cancel or otherwise terminate any of the funding arrangements available under the Contributions, Funding and Plan Assets Section, including, by way of example and not by way of limitation, the right to change insurance carriers and the right to provide previously insured benefits on a partially insured or fully uninsured basis.

HIPAA PRIVACY

Notice of Privacy Practices

This Notice of Privacy Practices ("Notice") applies to Protected Health Information (defined below) associated with Jim Ellis Atlanta, Inc. Health and Welfare Plan provided by Jim Ellis Atlanta, Inc. to its Employees and its Employee's Dependents. This Notice describes how Jim Ellis Atlanta, Inc. may use and disclose Protected Health Information to carry out payment and health care operations, and for other purposes that are permitted or required by law. This Notice is effective January 1, 2021.

Copy of this Notice: The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Officer.

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Covered Persons. Privacy Standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Covered Person's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI.
2. The Covered Person's privacy rights with respect to his or her PHI.
3. The Plan's duties with respect to his or her PHI.
4. The Covered Person's right to file a complaint with the Plan and with the Secretary of HHS.
5. The person or office to contact for further information about the Plan's privacy practices.
6. Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

Definitions

- **Breach** means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

- **Protected Health Information ("PHI")** means individually identifiable health information, as defined by HIPAA, that is created or received by the Plan and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

How Health Information May Be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose, the minimum necessary amount, an individual's PHI, without obtaining authorization, only if the use or disclosure is for any of the following:

1. To carry out payment of benefits.

2. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Primary Uses and Disclosures of PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information.
3. Other Covered Entities: The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan documents or as required by law (as defined in the Privacy Standards).
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI.
3. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations.
4. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions.
5. Not use or disclose genetic information for underwriting purposes.
6. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware.
7. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524).
8. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526).
9. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or Employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq).
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

Required Disclosures of PHI

1. Disclosures to Covered Persons: The Plan is required to disclose to a Covered Person most of the PHI in a Designated Record Set when the Covered Person requests access to this information. The Plan will disclose a Covered Person's PHI to an individual who has been assigned as his or her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Covered Person's personal representative if it has a reasonable belief that the Covered Person has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Covered Person's best interest to treat the person as his or her personal representative, or treating such person as his or her personal representative could endanger the Covered Person.

2. Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Covered Person's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Covered Person's Rights

The Covered Person has the following rights regarding PHI about him/her:

1. Request Restrictions: The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his or her care or payment for his or her care. The Plan is not required to agree to these requested restrictions.
2. Right to Receive Confidential Communication: The Covered Person has the right to request that he or she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. Right to Receive Notice of Privacy Practices: The Covered Person is entitled to receive a paper copy of the plan's Notice of Privacy Practices at any time. To obtain a paper copy, contact the Privacy Officer.
4. Accounting of Disclosures: The Covered Person has the right to request an accounting of disclosures the Plan has made of his or her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six years prior to his or her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Officer.
5. Access: The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he or she may be charged a fee to cover the costs of copying, mailing, and other supplies. If a Covered Person wants to inspect or copy PHI, or to have a copy of his or her PHI transmitted directly to another designated person, he or she should contact the Privacy Officer. A request to transmit PHI directly to another designated person must be in writing, signed by the Covered Person and the recipient must be clearly identified. The Plan must respond to the Covered Person's request within 30 days (in some cases, the Plan can request a 30 day extension). In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. Amendment: The Covered Person has the right to request that the Plan change or amend his or her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he or she does not provide a reason for the request.
7. Other uses and disclosures not described in this section can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Questions or Complaints

If the Covered Person wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his or her privacy rights, please contact the Plan

using the following information. The Covered Person may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Covered Person with the address to file his or her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Covered Person for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information

Vice President of Human Resources
Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Fax: (770) 624-2839
Email: brooke@jimellis.com

HIPAA SECURITY

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Health Insurance Portability and Accountability Act (HIPAA) and other applicable law shall override the following wherever there is a conflict, or a term or terms is/are not hereby defined.

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under HIPAA.

Definitions

- **Electronic Protected Health Information (ePHI),** as defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103), means individually identifiable health information transmitted or maintained in any electronic media.
- **Security Incidents,** as defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304), means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. 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.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.
5. Establish safeguards for information, including security systems for data processing and storage.
6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards.
7. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:
        i. Privacy Officer.
        ii. Individuals described in Appendix B.
        iii. Information Technology Department.
    b. The access to and use of PHI by the individuals identified above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan. "Summary health information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Resolution of Noncompliance

In the event that any authorized individual of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the Privacy Officer. The Privacy Officer shall take appropriate action, including:

1. Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach.
2. Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment.
3. Mitigating any harm caused by the breach, to the extent practicable.
4. Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
5. Training Employees in privacy protection requirements and appoint a Privacy Officer responsible for such protections.
6. Disclosing the Covered Person's PHI to the Secretary of the U.S. Department of Health and Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

STATEMENT OF ERISA RIGHTS

Covered Person's Rights

As a Covered Person in the Plan, the Covered Person is entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About the Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for the Employee and eligible Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or eligible Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing the Covered Person's COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Covered Persons and beneficiaries. No one, including the Employer, the union (if any), or any other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a welfare benefit or exercising the Covered Person's rights under ERISA.

Enforce the Covered Person's Rights

If a Covered Person's claim for a welfare benefit is denied or ignored, in whole or in part, the Covered Person has 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 time schedules. Under ERISA, there are steps the Covered Person can take to enforce the above rights. For instance, if the Covered Person requests a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, the Covered Person may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Covered Person has a claim for benefits which is denied or ignored, in whole or in part, the Covered Person may file suit in a State or Federal court. In addition, if the Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, the Covered Person may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If the Covered Person is successful, the court may order the person the Covered Person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the Covered Person's claim is frivolous.

Assistance with the Covered Person's Questions

If the Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If the Covered Person has any questions about this statement or about rights under ERISA, or needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C., 20210. The Covered Person may also obtain certain publications about his or her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

APPENDIX A - APPLICABLE COMPONENT BENEFIT PLANS

All of the following attachments to this Plan may be obtained from the Plan Administrator upon written request, at no charge:

Medical Benefits:

Plan Name: Jim Ellis Atlanta, Inc. Medical Plan
Plan Effective Date: January 1, 2024
Plan Number: 501
Group Number: 31N
Third Party Administrator: Nova Healthcare Administrators, Inc.
6400 Main Street, Suite 210
Williamsville, NY 14221
Phone: 1 (855) 206-1040
E-mail: asknova@novahealthcare.com

Prescription Drug Benefits:

Plan Name: Jim Ellis Atlanta, Inc. Medical Plan
Plan Effective Date: January 1, 2024
Plan Number: 501
Group Number: 20131NA
Third Party Administrator: Independent Health's Pharmacy Benefit Dimensions, LLC.
511 Farber Lakes Drive, Buffalo, NY 14221
Phone: 888-878-9172
Email: servicing@pbdrx.com

Health Flexible Spending Account

Effective Date: January 1, 2024
Plan Number: 501
Third Party Administrator: Medcom Benefit Solutions
1061 Riverside Ave #2
Jacksonville, FL 32204
Phone: 1 (800) 523-7542

Dental Benefits:
Plan Name: Jim Ellis Atlanta, Inc. Dental Plan
Plan Effective Date: January 1, 2021
Group Number: GB05026
Carrier: Anthem
Phone: 1 (800) 627-0004
Website: www.anthem.com

Vision Benefits:
Plan Name: Jim Ellis Atlanta, Inc. Vision Plan
Plan Effective Date: January 1, 2021
Group Number: GB05026
Carrier: Anthem
Phone: 1 (866) 723-0515
Website: www.anthem.com

Group Term Life Insurance and Accidental Death and Dismemberment Insurance:
Plan Name: Jim Ellis Atlanta, Inc. Group Employer-Paid Term Life Plan
Plan Effective Date: January 1, 2021
Policy Number: GA1943
Carrier: Greater Georgia Life/Anthem
P.O. Box 281487
Atlanta, GA 30384
Phone: 1 (800) 851-8544

Group Disability Insurance:
Plan Name: Jim Ellis Disability Plan
Effective Date: January 1, 2021
Policy Number: GA1943
Carrier: Greater Georgia Life/Anthem
P.O. Box 281487
Atlanta, GA 30384
Phone: 1 (800) 232-0113

Critical Illness Coverage:
Plan Name: Jim Ellis Critical Illness Plan
Effective Date: January 1, 2021
Group Number: 70271-4CCI
Carrier: Voya Financial
Phone: 1 (877) 236-7564

Accident Coverage:
Plan Name: Jim Ellis Accident Plan
Effective Date: January 1, 2021
Group Number: 70271-4CCI
Carrier: Voya Financial
Phone: 1 (877) 236-7564

Cafeteria Plan:
Plan Name: Jim Ellis Atlanta, Inc. Section 125 Cafeteria Plan
Plan Effective Date: November 1, 2016; Restated January 1, 2021
Administrator: Jim Ellis Atlanta, Inc.
5901 Peachtree Industrial Blvd.
Atlanta, GA 30341
Phone: (770) 458-6811
Website: www.jimellis.com

NOTE: This Appendix A shall be subject to modification without formal amendment of the Plan.

APPENDIX B - EMPLOYEES OF THE EMPLOYER APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

Employees of the Employer Approved to Have Access to Protected Health Information, is as follows:

Chief Legal Officer
Chief Privacy Officer
Vice President
Vice President of Human Resources
Human Resources Manager

APPENDIX C - PARTICIPATING EMPLOYERS

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