Welfare Benefit Plan

Plan Document

WRAP Plan

California Automotive Retailing Group
Health and Welfare Plan

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California Automotive Retailing Group Health and Welfare Plan
PLAN DOCUMENT

DEFINITIONS
If any definition conflicts with a definition in a Benefit Document the definition in the Benefit Document will govern.

ACA
Means the Patient Protection and Affordable Care Act of 2010 as amended from time to time.

ADOPTING EMPLOYER
Means any corporation, sole proprietor, or other entity named in the Adoption Agreement and any successor who by merger, consolidation, purchase, or otherwise assumes the obligations of the Plan. The Adopting Employer will be a named Fiduciary for purposes of ERISA section 402(a).

ADOPTION AGREEMENT
Means the document executed by the Adopting Employer through which it adopts the Plan and thereby agrees to be bound by all terms and conditions of the Plan.

ALTERNATE RECIPIENT
Means any Child of a Participant in any Health Care Component who is recognized under a QMCSO as having a right to enrollment under the Plan.

BENEFICIARY
Means the individuals who are designated by the Participant or the Plan Component to receive benefits from the Plan. An Eligible Dependent is a Beneficiary of the Plan Component.

BENEFIT DOCUMENT
Means any and all Insurance Policies and other documents, such as benefits booklets, that set forth the terms and conditions of a Plan Component. The Benefit Documents, including all terms and conditions of each Plan Component, are incorporated by reference in this document and constitute part of the Plan. Any amendment to a Benefit Document will automatically constitute an amendment to the Plan.

CHILD
Means an individual who is 1) the son, daughter, stepson, or stepdaughter of the Participant, or 2) an eligible foster child of the Participant pursuant to Code section 152(f)(1).

CLAIM
Means a request for benefits made by a Claimant in accordance with the Plan's procedures.

CLAIMANT
Means a Participant or Eligible Dependent who submits a Claim under a Plan Component.

COBRA
Means the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended from time to time.

CODE
Means the Internal Revenue Code of 1986 as amended from time to time.

CONCURRENT CLAIM
Means any Claim that arises when the Plan Administrator has approved an ongoing course of treatment to be provided over a period of time or consisting of a number of treatments, and either 1) the Plan determines that the course of treatment should be reduced or terminated, or 2) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

CONTRIBUTION
Means the amounts paid by the Employer or the Participant equal to the cost of coverage under a Plan Component.

DENTAL PLAN COMPONENT
Means a Plan Component that provides dental coverage.

DEPENDENT
Means the Spouse, Child, or other dependent of an Employee, as defined in the applicable Benefit Document.

DOL
Means the Department of Labor.

DOMESTIC PARTNER
Means an individual who is in a domestic partnership with the Participant as defined in the applicable Benefit Document and as determined by the Employer.

EFFECTIVE DATE
Means the date the Plan (or amendment or restatement of the Plan) becomes effective as indicated in the Adoption Agreement.

ELECTRONIC PROTECTED HEALTH INFORMATION
Means Protected Health Information that is transmitted by electronic media or maintained in electronic media and as defined pursuant to HIPAA Privacy Rule section 160.103. Unless otherwise specifically noted, Electronic Protected Health Information shall not include enrollment/disenrollment information and summary health information.

ELIGIBLE DEPENDENT
Means a Dependent that becomes covered under one or more of the Plan Components.

ELIGIBLE EMPLOYEE
Means, an Employee that satisfies the Plan's eligibility requirements under Plan Section 2.01.

EMPLOYEE
Means an individual whom the Employer classifies as a common-law employee and who is on the Employer's payroll, but does not include the following: 1) any leased employee (including but not limited to those individuals defined as leased employees in Code section 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's payroll or is determined by the IRS or others to be a common-law employee of the Employer; and 2) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer.

EMPLOYEE ASSISTANCE PROGRAM PLAN COMPONENT
Means a Plan Component that provides benefits in the form of assessments, counseling, or referral services to assist in managing personal situations.

EMPLOYER
Means the Adopting Employer. A partnership is considered to be the Employer of each of the partners and a sole proprietorship is considered to be the Employer of the sole proprietor.

ENTRY DATE
Means the first day after the Eligible Employee or the Eligible Dependent has satisfied the applicable eligibility requirements of the applicable Plan Component, provided that a timely coverage election is made in accordance with the terms of the applicable Plan Component. Each Plan Component may establish separate enrollment procedures, including applicable entry dates.

ERISA
Means the Employee Retirement Income Security Act of 1974 as amended from time to time

FIDUCIARY
Means a person who exercises any discretionary authority or control with respect to management of the Plan or has any discretionary authority or responsibility regarding the administration of the Plan, as defined in ERISA section 3(21). The Employer and such other individuals either appointed by the Employer or deemed to be fiduciaries as a result of their actions shall serve as Fiduciaries under this Plan and fulfill the fiduciary responsibilities described in Part 4, Title I of ERISA including discharging their duties with respect to the Plan solely in the interest of the Participants, Eligible Dependents, and Beneficiaries with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

FMLA
Means the Family and Medical Leave Act of 1993 as amended from time to time.

HEALTH CARE PLAN COMPONENT
Means an employee welfare benefit plan that provides medical care to Employees and their Dependents either directly, through insurance or reimbursement, or otherwise and includes a Major Medical Plan Component, a Dental Plan Component, a Vision Plan Component, an HRA Plan Component, and an Employee Assistance Program Plan Component.

HEALTH REIMBURSEMENT ARRANGEMENT PLAN COMPONENT (HRA PLAN COMPONENT)
Means an employer-funded arrangement that reimburses Participants for medical expenses incurred by the Participant and its Dependents up to a maximum dollar amount for a coverage period.

HIPAA
Means the Health Insurance Portability and Accountability Act of 1996 as amended from time to time.

INDEPENDENT REVIEW ORGANIZATION (IRO)
Means an entity that conducts independent external reviews of adverse benefit determinations.

INSURANCE POLICY
Means each applicable insurance contract and health maintenance organization ("HMO") contract or other similar contract, any amendments thereto, and any successor contract.

INSURER
Means an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state, that is subject to state law regulating insurance, and that issues an Insurance Policy. The term Insurer also includes an HMO that is either a federally qualified HMO, an organization recognized as an HMO under state law, or a similar organization regulated for solvency under state law in the same manner and to the same extent as such an HMO and that issues an Insurance Policy.

IRS
Means the Internal Revenue Service.

MAJOR MEDICAL PLAN COMPONENT
Means a Health Care Plan Component that provides minimum essential coverage and that is not otherwise an excepted benefit.

PARTICIPANT
Means any Eligible Employee who has satisfied the eligibility requirements of a Plan Component, has been enrolled or elected to enroll in such Plan Component, and has not for any reason become ineligible to continue participation in the Plan Component.

PHSA
Means the Public Health Service Act of 1944 as amended from time to time.

PLAN
Means the California Automotive Retailing Group Health and Welfare Plan herein adopted by the Employer. The Plan consists of this Plan Document, the corresponding Adoption Agreement, any Benefit Document, and any attachments or amendments as completed and signed by the Employer, including any amendment provisions adopted prior to the Effective Date of the Plan that are not superseded by the provisions if this is a restatement of an existing plan.

PLAN ADMINISTRATOR
Means the Adopting Employer unless the managing body of the Adopting Employer designates a person or persons other than the Adopting Employer as the Plan Administrator. The managing body of the Adopting Employer may also appoint a successor Plan Administrator. The Adopting Employer will also be the Plan Administrator if the person or persons so designated ceases to be the Plan Administrator and a successor Plan Administrator is not appointed. The Adopting Employer may establish an administrative committee that will carry out the Plan Administrator's duties. Members of the administrative committee may allocate the Plan Administrator's duties among themselves. If the managing body of the Adopting Employer designates a person or persons other than the Adopting Employer as Plan Administrator, such person or persons will serve at the pleasure of the Adopting Employer and will serve pursuant to such procedures as such managing body may provide. Each such person will be bonded if required by law. The Plan Administrator is the named Fiduciary of the Plan for purpose of ERISA section 402(a)(1) with authority to control and manage the operation and administration of the Plan and is responsible for complying with all reporting and disclosure requirements of Part I of Subtitle B of Title I of ERISA.

PLAN COMPONENT
Means each benefit component provided under the Plan as indicated in the Adoption Agreement.

PLAN DOCUMENT
Means this Plan Document.

PLAN YEAR
Means the 12-consecutive month period that coincides with the Adopting Employer's tax year or such other 12-consecutive month period as is designated in the Adoption Agreement. Notwithstanding the preceding, a Plan Year may be a period less than 12 months, as defined in the Adoption Agreement.

POST-SERVICE CLAIM
Means a Claim under a Major Medical Plan Component as defined in Labor Regulation section 2560.503-1(m)(3).

PREMIUMS
Means the fees paid for the Participant's cost of coverage for a Plan Component.

PRE-SERVICE CLAIM
Means a Claim under a Major Medical Plan Component as defined in Labor Regulation section 2560.503-1(m)(2).

PRIVACY OFFICER
Means a person (or persons) whose job is to manage and monitor compliance with privacy laws and the Employer's privacy policy.

PROTECTED HEALTH INFORMATION (PHI)
Means Protected Health Information as such term is defined in HIPAA Privacy Rule section 160.103.

QUALIFIED BENEFICIARY
Means an individual as defined in Treasury Regulation section 54.4980B-3 and in parallel continuation coverage requirements under ERISA and the PHSA.

QUALIFYING EVENT
Means an event as defined in Treasury Regulation section 54.4980B-4 and in parallel continuation coverage requirements under ERISA and the PHSA.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)
Means a medical child support order that creates or recognizes the right of an Alternate Recipient to receive benefits for which a Participant is eligible under a Health Care Plan Component, or assigns to an Alternate Recipient the right of a Participant or Beneficiary to receive benefits under a Health Care Plan Component, and is recognized by the Plan as "qualified" because it includes information that meets other requirements of the QMCSO provisions. In addition, a properly completed National Medical Support Notice will be treated as a QMCSO.

SELF-INSURED
Refers to a Plan Component that pays Claims from the general assets of the Employer or from a trust.

SPOUSE
Means an individual who is legally married to a Participant. An individual shall be considered legally married regardless of where the individual is domiciled if either of the following apply: 1) the individual is married in a state, possession, or territory of the United States and the individual is recognized as lawfully married in that state, possession, or territory of the United States; or 2) the individual was married in a foreign jurisdiction and the laws of at least one state, possession, or territory of the United States recognize him or her as lawfully married. Depending on the Plan Component, the term Spouse may include a Domestic Partner.

TERMINATION OF EMPLOYMENT
Means a Participant's employment status due to separation of employment. A Participant who does not return to work for the Employer on or before the expiration of an authorized leave of absence from such Employer will be deemed to have incurred a Termination of Employment when such leave ends.

THIRD-PARTY ADMINISTRATOR (TPA)
Means the entity appointed by the Plan Administrator for the administration of a Plan Component that is Self-Insured.

TRUSTEE
Means, if applicable, an individual, individuals, or corporation appointed in a separate trust agreement by the Adopting Employer as Trustee or any duly appointed successor. A corporate Trustee must be a bank, trust company, broker, dealer, or clearing agency as defined in Labor Regulation section 2550.403(a)-1(b). In the event of any conflict between the terms of the Plan and the terms of the separate trust agreement, the terms of the Plan will control.

URGENT CARE CLAIM
Means a Claim under a Major Medical Plan Component for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

USERRA
Means the Uniformed Services Employment and Reemployment Rights Act of 1994 as amended from time to time.

VISION PLAN COMPONENT
Means a Plan Component that provides vision coverage.

SECTION ONE: EFFECTIVE DATES

Pursuant to the DEFINITIONS Section of the Plan, the Effective Date means the date the Plan becomes effective as indicated in the Adoption Agreement. However, certain provisions of the Plan may have effective dates different from the Plan Effective Date, if, for example, the Plan is amended after the Effective Date.

SECTION TWO: ELIGIBILITY

2.01. ELIGIBILITY TO PARTICIPATE

An Employee shall become eligible to participate in the Plan as of the first day the Employee becomes eligible under any Plan Component. If elected in the Adoption Agreement, the Plan Components will cover Dependents. In addition, if elected in the Adoption Agreement and unless otherwise excluded under the terms of the applicable Benefit Document, the Plan Component will cover Domestic Partners.

2.02. PLAN ENTRY

A. Plan Restatement – If this Plan is an amendment or restatement of a prior Plan Document, each Employee who was a Participant under the prior Plan Document before the Effective Date will continue to be a Participant in this Plan.

B. Effective Date – If this is an initial adoption of the Plan by the Employer, an Employee will become a Participant in the Plan as of the Effective Date if the Employee has met the eligibility requirements of Plan Section 2.01 as of such date. After the Effective Date, each Employee will become a Participant on the first Entry Date coinciding with or following the date the Employee satisfies the eligibility requirements of Plan Section 2.01.

C. Notification – The Plan Administrator shall notify each Employee who becomes an Eligible Employee under the Plan and shall furnish the Eligible Employee with the enrollment forms or other documents that are required to be completed by the Eligible Employee. Such notification will be in writing, or in any other form permitted under rules promulgated by the IRS or DOL. The Eligible Employee will execute such forms or documents and make available such information as may be required by the Plan Administrator.

2.03. SPECIAL ENROLLMENT RIGHTS

If an Eligible Employee declines enrollment in a Major Medical Plan Component because of other health coverage, the Eligible Employee may be able to enroll along with any Dependents in the Major Medical Plan Component if eligibility is lost for the other health coverage (or because the employer sponsoring the other health coverage stopped contributing toward such coverage). However, the Eligible Employee must request enrollment within 30 days after the other health coverage ends (or 30 days after the employer sponsoring the other health coverage ceases paying Contributions for the other health coverage). If the other health coverage is continuation coverage, the entire continuation coverage period must be exhausted before the Eligible Employee can enroll in the Plan. If the Eligible Employee otherwise declines to enroll, the Plan Administrator may require the Eligible Employee to wait until the next open enrollment to enroll in the Major Medical Plan Component.

In addition, if an Eligible Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Eligible Employee may enroll in the Major Medical Plan Component along with any Dependents, provided that the Eligible Employee requests enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If the Eligible Employee otherwise declines to enroll, the Eligible Employee may be required to wait until the next open enrollment to enroll in the Major Medical Plan Component.

Furthermore, Eligible Employees and their Dependents who are not enrolled in a Major Medical Plan Component shall be eligible to enroll for coverage within 60 days after 1) becoming ineligible for coverage under Medicaid or Children's Health Insurance Program ("CHIP"), or 2) becoming eligible for financial assistance under a Medicaid, CHIP, or state plan. For purposes of this paragraph, Medicaid means the state's health care coverage provided to eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities in accordance with Title XIX of the Social Security Act of 1935 as amended from time to time.

2.04. TERMINATION OF PARTICIPATION

The coverage of a Plan Participant will terminate in accordance with the terms and conditions set forth in the SPD and Benefit Documents for each applicable Plan Component.

2.05. CONTINUATION COVERAGE RIGHTS

In the event that participation in a Health Care Plan Component would terminate due to a Qualifying Event, a Participant and/or the Eligible Dependents may have the right to purchase continued coverage for a Health Care Plan Component for a temporary period, as provided under COBRA and any state continuation requirements that are imposed on Insurers that underwrite the insured Plan Components. If elected in the Adoption Agreement, Domestic Partners will be provided Continuation coverage rights as explained in detail in the applicable Benefit Document or in notices related thereto.

2.06. TERMS OF EMPLOYMENT

Nothing with respect to the establishment of the Plan or trust or any action taken with respect to the Plan, nor the fact that an Employee has become a Participant, will give to that Employee any right to employment or continued employment or grant any other rights except as specifically set forth in this Plan, ERISA, or other applicable law or regulation. Furthermore, the Plan will not limit the right of the Employer to discharge an Employee or to otherwise make employment determinations in relation to an Employee without regard to the effect such treatment may have upon the Employee's rights under the Plan.

2.07. FULL-TIME EMPLOYEE STATUS UNDER THE ACA LARGE EMPLOYER MANDATE

Certain employees who are hired into positions that are not initially benefit-eligible may become Participants in the Plan by achieving "Full-Time Status" ("ACA-FT") under the ACA's special eligibility rules for variable-hour, part-time, and seasonal employees. The Employer shall administer the ACA-FT eligibility procedures in a manner that is consistent with the final regulations issued by the Department of Treasury related to the "shared responsibility" provisions of the ACA.

SECTION THREE: PLAN COMPONENTS AND FUNDING

3.01. PLAN COMPONENTS

The Plan includes various Plan Components as listed on the INSURERS AND PROVIDERS OF PLAN COMPONENTS ATTACHMENT to the Plan's Adoption Agreement. Definitions and the applicable provisions regarding eligibility, coverage, exclusions, and procedures of each Plan Component are contained in the corresponding Benefit Document.

3.02. FUNDING POLICY

Each Plan Component is either insured or Self-Insured. If Self-Insured, the Plan Component pays benefits through the general assets of the Employer or through a trust. For a list of Plan Components and their funding policy, see the INSURERS AND PROVIDERS OF PLAN COMPONENTS ATTACHMENT of the Plan's Adoption Agreement. Benefits under the Plan may be fully funded through Employer Contributions or Participant Contributions or in part by Employer Contributions and Participant Contributions. Such Contributions shall be made in the manner prescribed by the Employer.

3.03. CONTRIBUTIONS

A. Employee Contributions – The Employer may require that Participant Contributions be made through payroll deductions. Participant payroll deductions may be included or excluded from their taxable income as determined by the Employer and in accordance with the applicable law or regulation.

B. Employer Contributions – The Employer may make its Contributions in an amount that, in the Employer's sole discretion, is sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Participant Contributions. The Employer may pay its Contribution and Participant Contributions to an insurance carrier or, with respect to those benefits that are Self-Insured, may pay benefits as needed directly from its general assets. The Employer is not contractually obligated to continue Contributions and reserves the right to reduce, suspend, or discontinue any or all Employer Contributions at any time and for any reason.

3.04. NO TRUST

Except as otherwise required by law, nothing herein will be construed to require the Employer or the Plan Administrator to establish a trust, maintain any fund, or segregate any assets for the benefit of any Participant or Beneficiary, and neither the Participant nor the Beneficiary shall have any claims against, right to, or security or other interest in any fund, account, or asset of the Employer.

Notwithstanding the foregoing, the Adopting Employer may, at its sole discretion or as required by law, establish a trust for the purpose of paying benefits under any Plan Component. All payments of benefits under a Plan Component funded through a trust shall be made out of the trust. Assets held in trust may also be used to pay the Plan's administrative expenses.

If the Adopting Employer establishes a trust for one or more Plan Components, the assets of the Plan corresponding to those Plan Components will be held by the Trustee pursuant to an agreement executed by the Adopting Employer and the Trustee. Assets held by the Trustee will not be earmarked on behalf of any Participant or Beneficiary.

3.05. COST SHARING

The amount of Contributions payable by Participants or Beneficiaries under a Plan Component may be established by the Adopting Employer at its discretion and revised periodically. However, if a Plan Component is offered as a part of a collective bargaining agreement, the amount of Contributions payable by Participants or Beneficiaries may be established under the terms of the corresponding collective bargaining agreement.

From time to time the Adopting Employer may, in its sole discretion, establish 1) deductibles, 2) copays or coinsurance, and 3) maximum out-of-pocket amounts. Deductibles, copays, coinsurance, and maximum out-of-pocket amounts may vary among the coverage options available under the Plan Components, among the different features of a single coverage option, among groups of Participants, or in any other manner determined in the discretion of the Adopting Employer. Notwithstanding the foregoing, in no event shall the out-of-pocket limit exceed amounts permissible under PHSA section 2707(b), if applicable.

3.06. COORDINATION OF BENEFITS

If the applicable Benefit Document does not include coordination of benefits rules, or if such document includes incomplete rules, then coordination of benefits with other coverage will be determined in accordance with this Section 3.06.

A. General – The Plan has the right to coordinate its payment of any benefit with other coverage under which the Participant or Eligible Dependent is covered so that the total benefits paid by the Plan together with the other coverage does not exceed the level of benefits that would otherwise be paid by the Plan. When a Participant or Eligible Dependent is covered by other coverage under this coordination of benefits rule, the Plan is designated either the primary or secondary payer, as determined under Plan Section 3.06(B). As the primary payer, the Plan will pay benefits first and will not take into account benefits payable under other coverage when determining the benefits it pays. Any other coverage that pays benefits after the primary payer is designated the secondary payer. As a secondary payer, the Plan will reduce its benefits by those benefits payable under other coverage and may limit the benefits it pays. These rules apply whether or not a Claim is made under the other coverage. If a Claim is not made, benefits under the Plan will be pended or denied until documentation is received showing a Claim made with the primary payer.

For purposes of this coordination of benefits rule, other coverage includes the following:

1. Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation.
2. Group insurance or other coverage for a group of individuals, including coverage under another employer plan or student coverage obtained through an educational institution.
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans.
4. Any coverage under governmental plans, such as Medicare, but not including a state plan under Medicaid or any governmental plan when, by law, its benefits are secondary to those of any private insurance or nongovernmental program.

5. Any private or association policy or plan of medical expense reimbursement that is group or individual rated.
6. Any excess Insurance Policy.
7. Any retiree medical plan.

B. Determination of Primary Payer or Secondary Payer Status – If coverage does not contain a coordination of benefits provision, the coverage is always the primary payer. If the coverage has a coordination of benefits provision, the following rules will apply to the Plan:

1. No-Fault Coverage, Personal Injury Protection, and Medical Payment Coverage – The Plan will be the secondary payer. In the case of no-fault coverage, the Plan will pay first then seek reimbursement as the secondary payer.
2. Participant Coverage (Primary Insured) – The Plan will be the secondary payer.
3. Dependent Coverage (Parent) – The Plan will be the primary payer if the Participant is the parent of the Eligible Dependent Child and the Participant's birthday occurs earlier in the calendar year compared to the other parent's birthday. If both parents have the same birthday, the Plan will be the primary payer if the Plan has covered the Eligible Dependent Child for the longest period of time compared to the other coverage.
4. Dependent Coverage (Divorced/Separated Parents) – The Plan will be the primary payer if the parents are divorced or separated, the Participant is the parent with custody over the Eligible Dependent Child, and the Participant has not remarried. If the parents are divorced or separated and the Participant is the parent with custody over the Eligible Dependent Child and has remarried, the Plan will be the primary payer, the stepparent's coverage will be the secondary payer, and the coverage of the parent without custody will pay last.
5. Court Decree – The Plan will be primary payer if the Participant is the parent with financial responsibility over the Eligible Dependent Child's health care expenses pursuant to a court decree.
6. Continuation Coverage – The Plan will be the primary payer if the individual is covered as an Employee, member, subscriber, or retiree of the Plan. The Plan will be the secondary payer if the individual is covered as a Qualified Beneficiary pursuant to continuation coverage.
7. Other – When items 1 through 7 above do not establish an order of benefit determination, the Plan will be the primary payer if the Plan has covered the Participant or Eligible Dependent for the longest period of time compared to the other coverage.

C. Special Rule for Retiree Medical Plans – If a Participant or Eligible Dependent is covered under a retiree plan that includes a coordination of benefits provision, the retiree plan's coordination of benefits provision shall govern.

D. Additional Rules – For the purpose of coordinating benefits the Plan will also apply the following rules.

1. If a Participant or Eligible Dependent resides in a state where automobile personal injury protection or medical payment coverage is mandatory, the Plan will be the secondary payer and the other coverage will be the primary payer. The Plan will reduce benefits paid under the Plan to an amount equal to, but not less than, the state's mandatory minimum requirement.
2. The Plan will have first priority with respect to its right to reduction, reimbursement, and subrogation.
3. The Plan will be secondary payer to any excess Insurance Policy.
4. The Participant or Eligible Dependent must follow the guidelines of the primary payer in order for the Plan to pay as secondary payer.
5. The Plan will not coordinate benefits with an HMO or any similar managed care plan where the Participant or Eligible Dependent only pays a co-payment or fixed dollar amount. In that case, if any portion of a medical or dental Claim is paid by an HMO or similar managed care plan, the Plan will not pay any amount toward the co-payment or fixed dollar amount.
6. The Plan will not coordinate with any other plan, other than Medicare or as otherwise required by law, with respect to a covered transplant.
7. If any portion of a transplant Claim may be paid by another plan, the Plan will not pay any amount of the transplant benefit Claim.
8. The Plan does not coordinate benefits with respect to prescription drugs. If any portion of a prescription drug Claim is paid by any other plan, the Plan will not pay any amount of the pharmacy benefit Claim.
9. The Plan will not coordinate benefits on any health care credit provided by the Plan. If a health care credit has not been exhausted, the Plan will pay the health care credit first and then the coordination rules in this section will apply. If the health care credit has been exhausted, the coordination rules in this section will apply.

E. Medicare – In compliance with the Social Security Act, the Plan will be the primary payer if a Participant or Eligible Dependent is eligible or enrolled in Medicare and meets certain requirements. In certain limited circumstances the Plan will pay benefits as secondary payer to Medicare.

SECTION FOUR: CLAIMS AND APPEALS

4.01. PLAN COMPONENT CLAIMS AND APPEALS PROCEDURES

Claimants must follow the Claims submission rules and Claims appeal procedures contained in the applicable Component Documents to obtain payment of benefits under the Plan, but only to the extent such procedures are consistent with the ACA (if applicable) and DOL Regulation Section 2560.503-1 as in effect on the date the claim was received. Claims arising under this Plan document shall be brought under the procedures in this Section Four. However, notwithstanding any terms in this Section, the procedures set forth herein will not provide a Claimant with any rights greater than those provided for under the applicable regulations.

Each Claimant shall be responsible for supplying additional information as required by the Plan Administrator. If the Plan Administrator, in its sole discretion, determines that the Claimant has failed to furnish a required or requested document, no benefits shall be payable under the Plan.

4.02. CLAIMS UNDER DISABILITY PLAN COMPONENTS

If the applicable Benefit Document does not include Claims and appeals procedures for Claims under a Disability Plan Component, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section 4.02.

A. Timing of Claims Decisions – If a Claim is wholly or partially denied, the Plan Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 45 days after receipt of the Claim by the Plan Administrator.

This period may be extended by the Plan Administrator for up to 30 days, provided that the Plan Administrator determines that such an extension is necessary due to matters beyond the control of the Plan Administrator and notifies the Claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision. If, prior to the end of the first 30-day extension period, the Plan Administrator determines that, due to matters beyond its control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the Claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the Plan Administrator expects to render a decision. In the case of any extension, the notice of extension shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Claim, and the additional information needed to resolve those issues. The Claimant shall be afforded at least 45 days within which to provide the specified information.

B. Contents of the Notice of Adverse Benefit Determination – The notice of adverse benefit determination shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. Information sufficient to identify the Claim.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific Plan provisions on which the determination is based.
4. A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.
5. A discussion of the decision, including an explanation of the basis for disagreeing with or not following
    a. the views presented by the Claimant to the Plan Administrator of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;
    b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan Administrator in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; or
    c. a disability determination made by the Social Security Administration regarding the Claimant, presented by the Claimant to the Plan Administrator.
6. If the adverse benefit determination is based on medical necessity, experimental treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.
7. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.
8. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.
9. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review.

C. Review of Adverse Benefit Determinations – The Claimant may request a review of the adverse benefit determination for 180 days following receipt of a notification of an adverse benefit determination. The request for review must be filed in writing with the Plan Administrator. The request for review may include written comments, documents, records, and other information relating to the Claim.

The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.

The review of an adverse benefit determination will take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate named Fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.

In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named Fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation under this paragraph will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual.

Before the Plan Administrator can issue an adverse benefit determination on review on a disability benefit Claim, the Plan Administrator shall provide the Claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, Insurer, or other person making the benefit determination (or at the direction of the Plan Administrator, Insurer, or such other person) in connection with the Claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided under Plan Section 4.02(A) to give the Claimant a reasonable opportunity to respond prior to that date.

Before the Plan Administrator can issue an adverse benefit determination on review on a disability benefit Claim based on a new or additional rationale, the Plan Administrator shall provide the Claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which notice of the adverse benefit determination on review is required to be provided under Plan Section 4.02(A) to give the Claimant a reasonable opportunity to respond prior to that date.

D. Timing of Review Determinations – The Plan Administrator shall notify the Claimant of its benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the Claimant's request for review of the initial adverse benefit determination by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.

E. Contents of the Notice of Adverse Benefit Determination on Review – The Plan Administrator will provide the Claimant with a notification of the Plan's benefit determination on review. In the case of an adverse benefit determination on review, the notification shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. Information sufficient to identify the Claim.
2. The specific reason or reasons for the adverse determination on review.
3. Reference to the specific Plan provisions on which the benefit determination is based.
4. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.
5. A statement describing any voluntary appeal procedures offered by the Plan and the Claimant's right to obtain, upon request, sufficient information relating to the voluntary level of appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the Claimant's rights to any other benefits under the Plan and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process.
6. A statement of the Claimant's right to bring an action under ERISA section 502(a) with a description of any applicable contractual limitations period that applies to the Claimant's right to bring such an action, including the calendar date on which the contractual limitations period expires for the Claim.
7. A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    a. the views presented by the Claimant to the Plan of health care professionals treating the Claimant and vocational professionals who evaluated the Claimant;

b. the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

c. a disability determination regarding the Claimant presented by the Claimant to the Plan made by the Social Security Administration.

8. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

9. Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

4.03. CLAIMS UNDER HEALTH CARE PLAN COMPONENTS

If the applicable Benefit Document does not include Claims and appeals procedures for Claims under a Health Care Plan Component, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section 4.03.

A. When Health Care Plan Component Claims Must Be Filed – Unless specifically provided otherwise in a Health Care Plan Component or pursuant to applicable law or regulation, a Claim under a Health Care Plan Component must be filed within one year of the date charges for the services were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. Charges are considered incurred when treatment or care is given or supplies are provided. Claims filed later than such date shall be denied, unless it is shown that it was not reasonably possible to file within one year of the date charges for services were incurred. All Claims must be submitted by the Claimant in accordance with Plan's procedures and include the corresponding forms required by the Plan Administrator.

B. When a Pre-Service Claim (Including a Concurrent Claim That Is Also a Pre-Service Claim) Is Considered Filed – A pre-service Claim is considered to be filed when the request for approval of a treatment or service is made and received by the Plan Administrator in accordance with the Plan's procedures.

C. When a Post-Service Claim Is Considered Filed – A Post-Service Claim is considered to be filed when all of the following information is received by the Plan Administrator:

1. The date of the services.
2. The name, address, telephone number, and tax identification number of the provider of the services.
3. The place where the services were rendered.
4. The diagnosis and procedure codes.
5. The cost of services.
6. The name of the Plan.
7. The name of the Participant or Eligible Dependent.
8. The name of the patient.

Upon receipt of this information, the Claim will be deemed to be filed with the Plan. The Plan Administrator will determine if enough information has been submitted to adjudicate the Claim. If not, the Plan Administrator may request more information. The Plan Administrator must receive the additional information within 45 days from receipt by the Claimant of the request for additional information. Failure to do so may result in Claims being declined or benefits reduced.

D. Timing of Claim Decisions – The Plan Administrator shall notify the Claimant of a denial (and, in the case of Pre-Service Claims and Concurrent Claims, of decisions that a Claim is payable in full) as described below.

1. Urgent Care Claims – If the Claimant has provided all of the necessary information, the Plan Administrator will notify the Claimant of its decision as soon as possible, taking into account the medical exigency, but not later than 72 hours after receipt of the Claim. This time period cannot be extended by the Plan Administrator.

   If the Claimant has not provided all of the information needed to process the Claim, then the Plan Administrator will notify the Claimant as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the Claim. The Claimant will have 48 hours to provide the specified information. The Plan Administrator will notify the Claimant of its determination of benefits as soon as possible (taking into account the medical exigency), but not later than 48 hours after the earlier of a) the Plan's receipt of the specified information, or b) the end of the period afforded the Claimant to provide the information.

2. Pre-Service Claims – If the Claimant has provided all of the information needed to process the Claim, the Plan Administrator will notify the Claimant of its decision within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the Claim. This period may be extended by the Plan Administrator for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator and notifies the Claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

   If the Claimant has not provided all of the information needed to process the Claim, the Plan Administrator will notify the Claimant as to what specific information is needed as soon as possible, but not later than five days after receipt of the Claim. The Claimant will be given at least 45 days from receipt of the notice within which to provide the specified information.

3. Concurrent Claims –

   a. *Plan Notice of Reduction or Termination* – If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), the Plan Administrator will notify the Claimant of its decision sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

   b. *Request by Claimant Involving Urgent Care* – If the Plan Administrator receives an Urgent Care Claim from a Claimant to extend the course of treatment beyond a previously prescribed period of time or number of treatments, the Plan Administrator will notify the Claimant of its decision as soon as possible, taking into account the medical needs, but not later than 24 hours after receipt of the Claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as an Urgent Care Claim and will be decided accordingly.

   c. *Request by Claimant Involving Non-Urgent Care* – If the Plan Administrator receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments and the Claim is not an Urgent Care Claim, the request will be treated as a new Claim and will be decided within the time frame appropriate to the type of Claim (either as a Pre-Service or a Post-Service Claim).

4. Post-Service Claims – If the Claimant has provided all of the information needed to process the Claim, the Plan Administrator will notify the Claimant of its decision within a reasonable period of time, but not later than 30 days after receipt of the Claim. This period may be extended by the Plan Administrator for up to 15 days, provided the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan Administrator and notifies the Claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan Administrator expects to render a decision.

   If the extension described above is necessary because the Claimant failed to submit the information necessary to decide the Claim, the notice of extension must describe specifically the required information. The Claimant shall be afforded at least 45 days from the receipt of such notice within which to provide the specified information.

E. Calculating Time Periods – The period of time within which a benefit determination is required to be made shall begin at the time a Claim is deemed to be filed in accordance with the procedures of the Plan.

F. Notice of Denial – The notice of a denial of a Claim shall be either in writing or in any other form permitted under rules promulgated by the DOL. Notwithstanding the foregoing, a Claimant may be notified orally in the case of an Urgent Care Claim, as long as a notice of denial in writing or in any other form permitted under rules promulgated by the DOL is furnished to the Claimant within three days of the oral notice. The notice of denial shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. Information sufficient to identify the Claim.
2. The specific reason for the denial.
3. Reference to the specific Plan provisions on which the denial is based including a copy of any internal guideline used in the benefit determination or notice of where and how to obtain a copy free of charge.
4. A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation as to why such information is necessary.
5. An explanation of the Plan's Claims appeals procedures.
6. Claimant's right to bring a civil action under ERISA section 502(a).
7. If the Claim is denied based on medical necessity, experimental treatment, or a similar exclusion or limitation, an explanation of the scientific or clinical judgment applied in the benefit determination or notice of where and how to obtain a copy free of charge.
8. For purposes of Urgent Care Claims, a description of the expedited review process.

G. Claims Appeal Process – An adverse benefit determination eligible for internal appeal processes includes a denial, reduction, or termination of, or failure to provide or make a payment for, a benefit (including a rescission of coverage), based on at least one the following:

1. A determination of a Claimant's eligibility to participate in the Health Care Plan Component.

2. A determination that a benefit is not a covered benefit.

3. The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits.

4. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

H. When an Appeal Must Be Filed – A Claimant can appeal an adverse benefit determination within 180 days following receipt of a notification of an adverse benefit determination.

The Claimant or his duly authorized representative may

1. Request a review by providing written notice to the Plan Administrator;

2. Submit written comments, documents, records, and other information relating to the Claim; and

3. Upon request, have reasonable access to and copies of all documents, records, and other information relevant to the Claim.

I. Timing of Notification of Benefit Determination on Review – The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following time frames:

1. Urgent Care Claims – As soon as possible, taking into account the medical needs, but not later than 72 hours after receipt of the appeal.

2. Pre-Service Claims – Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

3. Concurrent Claims – The response will be made in the appropriate time period based upon the type of Claim (Urgent Care Claim, Pre-Service Claim, or Post-Service Claim).

4. Post-Service Claims – Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

J. Internal Review and Decision on Appeal

1. Full and Fair Review – The Plan Administrator shall take into account all comments, documents, and other information submitted by the Claimant without regard to whether the information was submitted with the original Claim and without deference to the original determination. The decision shall be based in whole or in part on a medical judgment, with consultation with the appropriate independent health care professionals, if the Claim involves investigational or experimental treatment or issues of medical necessity. If applicable, the decision shall identify such medical professionals.

   A Claimant shall be entitled to obtain, free of charge, any new or additional evidence considered by the Plan Administrator in connection with the Claim. Such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give the Claimant a reasonable opportunity to respond. In addition, before the Plan Administrator can issue an adverse benefit determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale also must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required.

2. Decision – The decision of the Plan Administrator shall be written in a manner calculated to be understood by the Claimant and set forth the following information:

   a. Information sufficient to identify the Claim.

   b. The specific reason for denial upon review.

   c. Specific references and copies of the pertinent Plan provisions or internal guidelines on which the decision was based.

   d. A statement providing that the Claimant can receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to their Claim.

   e. If an internal rule, guideline, protocol, or similar criterion was relied upon in making the determination, either the specific rule, guideline, or protocol, or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the review determination and that a copy of such rule, guideline, protocol, or similar criterion will be provided to the Claimant free of charge upon request.

   f. If the appeal is denied based on medical necessity, experimental treatment, or a similar exclusion or limitation, an explanation of the scientific or clinical judgment applied on the benefit determination or notice of where and how to obtain a copy.

g. A statement describing the Plan's external review procedures and the time limits applicable to such procedures, including information about how to initiate an external review and a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review. The statement must also disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman, if any, established by the Department of Health and Human Services to assist the Claimant with the internal Claims and appeals and external review procedures.

3. Second Appeal – If the Claimant receives an adverse determination of the appeal, the Claimant may file a second appeal. The second appeal must be filed no later than 30 days from the date indicated on the response letter to the first appeal. The timing of the response to the second appeal shall be made in accordance with the same guidelines as those outlined for the first appeal.

K. External Review – An "external review" is a review by an independent third party of a Plan's final internal determination to deny a Claim.

1. Availability of External Review – Unless the Plan is grandfathered, a Claimant may request to have the Claim reviewed by an IRO, not employed by the Plan or the Insurer, through an external review process. A Claimant must exhaust all internal Claims and appeal procedures before exercising their right to external review. The external review process is available when the Plan Administrator denies treatment based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; when the Plan Administrator determines that the care is experimental and/or investigational; or for rescissions of coverage. If the IRO's decision is to reverse the Plan's benefits denial, the Plan must immediately provide coverage or payment for the Claim (including immediate payment of benefits).

2. When External Review Must Be Requested – A Claimant must request the external review in writing no later than four months after the date the Insurer or the Plan Administrator notifies the Claimant of a final adverse benefit determination.

3. State External Review Process – The Plan Administrator of a Health Care Plan Component that is financed through Insurance Policies will process a Claimant's request for external review in accordance with the state external review process that is applicable to the Insurer and that includes, at a minimum, the consumer protections in the NAIC Uniform Model Act. If the state external review process is not applicable to the corresponding Insurer or, if applicable, does not include the consumer protections in the NAIC Uniform Model Act, then the Plan Administrator of the Health Care Plan Component must process the Claimant's request for external review in accordance with the federal external review process set forth in PHSA section 2719(b)(2) and regulations thereunder.

4. Self-Insured Health Care Plan Component – The Plan Administrator of a Health Care Plan Component that is Self-Insured will process a Claimant's request for external review in accordance with the federal external review process set forth in PHSA section 2719(b)(2) and regulations thereunder. Notwithstanding the foregoing, a Health Care Plan Component subject to the federal external review may elect to process a Claimant's request for external review in accordance with the state external review process if such process is available.

5. Consumer Protections – The external review procedures include the following minimum consumer protections:

   a. The Plan or Insurer will allow the Claimant at least four months to file a request for external review after the receipt of the notice of adverse benefit determination or final internal adverse benefit determination.

   b. Within five business days following the date of receipt of the external review request, the Plan or Insurer will complete a preliminary review of the request to determine whether 1) the Claimant is or was covered under the Plan at the time of service (or the request for service, as applicable), 2) the Claim does not relate to eligibility, 3) the Claimant has exhausted the Plan's or Insurer's internal appeal process, and 4) the Claimant has provided all the information required to process an external review. Within one business day after completion of the preliminary review, the Plan or Insurer will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and current contact information for the Employee Benefits Security Administration. If the request is not complete, such notification will describe the information or materials needed to make the request complete. The Plan or Insurer will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

   c. The Claimant must be notified and allowed to submit additional information in writing to the IRO, which the IRO must consider when conducting the external review. The IRO must allow the Claimant at least 10 business days to submit any additional information, and any additional information submitted by the Claimant must be forwarded to the Insurer (or Plan Administrator) within one business day of receipt by the IRO.

   d. For a standard external review, the IRO must provide written notice to the Insurer (or Plan Administrator) and the Claimant of its decision to uphold or reverse the adverse benefit determination no later than 45 days after the receipt of the request for external review. The IRO decision will be binding on the Claimant, as well as the Insurer or Plan Administrator (except to the extent other remedies are available under state or federal law).

   e. For an expedited external review, the IRO must provide notice of the decision no later than 72 hours after receipt of the request for external review (if notice of the IRO's decision is not in writing, the IRO must provide written confirmation of its decision within 48 hours after the date of the notice of the decision).

6. Expedited External Review – A Claimant may request an "expedited" external review if the timeframe for completing an expedited internal appeal or standard external review would seriously jeopardize the Claimant's life or health or jeopardize the Claimant's ability to regain maximum function. The Claimant may also request an expedited external review if the Claimant has received emergency services but has not yet been discharged from a facility.

4.04. CLAIMS UNDER OTHER PLAN COMPONENTS

If the applicable Benefit Document does not include Claims and appeals procedures for Claims under a Non-Disability Non-Health Care Plan Component, or if such document includes procedures that do not satisfy the minimum requirements of ERISA, then the Claims and/or appeals will be determined in accordance with this Section 4.04.

A. When Other Plan Component Claims Must Be Filed – If a Claim is wholly or partially denied, the Plan Administrator shall notify the Claimant of the Plan's adverse benefit determination within a reasonable period of time, but not later than 90 days after receipt of the Claim by the Plan. If the Plan Administrator determines that special circumstances require an extension of time for processing the Claim, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the benefit determination.

B. Contents of the Notice of Adverse Benefit Determination – The notice of adverse benefit determination shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. Information sufficient to identify the Claim.
2. The specific reason or reasons for the adverse determination.
3. Reference to the specific Plan provisions on which the determination is based.
4. A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under ERISA section 502(a) following an adverse benefit determination on review.

C. Review of Adverse Benefit Determinations – The Claimant may request a review of the adverse benefit determination within 60 days following receipt of a notification of an adverse benefit determination. The request for review must be filed in writing with the Plan Administrator. The request for review may include written comments, documents, records, and other information relating to the Claim.

The Claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.

The review of an adverse benefit determination will consider all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination.

D. Timing of Review Determinations – The Plan Administrator shall notify a Claimant of the Plan's adverse benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the Claimant's request for review by the Plan Administrator, unless the Plan Administrator determines that special circumstances require an extension of time for processing the Claim. If the Plan Administrator determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan Administrator expects to render the determination on review.

E. Contents of the Notice of Adverse Benefit Determination on Review – The Plan Administrator will provide a Claimant with a notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall, in a manner calculated to be understood by the Claimant, set forth the following:

1. The specific reason or reasons for the adverse determination on review.
2. Reference to the specific Plan provisions on which the benefit determination is based.
3. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim.

4.05. LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

A Participant may not start a lawsuit to obtain benefits until after the Participant has requested a review and a final decision has been reached on review, or until the appropriate time frames described in the applicable Benefit Document. If the Benefit Document does not describe time frames or includes time frames that do not satisfy the minimum time frames of ERISA, then the timeframes described in Plan Sections 4.02, 4.03, and 4.04, as applicable, must have elapsed since the Participant filed a request for review and the Participant has not received a final decision or notice that an extension will be necessary to reach a final decision. The Participant may pursue a remedy under ERISA section 502(a) without exhausting the Plan's appeal procedures if the Plan has failed to follow them. No civil suit may be filed later than one year after 1) the end of the year in which medical reimbursements were provided, or 2) the Plan rendered its final determination

regarding eligibility. All lawsuits must be filed in a federal court where the Plan is administered. For this purpose, a Plan is considered administered at the plan sponsor's business address.

SECTION FIVE: MISCELLANEOUS

5.01. DEFINITIONS

Subject to modification in the Adoption Agreement, words and phrases used in the Plan with initial capital letters will have the meanings set forth in the portion of the Plan entitled "Definitions" unless the context indicates that other meanings are intended.

5.02. EXCLUSIVE BENEFIT

The Plan has been established for the exclusive benefit of Participants, Eligible Dependents, and Beneficiaries and, except as otherwise provided herein, all Contributions under the Plan may be used only for such purpose.

5.03. PLAN INTERPRETATION

All provisions of this Plan shall be interpreted and applied in a uniform and nondiscriminatory manner. This Plan shall be read in its entirety and not severed except as provided in Plan Section 5.17.

5.04. POWERS AND DUTIES OF THE PLAN ADMINISTRATOR

A. Powers of the Plan Administrator – The Plan Administrator, under its sole and absolute discretion, shall have the exclusive right, power, and authority to control and manage the operation and administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator shall have the sole and absolute discretionary authority and power to

1. establish such uniform and nondiscriminatory rules and procedures that it deems necessary to carry out the terms of the Plan;
2. correct any defect, supply any omission, or reconcile any inconsistency in such manner and to such extent as will be deemed necessary or advisable to carry out the purpose of the Plan;
3. formulate, interpret, and apply rules, regulations, and policies necessary to administer the Plan in accordance with its terms;
4. determine questions, including legal or factual questions, relating to the payment of benefits under the Plan;
5. resolve and/or clarify any ambiguities, inconsistencies, and omissions arising under the Plan; and
6. appoint several individuals or entities to assist in the administration of the Plan and allocate the duties of the Plan Administrator among those appointed.

Benefits under the Plan will be paid or provided only if the Plan Administrator decides in its sole and absolute discretion that the Participant or Eligible Dependent is eligible to receive them.

All determinations made by the Plan Administrator with respect to any matter arising under the Plan shall be final and binding on all parties and may not be overturned unless found by a court to be arbitrary and capricious.

B. Duties of the Plan Administrator – The Plan Administrator shall be charged with the duties of the general administration of the Plan. Without limiting the generality of the foregoing, the Plan Administrator will

1. administer the Plan for the exclusive benefit of the Participants and Eligible Dependents in accordance with the specific terms of the Plan;
2. determine all questions of interpretation or policy in a manner consistent with the Plan's documents;
3. determine all questions relating to the eligibility of Employees to become or remain Participants under the Plan;
4. maintain all records necessary for the administration of the Plan;
5. prepare and file such disclosures and tax forms as may be required from time to time by the Secretary of Labor or the Secretary of the Treasury;
6. furnish each Employee, Participant, or Eligible Dependent such notices, information, and reports under such circumstances as may be required by law; and
7. periodically review the performance of each Fiduciary and all other relevant parties to ensure such individuals' obligations under the Plan are performed in a manner that is acceptable under the Plan and applicable law.

C. Nondiscrimination and Consistency Required – Any procedure, discretionary act, interpretation or construction taken by the Plan Administrator shall be done in a uniform and nondiscriminatory manner and shall be consistent with the intent that the Plan shall continue to comply with the Code.

5.05. PLAN AMENDMENTS

A. General – The Adopting Employer, at any time and from time to time, may amend or restate any or all of the Plan provisions without the consent of any Participant, including deleting, adding or modifying the terms of any Plan Component.

B. Unilateral Authority – By adopting the Plan, the Adopting Employer retains the exclusive power and the duty to amend the Plan without any further action or consent of other Related Employers. Specifically, it is understood that amendments may be made unilaterally by the Adopting Employer.

C. Permitted Amendments – The Adopting Employer may amend the Plan to 1) change options previously selected in the Adoption Agreement, 2) amend administrative Plan provisions provided the amended provisions are not in conflict with any other Plan provisions, and 3) make amendments that are related to a change in legal requirements.

D. Administrative Requirements – An Adopting Employer that wishes to amend the Plan shall document the amendment in writing, executed by a duly authorized officer of the Adopting Employer. If the amendment is in the form of a restated Adoption Agreement, the amendment will become effective on the date provided in the Adoption Agreement. Any other amendment will become effective as described therein upon execution by the Adopting Employer.

5.06. PERMANENCY

The Employer expects to continue this Plan indefinitely, but such continuance is not a contractual obligation. Neither the Adoption Agreement nor the Plan nor any amendment or modification thereof nor the paying of Employer Contributions hereunder will be construed as giving any Participant, or Eligible Dependent or any other person any legal or equitable right against the Employer, any Fiduciary, the Trustee (or Custodian, if applicable), or the Plan Administrator except as specifically provided herein, or as provided by law.

5.07. PLAN TERMINATION

The Adopting Employer is establishing this Plan with the intent that it will be maintained for an indefinite period of time. Notwithstanding the foregoing, the Adopting Employer (or its successor) reserves the right to terminate the Plan, in whole or in part, at any time by appropriate action of its managing body or a duly authorized officer. Such termination will be effective on the date specified by the Adopting Employer (or its successor). In the event the Plan is terminated, no further reimbursements shall be made except those Claims that were incurred prior to the date of termination.

5.08. CONTINUANCE OF PLAN BY SUCCESSOR EMPLOYER

Notwithstanding the preceding, a successor of the Adopting Employer may continue the Plan and be substituted in the place of the present Adopting Employer. The successor and the present Adopting Employer (or, if deceased, the executor of the estate of a deceased self-employed individual who was the Adopting Employer) must execute a written instrument authorizing such substitution, and the successor shall amend the Plan in accordance with Plan Section 5.05.

5.09. ACTION BY THE EMPLOYER

Whenever the Employer under the terms of the Plan is permitted or required to do or perform any act or matter or thing, it shall be done and performed by a person duly authorized by its legally constituted authority.

5.10. RIGHT TO RECOVER OVERPAYMENT

Payments are made in accordance with the provisions of the Plan and the applicable Benefit Document. If it is determined that payment was made for an ineligible charge or that other insurance was considered primary, the Plan Administrator, on behalf of the Plan, has the right to recover the overpayment. The Plan Administrator or a representative of the Insurer or TPA, on behalf of the Plan, will attempt to collect the overpayment from the party to whom the payment was made. However, the Plan Administrator, on behalf of the Plan, reserves the right to seek overpayment from any Participant, Eligible Dependent, Qualified Beneficiary, or Beneficiary. Failure to comply with this request will entitle the Plan Administrator to withhold benefits due to a Participant, Eligible Dependent, Qualified Beneficiary, or Beneficiary or the Employer to withhold wages from a Participant. In addition, the Plan Administrator has the right to engage an outside collection agency to recover overpayments on the Plan's behalf if the Plan Administrator's collection effort is not successful.

The Benefit Documents may contain information regarding the Plan Administrator's right to subrogate or seek reimbursement of erroneously paid benefits, including payments in excess of the amount appropriately payable, if applicable, to the Plan Component.

5.11. INDEMNIFICATION

To the fullest extent authorized by law, and to the extent not otherwise covered by insurance, the Plan Administrator, officers, and Employees of the Adopting Employer who provide services to the Plan shall be indemnified by the Adopting Employer against any and all liabilities arising by reason of any act, or failure to act, in relation to the Plan including without limitation, expenses reasonably incurred in the defense of any claim relating to the Plan, and amounts paid in compromise or settlement relating to the Plan, unless 1) it is established by a final judgment or a court of competent jurisdiction that such act or failure to act constituted gross negligence or willful misconduct, or 2) in the event of a settlement or other disposition of the claim, it is determined in a written opinion of legal counsel to the Plan that the act constituted gross negligence or willful misconduct.

5.12. NO EMPLOYMENT CONTRACT

This Plan shall not be deemed to constitute an employment contract between the Employer and any Participant or to be a consideration or an inducement for the employment of any Participant or Employee. Nothing contained in this Plan shall be deemed to give any Participant or Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Participant or Employee at any time regardless of the effect that such discharge shall have upon him as a Participant of this Plan.

5.13. EXAMINATION OF RECORDS

The Plan Administrator shall make available to each Participant and any other Employee of the Employer such records that are under the control of the Plan Administrator that pertain to their interest under the Plan for examination at reasonable times during normal business hours.

5.14. NO GUARANTEE OF TAX CONSEQUENCES

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

If a benefit paid under the Plan constitutes gross income for the Participant and is subject to tax liability, the Participant shall not have recourse of any type against the Employer, the Plan Administrator, or Fiduciaries with respect to such tax liability or any expense incurred by the Participant to cover such tax liability.

5.15. HEADINGS

The headings of the Plan have been inserted for convenience of reference only and are to be ignored in any construction of the provisions hereof.

5.16. GENDER AND NUMBER

Wherever any words are used herein in the masculine, feminine or neutral gender, they shall be construed as though they were also used in another gender in all cases where they would so apply, and whenever any words are used herein in the singular or plural form, they shall be construed as though they were also used in the other form in all cases where they would so apply.

5.17. SEVERABILITY

If any clause or Section of the Plan or a Benefit Document is held invalid or unenforceable, such holding will not affect the validity and enforceability of the remaining clauses or Sections of the Plan or Benefit Document. The Plan and the Benefit Document will be interpreted and enforced as if it did not contain the invalid or unenforceable clause.

5.18. GOVERNING LAW

A. **General** – This Plan shall be construed and enforced according to the Code, ERISA, other federal laws and the laws of the state or commonwealth in which the Adopting Employer's principal office is located, other than its laws respecting choice of law, to the extent not preempted by the Code, ERISA, or any other federal law.

B. **Parallel Applicability** – References in the Plan to ERISA shall be deemed to also be references to the corresponding sections of the Code or the PHSA, and vice versa, when applicable.

C. **Conflicting Documents** – If the terms of this Plan document conflict with the terms of the Plan-related Benefit Documents, the terms of the Plan-related Benefit Documents will control, unless superseded by applicable law. If there is a conflict between the Benefit Documents and this Plan document with respect to the legal compliance requirements of ERISA and any other federal law, this Plan document will control, unless superseded by applicable law.

D. **Health Care Plan Components** – In addition to the general terms of the Plan, the following mandates apply to the Health Care Plan Components, if applicable:

1. ACA – It is the intent of the Plan that its Health Care Plan Components will comply, to the extent applicable, with the requirements of ACA.

2. Americans with Disabilities Act (ADA) – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Americans with Disabilities Act (ADA) as amended from time to time.

3. Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) – Notwithstanding anything in the Plan to the contrary, to the extent required by Code section 4980B and Treasury Regulations thereunder a Qualified Beneficiary who would lose coverage under the Plan upon the occurrence of a Qualifying Event (as defined in Code section 4980B-3 and parallel ERISA and PHSA sections) shall be permitted to continue coverage under the Plan by electing to pay the applicable cost of coverage, in accordance with procedures established by the Plan Administrator that are consistent with COBRA. The Adopting Employer shall notify each Participant and their Dependents of their rights under COBRA in accordance with applicable law or regulation. If the Employer is a small employer, as defined under COBRA and regulations thereunder, the provision of the preceding paragraph will not apply to the Plan. Notwithstanding the foregoing, COBRA continuation coverage cost will not include unused amounts carried over from the prior year.

4. Extended Coverage Under State Laws – To the extent that the Plan is required under state law to provide extended coverage similar to COBRA, the Plan will comply with the applicable extended coverage requirements. If extended coverage is required under state law, affected individuals, coverage, and duration of extended coverage will be determined by the applicable state law.

5. Family and Medical Leave Act (FMLA) – If the Employer is subject to FMLA, a Participant who is on an approved leave of absence under FMLA will be allowed to maintain coverage under a Health Care Plan Component on the same basis as coverage would have been provided if the Participant had been continuously employed during the entire leave period. Extended coverage of a Health Care Plan Component under FMLA will be provided to the extent required by and in accordance with FMLA and applicable regulations.

6. Genetic Information Nondiscrimination Act (GINA) – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information Nondiscrimination Act as amended from time to time.

7. Health Insurance Portability and Accountability Act (HIPAA) – Notwithstanding anything in this Plan to the contrary, this Plan shall be operated in accordance with HIPAA and the corresponding regulations as amended from time to time.

8. Mental Health Parity and Addiction Equity Act – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Mental Health Parity and Addiction Equity Act and ERISA section 712 as amended from time to time.

9. Michelle's Law – Notwithstanding anything in the Plan to the contrary, the Plan will comply with Michelle's Law, Public Law No. 110-381 (2008) as amended from time to time.

10. Newborns' and Mothers' Health Protection Act (NMHPA) – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Newborns' and Mothers' Health Protection Act as amended from time to time.

11. Title VII of the Civil Rights Act of 1964 – Notwithstanding anything in the Plan to the contrary, the Plan will comply with Title VII of the Civil Rights Act of 1964 as amended from time to time.

12. Uniformed Services Employment and Reemployment Rights Act (USERRA) – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) as amended from time to time.

13. Women's Health and Cancer Rights Act – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Women's Health and Cancer Rights Act of 1998 as amended from time to time.

14. Consolidated Appropriations Act 2021 – Notwithstanding anything in the Plan to the contrary, the Plan will comply with the Consolidated Appropriations Act of 2021 (CAA) as amended from time to time.

5.19. PRIVACY AND SECURITY

A. General – Except for a Health Care Plan Component that is self-administered and has fewer than 50 Participants, the Plan Component will be operated in accordance with HIPAA and the corresponding regulations, as amended from time to time.

B. HIPAA Privacy Standards

1. The authorized representative of the Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this Plan Section 5.19(B) are met.

2. Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment functions and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set forth in the Privacy Standards, but the term "payment" generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. If the persons to whom information is disclosed violate this Plan Section 5.19(B), or applicable law or regulation, the Plan shall cease disclosing such information.

3. The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform their duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the Employer's control. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

4. Authorized members of the Employer's workforce who receive Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform their duties with respect to the Plan.

5. In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section 5.19 and the HIPAA Privacy Rule, the incident shall be reported to the Plan's Privacy Officer. In addition, the Privacy Officer and the Employer must take the following steps:

    a. The Privacy Officer must

        i. investigate 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;

        ii. make 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;

        iii. mitigate any harm caused by the breach, to the extent practicable; and

        iv. document the incident and all actions taken to resolve the issue and mitigate any damages.

    b. The Employer must provide certification to an authorized representative of the Plan that it agrees to

        i. not use or further disclose the information other than as permitted or required by the Plan or as required by law;

        ii. ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

        iii. not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

iv. report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section 5.19 or required by law;

v. make available Protected Health Information to individual Plan members in accordance with HIPAA Privacy Rule section 164.524;

vi. make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with HIPAA Privacy Rule section 164.526;

vii. make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members in accordance with HIPAA Privacy Rule section 164.528;

viii. make its internal practices, books, and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule;

ix. return or destroy (if feasible) all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

x. ensure the adequate separation between the Plan and members of the Employer's workforce, as required by HIPAA Privacy Rule section 164.504(f)(2)(iii).

6. Failure to comply with the terms of this Plan Section 5.19(B) shall be resolved by persons entitled to use or disclose Protected Health Information in a timely manner.

C. HIPAA Electronic Security Standards.

If this Plan is subject to the Security Standards for the Protection of Electronic Protected Health Information (HIPAA Privacy Rule Parts 160, 162, and 164, the "Security Standards"), then this Plan Section 5.19(C) shall apply as follows:

1. The Employer agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of Electronic Protected Health Information that the Employer creates, maintains, or transmits on the Plan's behalf. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

2. The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

3. The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements described in this Plan Section 5.19(C).

4. The Employer will report to the Plan any security incident under the Security Standards of which it becomes aware.

5. The Employer will establish reasonable and appropriate security measures to ensure adequate separation between the Plan and the Employer, in support of the requirements described in this Plan Section 5.19(C).

5.20. Procedures and Other Matters Regarding Qualified Medical Child Support Orders

Any Alternate Recipient under a QMCSO shall become enrolled in the Plan Component affected by such QMCSO in accordance with the terms of the QMCSO and the Plan Component.

A. Receipt of a Medical Child Support Order – When the Plan Administrator receives a medical child support order pertaining to the Health Care Plan Component of the Plan, the Plan Administrator shall

1. notify the Eligible Employee and each Alternate Recipient named in the medical child support order that a medical child support order has been received by the Plan and provide a copy of these procedures to the Eligible Employee and each Alternate Recipient; and

2. review the medical child support order and enter a determination that it is a QMCSO if it

a. creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which an Eligible Employee is eligible under the Plan or recognizes the existence of an Alternate Recipient's right to receive benefits for which the Eligible Employee is eligible under the Plan;

b. contains the name and the last known mailing address (if any) of the Eligible Employee and the name and mailing address of each Alternate Recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or a political subdivision thereof may be substituted for the mailing address of any such Alternate Recipient;

c. contains the name of the Plan subject to the order;

d. provides a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

e. indicates the period to which such order applies; and

f. does not require the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act as amended from time to time.

B. Determination of QMCSO – If the Plan Administrator determines that the medical child support order constitutes a QMCSO, then the Plan shall provide the Eligible Employee and the Alternate Recipient a written notification informing them of the coverage determination. The Plan shall initiate coverage of the Alternate Recipient in accordance with the order. If, as a condition for covering the Alternate Recipient, the Eligible Employee must be enrolled in the Health Care Plan Component, the Plan will enroll both the Eligible Employee and the Alternate Recipient. The Eligible Employee will be responsible for the cost associated with the provisions of coverage under the QMCSO. If the Plan Administrator determines that the order does not constitute a QMCSO, then the Plan shall provide the Eligible Employee and the Alternate Recipient a written notification informing them of the negative coverage determination.

C. Appeal – The Alternate Recipient may appeal a negative coverage determination entered by the Plan Administrator in relation to a medical child support order. The appeal must be filed with the Plan Administrator within 180 days after the negative coverage determination is entered by the Plan Administrator. The Claims appeal process of the Claims procedures applicable to the Health Care Plan Component shall apply and will be binding upon all parties involved.

5.21. SUBROGATION

If the applicable Benefit Document does not include subrogation clauses, then the following Section 5.21 will apply.

The Plan Administrator may reduce or deny benefits under a Health Care Plan Component otherwise paid by the Plan and recover or subrogate 100 percent of such benefits paid by the Plan for a Participant or Eligible Dependent in the following situations: 1) any judgment, settlement, or payment made or to be made because of an accident or malpractice, including but not limited to other insurance; 2) any automobile or recreational vehicle insurance coverage or benefits, including but not limited to uninsured or underinsured motorist coverage; 3) any business medical and/or liability insurance coverage or payments; and 4) any attorneys' fees. The right to reimbursement applies when the Plan pays benefits and a judgment, payment, or settlement is made on behalf of the Participant or Eligible Dependent for whom benefits were paid. Reimbursement to the Plan of 100 percent of these charges shall be made at the time any such payment is received by a Participant or Eligible Dependent, their representative, or any other entity. The right to reduction, reimbursement, and subrogation is based on the terms of the Plan in effect at the time of judgment, payment, or settlement.

The Plan has first priority with respect to its right to reduction, reimbursement, and subrogation. The Plan has the right to recover interest on the amount paid by the Plan. The Plan has the right to 100 percent reimbursement in a lump sum. The Plan is not subject to any state laws or equitable doctrines, including, but not limited to, the common fund doctrine, which could otherwise require the Plan to reduce its recovery by any portion of a Participant's or Eligible Dependent's attorneys' fees or costs. The Plan is not responsible for the Participant's or Eligible Dependent's attorneys' fees, expenses, or costs. The Plan's right applies regardless of whether any payments to a Participant or Eligible Dependent are designated as payment for, but not limited to, 1) pain and suffering, or 2) medical benefits. This applies regardless of whether a Participant or Eligible Dependent has been fully compensated for injuries. The Plan's right to reduction, reimbursement, and subrogation applies to any funds recovered from another party, by or on behalf of the estate of any Participant or Eligible Dependent. The Plan's first priority right shall not be reduced due to the negligence of the Participant or Eligible Dependent.

A Participant and Eligible Dependent, and their representative, must cooperate in efforts to obtain reimbursement to the Plan from third parties. In the event that a Participant or Eligible Dependent is entitled to sue and recover payments from any third party, other than the Plan or an Insurer, to pay for or cover benefits already provided under the terms of the Plan, but decides not to pursue such Claims, the Plan is fully subrogated to pursue such Claims without the authorization of the Participant or Eligible Dependent. Any amounts recovered by the Plan under its subrogation rights will be limited to benefits already provided under the terms of the Plan and related legal costs.

The Participant and Eligible Dependent are required to fully cooperate, as it may be required by the Plan, in the pursuit of such Claims, including but not limited to

A. filling subrogation forms and authorization as required by the Plan;

B. not signing settlement agreements with the third parties involved without the express authorization of the Plan;

C. pursuing, at their own expense, Claims against third parties as required by the Plan;

D. meeting with the Plan and its attorney as required by the Plan;

E. being available as witnesses;

F. providing evidence and other information as needed;

G. appearing in administrative, mediation, arbitration, or court hearings; and

H. signing documents as required by the Plan.

If a Participant or Eligible Dependent refuses to cooperate with the Plan as required under this Plan Section 5.21, the Plan may offset the amounts that could have been recovered, as determined by the Plan under its sole discretion, from future benefits, payments, services, or credits due or paid under the Plan to a Participant or Eligible Dependent. A Participant, Eligible Dependent, and/or their representative may not do anything to hinder reimbursement of overpayment to the Plan after benefits have been accepted by a Participant, Eligible Dependent, and/or their representative.

The Plan may also intervene in any administrative, mediation, arbitration, or court hearings held under Claims already filed by the Participant, Eligible Dependent, or their representative.

Participants and Eligible Dependents will not be entitled to be made whole before the Plan can exercise its overpayments, recovery, or subrogation rights. The "made whole" doctrine will not apply to any overpayment, recovery, or subrogation and any benefits paid by the Plan can be recovered from any amount the Participant or Eligible Dependent recovers from a third party.

5.22. NONALIENATION OF BENEFITS

No benefit, right, or interest of any Participant, Eligible Dependent, or Beneficiary under a Plan Component shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, including any liability for, or subject to, the debts, liabilities, or other obligations of such person. Any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge, garnish, execute, levy upon, or otherwise dispose of any right to benefits payable hereunder or legal causes of action shall be void. Notwithstanding the foregoing, the Plan may choose to remit payments directly to health care providers with respect to covered services, if authorized by Participants or Eligible Dependents, but only as a convenience to Participants and Eligible Dependents. Health care providers are not, and shall not be construed as, either "Participant" or "Beneficiary" under the Plan and have no right to receive benefits from the Plan or to pursue legal causes of action on behalf of (or in place of) Participants or Eligible Dependents under any circumstances.

5.23. RESPONSIBILITIES OF PARTICIPANT AND BENEFICIARIES

Each Participant and Beneficiary shall be responsible for providing the Plan Administrator, Employer, Insurer, and/or TPA, as applicable, with the Participant's or Beneficiary's current address. In the event that a Participant or Beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made 1) because the current address according to the Employer's records is incorrect, 2) because the Participant or Beneficiary fails to respond to the notice sent to the current address according to the Employer's records, 3) because of conflicting Claims to such payments, or 4) because of any other reason, the amount of such payment, if and when made, shall be determined under the provisions of the Plan without payment of any interest or earnings. If, after reasonable efforts, the Plan Administrator is unable to locate any Participant or Beneficiary whose benefits under the Plan have become distributable, such benefits may be forfeited in accordance with the terms of the Plan. If the Participant or Beneficiary subsequently applies for benefits, the amount so forfeited will be paid to the Participant or Beneficiary. Notwithstanding the foregoing, with respect to any benefit or arrangement that is underwritten by insurance, the terms of the Insurance Policy shall control to the extent such terms are inconsistent with this Plan Section 5.23.

SECTION SIX: ADOPTING EMPLOYER SIGNATURE

Adoption Agreement must contain the signature of an authorized representative of the Adopting Employer evidencing the Employer's agreement to be bound by the terms of the Plan Document and Adoption Agreement.

Welfare Benefit Plan

Adoption Agreement

WRAP Plan

California Automotive Retailing Group
Health and Welfare Plan

California Automotive Retailing Group Health and Welfare Plan
Adoption Agreement

EMPLOYER INFORMATION

Adopting Employer

Name of Adopting Employer:	California Automotive Retailing Group, Inc. dba Saturn of Concord/Pleasanton
Address:	4200 Johns Monego Court Dublin, CA 94568
Telephone:	925-876-7493
Adopting Employer's Federal Tax Identification Number:	71-0923180
Type of Business:	Private Sector

PLAN INFORMATION

Amended and Restated Plan

Name of the Plan:	California Automotive Retailing Group Health and Welfare Plan
Plan Number:	501
Plan Year:	January 1 through December 31 of the same calendar year.
The Plan originally took effect on:	July 1, 2003.
The Effective Date of this Plan is:	January 1, 2025.

ELIGIBILITY

Part A. Coverage of Dependents
Will any of the Plan Components cover Dependents?

- Yes.

Part B. Coverage of Domestic Partners
Will any of the Plan Components cover Domestic Partners?

- Yes.

NOTE: *Notwithstanding the elections made above, if the underlying Plan Component does not extend coverage to Dependents or Domestic Partners, the terms of the underlying Plan Component Document will apply.*

PLAN COMPONENTS OFFERED AND FUNDING METHODS

See the INSURERS AND PROVIDERS OF PLAN COMPONENTS ATTACHMENT to this Adoption Agreement for the list of Plan Components offered and funding methods.

EMPLOYER SIGNATURE

The following attachment applies to this Plan and is attached to this Adoption Agreement:

- Insurers and Providers of Plan Components Attachment.

Authorized Adopting Employer Signature

I am an authorized representative of the Adopting Employer named above and I state the following:

1. **I understand that the purpose of this Plan Document is to comply with ERISA;**
2. **I acknowledge that I have relied upon my own legal and tax advisors regarding the completion of this Adoption Agreement and any related attachments; and**
3. **I have received a copy of this Adoption Agreement and the corresponding Plan Document.**

Signature of Adopting Employer _____ Date Signed _____

Type Name _____ Title _____

INSURERS AND PROVIDERS OF PLAN COMPONENTS ATTACHMENT

INSURERS AND PROVIDERS

The Component Documents for each of the Plan Components listed below are incorporated by reference herein and are an integral part of the Plan. This list is subject to modification from time to time in accordance with Plan Section 5.05.

The following Plan Components are fully insured with Benefits provided through Insurance Policies:

Fully-Insured Benefits	Policy/Group No.	Type of Benefit
Kaiser Foundation Health Plan, Inc. 1 Kaiser Plaza Oakland, CA 94612	600529	Medical – HMO Medical – HDHP
Sun Life & Health Insurance Company 96 Worcester Street Wellesley Hills, MA 02481	963781	Dental – DHMO Dental – PPO
		Vision
		Basic Life/AD&D (with EAP)
Sutter Health Plus 2480 Natomas Park Drive Suite 150 Sacramento, CA 95833	506332	Medical – HMO Medical – HDHP
UnitedHealthcare Insurance Company 185 Asylum Street Hartford, CT 06103-3408	05V2298	Medical

The following Plan Component is self-insured with the Benefit paid through the general assets of the Employer:

Self-Insured Benefits	Contract No.	Type of Benefit
Navia Benefit Solutions 600 Naches Avenue South West Renton, WA 98057	AUG	Health Reimbursement Arrangement (HRA)