Hansel Auto Group
Employee Benefit Plan

Summary Plan Description Wrap Document

Adopted In

2023

This document together with the applicable insurance contracts, carrier plan documents and certificate insurance booklets which are incorporated herein by reference, constitute the Summary Plan Description/written plan document for the Hansel Auto Group Employer Employee Benefit Plan.

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INTRODUCTION

This document (the Summary Plan Description (SPD) Wrap Document) constitutes the governing plan document and SPD for Hansel Auto Group Employee Benefit Plan and presents information about all the health and welfare benefit plans maintained by Hansel Auto Group (Employer), and your rights and benefits as a Plan Participant. Please refer to the "Subsidiary Contracts" (i.e., applicable certificate of coverage, subscriber agreement, or evidence of coverage booklet, which are incorporated herein by reference as described below) for more details on specific items such as benefit coverage, definitions, coordination of benefits, claims procedures and exclusions and limitations.

The actual terms and conditions of the Subsidiary Contracts offered under this Plan are contained in separate, written documents governing each respective benefit. In the event of a conflict between this SPD and a Subsidiary Contract, the terms of the Subsidiary Contract shall govern. Each separate Subsidiary Contract, as amended or subsequently replaced, is hereby incorporated by reference as if fully recited herein.

This Wrap Document and the incorporated Subsidiary Contracts have been prepared for Plan Participants, and together constitute the Summary Plan Description for your Welfare Benefit Plan. This is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974.

Please read this SPD carefully and keep it along with your other benefit plan information for future reference.

This Wrap Document contains a summary in English of your rights and benefits under the Hansel Auto Group Employee Benefit Plan. If you have difficulty understanding any part of this Wrap Document, contact the Plan Administrator for assistance.

GENERAL TERMS AND CONDITIONS

This Welfare Benefit Plan is established for the purpose of providing the employee welfare benefits listed herein for the benefit of eligible Employees and Dependents. This Plan document, together with the Adoption Agreement and Governing Documents described herein constitutes the written plan document required by ERISA § 402(a), and is an employee Welfare Benefit Plan (within the meaning of ERISA § 3(l)). The Plan, also provides benefits in accordance with the applicable requirements of federal laws such as, Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Newborns' and Mothers' Health Protection Act (NMHPA), Mental Health Parity Act (MHPA), and the Women's Health and Cancer Rights Act (WHCRA) and the Genetic Information Non-Discrimination Act (GINA).

In addition, some of the Welfare Programs are offered on a pre-tax basis through the Section 125 Plan in accordance with the Internal Revenue Code.

PLAN INFORMATION

The name of the Medical Carrier that insures benefits under the Plan is:

Anthem Blue Cross Life & Health Insurance Co. PPO

Benefit Program Plan Name:	**Anthem - PPO**
Plan Year	January 01 through December 31
Benefit Funding Type:	Fully Insured
Policy Number:	278051
Insurance Carrier Address:	21555 Oxnard St. Woodland Hills, CA 91365
Insurance Carrier Phone:	800-388-1116
Insurance Carrier URL:	http://www.anthem.com
Dental is Included in this Plan	No
Vision is included in this Plan	No
Pharmaceutical is included in this Plan	Yes
Eligible Employee:	Employees working at least 30 hours per week
Excluded Classes:	Part Time
Benefit Waiting Period:	1st of Month following 60 Days
Eligible Dependents:	Spouse or Domestic Partner and Dependents up to the age of 26
Employee Coverage Only Contributions:	Yes - Employee and Employer contribute
Employee and Spouse (or Domestic Partner) Coverage Contributions:	Yes - Employee and Employer contribute
Employee and Dependents Contributions:	Yes - Employee and Employer contribute
Employee and Family Contributions:	Yes - Employee and Employer contribute
If Employee contributes to premium, is that contribution collected Pre-Tax	Yes
Grandfathered:	No

The name of the Medical Carrier that insures benefits under the Plan is:

Kaiser Foundation Health Plan

Benefit Program Plan Name:	**Kaiser - HMO**
Plan Year	January 01 through December 31
Benefit Funding Type:	Fully Insured
Policy Number:	603905
Insurance Carrier Address:	P.O. Box 12923 Oakland, CA 94604
Insurance Carrier Phone:	800-390-3510
Insurance Carrier URL:	http://www.kp.org
Dental is Included in this Plan	No
Vision is included in this Plan	No
Pharmaceutical is included in this Plan	Yes
Eligible Employee:	Employees working at least 30 hours per week
Excluded Classes:	Part Time
Benefit Waiting Period:	1st of Month following 60 Days
Eligible Dependents:	Spouse or Domestic Partner and Dependents up to the age of 26
Employee Coverage Only Contributions:	Yes - Employee and Employer contribute
Employee and Spouse (or Domestic Partner) Coverage Contributions:	Yes - Employee and Employer contribute
Employee and Dependents Contributions:	Yes - Employee and Employer contribute
Employee and Family Contributions:	Yes - Employee and Employer contribute
If Employee contributes to premium, is that contribution collected Pre-Tax	Yes
Grandfathered:	No

The name of the Dental Carrier that insures benefits under the Plan is:

Anthem Blue Cross Life & Health Insurance Co.

Benefit Program Plan Name:	**Anthem - DPPO**
Plan Year	January 01 through December 31
Benefit Funding Type:	Fully Insured
Policy Number:	278051
Insurance Carrier Address:	P.O. Box 1115 Minneapolis, MN 55440
Insurance Carrier Phone:	877-567-1804
Insurance Carrier URL:	http://www.anthem.com/ca
Eligible Employee:	Employees working at least 30 hours per week
Excluded Classes:	Part Time
Benefit Waiting Period:	1st of Month following 60 Days
Eligible Dependents:	Spouse or Domestic Partner and Dependents up to the age of 26
Employee Coverage Only Contributions:	Yes - Employee and Employer contribute
Employee and Spouse (or Domestic Partner) Coverage Contributions:	Yes - Employee and Employer contribute
Employee and Dependents Contributions:	Yes - Employee and Employer contribute
Employee and Family Contributions:	Yes - Employee and Employer contribute
If Employee contributes to premium, is that contribution collected Pre-Tax	Yes

The name of the Vision Carrier that insures benefits under the Plan is:

Anthem - Blue View Vision

Benefit Program Plan Name:	**Anthem - Vision**
Plan Year	January 01 through December 31
Benefit Funding Type:	Fully Insured
Policy Number:	278051
Insurance Carrier Address:	P.O. Box 8504 Mason, OH 45040
Insurance Carrier Phone:	866-723-0515
Insurance Carrier URL:	http://www.anthem.com
Eligible Employee:	Employees working at least 30 hours per week
Excluded Classes:	Part Time
Benefit Waiting Period:	1st of Month following 60 Days
Eligible Dependents:	Spouse or Domestic Partner and Dependents up to the age of 26
Employee Coverage Only Contributions:	Yes - Employee and Employer contribute
Employee and Spouse (or Domestic Partner) Coverage Contributions:	Yes - Employee and Employer contribute
Employee and Dependents Contributions:	Yes - Employee and Employer contribute
Employee and Family Contributions:	Yes - Employee and Employer contribute
If Employee contributes to premium, is that contribution collected Pre-Tax	Yes

The name of the Group Life Carrier that insures benefits under the Plan is:

Anthem Blue Cross Life & Health Insurance Co.

Benefit Program Plan Name:	**Anthem - Life and AD&D with travel accident**
Plan Year	January 01 through December 31
Benefit Funding Type:	Fully Insured
Policy Number:	278051
Insurance Carrier Address:	Life Claims Service Center, P.O Box 724767 Atlanta, GA 31139
Insurance Carrier Phone:	888-231-5032
Insurance Carrier URL:	http://www.anthem.com/ca
Eligible Employee:	Employees working at least 30 hours per week
Excluded Classes:	Part Time
Benefit Waiting Period:	1st of Month following 60 Days
Eligible Dependents:	No Other Eligible Individuals
Employee Coverage Only Contributions:	Yes - Employer only contributes
Employee and Spouse (or Domestic Partner) Coverage Contributions:	Yes - Employer only contributes
Employee and Dependents Contributions:	Yes - Employer only contributes
Employee and Family Contributions:	No
If Employee contributes to premium, is that contribution collected Pre-Tax	No

The name of the Group EAP Carrier that insures benefits under the Plan is:

Managed Health Network

Benefit Program Plan Name:	**Employee Assistance Plan**
Plan Year	January 01 through December 31
Benefit Funding Type:	Fully Insured
Policy Number:	1190
Insurance Carrier Address:	503 Canal Blvd. Point Richmond, California 94804
Insurance Carrier Phone:	510-620-6339
Insurance Carrier URL:	https://www.mhn.com/members/behavioral-health.html
Eligible Employee:	Employees working at least 30 hours per week
Excluded Classes:	Part Time
Benefit Waiting Period:	1st of Month following 60 Days
Eligible Dependents:	No Other Eligible Individuals
Employee Coverage Only Contributions:	Yes - Employer only contributes
Employee and Spouse (or Domestic Partner) Coverage Contributions:	No
Employee and Dependents Contributions:	No
Employee and Family Contributions:	No
If Employee contributes to premium, is that contribution collected Pre-Tax	No

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for the general administration of the Plan, including the Health Benefit Programs referenced above, and shall be the "Plan Administrator" and "named fiduciary" within the meaning of ERISA under the Plan and the Benefit Programs (except to the extent another person or entity is specifically designated; provided, however, for Fully Insured Benefit Programs, unless specifically provided otherwise in the Governing Documents, the Insurer shall be the "named fiduciary," and claims fiduciary responsible for administering and determining benefits under such Benefit Program, and shall have full authority and discretion to interpret the terms of the Benefit Program for those purposes. With respect to the Plan, including the Welfare Benefit Programs identified in this document, the Plan Administrator shall have, without limitation, the following discretionary authority, duties and powers:

1) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

2) Except to the extent reserved to the Insurer with respect to a Fully Insured Benefit Program, to interpret the provisions of the Plan, make findings of fact, and correct errors in, supply omissions from, and resolve inconsistencies or ambiguities in the language of the Plan, and to decide all claims and appeals arising under the Plan;

3) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

4) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

5) To allocate and delegate its fiduciary and administrative responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing. Without limitation, the Plan Administrator may designate other organizations or persons (who also may be employed by an Employer) to carry out the following:

    a. pursuant to an administrative services or claims administration agreement, the responsibility for administering and managing a Welfare Benefit Program or programs, including the processing and payment of claims under the Welfare Benefit Program and the recordkeeping related thereto;

    b. the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any government agency or to be prepared and disclosed to Employees, Participants or other persons entitled to disclosure under the Benefit Programs; and

    c. the responsibility to review claims or claim denials under the Benefit Programs, including discretionary authority to act as claims fiduciary to determine adverse claims determinations within the meaning of Department of Labor Regulation § 2560.503-1.

Subject to applicable law, any interpretation of the provisions of the Plan and the Welfare Benefit Programs and any decisions on any matter within the discretion of the Plan Administrator made by the Plan Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Plan Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Plan Administrator shall not be liable in any manner for any determination of fact made in good faith.

PLAN CONTACT INFORMATION

Plan Sponsor & Plan Administrator:

The name, address and telephone number of the Plan **Sponsor** is:

Hansel Auto Group
1125 Auto Center Drive
Petaluma, CA 94952
Phone: (707) 769-2333

The name, address and telephone number of the Plan **Administrator** is:

Hansel Auto Group
1125 Auto Center Drive
Petaluma, CA 94952
Phone: (707) 769-2333

Plan Fiduciary:

The name, address and telephone number of the Plan **Fiduciary** is:

Hansel Auto Group
1125 Auto Center Drive
Petaluma, CA 94952
Phone: (707) 769-2333

Agent for Service of Legal Process:

The name and address of the Agent for Service of Legal Process is:

Hansel Auto Group
1125 Auto Center Drive
Petaluma, CA 94952
Phone: (707) 769-2333

Important Disclaimer:

Plan benefits are provided under contracts between the Employer and the carriers. If the terms of this Summary Plan Description document conflict with the terms of the Welfare Program Subsidiary Contract, the terms of the Welfare Program Subsidiary Contract will control, unless superseded by applicable law.

Identification numbers:

The Federal Employer Identification Number of the Plan Sponsor listed above is: 94-2876864

Additional entities covered under the Plan:

Hansel Acura, Hansel BMW, Hansel Collision Center, Hansel Enterprises, Inc., Hansel Ford Lincoln, Hansel Henry Curtis Ford, Hansel Honda, Hansel Mazda, Hansel Prestige, Hansel Subaru, Hansel Toyota, Hansel VW

Plan Number is 501

PLAN AMENDMENT OR TERMINATION

Amendment

The Employer reserves the right to amend any part or all of the Plan or a Welfare Benefit Program at any time or from time to time by written instrument.

Termination

The Employer reserves the right to terminate the Plan or a Welfare Benefit Program at any time by written instrument. The Plan or Welfare Benefit Program, as applied to any single Employer, may be terminated at any time by such Employer, subject to consent of the Employer.

Sources of Plan Contributions

Plan Year – January 1st through December 31st

Plan Contributions - Contributions for coverage may be made solely by the Plan Sponsor, solely by Participants, or by a combination of the Plan Sponsor and Participants.

Employee contributions will be paid through payroll deduction. Eligible plan premiums may be deducted on a Pre-Tax basis (subject to IRS Code § 125 rules). Actual contribution rates will be published during the Employer's open enrollment period in each year.

Carrier documentation and/or your open enrollment guide provide the specific contribution information for each Health Benefit Program.

CLAIMS AND APPEALS

Claims

All claims for benefits under the Plan and any assignment of benefits to a provider shall be made, processed and paid, in accordance with Department of Labor Regulations § 2560.503-1 and other applicable law, and the terms and conditions of the applicable Benefit Program (referenced in the tables above) and the related provisions of the Summary Plan Description for each Benefit Program. The Claims Administrator shall be the claims fiduciary unless this function is delegated to another person or entity under this Section.

No Estoppel of Plan

No person is entitled to any benefit under the Plan except and to the extent expressly provided under the terms and conditions of the applicable Benefit Program. The fact that payments have been made from the Plan in connection with any claim for benefits does not (a) establish the validity of the claim; (b) provide any right to have such benefits continue for any period of time; or (c) prevent the Plan from recovering the benefits paid to the extent that the Claims Administrator determines that there was no right to payment of the benefits under the Plan. Thus, if a benefit is paid and it is thereafter determined that such benefit should not have been paid (whether or not attributable to an error by the Participant or any other person), then the Claims Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any prior overpayment theretofore made to or on behalf of such Participant from any succeeding payments to or on behalf of such Participant under the Plan or from any amounts due or owing to such Participant by the Employer or under any other plan, program, or arrangement benefiting the Employees or former Employees of the Employer, or otherwise recovering such overpayment from whomever has benefited from it.

If the Claims Administrator determines that an underpayment of benefits has been made, then the Claims Administrator shall take such action as it deems necessary or appropriate to remedy such situation.

Claims Procedures

The specific guidelines for filing a claim or a request for a review of a denied claim shall be set out in the Subsidiary Contracts for each Welfare Benefit Program. Such procedures shall comply with the general provisions of this Section and shall be designed to ensure the independence and impartiality of the persons involved in making decisions on such claims. A claimant must follow all internal claims and appeal procedures and, where applicable, all external review procedures before a claimant can file a lawsuit to contest the decision.

For disability claims made on or after April 1, 2018, if a plan participant has been denied a benefit based on an adverse determination of disability and the new procedures established by (DOL Regulation §2560.503-1) are not strictly followed, then the claimant will be deemed to have exhausted administrative remedies and may seek action in court.

Definitions

For purposes of this Section, the following terms shall have the meanings set forth below:

1. “Adverse Benefit Determination” means a total or partial denial of a Claim. For a Non-Grandfathered Plan, a retroactive rescission of coverage due to fraud or misrepresentation shall be treated as an Adverse Benefit Determination.

2. “Appeal” means a claimant’s written request for review of an Adverse Benefit Determination in accordance with the Appeal Section below.

3. “Claim” means any request for a benefit under a Welfare Benefit Program, made by a claimant or representative that complies with the reasonable procedures for making benefit claims under such Benefit Program.

4. “Concurrent Care Claim” means a claim for an ongoing course of treatment to be provided over a period of time or number of treatments. Any reduction or termination by a Benefit Program of the course of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments originally approved is considered an Adverse Benefit Determination.

5. “Final Adverse Benefit Determination” means an Adverse Benefit Determination issued in connection with the last stage of Appeal as set forth in the Appeal Section below.

6. “Non-Grandfathered Plan” means a Welfare Benefit Program that is (1) subject to Title I of the Patient Protection and Affordable Care Act of 2010, as amended, and (2) does not meet the requirements for “grandfathered status” within the meaning of that Act.

7. “Post-Service Claim” means any Claim that is not a Pre-Service Claim, an Urgent Care Claim or a Concurrent Care Claim.

8. “Pre-Service Claim” means any claim for a benefit under a Health Benefit Program that conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

9. “Urgent Care Claim” means a special type of Pre-Service Claim for medical care or treatment with respect to which the time frame for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim. A physician with knowledge of the claimant’s medical condition may determine if a Claim is one involving urgent care. If there is no such physician, an individual acting on behalf of the Health Benefit Program applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

Notice to Claimant of Adverse Benefit Determinations.

Initial Claims

Except with respect to Urgent Care Claims (the notification for which may be oral followed by written or electronic notification within three days of the oral notification), upon its initial determination of a Claim, the Claims Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the claimant:

a. The specific reason or reasons for the adverse determination, including for Non-Grandfathered Plans, the denial code and its corresponding meaning, and a description of the Non-Grandfathered Plan's standard, if any, that was used in denying the Claim.
b. Reference to the specific Welfare Program provisions on which the determination was based.
c. 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.
d. A description of the Welfare Program's appeal procedures, including any voluntary appeal procedures offered by the Welfare Program and for Non-Grandfathered Plans, any external review procedures, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under ERISA Section §502.
e. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge, or a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.
f. If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Benefit Program to the claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request.
g. For Non-Grandfathered Plans, information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the Claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
h. For Non-Grandfathered Plans, information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals procedures and external review process.

Appeals

The Claims Administrator shall also provide written or electronic notice of an Adverse Benefit Determination on Appeal. This notice shall contain the information listed in subsections **Initial Claims** (a) through (h) above, as well as:

1) 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 Claim.
2) In the case of a Final Adverse Benefit Determination for a Non-Grandfathered Plan, a discussion of the decision.

When a claimant receives an Adverse Benefit Determination, the claimant has 180 days following receipt of the notification in which to request a review of the decision, unless a shorter time is permitted by law. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, they will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

a. was relied upon in making the benefit determination;
b. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
c. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Welfare Program documents and Welfare Program provisions have been applied consistently with respect to all claimants; or
d. constituted a statement of policy or guidance with respect to the Welfare Program concerning the denied treatment option or benefit.

For Non-Grandfathered Plans, the Claims Administrator shall provide the claimant any new or additional evidence that is relied upon, considered, or generated by or at the direction of the Non-Grandfathered Plan. This new evidence shall be provided free of charge and must be provided to claimant as soon as possible and sufficiently in advance of the time within which a Final Adverse Benefit Determination is required, to allow the claimant time to respond.

If a Final Adverse Benefit Determination will be based on a new or additional rationale, the claimant must be provided with this rationale as soon as possible and sufficiently in advance of the date on which the Final Adverse Benefit Determination must be provided, in order to give the claimant a reasonable opportunity to respond prior to that date.

The Claims Administrator's review shall 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 Adverse Benefit Determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a

fiduciary of the Welfare Benefit Program who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the Adverse Benefit Determination was based 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 Claims Administrator shall consult with a health care professional who was not involved in the original Adverse Benefit Determination, nor a subordinate of any individual involved in the original Adverse Benefit Determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Health Benefit Program in connection with the initial Adverse Benefit Determination will be identified.

If specifically provided under the Health Benefit Program, a claimant may bring a second appeal, which shall be subject to the terms of this Section.

Voluntary Appeals

If a Welfare Benefit Program provides for a voluntary appeal process, the terms of this section shall apply. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Benefit Program waives any right to assert that a claimant has failed to exhaust administrative remedies because they did not elect to submit a benefit dispute to the voluntary appeal provided by the Benefit Program. A claimant may elect a voluntary appeal after exhaustion of appeals of an Adverse Benefit Determination as explained in the section above, entitled, "Appeals."

The Benefit Program will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Benefit Program; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal.

Time for Responses

Upon receipt of a Claim or an Appeal of an Adverse Benefit Determination, the Claims Administrator (or its delegate) shall make its determination and provide any required notice within the following time periods.

Urgent Care Claims - The Claims Administrator shall decide the claim as soon as feasible, but no later than 72 hours following receipt of the Claim. For Non-Grandfathered Plans, this time should be as soon as possible. If additional information is needed in order to decide the Claim, the Claims Administrator will notify the claimant within 24 hours and the claimant shall have at least 48 hours to provide the required information. The Claims Administrator will notify claimant of its benefit

determination within 48 hours after the earlier of: (i) receipt of the required information, or (ii) the expiration of the period afforded to claimant to provide the information. In the case of an Adverse Benefit Determination, claimant will be provided a description of the expedited claim review process for urgent care claims.

Appeal of an Adverse Benefit Determination shall be decided as soon as feasible, but no later than 72 hours after the Claims Administrator receives the request for review or Appeal.

Pre-Service Claims - A Pre-Service Claim shall be decided within 15 days after the Claims Administrator receives the Claim, although the review period may be extended an additional 15 days if necessary due to circumstances beyond the Claims Administrator's control. The claimant will be notified within the original 15-day period of the reason for the extension and the date the Claims Administrator expects to render its decision.

If the Claimant does not follow a Health Benefit Program's procedures for filing a Pre-Service Claim, the Claims Administrator must notify the claimant within 5 days of the proper procedures for the claimant to complete the claim.

If the Claims Administrator cannot render a decision within 15 days because the claimant has not provided sufficient information to review the claim, the notice of extension must describe the specific information needed to complete the claim. The claimant will be given at least 45 days from receipt of this notice to provide the required information. The Claims Administrator has 15 days after it receives the information to render its decision.

The Claims Administrator will decide an appeal of a denied Pre-Service Claim within 30 days after receiving the request for review; provided, if a Health Benefit Program provides for two levels of appeal, the Claims Administrator shall decide each level of appeal within 15 days.

Concurrent Care Claims - An Adverse Benefit Determination involving Concurrent Care Claim will be made sufficiently in advance of any reduction in or termination of treatment to allow the claimant to appeal the Adverse Benefit Determination. If a course of treatment involves Urgent Care, the claimant's request to extend the course of treatment will be decided as soon as possible, but not later than 24 hours after the Claims Administrator receives the request, provided that the request is made at least 24 hours prior to the expiration of treatment.

Post-Service Claims - A Post-Service Claim shall be decided within 30 days after the Claims Administrator receives the Claim. The Claims Administrator may extend the review period for an additional 15 days if necessary due to circumstances beyond the control of the Claims Administrator. The Claims Administrator will notify the claimant within the original 30-day period of the reason for the extension and the date by which the Claims Administrator expects to render its decision.

If the Claims Administrator cannot render a decision within 30 days because the claimant has not provided sufficient information to determine whether, or to what extent, benefits are covered or payable under the Health Benefit Program, the notice of extension will describe the specific information needed to complete the Claim. The claimant will be given at least 45 days from receipt of the notice to provide the required information. The Claims Administrator has 15 days from the date of receiving such information to render its decision.

An appeal involving a Post-Service Claim shall be decided by the Claims Administrator within 60 days after receiving the request for review; provided, if a Health Benefit Program provides for two levels of appeal, the Claims Administrator shall decide each level of Appeal within 30 days.

External Review Process

For Non-Grandfathered Plans, upon exhaustion of the internal Claims and Appeal procedures, a claimant may request that the Claim be reviewed under the Non-Grandfathered Plan's external review process. The Non-Grandfathered Plan shall comply with the applicable state external review process, if any, and if none, the federal external review process. If the federal external review process applies, the following guidelines shall apply.

The claimant must file their request for external review within 4 months after receipt of the Final Adverse Benefit Determination.

The Claims Administrator will determine whether the Claim is eligible for review under the external review process. This determination is based on whether:

1. The claimant is or was covered under the Non-Grandfathered Plan at the time the Claim was made or incurred;
2. The claimant has exhausted the Non-Grandfathered Plan's internal Claims and Appeal procedures; and
3. The claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Claims Administrator will provide written notification to the claimant of whether the Claim is eligible for external review.

If the request for review is complete but not eligible for external review, the Claims Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll-free number.

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the external review process, the Claims Administrator will assign it to a qualified Independent Review Organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Non-Grandfathered Plan. The Non-Grandfathered Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the external review process will end.

If the Non-Grandfathered Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

1. The claimant's medical records;

2. The attending health care professional's recommendation;
3. Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, claimant, or the claimant's treating provider;
4. The terms of the Non-Grandfathered Plan;
5. Appropriate practice guidelines;
6. Any applicable clinical review criteria developed and used by the Health Benefit Plan; and
7. The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Non-Grandfathered Plan and the claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

1. A general description of the reason for the external review, including information sufficient to identify the Claim;
2. The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
3. References to the evidence or documentation the IRO considered in reaching its decision;
4. A discussion of the principal reason(s) for the IRO's decision;
5. A statement that the determination is binding and that judicial review may be available to the claimant; and
6. Contact information for any applicable office of health insurance consumer assistance or ombudsman established under federal guidelines.

Generally, a claimant must exhaust the Non-Grandfathered Plan's claims and appeal procedures in order to be eligible for the external review process. However, an expedited external review is available if:

1. The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Non-Grandfathered Plan's internal claims and appeal procedures would seriously jeopardize the claimant's life, health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or
2. The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the claimant's life, health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Non-Grandfathered Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Non-Grandfathered Plan.

MISCELLANEOUS RULES

Information to be Furnished by Participants

Participants under the Health Benefit Plan must furnish the Plan Administrator with such evidence, data or information, as the Plan Administrator considers necessary or desirable to administer the Health Benefit Plans. A fraudulent or knowing misstatement or omission of fact made by a participant or dependent in an enrollment form, a Claim for benefits or similar matter may result in cancellation of coverage and/or denial of Claims for benefits.

Records

As a condition of receiving benefits payable under a Benefit Program, a Participant may be required to provide the Plan Administrator with any evidence and records of expenses incurred by such Participant and each of such Participant's Dependents in such form as the Plan Administrator shall from time to time specify.

Rescission

The Health Benefit Plans, as Welfare Benefit Plans, may not rescind a participant's coverage (that is, terminate that coverage retroactively) except in the case of fraud or the individual's intentional misrepresentation of a material fact, as prohibited by the Plan terms. In such cases of fraud or intentional misrepresentation the Plan will rescind coverage by providing a 30-day notice of such action.

The Plan must provide at least 30 days' advance written notice to each participant who would be affected before any coverage may be rescinded.

Separately, the Plan may cancel coverage, even retroactively, if the termination of coverage is due to a failure to pay required premiums or contributions toward the cost of coverage on a timely basis.

Uniform Rules

The Plan Administrator shall administer the Health Benefit Plans and the Benefit Programs on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons in similar situations.

No Vested Interest

No person shall have any right, title or interest in or to any contributions made under the Health Benefit Plans and the Benefit Programs, such contributions being made for the sole purpose of providing benefits under the Benefit Programs in accordance with their terms. Neither the Employer, the Plan Administrator, nor any Insurer shall in any way guarantee the payment of any benefit that may be or become due to any person under the Plan or the Benefit Programs.

Employment Rights

Employment rights of an Employee shall not be deemed to be enlarged or diminished by reason of establishment of, or participation in, the Health Benefit Plans or any Benefit Program, nor shall

establishment of the Plan and the Benefit Programs confer upon any Employee any right to be retained in the service of an Employer.

Cost of Plan and Program Administration

The costs and expenses incurred in the administration of the Plan and the Benefit Programs shall be paid, in the discretion of the Plan Administrator, (i) from assets accumulated under the Plan and the Benefit Programs, if any; (ii) from Employee contributions; or (iii) by the Employer and Employee in such proportion as the Employer or the Plan Administrator shall determine.

Evidence

Evidence required of anyone under the Plan and the Benefit Programs may be by certificate, affidavit, document, or other information the Plan Administrator considers pertinent and reliable, and signed, made or presented by the proper party or parties.

Physical Examination and Autopsy

In addition to any rights and privileges granted under a Benefit Program, the Plan Administrator, at its own expense, shall have the right and opportunity to have a physician, designated by the Plan Administrator, examine any individual whose injury or sickness is the basis of a claim under the Plan and the Benefit Programs, when and as often as it may reasonably require during the pendency of a claim or any period of benefits under the Plan and the Benefit Programs and to make an autopsy in case of death, provided it is not otherwise prohibited by law. Notwithstanding the foregoing, a Benefit Program that is not an excepted Benefit Program under ERISA § 732(b), (c) or (d), shall not request or require an individual to undergo a genetic test.

Recovery of Benefits

If, because of fraud, mistake or any other reason, a person receives a benefit payment under the Plan or a Benefit Program that exceeds the benefit payment that should have been made, the Plan Administrator shall have the right to recover the amount of such excess from such person. However the Plan Administrator may, at its option, deduct the amount of such excess from any subsequent benefits payable to, or for, the Participant or such Participant's Dependents to whom or on whose behalf the excess payment was made.

Lawsuits Concerning Benefits

No lawsuit may be brought by any person or entity to recover benefits under the Plan more than three years from the date Plan benefits are finally denied.

Workers' Compensation Not Affected

The Plan is not in lieu of, and does not affect any requirement for, coverage under Workers' Compensation.

Severability

In case any provisions of the Plan or any Benefit Program shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan or any Benefit Program, and the Plan and all Benefit Programs shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan or Benefit Program.

Failure to Enforce

Failure to enforce any provision of the Plan shall not affect the Employer's or Plan Administrator's right thereafter to enforce such provision, nor shall such a failure affect the Employers' or Plan Administrator's right to enforce any other provision of the Plan.

Indemnification

The Employer shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under the Plan or ERISA.

SECTION 125 PLAN

General

If elected in an Adoption Agreement, the Welfare Programs shall include a Section 125 Plan, which shall permit Employees to choose between cash (or other taxable benefits) and the Health Benefit Programs on a non-taxable basis, subject to the requirements of Code § 125 and the regulations thereunder.

Eligibility

Notwithstanding anything to the contrary contained in any document governing the Section 125 Plan, participation in the Section 125 Plan shall be restricted to Employees, which may include former Employees if permitted in the governing documents.

Irrevocable Elections

An Employee's election under the Section 125 Plan shall be effective for the Plan year, and shall be irrevocable, except to the extent permitted under the Governing Documents and Treasury Regulation § 1.125-4.

Additional Required Terms

Additional terms required under Code § 125 shall be set forth in the governing documents for the Section 125 Plan.

ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Special Enrollment Period

Once you are enrolled, you may make changes to your Benefit Program Elections only during open enrollment or if you have a change in status that affects the eligibility of you or your dependents, *and* the requested election change corresponds (e.g. if an employee gets married they may add their spouse to the plan) with the effect on your eligibility.

A Qualified Change in Status includes:

- A change in your *Legal Marital Status* such as marriage, death of a spouse, divorce, legal separation or annulment.
- A change in your *number of dependents* such as birth, a, placement for adoption, or death of a child.
- A change in *employment status* such as commencement or termination of employment for you, your spouse, or your dependent.
- A change in *work schedule* such as a reduction or increase in hours including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse, or your dependent.
- If your *dependent satisfies or ceases to satisfy the requirements for unmarried if applicable.*
- *Dependents* due to factors such as age or dependent status.
- A change in *residence or worksite* for you, your spouse, or your Dependent.
- The receipt of a *Qualified Child Support Order*.
- A change in *Entitlement to Medicare or Medicaid* for you, your spouse or your dependent.
- A change in *Eligibility for COBRA* for you, your spouse or your dependent while you are still an active employee.
- HIPAA Special Enrollment Opportunities:
    - Special enrollment opportunities when a current employee or a current employee's dependent loses other coverage (coverage loss special enrollments)
    - Special enrollment opportunities due to birth, adoption, or placement for adoption of a child with a current employee or a participant who is not a current employee, or marriage of a current employee or a participant who is not a current employee (new dependent special enrollments)
    - Special enrollment opportunities when a current employee or a current employee's dependent loses Medicaid or CHIP coverage or becomes eligible for Medicaid or CHIP premium assistance (Medicaid and CHIP special enrollments)
- Health Insurance Premium Payment (HIPP) is also an allowed change.

Under limited circumstances, your Employer may permit you to make a mid-year election change that corresponds to changes made by your spouse's or Dependent's employer plan (i.e. during the other plan's open enrollment period).

However, all election changes must be requested within 30 days of the event in question, with the exception of Medicare/Medicaid change (which must be requested within 60 days of the event in question) unless stipulated differently by state regulations or by carrier contract.

Employee Benefit Eligibility

Beginning in 2015, the Affordable Care Act (ACA) imposes a penalty on applicable large employers (ALEs) that do not offer health insurance coverage to substantially all full-time employees and dependents.

Full-Time employees will be measured using the Monthly Measurement Method - The monthly measurement method involves a month-to-month analysis where full-time employees are identified based on their hours of service for each calendar month. This method is not based on averaging hours of service over a prior measurement period. Month-to-month measuring may cause practical difficulties for employers, particularly if there are employees with varying hours or employment schedules, and it could result in employees moving in and out of health plan coverage on a monthly basis

Part-Time or Variable Hour employees will be measured using the Look-back Measurement Method - Under the look-back measurement method, an employer counts an employee's hours of service during one period (called a measurement period) to determine their full-time status for a future period (called the stability period).

The company's Look-back Measurement Method is defined below.

Look-Back Measurement Method

The Employer offers coverage under its medical plan(s) to Full-Time Employees. A Full-Time Employee is an Employee who is employed, on average, for at least 30 hours of service per week or 130 hours of service in a calendar month. Full-Time Employees may also elect coverage for their spouse, (or domestic partner if allowed) and dependent children up to age 26.

The Employer will use a Look-Back Measurement Method to determine whether an employee is a Full-Time Employee for purposes of Medical Plan coverage. The Look-Back Measurement Method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Medical Plan coverage determinations.

The Look-Back Measurement Method applies to Employees enrolled in a medical plan offered by the Employer.

The Look-Back Measurement Method involves three different periods:

- **A Measurement Period** for counting an Employee's hours of service (also called a Standard Measurement Period or an Initial Measurement Period);
- **A Stability Period** when the Employee is either treated as full-time or non-full-time for Plan eligibility purposes; and
- **An Administrative Period** that allows time for Plan enrollment and disenrollment.

The Employer establishes how long these periods will last, subject to specified IRS parameters.

An ongoing employee is one who has been employed by the Employer for at least one complete Standard Measurement Period (SMP). If an ongoing employee was employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the SMP, the employee is

treated as a full-time employee for a set period into the future, known as the Stability Period. This means that, as a general rule, the employee is eligible for Plan coverage during the Stability Period, regardless of the employee's number of hours of service during the Stability Period, as long as they remain an employee.

Hansel Auto Group's Initial Measurement Period is: None

Hansel Auto Group's Initial Administrative Period is: None

Hansel Auto Group's Initial Stability Period: None

Hansel Auto Group's Ongoing Measurement Period: None

Hansel Auto Group's Ongoing Administrative Period: None

Hansel Auto Group's Ongoing Stability Period: None

Employee Eligibility Due to Status Change from Part-Time to Full-Time

In addition to utilizing the Look-Back Measurement Method to determine eligibility for health benefits (described above), there is an additional opportunity for an employee to become eligible under the Medical Plan. Specifically, employees who are deemed part-time under the Look-Back Measurement Method but who are formally promoted into a permanent, full-time position will be eligible to enroll in medical benefits under the Plan per the eligibility criteria set forth in the Medical Plan Information Section of the Document.

Employee Eligibility Due to Status Change from Full-Time to Part-Time

Medical Plan benefits for an employee who has a change in status from full-time to part-time will remain qualified for benefits for the remaining portion of the current stability period. Benefits should not be cancelled in this situation until the end of the stability period in which the employee moves into the part-time position. However, the employer is allowed to switch to the monthly measurement method for an employee for a period of 3 months, during which time they cannot exceed 30 hours per week for any week, moving to part-time starting with the first day of the 4th full month after the employee moves to a part-time position

Proof of Dependent Eligibility

The Employer reserves the right to verify that your dependent is eligible or continues to be eligible for coverage under the Plan's Benefit Programs. If you are asked to verify a dependent's eligibility for coverage, you will receive a notice describing the documents that you need to submit. To ensure that coverage for an eligible dependent continues without interruption, you must submit the required proof within the designated timeframe. To make an election change, contact your Plan Administrator.

COBRA

Continuation of benefits under COBRA

Qualified Beneficiaries shall have all continuation rights required by the Consolidated Omnibus Budget Reconciliation Act ("COBRA") for group health plan benefits offered under Welfare Programs. To the extent a Welfare Program offering health benefits does not specify COBRA Continuation Coverage rights in accordance with Code Section 4980B, the Plan shall be administered in accordance with Code Section 4980B and 29 CFR Part 2590.606-1 through 2590.606-4, with respect to the final COBRA notice rules and regulations for group health plans. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section.

Other Options

You may have other options available to you when you lose group health plan coverage.

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Election of COBRA

COBRA Continuation Coverage for Terminated Participants

In the event a Covered Employee, Qualified Dependent or Qualified Beneficiary experiences a Qualifying Event, the Plan Administrator shall provide notice of COBRA Continuation Coverage that shall inform such individual of their rights and obligations with respect to COBRA Continuation Coverage under the Plan.

A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at their own expense, if their participation under the Plan would terminate as a result of either of the following Qualifying Events:

a. termination of employment (other than for gross misconduct); or
b. reduction of hours of employment with the Employer.

COBRA Continuation Coverage for Qualifying Dependent

A Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at their own expense:

- **Qualifying Events for Spouses**
    - Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
    - Reduction in the hours worked by the covered employee below plan eligibility requirements.

    - Covered employee becoming entitled to Medicare.
    - Divorce or legal separation of the covered employee.
    - Death of the covered employee.
- **Qualifying Events for Dependent Children**
    - Loss of dependent child status under the plan rules.
    - Voluntary or involuntary termination of the covered employee's employment for any reason other than gross misconduct.
    - Reduction in the hours worked by the covered employee below plan eligibility requirements.
    - Covered employee becoming entitled to Medicare.
    - Divorce or legal separation of the covered employee.
    - Death of the covered employee

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required COBRA election enrollment materials within a maximum of sixty (60) days from the later of:

a. loss of coverage; or
b. the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

The Employer shall, in the event of a Qualifying Event that is either a Termination of Employment (other than for gross misconduct) or a reduction of hours, notify the Plan Administrator (or its designee) within thirty (30) days of the later of the date of the Qualifying Event or the date that coverage under the Plan ends. Such notice shall be given in a form and manner as determined by the Plan Administrator, in its sole discretion, in compliance with applicable law. The Plan Administrator shall then notify the Covered Employee and all covered Dependents of their right to elect COBRA Continuation Coverage within fourteen (14) days of such notice from the Employer.

Failure to enroll for COBRA Continuation Coverage during this maximum sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Plan and such right to COBRA Continuation Coverage shall not be reinstated. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or their Spouse shall be deemed to be an election for that Covered Employee's Qualifying Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on their behalf by a third party (including a third party that is not a Qualified Beneficiary). In the event the Plan Administrator determines that a Covered Employee, Qualified Dependent or Qualified Beneficiary who has furnished a notice of Qualifying Event, second Qualifying Event or disability determination is not entitled to COBRA Continuation Coverage, the Plan Administrator shall provide a notice of unavailability of COBRA Continuation Coverage to such affected individual in accordance with 29 CFR Part 2590.606-4(c).

Period of COBRA Coverage

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of Termination of Employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to eighteen (18) months (Federal COBRA), (thirty-six (36) months in the State of New York), measured from the date of the Qualifying Event. With respect to all other Qualifying Events, a Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage for up to thirty-six (36) months from the date of the Qualifying Event.

A Qualified Beneficiary who properly elects and renders payment for the initial Continuation Coverage Contribution shall have such COBRA Continuation Coverage effective on the date of the Qualifying Event.

Coverage under this Section may be terminated early and may not continue beyond certain deadlines based on:

a. the date on which the Employer ceases to maintain a group health plan;
b. the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with this Plan;
c. the date the Qualified Beneficiary, after the date they elect COBRA Continuation Coverage, first becomes enrolled in Medicare;
d. the date the Qualified Beneficiary, after the date they elect COBRA Continuation Coverage, first becomes covered under another group health plan and is no longer subjected to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or
e. in the case of a disabled Qualified Beneficiary (and their disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage extension, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

In the event the Plan Administrator terminates COBRA Continuation Coverage of a Qualified Beneficiary prior to the end of the maximum available Continuation Coverage Period, the Plan Administrator shall provide a notice of such termination to each affected Qualified Beneficiary in accordance with 29 CFR Part 2590.606-4(d).

Contribution Requirements for Coverage

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation

Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary shall have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period. The thirty (30) day grace period shall not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. Once terminated, COBRA Continuation Coverage shall not be reinstated.

The Continuation Coverage Contribution shall be one hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section of this Plan, an amount not significantly less than the amount the Plan requires to be paid shall be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

Limitation on Qualified Beneficiary's Rights to COBRA Continuation Coverage

If a Qualified Beneficiary loses, or will lose health coverage under the Plan as a result of divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Covered Employee must notify the Plan Administrator within a maximum of sixty (60) days of the divorce, legal separation or loss of Dependent status. Such notice shall be required to comply with the Plan's notice procedures as contemplated by this Plan, in accordance with applicable law. Failure to make timely notification shall result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Plan; such right shall not be reinstated.

A Qualified Beneficiary must notify the Plan Administrator of the birth to, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage. The notice must be provided within a maximum of thirty (30) days of the child's birth, adoption or placement for adoption with the Qualified Beneficiary, subject to the Plan's notice procedures.

Extension of COBRA Continuation Coverage Period

If a second Qualifying Event that is not a Termination of Employment or reduction in hours occurs during an eighteen (18) month extension period explained above, coverage may be continued for a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualifying Dependent. A second Qualifying Event will result in an extension of the initial Continuation Coverage Period if such Qualifying Event would have resulted in a loss of coverage under the Plan had the first Qualifying Event not occurred. Such extension of COBRA Continuation Coverage applies only to Qualifying Dependents. Therefore, such extension would apply to a child

adopted by or placed for adoption with a Qualified Beneficiary, but would not apply to a Spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial eighteen (18) month continuation period. Notwithstanding the foregoing, terminating employment after a Qualifying Event that is a reduction in hours of employment does not extend the maximum Continuation Coverage Period beyond eighteen (18) months of COBRA Continuation Coverage.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

a. the Social Security Administration determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or anytime within the first sixty (60) days of COBRA Continuation Coverage; and

b. the disabled Qualified Beneficiary provides evidence to the Plan Administrator of such Social Security Administration determination within sixty (60) days of the date of such determination but not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage in a manner consistent with the Plan's reasonable notice procedures as contemplated by this Plan. Failure to notify the Plan Administrator of such determination within the time period stated above will result in the loss of the Qualified Beneficiary's right to an extension of the initial eighteen (18) month period of COBRA Continuation Coverage and such right will not be reinstated. In such event, if the disabled Qualified Beneficiary is receiving COBRA Continuation Coverage, the Continuation Coverage Contribution shall be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19th) through twenty-ninth (29th) month of COBRA Continuation Coverage. Otherwise, the Continuation Coverage Contribution shall continue to be one hundred two percent (102%) of the cost of coverage for the nineteenth (19th) through twenty-ninth (29th) months of coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the Social Security Administration that they are no longer disabled, the Qualified Beneficiary must notify the Plan Administrator within thirty (30) days of the date of that determination in a manner consistent with the Plan's notice procedures as contemplated by this Plan. Such a final determination shall end the disability extension of COBRA coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date or (ii) the end of the Continuation Coverage Period without regard to the disability extension.

Responses to Information Regarding Qualified Beneficiary's Right to Coverage

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the COBRA Continuation Coverage election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA Continuation Coverage is elected. If a provider of health care (such as a

physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

Coordination of Benefits - Medicare and COBRA

For purposes of this Section, "Medicare Entitlement" means being entitled to Medicare due to either: (1) enrollment (automatically or otherwise) in Medicare Parts A or B, or (2) being medically determined to have end-stage renal disease ("ESRD"), and (a) having applied for Medicare Part A; (b) having satisfied any waiting period requirement and (c) being either (i) insured under Social Security, (ii) entitled to retirement benefits under Social Security or (iii) a spouse or dependent of a person satisfying either (i) or (ii). Such Medicare entitlement is a COBRA terminating event.

If you already have COBRA when you enroll in Medicare, your COBRA coverage usually ends on the date you enroll in Medicare. Your spouse and dependents may keep COBRA for up to 36 months, regardless of whether you enroll in Medicare during that time.

If you already have Medicare when you become eligible for COBRA, you will be allowed to enroll in COBRA subject to specific language in the Governing Documents.

Relocation and COBRA Coverage

If a Qualified Beneficiary moves outside the service area of a region-specific group health benefit package, alternative coverage, if available to similarly situated active Employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage.

COBRA Coverage and HIPAA Special Enrollment Rules

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") rules as if the Qualified Beneficiary were an Employee or Participant in the Plan, provided that such family members do not become Qualified Beneficiaries, and who are therefore eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge coverage between this Plan and any future coverage under another group health plan.

Procedures for Providing Notices

The Plan Administrator shall establish procedures for the furnishing of notices required by a Covered Employee, Qualifying Dependent or Qualified Beneficiary to the Employer and/or Plan Administrator including Qualifying Event notices, notice of disability determination or Medicare entitlement, change in disability determination, and Medicare entitlement. Such procedures may: be described in the Plan's Summary Plan Description; specify the individual or entity designated to receive such notices; specify the form and means of delivery of such notices (including requiring the use of certain forms when submitting such notices); describe the information required by the Plan to provide COBRA Continuation Coverage rights; and shall comply with

applicable federal laws regarding requirements for timing and content of such notices. Moreover, the Plan Administrator may select or appoint another entity or individual to handle COBRA administration, where applicable.

COBRA Definitions

For purposes of this Section only, the following definitions shall apply:

(a) **"COBRA"** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(b) **"COBRA Continuation Coverage"** means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage shall be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of this Plan are modified for Similarly Situated Beneficiaries, such coverage shall also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to Similarly Situated Qualified Beneficiaries.

(c) **"Continuation Coverage Contribution"** means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for COBRA Continuation Coverage.

(d) **"Continuation Coverage Period"** means the applicable time period for which Continuation Coverage may be elected.

(e) **"Covered Employee"** means an Employee covered under this Plan on the day prior to the Qualifying Event. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.

(f) **"Annual Enrollment Period"** means a period during which an Employee covered under the Plan can choose to be covered under another Plan or under another benefit option within the same plan, or add or eliminate coverage of family members.

(g) **"Qualified Beneficiary"** means a Covered Employee or Qualifying Dependent.

(h) **"Qualifying Dependent"** means:

i. a Covered Employee's Spouse or Dependent child covered under this Plan on the day prior to the Qualifying Event; or

ii. a Dependent child who is born to, adopted by or placed for adoption with a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

(i) **"Qualifying Event"** means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage in the absence of this provision:

i. a Covered Employee's Termination of Employment, for any reason other than gross misconduct;

ii. a Covered Employee's reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;

iii. a Covered Employee's divorce or legal separation;

iv. a Qualified Dependent ceasing to qualify as a Dependent under the provisions of this Plan;

v. a Covered Employee's entitlement to benefits under Medicare;

vi. the death of a Covered Employee; or

vii. the failure of a Covered Employee to return from FMLA leave.

Loss of coverage includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in subsections (i) – (vii). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(j) **"Similarly Situated Beneficiaries"** means Employees or their Dependents, as applicable, who are Participants in this Plan.

BENEFIT PLAN PROVISIONS

All documents relating to the Hansel Auto Group Welfare Benefit Plan, including the Evidence/Certificate of Coverage for each plan, Listing of Network Providers, Contribution Rates, General COBRA Notice, General HIPAA, Medicare Creditable Coverage Notice and any other relevant Plan Documents or Notices, are available to employees and their dependents. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Administrator.

In addition to this Wrap Document please refer to the applicable Subsidiary Contract and any other applicable plan document for each Welfare Program's specific details. These documents will include the description of benefits, cost-sharing provisions, requirements for use of network providers and circumstances by which benefits may be excluded or denied.

STATUTORY PROVISIONS

Family and Medical Leave Act (FMLA)

To be eligible for FMLA leave, employees must have worked for covered employers for a total of 12 months (which do not need to be consecutive) and for at least 1,250 hours in the previous 12 months, immediately preceding the leave. The 1,250-hour threshold can be met whether employees work full-time or part-time. Employers with multiple worksites are covered by FMLA if the worksites are within a 75-mile radius of each other and the number of employees equals 50 or more by counting employees at all worksites. The 75-mile radius is measured in surface miles, rather than linear miles.

If you go on a qualified unpaid leave under the Family and Medical Leave Act of 1993 (FMLA), the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave), the employer will continue to maintain your health plan benefits on the same terms and conditions as though you were still an active employee. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave.

Your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time, unless otherwise required by federal, state, or local law. Except as otherwise provided in the FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse the Employer for the cost of the coverage provided to you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on, and minus any employee contribution you already made). For more information on FMLA, please contact the Employer, where you may obtain a summary of your rights under FMLA without charge. The Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage.

If coverage is terminated for failure to make payments while you are on an approved Family or Medical Leave of Absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible

under the Plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

The Plan intends to comply with all existing FMLA regulations. If, for some reason, the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

Military Leave Coverage

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services.

As used in this provision, "Uniformed Services" means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty;
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funeral honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

- You fail to make a premium payment within the required time;

- You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
- You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described above under the section entitled "COBRA".

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under the Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the Veterans Administration (VA). (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If, for some reason, the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the Plan in accordance with such actual regulations.

Leave of Absence Mandated Under State And Local Laws

The Plan may be required to maintain coverage for an employee based on the provisions of applicable state or local laws. Such laws may allow employees protected leave for various reasons such as sick leave, family leave, parental leave, domestic violence leave or other reasons mandated by state and local statutes.

BENEFIT CONTINUATION PROVISIONS FOR NON-STATUTORY LEAVE OF ABSENCE

Coverage under the plan may be continued under the provisions of applicable company policy. The Plan may allow an employee to remain covered when a leave of absence is needed for personal or medical reasons and when the employee does not qualify for leave under statute such as FMLA or USERRA or state /local statute as noted above. There may be limits to the amount of time the employee may remain on the plan as an active participant and after such time, the employee may be offered continuation of coverage under federal COBRA or state continuation of coverage provisions. Please refer to the company's Employee Handbook for specific provisions related to such non-statutory leaves of absence.

AFFORDABLE CARE ACT

The Plan will also comply with stability rules under the Affordable Care Act (ACA), where the employee may still be able to maintain coverage under the plan outside of a leave of absence provided for under statute or under applicable company policy.

AMENDMENT OR TERMINATION OF THE PLAN

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine all materials provided to you each year to determine the benefits of the Plan.

No Contract of Employment

The Plan is not intended to, and does not, either directly or indirectly constitute any form of employment contract or other employment arrangement between you and Employer.

Other Materials

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by Plans are part of the Summary Plan Description. Please refer to these materials for other important provisions regarding your participation in the Plan.

HIPAA PRIVACY AND SECURITY STANDARDS

General

If a Health Benefit Program is not exempt from the requirements of the Privacy Standards and the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), then this Section shall apply. The Plan also intends to comply with any applicable state laws relating to privacy and security.

Privacy and Security Standards

The Plan shall not disclose Protected Health Information (PHI) to any member of an Employer's workforce unless each of the conditions set out in this Section are met. PHI shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. PHI shall include "genetic information," as defined in the Privacy Standards. "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.

PHI disclosed to members of the Employer's workforce shall be used or disclosed by the Employer only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan treatment, payment functions and health care operations. The terms "treatment," "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" shall include activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information shall not be used or disclosed for "underwriting" purposes, as defined in the Privacy Standards.

The Plan shall disclose PHI only to members of the Employer's workforce who are authorized to receive such PHI, 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 control of the Employer. The Employer shall keep an updated list of those authorized to receive PHI.

1) An authorized member of the Employer's workforce who receives 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.
2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's Privacy Officer. The Privacy Officer shall take appropriate action, including:
    a) investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately, whether there is a pattern of breaches, and the degree of harm caused by the breach;

b) 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;

c) mitigation of any harm caused by the breach, to the extent practical; and documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

3) By executing the Welfare Benefit Plan Adoption Agreement that accompanies this document, the Employer and all affiliated Employers agree to:

a) Not use or further disclose the PHI other than as permitted or required by the Plan documents or as required by law;

b) 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 behalf of the Plan;

c) Ensure that any agent or subcontractor, (i) 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, and/or (ii) 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;

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

e) Report to the Plan any use or disclosure of the PHI of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

f) Make available PHI to individual Plan members as required by Section 164.524 of the Privacy Standards;

g) Make available PHI for amendment by individual Plan members and incorporate any amendments to Protected Health Information as required by Section 164.526 of the Privacy Standards;

h) Make available the PHI required to provide an accounting of disclosures to individual Plan members as required by Section 164.528 of the Privacy Standards;

i) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

j) If feasible, return or destroy all PHI 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

k) Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above, and to use reasonable and appropriate security measures to comply with this provision.

HIPAA NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after you or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Hansel Auto Group
1125 Auto Center Drive
Petaluma, CA 94952
Phone: (707) 769-2333

STATEMENT OF ERISA RIGHTS

As a participant in the Plan (which is a type of Employee Welfare Benefit Plan called a "group health plan") you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and if applicable, collective bargaining agreements, and copies of the latest Annual Report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Medical Loss Ratio (MLR)

In certain circumstances under the Medical Loss Ratio Standards in section 2718 of the Patient Protection and Affordable Care Act of 2010 (PPACA), rebates may be paid to this Plan. The federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the Plan Sponsor and Plan costs paid by participants. The participant portion of the rebate will be used for the benefit of the Plan participants. This can be done by a number of actions, including but not limited to lowering the Plan costs for the participants for the next Plan Year, applied towards the cost of administering the Plan, paid as taxable income to the participants, or in any manner that allocates the rebate to Participants based on each Participant's actual contributions, or to apportion it on any other reasonable basis.

Continue Group Health Plan Coverage

To continue health care coverage for yourself, legal spouse defined by Federal and State Law, or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description Wrap Document and the documents governing the Plan on the rules governing your COBRA Continuation Coverage Rights.

Qualified Medical Child Support Order Procedures

If a Health Benefit Program is subject to ERISA § 609(a), then this Section shall apply. Such Health Benefit Program shall provide benefits in accordance with the terms of a Qualified Medical Child Support Order that meets the requirements of ERISA § 609(a). Each Health Benefit Program shall establish reasonable written procedures to determine whether a medical child support order is a Qualified Medical Child Support Order. Such procedures shall be made available upon request of a participant at no charge.

Medicaid

If a Health Benefit Program is subject to ERISA § 609(b), then this Section shall apply.

Payment for benefits with respect to a participant under a Health Benefit Program will be made in accordance with any assignment of rights made by or on behalf of such participant or a beneficiary of the participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

a. The fact that a participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

b. To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a Health Benefit Program has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

Newborn and Mothers Health Protection Act

Group Health Plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Mental Health Parity and Addiction Equity Act

A Health Benefit Program that provides both medical and surgical benefits and mental health and/or substance abuse benefits shall not impose any limits on mental health or substance abuse benefits that violate the requirements of ERISA § 712.

Women's Health and Cancer Rights Act

If a Health Benefit Program is subject to ERISA § 713 and provides medical and surgical benefits with respect to a mastectomy, then this Section shall apply. Such Health Benefit Program shall, with respect to a participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, provide coverage for the following (subject to applicable deductibles, copayments and other Health Benefit Program limitations):

1) reconstruction of the breast on which the mastectomy has been performed;

2) surgery and reconstruction of the other breast to produce a symmetrical appearance;

3) prostheses; and

4) treatment of physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

This Plan complies with these requirements. Benefits for these items generally are comparable to those provided under this Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Patient Protection and Affordable Care Act Notice

If a Health Benefit Program is not exempt under ERISA § 732 from the requirements of Title I of the Patient Protection and Affordable Care Act of 2010, the Health Benefit Program shall be operated in accordance with such requirements.

If the Plans and issuers **require or allow for the designation of primary care providers** by participants or beneficiaries:

> Employer's medical plan requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the Plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the Group Health Plan or health insurance issuer will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator or issuer.

If the Plans and issuers require or allow for the designation of a **primary care provider for a child**; you may designate a pediatrician as the primary care provider.

If the Plans and issuers that provide coverage **for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider**:

> You do not need prior authorization from the Group Health Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator or issuer.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility.

ALABAMA – Medicaid	CALIFORNIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: https://dhcs.ca.gov/hipp Phone: 916-445-8322 Email: hipp@dhcs.ca.gov
ALASKA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711
ARKANSAS – Medicaid	**FLORIDA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrec overy.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Website: https://medicaid.georgia.gov/health-insurance- premium-payment-program-hipp Phone: 678-564-1162, Press 1	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: (617) 886-8102
INDIANA – Medicaid	**MINNESOTA – Medicaid**
Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739

IOWA – Medicaid and CHIP (Hawki)	MISSOURI – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
KANSAS – Medicaid	**MONTANA – Medicaid**
Website: http://www.kancare.ks.gov/ Phone: 1-800-792-4884	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KENTUCKY – Medicaid	**NEBRASKA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
LOUISIANA – Medicaid	**NEVADA – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Medicaid Website http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
MAINE – Medicaid	**NEW HAMPSHIRE – Medicaid**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740. TTY: Maine relay 711	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852- 3345, ext. 5218

NEW JERSEY – Medicaid and CHIP	SOUTH DAKOTA - Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://dss.sd.gov Phone: 1-888-828-0059
NEW YORK – Medicaid	**TEXAS – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: http://gethipptexas.com/ Phone: 1-800-440-0493
NORTH CAROLINA – Medicaid	**UTAH – Medicaid and CHIP**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
NORTH DAKOTA – Medicaid	**VERMONT– Medicaid**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
OKLAHOMA – Medicaid and CHIP	**VIRGINIA – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.coverva.org/en/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924
OREGON – Medicaid	**WASHINGTON – Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
PENNSYLVANIA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
RHODE ISLAND – Medicaid and CHIP	**WISCONSIN–Medicaid and CHIP**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

SOUTH CAROLINA – Medicaid	WYOMING – Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext. 61565

Genetic Information Nondiscrimination Act ("GINA")

"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits Group Health Plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

GINA prohibits a Group Health Plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group.

The term "genetic information" means, with respect to any individual, information about:

1) Such individual's genetic tests;
2) The genetic tests of family members of such individual; and
3) The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

"Family members" include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption.

"Underwriting" includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

Subrogation and Recovery

If a Participant incurs covered expenses or receives benefits under a Benefit Program with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan retains all rights of subrogation, recovery and reimbursement as set out more specifically in the governing documents for each Benefit Program.

Prudent Actions by Plan Fiduciaries

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

INSTRUCTIONS FOR GROUP HEALTH PLANS AND HEALTH INSURANCE ISSUERS

(For use for plan years beginning on or after January 1, 2022)

Federal law requires group health plans and health insurance issuers offering group or individual health insurance coverage to make publicly available, post on a public website of the plan or issuer, and include on each explanation of benefits for an item or service with respect to which the requirements under section 9816 of the Internal Revenue Code (the Code), section 716 of the Employee Retirement Income Security Act (ERISA), and section 2799A-1 of the Public Health Service Act (PHS Act) apply, information in plain language on:

(1) the restrictions on balance billing in certain circumstances,

(2) any applicable state law protections against balance billing,

(3) the requirements under Code section 9816, ERISA section 716, and PHS Act section 2799A-1, and

(4) information on contacting appropriate state and federal agencies in the case that an individual believes that a provider or facility has violated the restrictions against balance billing.[1]

Plans and issuers may, but aren't required to, use this model notice to meet these disclosure requirements. To use this document properly, the plan or issuer should review and complete it in a manner consistent with applicable state and federal law. The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will consider use of this model notice in accordance with these instructions to be good faith compliance with the disclosure requirements of section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, if all other applicable requirements are met.

If a state develops model language for its disclosure notice that is consistent with section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act, the Departments will consider a plan or issuer that makes good faith use of the state-developed model language to be compliant with the federal requirement to include information about state law protections.

Language access

Use of Plain Language

Plans and issuers are encouraged to use plain language in the disclosure notice and test the notice for clarity and usability when possible.

Plain language, accessibility, and language access resources:

- Plainlanguage.gov/guidelines
- Section508.gov
- LEP.gov

[1] Section 9820(c) of the Code, section 720(c) of ERISA, and section 2799A-5(c) of the PHS Act.

Compliance with Federal Civil Rights Laws

Entities that receive federal financial assistance must comply with federal civil rights laws that prohibit discrimination. These laws include section 1557 of the Affordable Care Act, Title VI of the Civil Rights Act of 1964, and section 504 of the Rehabilitation Act of 1973. Section 1557 and title VI require covered entities to take reasonable steps to ensure meaningful access to individuals with limited English proficiency, which may include offering language assistance services such as translation of written content into languages other than English.

Section 1557 and section 504 require covered entities to take appropriate steps to ensure effective communication with individuals with disabilities, including provision of appropriate auxiliary aids and services. Auxiliary aids and services may include interpreters, large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind or have low vision, or who are deaf or hard of hearing. Information provided through information and communication technology also must be accessible to individuals with disabilities, unless certain exceptions apply. Plans and issuers are reminded that the disclosure notice must comply with applicable state or federal language-access standards.

NOTE: The information provided in these instructions is intended to be only a general summary of technical legal standards. It is not intended to take the place of the statutes, regulations, or formal policy guidance on which it is based. Refer to the applicable statutes, regulations, and other interpretive materials for complete and current information.

Do not include these instructions with the disclosure notice provided to participants, beneficiaries, or enrollees.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid Office of Management and Budget (OMB) control number. The valid OMB control number for this information collection is 1210-XXXX. The time required to complete this information collection is estimated to average 3.5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:

    - Cover emergency services without requiring you to get approval for services in advance (prior authorization).

    - Cover emergency services by out-of-network providers.

    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

    - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the applicable entity responsible for enforcing the federal and/or state balance or surprise billing protection laws.

Visit www.dol.gov for more information about your rights under federal law.

ENFORCE YOUR RIGHTS

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest Annual Report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Receive a summary of the Plan's annual financial report.

Should the Employer be required to file a Form 5500 the Plan Administrator is required by law to furnish each Participant with a copy of the Summary Annual Report (SAR) that provides a financial summary of the Plan.

DEFINITIONS

The following terms, where capitalized, shall have the meanings set forth below unless otherwise specified herein:

(a) **"Adoption Agreement**" means a written document signed by a corporate officer adopting the Plan on the part of the organization.

(b) **"Beneficiary"** means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

(c) **"Benefit Program and Health Benefit Program"** means the Welfare Benefit Plans being offered to the employees.

(d) **"Claims Administrator"** means the insurance Employer, third party administrator or other entity designated by the Plan Administrator to determine benefit eligibility and availability and/or pay claims for benefits under this Plan or a Welfare Program under this Plan.

(e) **"Code"** means the Internal Revenue Code of 1986, as amended.

(f) **"Company"** means Hansel Auto Group. In the event of a reorganization, merger or similar transaction affecting the Company, any successor entity may adopt the Plan for the benefit of Employees of such successor, in which event, the Plan shall continue without any gap or lapse in coverage.

(g) **"Dependent"** means a covered Dependent under the Plan as defined under the terms of the respective Welfare Program.

(h) **"Effective Date"** means January 1st.

(i) **"Employee"** means, unless otherwise specified in a Welfare Program incorporated herein, any person currently employed by the Employer who is receiving compensation for services performed and who is classified by the Employer as a salaried or hourly full-time employee regularly scheduled the amount of hours per week as noted in the Eligible Employee Section of the Plan Information Section of this document. Employees on certain leaves of absence are also eligible to participate, subject to additional terms and conditions as specified in this Plan. "Employee" shall not include any person classified on the Employer's records as other than an employee. For example, "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classifications, regardless of any subsequent or retroactive reclassification or determination by a governmental agency that any such person is a common law employee of an Employer. Notwithstanding anything to the contrary contained herein or in the Welfare Programs, Employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer that constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be eligible to participate in the Plan.

(j) **"Employer"** means the Company, and any other entity that participates in the Plan with the approval of the Plan Administrator. The Plan Administrator shall have the right to terminate

any Employer's adoption of the Plan at any time. If an Employer merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Employees covered by the Plan immediately before such merger or consolidation, be the Employer as defined hereunder, unless the Plan Administrator specifies to the contrary. In case of any other merger or consolidation, the successor shall not be the Employer except to the extent that it acts to adopt the Plan.

(k) **"ERISA"** means the Employee Retirement Income Security Act of 1974, as amended.

(l) **"Former Employee"** means any person formerly employed as an Employee of the Employer.

(m) **"Fully Insured Benefit Programs"** means a plan where the Employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.

(n) **"Independent Review Organization" (IRO)** means a third-party organization contracted to collaborate in the decision-making process on claims.

(o) **"Insurer"** means Insurance Company that issues a particular insurance policy to an insured.

(p) **"Governing Document(s)"** means the various carrier plan documents and this Summary Plan Description Wrap Document required by ERISA that include the Plan's terms for a number of items including eligibility, benefits, exclusions, a named fiduciary and Plan Administrator, claims and appeals procedures, funding information, and other items.

(q) **"Participant"** means an Employee or Former Employee of the Employer who meets the requirements for eligibility as set forth in this Plan and who properly enrolls in the Plan. A person shall cease to be a Participant when they no longer meets the requirements for eligibility.

(r) **"Participant Contribution"** means the Pre-Tax or Post-Tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used for the provision of benefits under a Self-Funded arrangement of the Company or an Employer as well as contributions used to purchase insurance contracts or policies.

(s) **"Plan"** means this Plan, the Hansel Auto Group Welfare Benefit Plan, which consists of this document, and each Welfare Program incorporated hereunder by reference, as amended from time to time.

(t) **"Plan Administrator"** shall have the same meaning as set forth in ERISA Section 3(16). The Plan Administrator for the Plan shall be the Employer, unless another entity or person is appointed by the Employer.

(u) **"Plan Fiduciary"** means the Company

(v) **"Plan Sponsor"** means the Company

(w) **"Plan Year"** means the twelve (12) consecutive month period commencing on January of such year.

(x) **"Subsidiary Contracts"** means any description of benefits, certificate of coverage, subscriber agreement, or evidence of coverage booklet, referenced by this SPD. These documents provide more details on specific items such as benefit coverage, definitions, coordination of benefits, claims procedures, exclusions and limitations.

(y) **"Summary Plan Description (SPD)"** means any Summary Plan Description, Summary of Material Modifications or other Employee communication that describes the benefits under a Welfare Program, and has been included by the Employer and/or Employer as part of this Plan by reference.

(z) **"Spouse"** means the legal spouse (as defined by state law, as applicable) of a Participant.

(aa) **"Welfare Benefit Plan"** means a type of employer-sponsored employee Welfare Benefit Plan. 419(e) Welfare Benefit Plans qualify under paragraph (e) of Section 419 of the Internal Revenue Code. They provide a range of benefits to employees, such as life, health, disability, long-term care and post-retirement medical.

(bb) **"Welfare Program"** means a Welfare Program incorporated into this Plan that is offered by the Company and/or an Employer that provides any Employee a benefit that would be treated as an "employee Welfare Benefit Plan" under Section 3(1) of ERISA if offered separately.

(cc) **"Welfare Program Document"** means a written arrangement, including any contract between an Employer and an insurance company, health maintenance organization ("HMO"), administrative service organization ("ASO") or other similar organization to provide benefits, a plan document or other instrument under which a Welfare Program is established and operated.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries,

Pension and Welfare Benefits Administration,

U.S. Department of Labor, 200 Constitution Avenue N.W.,

Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by contacting the Employee Benefits Security Administration.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Under the Employee Retirement Income Security Act (ERISA), A qualified medical child support order (QMCSO) is a court decree that orders an alternate beneficiary, such as a plan participant's child or step-child, is entitled to be covered by the participant's group health plan.

Status of Order

The Plan Administrator or its designee shall recognize the Order as a Qualified Medical Child Support Order if the Order clearly satisfies all of the following requirements:

- The Order discloses the name and last known mailing address, if any, of the employee member and 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 (hereafter "governmental official") may be substituted for the mailing address of any such Alternate Recipient; provided, however, that an Order shall not fail to be a Qualified Medical Child Support Order merely because the Order does not specify the address of the employee member or an Alternate Recipient, if the Plan Administrator or its designee is otherwise aware of the address of such employee member or Alternate Recipient.
- The Order specifies a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined.
- The Order identifies the period to which such Order applies.
- The Order does not require any type or form of benefits or any opinion that is 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 added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993.

Procedural Requirements

- *Notice of Receipt and Copy of Procedure Order.* Upon receipt by the Plan of any Medical Child Support Order, the Plan Administrator or its designee shall promptly notify the employee member and each Alternate Recipient that it has received such Order and the Plan Administrator or its designee shall provide the employee member and each Alternate Recipient with a copy of this Procedure.
- *Notification Following Qualification Determination.* Within a reasonable time after receipt by the Plan Administrator or its designee of a Medical Child

Support Order, or within such time period as shall be established under any applicable regulations issued by the Secretary of Labor or the Secretary of the Treasury, the Plan Administrator or its designee shall determine whether the Order is a Qualified Medical Child Support Order and shall notify the employee member and each Alternate Recipient of such determination. If the Plan Administrator or its designee determines that an Order is not a Qualified Medical Child Support Order, such notice shall advise that Alternate Recipient that he or she may have a right to petition the issuing court to amend the Order. Notifications shall be sent to the addresses specified in the Order, or if the Order does not specify addresses, to the last known address of the employee member and the Alternate Recipient.

- *National Medical Support Notice.* In the case of a National Medical Support Notice that is deemed a Qualified Medical Child Support Order, the Plan Administrator or its designee shall within 40 business days after the date of the Notice: (i) notify the state agency issuing the Notice whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or governmental official) to effectuate the coverage, and (ii) provide the custodial parent (or governmental official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.
- *Designation of Representative.* The Alternate Recipient shall be permitted to designate in writing a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order. Such written designation shall be provided to the Plan Administrator or its designee.
- *Payment for Benefits.* Any payment for benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. Payments to a governmental official whose name and address have been substituted for the address of an Alternate Recipient shall be treated as payment of benefits to the Alternate Recipient.

Actions Taken by the Plan Administrator

If the Plan Administrator or its designee acts in accordance with Part 4 of Title I of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), in treating a Medical Child Support Order as being (or not being) a Qualified Medical Child Support Order, then the Plan's obligation to the employee member and each Alternate Recipient shall be discharged to the extent of any payment made pursuant to such act of the Plan Administrator or its designee.

Treatment of Alternate Recipients

- A person who is an Alternate Recipient under a Qualified Medical Child Support Order shall be considered a beneficiary under the Plan for purposes of any applicable provisions of ERISA.
- A person who is an Alternate Recipient under any Medical Child Support Order shall be considered a participant under the Plan for purposes of the reporting and disclosure requirements of Part 1 of Title I of ERISA.

Modification of Procedure

This Procedure may be modified from time to time by the Plan Administrator or its designee in its discretion to conform to regulations promulgated by the Secretary of Labor or Secretary of the Treasury or any other applicable guidance thereunder.