2019 Summary Plan Description for the Dental Benefits Plan for Retail Associates
This booklet and all applicable insurance policies/evidence of coverage related to the benefits under the Plan constitutes the written instrument under which the AutoNation Dental Benefits Plan is established and maintained (i.e., Plan Document) for purposes of ERISA section 402(a) and the Summary Plan Description ("SPD"). This booklet summarizes the Plan in nontechnical language, so you can understand the benefits available to you but should be read in connection with the applicable insurance policy/evidence of coverage provided by the insurer listed in the section “Administrative Information.” The booklet does not grant or change your rights under the Plan, or those of your beneficiaries. If there is any conflict between this booklet and the certificate of coverage or insurance certificate, the certificate of coverage or insurance certificate will govern for benefit provisions while this booklet will govern for eligibility provisions. The insurance policy/evidence of coverage is available for review by contacting the Claims Administrator. Capitalized terms are defined in the section entitled “Definitions.”
# TABLE OF CONTENTS (CONTINUED)

| Claims Procedures Under the Dental HMO | 24 |
| **How to Appeal a Denied Claim** | 25 |
| Eligibility Appeals | 25 |
| Dental Benefit Appeals | 25 |
| Appointment of an Authorized Representative | 25 |
| Appeals Procedure | 25 |
| Level-One Appeal | 25 |
| Level-Two Appeal | 25 |
| Notice of Benefit Determination on Appeal | 26 |
| Relevant Information | 26 |
| Legal Action | 26 |
| Residents of Texas | 26 |
| When You Have a Complaint | 26 |
| Complaint Appeals Procedure | 27 |
| When You Have an Adverse Determination Appeal | 27 |
| Retrospective Review Requirements | 27 |
| Independent Review Procedure | 28 |
| Appeal to the State of Texas | 28 |
| **Coordination of Benefits** | 29 |
| If You Are Covered by Another Group Dental Plan | 29 |
| If You Recover Dental Payments From Another Party | 30 |
| **When Coverage Ends** | 31 |
| If You Are Granted a Leave of Absence | 31 |
| If You Terminate | 31 |
| At Other Times | 31 |
| Extended Coverage for Certain Services | 31 |
| **COBRA Continuation Coverage** | 32 |
| COBRA Qualifying Events and Length of Coverage | 32 |
| COBRA and Medicare | 32 |
| If You Are on Military Leave | 32 |
| If You or Your Dependent is Disabled | 32 |
| Electing COBRA | 34 |
| Your Cost for COBRA | 34 |
| COBRA Continuation Coverage Payments | 34 |
| When COBRA Continuation Coverage Ends | 34 |
| **Other Important Information** | 36 |
| No Guarantee of Employment | 36 |
| Future of the Plan | 36 |
| Statements Made by AutoNation | 36 |
| Plan Administrator | 36 |
| HIPAA Compliance | 36 |
| Security Measures | 38 |
| Right to Recover Overpayment | 38 |
| Subrogation & Reimbursement | 38 |
| Important Definitions | 40 |
| **Your Rights Under ERISA** | 45 |
| Benefit Inquiry & HIPAA Authorization for Release of Information From an AutoNation Plan | 46 |
| Administrative Information | 48 |
The AutoNation Dental Benefits Plan (“the Plan”) offers you a choice of two types of dental programs in most areas of the country — a Dental Preferred Provider Organization (DPPO) and, where available, a Dental Health Maintenance Organization (DHMO). The dental programs are designed to provide preventive and diagnostic services at little or no cost to you and provide help with the cost of basic and major restorative, prosthodontic and orthodontic services.

If you enroll for dental coverage under the Plan, you may also elect coverage for your Eligible Dependents, as defined in the Plan, under the same dental option as you elect for yourself.

Refer to “Your Coverage Options and Levels of Coverage.”

Who Is Eligible

You are eligible to participate in the Plan if you are a regular, Full-Time Associate of AutoNation, Inc. who is regularly scheduled to work at least 30 hours each week. See “When Coverage Begins.”

If you work under the provisions of a collective bargaining agreement, you are eligible to participate only if your agreement specifically provides for benefits under the AutoNation policies and Plans.

If You Transfer From One AutoNation Location to Another AutoNation Location

If you transfer from one AutoNation location to another, your eligibility status transfers with you to your new location. If you were enrolled in benefits at your previous location, you maintain the coverage you had in effect when you transfer as long as the option is available in the new location. You will receive a confirmation of your coverage. If the option you were enrolled in at your previous location is not available in the new location, you will be automatically enrolled in the designated default option and you will have 31 days from the date on the confirmation statement to change to another option.

If you are eligible after the transfer but were not previously eligible for benefits, the time you were employed Full-Time at your previous location will be counted toward the benefit eligibility (waiting) period at your new location.

If You Were Previously Part-Time and Become Full-Time

If you were previously a Part-Time, contract or temporary Associate and you become a Full-Time Associate, your prior service will not be credited toward your benefit eligibility (waiting) period.

If You Were Previously a Benefit Eligible Corporate Associate and Transferred into a Benefit Eligible Retail Associate Position

If you transfer from a benefit eligible Corporate position to a Retail benefit eligible position and previously met the waiting period under the Corporate Plan, your Effective Date of coverage under the Retail Plan will be the date of your transfer. If you had not met the waiting period under the Corporate Plan, your Effective Date of coverage will be determined under the Retail Plan’s eligibility provisions. You will receive credit for any hours worked as a Full-Time Associate under the Corporate Plan.
To enroll in the dental plan, you must first verify your eligibility. If you meet the requirements, you can enroll during the open enrollment period. If you have any questions or need assistance, please contact the benefits department at (123) 456-7890.

If you have questions or concerns about your dental benefits, please contact the benefits department at (123) 456-7890. You can also find more information on the company’s intranet or by visiting the benefits website. If you need to change your plan or make any changes to your coverage, please contact the benefits department as soon as possible.

If you or your dependent have a change in status that affects your eligibility for benefits, please notify the benefits department immediately. Failure to notify the benefits department in a timely manner may result in a delay in processing your claim or ineligibility for future coverage.

Please review this document carefully and sign the enrollment form. Return the completed form to the benefits department by the deadline to enroll in your dental plan.

If you have any questions or need assistance, please contact the benefits department at (123) 456-7890. Thank you for choosing our dental plan. We look forward to providing you with the best possible care.

[Signature]
[Your Name]
[Date]
ELIGIBILITY AND ENROLLMENT (CONTINUED)

- Subject to collective bargaining, unless the Plan is specifically included in the bargaining agreement
- A temporary or seasonal Associate, unless you work enough hours to become benefit eligible
- A leased Associate
- A contract Associate
- Employed by a location that does not participate in the Plan
- An Associate who is a nonresident alien receiving no earned income from sources within the United States

When Coverage Begins

If you are a new Associate, provided you enroll yourself and your Eligible dependents when you are first eligible to participate in the Plan, your coverage under the Plan is effective the first day of the fourth month after the month in which you were hired. However, if you are hired on the first day of a month your coverage under the Plan is effective the first day of the third month after the month in which you were hired. If you are not Actively at Work due to Injury, illness, temporary layoff or an approved Leave of Absence on the date coverage under the Plan normally would begin, coverage will begin on the date you return to Active Employment for one full day.

Coverage for your Eligible Dependents is effective when your coverage begins if you enroll your dependents and certify them with The Benefit Connection by the deadline at the same time you enroll. Otherwise, your dependents will be covered when they first become eligible or on the Qualifying Life Event date if you enroll them timely and submit proper documentation in support of the life event. See “Enrollment Change Due to a Qualifying Life Event.”

Leave of Absence

If you are on an approved Leave of Absence during your benefit eligibility (waiting) period, coverage begins for the option you elect on the date you would have become eligible had you been an Active Associate during your eligibility (waiting) period, if you are not actively at work due to injury, illness, temporary layoff or an approved Leave of Absence on the date coverage under the Plan normally would begin, coverage will begin on the date you return to Active Employment for one full day. If you do not enroll, you will be assigned to “no coverage.”

If you are enrolled in benefits and then go out on an approved Leave of Absence, you will be direct billed at the home address that is on file for you at The Benefit Connection. You will be billed on an after-tax basis the same amount that you would have paid as a contribution from your paycheck if you were an Active Associate. If you do not make any after tax payments while you are on leave, your benefits will be terminated retroactive to your Leave of Absence start date.

If you fail to continue to make timely after-tax payments via direct bill, your benefits will be terminated retroactive to the last date you paid in full. For the period you are on leave you must pay your required contributions in full by the due date specified on the direct bill (partial payments are not accepted).

Loss of coverage due to nonpayment is not considered a qualifying event under federal law (the Consolidated Omnibus Budget Reconciliation Act, known as COBRA).

When you return from an approved leave, your coverage will be reinstated, as of your return to work date, even if you lost coverage due to nonpayment. Payments for benefits for the dates you were on leave will not be automatically deducted from your paycheck upon your return to work.

After you have been on an approved Leave of Absence for six months, and if you had coverage immediately prior to and/or during your leave, COBRA continuation coverage will be offered to you.

If you return to work on your scheduled return to work date, your COBRA coverage will end, and your coverage that was in place prior to your Leave of Absence, if available, will be reinstated effective the day you return to work.

How to Enroll

You may enroll in benefits at the following times:

- Initial enrollment, occurs when you are hired and first become eligible for benefits
- Annual Enrollment, an enrollment period held once a year as determined by AutoNation
- An enrollment change permitted within 31 days of a Qualifying Life Event (within 60 days if you become eligible for Medicare/Medicaid/CHIP and 90 days for divorce)
Initial Enrollment

Prior to becoming eligible for benefits, you will receive notification that you can enroll online at www.KnowYourBenefits.org.

You must enroll online before the deadline indicated on the enrollment site. Contact The Benefit Connection at 1-877-550-BENE (2363) if you have questions concerning your online enrollment.

The elections you make will be effective the first day of the fourth month after the month in which you were hired. However, if you are hired on the first day of a month your coverage under the Plan is effective the first day of the third month after the month in which you were hired.

If you don’t enroll by the deadline indicated on The Benefit Connection website, you will have to wait until the next Annual Enrollment period to enroll, unless you experience a Qualifying Life Event during the Plan Year.

Annual Enrollment

Each year during Annual Enrollment, you may add, drop or change your level of coverage for the next Plan Year.

Before the Annual Enrollment period, you will be notified to log on to the benefit website at www.KnowYourBenefits.org.

To change your benefit elections, you must enroll online before the announced deadline. Contact The Benefit Connection at 1-877-550-BENE (2363) if you have questions concerning your online enrollment. The elections you make during the Annual Enrollment period will be effective for the following Plan Year, beginning January 1. If you do not actively enroll, your coverage will be defaulted according to the default rules for that Plan Year.

Enrollment Change Due to a Qualifying Life Event

If you are covered under the Plan, you may change your dental coverage if you experience certain Qualifying Life Events. If you are eligible and not currently enrolled, you may enroll in dental coverage if you experience a Qualifying Life Event.

Contact The Benefit Connection if you have questions regarding your Qualifying Life Event. Because you can pay for coverage on a pre-tax basis, certain federal income tax advantages apply to you. As a result, the Internal Revenue Service (IRS) sets certain restrictions on when you can make or change your pretax elections. Specifically, the elections you make during your initial or Annual Enrollment period must remain in effect for the entire Plan Year following the date you become eligible for coverage under the Plan.

If you experience a change in certain family or employment circumstances, you may enroll or change your benefits to fit your new situation without waiting for the next Annual Enrollment period. Any request to change your benefits must be consistent with the Qualifying Life Event.

The following are Qualifying Life Events:

- Marriage
- Divorce, legal separation or annulment
- Birth, adoption or placement for adoption of a child
- Death of your spouse or a dependent
- Change in eligibility status of a dependent
- Loss or gain of your spouse or dependents employment
- Change in your, your spouse or dependents employment status, such as a switch between Part-Time and Full-Time employment, a strike or lockout
- Significant change in the coverage provided to you, your spouse or your dependents
- A change in your place of residence or work, or that of your spouse or a dependent that affects your coverage
- You first become eligible for Medicare/Medicaid/CHIP coverage
- You, your spouse or your dependents originally declined coverage under this Plan due to coverage under another group health Plan, and you, your spouse or your dependents lose that coverage due to exhaustion of COBRA, loss of eligibility (for example, due to divorce or a dependent reaching age 26), or because Employer contributions toward that coverage were terminated

You may be required to cover a dependent if you are subject to a qualified medical child support order (QMCSO). If a QMCSO applies to you, you will be notified.
In some cases (e.g., your child becomes ineligible or you divorce), you may need to arrange for COBRA continuation coverage for your spouse or child, if it applies. See “COBRA Continuation Coverage” for details.

You must notify The Benefit Connection within 31 days of the life event (within 60 days if you become eligible for Medicare/Medicaid/CHIP and 90 days for divorce) and submit proper documentation, by the deadline, in support of it to change your current coverage during the Plan Year. If you do not notify The Benefit Connection within 31 days (within 60 days if you become eligible for Medicare/Medicaid/CHIP and 90 days for divorce) you will have to wait until the next Annual Enrollment period to make a change for the next Plan Year.

In addition, you may be required to provide documentation regarding the date of your status change. Intentionally providing false information may be considered grounds for termination or other legal action. Note that in the case of legal separation, divorce, death or loss of dependent status, the Plan reserves the right to terminate coverage for the ineligible individual at any time on a retroactive basis, to the extent permitted by law. Different time periods apply for HIPAA Special Enrollment Events.

Any change request must be consistent with your life event. As a result of a Qualifying Life Event, you may elect to add, drop or change your current coverage option under the Plan.

Your coverage change request, including any change in payroll deductions, will be effective on the date of the Qualifying Life Event (e.g., the date of your marriage or the date of your child’s birth) provided The Benefit Connection approves your request. You will be responsible for any retroactive benefit premiums owed if you added or had an increase in coverage.

By requesting this change, you certify that the information you are about to provide is true and correct. Any fraudulent statement, falsification or material omission of information may subject you to discipline up to and including termination of employment.

**Your Cost for Coverage**

Your cost for coverage under the Plan depends on the level of coverage and dental option you elect. Refer to The Benefit Connection website at www.KnowYourBenefits.org for the required contributions. You pay the full cost for coverage with pretax contributions. The cost may increase or decrease at the beginning of any Plan Year, January 1, as determined by AutoNation.

Pretax contributions are deducted from your pay each pay period before federal, Social Security and most state and local taxes are withheld. This reduces your taxable income and your net cost. Your Social Security benefit at retirement could be slightly reduced as a result. However, the tax savings usually offset the reduction.

During the Plan Year, your cost for coverage will be increased or decreased if either of the following events occurs:

- You transfer to another location or division with required contributions that differ
- You have a Qualifying Life Event and a change in the level of coverage. For example, if you are married during the Plan Year and add your spouse to coverage, the required contribution will change to the “Associate plus One Dependent” level instead of the “Associate Only” level of coverage

If you are enrolled in benefits and then go out on an approved Leave of Absence, you will be direct billed at the home address that is on file for you at The Benefit Connection. You will be billed on an after-tax basis the same amount that you paid as a contribution from your paycheck if you were an Active Associate. If you do not make any after tax payments while you are on leave, your benefits will be terminated retroactive to your Leave of Absence start date. If you fail to continue to make timely after-tax payments via direct bill, your benefits will be terminated retroactive to the last date you paid in full. For the period you are on leave you must pay your required contributions in full by the due date specified on the direct bill (partial payments are not accepted).

When you return from an approved leave, your coverage will be reinstated as of your return to work date, even if your loss of coverage was due to nonpayment. Payments for benefits for the dates you were on leave will not be automatically deducted from your paycheck upon your return to work.
HOW THE PLAN WORKS

Your Coverage Options and Levels of Coverage

Once each year during Annual Enrollment and/or if you experience a Qualifying Life Event, you will be given the opportunity to choose from one of the following options:

- Dental PPO
- Dental HMO, where available
- No dental coverage through AutoNation

If you enroll in dental coverage when you become eligible and/or experience a Qualifying Life Event, you may also elect to cover your Eligible Dependents. There are three levels of coverage from which to choose:

- You Only
- You Plus One Dependent
- You Plus Two or More Dependents

Dental PPO

Under any Dental PPO option, you may choose any Dentist to perform your necessary dental treatment. However, if the Dentist is participating under the Total Cigna DPPO network, pre-negotiated fees will apply to you, and covered dental services will be paid subject to the in-network schedule of benefits. You can expect to save on out-of-pocket costs since the participating Dentists will not charge you for any cost of a covered dental procedure that exceeds the negotiated fee for that procedure. You will be responsible only for payment of the difference between the Plan’s in-network benefit and the negotiated fee for a dental service that is covered under the Plan.

Benefits for in-network care are based on negotiated discounted fees. For out-of-network care, benefits are based on the Maximum Reimbursable Charge (MRC), as defined in the Plan, for the dental procedure or treatment. Amounts in excess of the Maximum Reimbursable Charge, if applicable, are not covered by the Plan.

If you choose to have your covered services performed by a Dentist who does not participate with the Total Cigna DPPO network, you are responsible for any charges above the Maximum Reimbursable Charge and any amount in excess of the Plan’s benefit and the Dentist’s charge, which will cost you more. Refer to the in-network and Out-of-Network Benefits in the respective Dental PPO benefits schedule.

Covered Services Under the Dental PPO

Benefits are payable under the Plan for the following dental services:

- Preventive and diagnostic dental services, such as exams and cleanings
- Basic services, such as amalgam fillings, root canals and simple extractions
- Major restorative services, such as crowns, complete dentures and certain appliances
- Orthodontic services for dependent children and adults

The Plan pays benefits only for dental treatment or services that meet all of the following requirements:

- Medically Necessary and/or Dentally Necessary
- Provided by or under the direction of a Dentist
- The least costly, clinically accepted treatment; covered after Your Deductible, if any, has been met;
- Eligible for reimbursement because the maximum annual benefit has not been exceeded;
- The charge does not exceed the amount allowed under the Alternate Benefit Provision;

Services are covered if they are essential for the necessary care of the teeth provided the treatment begins and ends while you or your Eligible Dependents are covered under the Plan. Dental Service begins when the actual service is performed, except for the following procedures:

- Treatment for fixed bridgework or full or partial dentures; service begins when the initial impressions are taken, and/or the abutment teeth are prepared
- Treatment for a crown, inlay or onlay; service begins when the tooth is prepared for the crown, inlay or onlay
- Root canal therapy; service begins when the pulp chamber of the tooth is opened
HOW THE PLAN WORKS (CONTINUED)

Annual Deductible

Your Annual Deductible, if required by your option, is the amount you must spend for covered dental service expenses each Plan Year, January 1—December 31 or your covered period, before the Plan pays benefits if you receive dental services with Cigna. After the individual Annual Deductible is met, the Plan pays a certain percentage of Covered Expenses incurred by the covered individual in the respective Dental benefits schedule.

Associates who also have enrolled themselves and one or more Eligible Dependents under the Plan will not pay more than the “family” Annual Deductible before benefits are payable under the Plan for covered services for family members. If that occurs, any other covered family members will not have to satisfy an Annual Deductible for the rest of the Plan Year for covered services before the Plan pays benefits.

The Annual Deductible contributed by any one family member toward the total family Annual Deductible will not exceed the “individual” Annual Deductible amount.

Coinsurance

Coinsurance is the specific percentage of the Allowance that you pay for covered dental services. Refer to the respective Dental benefits schedule for the Coinsurance percentages.

Maximum Annual Benefit

The Maximum Annual Benefit is the most the Plan will pay for a covered individual during the Plan Year, January 1—December 31. When you or a covered dependent reaches the Maximum Annual Benefit limit, benefits under the Plan are not payable for any additional dental services for that individual for the rest of the Plan Year. The Maximum Annual Benefit does not include any benefits payable for covered orthodontic services, which have a separate Maximum Lifetime Benefit. Refer to the Maximum Annual Benefit in each respective Dental benefits schedule.

Orthodontic Maximum Lifetime Benefit

The Plan pays up to $1,500 or $2,000 Maximum Lifetime Benefit for covered orthodontia treatment and/or appliances for each covered dependent child and adult. Refer to the respective Dental benefits schedule.

In-Network Benefits

In-network benefits are payable for covered services that are:

- Performed or prescribed by a Dentist who participates as a Total Cigna DPPO network provider, and
- Necessary in terms of generally accepted dental standards

Locating a Participating Dental Provider

For a list of participating Dentists in your local area, call Cigna at 1-800-CIGNA24 or visit www.KnowYourBenefits.org.

Out-of-Network Benefits

Out-of-network benefits are available for covered Dental Services that are:

- Performed or prescribed by a Dentist who does not participate with Cigna Dental, and
- Necessary in terms of generally accepted dental standards

Pre-Treatment Review

If your Dentist recommends treatment that is expected to exceed $300 or if a dental exam reveals the need for fixed bridgework, you should ask your Dentist to submit a treatment Plan for a Pre-Treatment Review within 20 days of the exam. Pre-Treatment Review will let you know whether the Plan will cover the proposed treatment and the estimated benefit provided under the Plan before treatment begins. This will also serve as an estimate for out-of-pocket expenses. The Dentist may submit a request to Cigna Dental online at www.cigna.com or call 1-800-CIGNA24.

You and your Dentist will receive a statement from Cigna indicating the estimated coverage available under the Plan for the proposed treatment.
### Schedule of Cigna Dental Plus Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Service</th>
<th>In-Network Benefits¹</th>
<th>Out-of-Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim form required</strong></td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Individual</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>- Family</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td><strong>Maximum Annual Benefit per covered individual</strong></td>
<td>$1,500</td>
<td></td>
</tr>
<tr>
<td><strong>Preventive and Diagnostic Services</strong></td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Oral exams – 2 per calendar year</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Cleaning of teeth (oral prophylaxis) – 2 per calendar year</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Bitewing X-rays – 2 images per calendar year</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Panoramic or full mouth X-rays – 1 set per 36 consecutive months</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Fluoride treatment – 2 treatments per calendar year for children up to age 19</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Sealants – 1 per tooth per 36 consecutive months for children under age 16</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>- Palliative (emergency) treatment of dental pain, if no other services other than X-rays and exam were done during the visit</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td><strong>Fillings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Amalgam filling – primary and permanent teeth</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>- Composite/resin filling</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Periodontal maintenance – limited to 2 times per calendar year following active periodontal therapy within the prior 24 months</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>- Periodontal surgery – 1 per tooth per 24 consecutive months per area of the mouth</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>- Periodontal scaling and root planning – 1 per quadrant per rolling 24 months</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>- Surgical extraction, including impacted teeth</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>- Root canal therapy</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>- Simple extractions</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>- Surgical removal of erupted tooth</td>
<td></td>
<td>60%</td>
</tr>
<tr>
<td>- General anesthesia³ – covered when Medically Necessary</td>
<td></td>
<td>60%</td>
</tr>
</tbody>
</table>
HOW THE PLAN WORKS (CONTINUED)

### Schedule of Cigna Dental Plus Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Service</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High noble (gold) or crown restorations are covered dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, or composite/resin restoration. Limited to 1 per 60 months period.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>▪ Fixed bridges 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Crowns 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Crown repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Inlays and onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Full dentures 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Partial dentures 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Relining dentures – Limited to 1 per tooth per 12 consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Repairs to dentures, partial dentures, crowns and bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Adjustments to dentures, partial dentures, crowns and bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Appliances for bruxism, including but not limited to occlusal guards and night guards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Implant services, implant supported cast restorations and implant supported fixed and removable dentures no more than 1 per tooth per 60 consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Repair of implants — limited to 1 in 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td>40% up to a $1,500 Maximum Lifetime Benefit</td>
<td>40% up to a $1,500 Maximum Lifetime Benefit</td>
</tr>
<tr>
<td>Orthodontia including appliance therapy for children and adults for the following services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Orthodontic work-up including:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o X-rays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Diagnostic casts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Treatment plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>o Fixed or removable retention appliances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Active monthly treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Participating in-network Dentists agree to accept the negotiated rate as payment in full for covered services. Your Coinsurance amount is based on the negotiated rate.

2 Charges above the maximum Reimbursable Charge as determined by the Claims Administrator are not payable under the Plan.

3 Anesthesia benefit differs by service. Check with the Plan for details.

4 Subject to Medical Necessity following six years since initial installation.
### HOW THE PLAN WORKS (CONTINUED)

#### Schedule of Cigna Dental Premium Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Service</th>
<th>In-Network Benefits¹</th>
<th>Out-of-Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim form required</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Individual</td>
<td>$100</td>
<td>$100</td>
</tr>
<tr>
<td>▪ Family</td>
<td>$300</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Maximum Annual Benefit per covered individual³</strong></td>
<td></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Annual Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Individual</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Family</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive and Diagnostic Services</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>▪ Oral exams – 2 per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Cleaning of teeth (oral prophylaxis) – 2 per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Bitewing X-rays – 2 images per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Panoramic or full mouth X-rays – 1 set per 36 consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Fluoride treatment – 2 treatments per calendar year for children up to age 19</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Sealants – 1 per tooth per 36 consecutive months for children under age 16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Palliative (emergency) treatment of dental pain, if no other services other than X-rays and exam were done during the visit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Fillings and General Anesthesia</strong></td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>▪ Amalgam filling – primary and permanent teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Composite/resin filling</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td>75%</td>
<td>75%</td>
</tr>
<tr>
<td>▪ Periodontal maintenance – limited to 2 times per calendar year following active periodontal therapy within the prior 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Periodontal surgery – 1 per tooth per 24 consecutive months per area of the mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Periodontal scaling and root planning – 1 per quadrant per rolling 24 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Surgical extraction, including impacted teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Root canal therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Simple extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ Surgical removal of erupted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>▪ General anesthesia³ – covered when Medically Necessary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### HOW THE PLAN WORKS (CONTINUED)

#### Schedule of Cigna Dental Plus Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Service</th>
<th>In-Network Benefits(^1)</th>
<th>Out-of-Network Benefits(^2)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High noble (gold) or crown restorations are covered dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, or composite/resin restoration. Limited to 1 per 60 months period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fixed bridges(^4)</td>
<td>60%</td>
<td>60%</td>
</tr>
<tr>
<td>- Crowns(^4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Crown repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Inlays and onlays</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Full dentures(^4)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Partial dentures(^4)</td>
<td>50% up to a $2,000</td>
<td>50% up to a $2,000</td>
</tr>
<tr>
<td>- Relining dentures –Limited to 1 per tooth per 12 consecutive months</td>
<td>Maximum Lifetime Benefit</td>
<td>Maximum Lifetime Benefit</td>
</tr>
<tr>
<td>- Repairs to dentures, partial dentures, crowns and bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Adjustments to dentures, partial dentures, crowns and bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Appliances for bruxism, including but not limited to occlusal guards and night guards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Implant services, implant supported cast restorations and implant supported fixed and removable dentures no more than 1 per tooth per 60 consecutive months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Repair of implants — limited to 1 in 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia including appliance therapy for children and adults for the following services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Orthodontic work-up including:</td>
<td>50% up to a $2,000</td>
<td>50% up to a $2,000</td>
</tr>
<tr>
<td>- X-rays</td>
<td>Maximum Lifetime Benefit</td>
<td>Maximum Lifetime Benefit</td>
</tr>
<tr>
<td>- Diagnostic casts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Treatment plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Fixed or removable retention appliances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Active monthly treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\(^1\) Participating in-network Dentists agree to accept the negotiated rate as payment in full for covered services. Your Coinsurance amount is based on the negotiated rate.

\(^2\) Charges above the maximum Reimbursable Charge as determined by the Claims Administrator are not payable under the Plan.

\(^3\) Anesthesia benefit differs by service. Check with the Plan for details.

\(^4\) Subject to Medical Necessity following six years since initial installation.
Exclusions

Under any Dental PPO option, the Plan does not pay benefits for any of the following services, supplies or Charges, among others. For limitations on specific covered services, please see the certificate of coverage.

- Replacement of a partial denture, complete denture, fixed bridge, any prosthesis, over implant, or the addition of teeth to a partial denture is not covered, unless the replacement is needed due to a necessary extraction of an additional functioning natural tooth while the person is covered under this plan (alternate benefits of adding a tooth to an existing appliance may be applied);

- Replacement of a crown, bridge, onlay, post/post and core, or other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture within the frequency limitation stated on the Schedule is not covered unless:
  - the replacement is made Necessary by the placement of an original opposing complete denture or the Necessary extraction of Natural Teeth; or
  - the crown, bridge, onlay, post/post and core, other laboratory prepared or CAD/CAM prepared restoration, partial denture, or complete denture while in the mouth, has been damaged beyond repair as a result of an injury received while a person is insured for these benefits;

- Replacement of any amalgam or resin-based composite restoration involving the same surface(s) on the same tooth by the same Dentist or a different Dentist in the same office within the frequency limitation stated on the certificate of coverage is not covered;

- A combination of radiographic images (such as ten or more periapical radiographic images; or a panoramic radiographic image with bite-wing radiographic images) completed on the same date of service will not be covered when the allowance meets or exceeds the allowance for an intraoral complete series of radiographic images. Plan reimbursement will be based on an intraoral complete series;

- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth. Allowable only on teeth with both periodontal pocket depths of 5 mm or greater and a prior history of periodontal therapy. Not allowable when more than eight (8) of these procedures are reported on the same date of service;

- Tissue preparation such as gingivectomy/gingivoplasty or crown lengthening as a separate allowance on the same date as a restoration on the same tooth;

- When covered by the Plan, any prosthesis over an implant is subject to the same exclusions, limitations, alternate benefit provisions, time limitations, and missing tooth limitations as standard traditional restorative, fixed and removable prosthetics;

- Covered Services to the extent that billed charges exceed the rate of reimbursement as described in the certificate of coverage;

- Any replacement of a crown, bridge, partial denture, or complete denture which is or can be made usable according to commonly accepted dental standards;

- Crowns, inlays, cast restorations, or other laboratory prepared or CAD/CAM prepared restorations on teeth unless the tooth cannot be restored with an amalgam or resin-based composite restoration due to major decay or fracture;

- Periodontal soft tissue surgery is limited to an allowance of three (3) qualifying teeth per quadrant in a twelve-month period (or per calendar year); and to one benefit per tooth every 36 months.

The benefits provided under the Plan will be reduced so that the total payment will not be more than 100% of the charge made for the dental service if benefits are provided for that service under the Plan and any medical expense plan or prepaid treatment program sponsored or made available by AutoNation.

Expenses Not Covered

Covered Dental Expenses will not include, and no payment will be made for:

- any services not stated in the certificate of coverage;

- procedures that are a covered expense under any other medical plan which provides group hospital, surgical, or medical benefits whether or not on an insured basis;

- charges incurred due to injuries which are intentionally self-inflicted;

- for services related to an injury or illness paid and/or received under workers’ compensation, occupational disease or similar laws;

- charges made by a hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected condition;
• services or supplies received as a result of dental disease, defect or injury due to an act of war, declared or undeclared;
• consultations and/or evaluations associated with services that are not covered;
• cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) which may include but is not limited to the following: bleaching (tooth whitening), facings, repairs to facings or replacement of facings on crowns or bridge units on molar teeth will always be considered cosmetic;
• replacement of fixed and/or removable appliances (including fixed and removable orthodontic appliances, if orthodontics is covered) that have been lost, stolen, or damaged due to patient abuse, misuse, or neglect;
• procedures, services, supplies, restorations, or appliances (except complete dentures), whose sole or primary purpose is to change or maintain vertical dimension;
• procedures, services, supplies, restorations or appliances whose main purpose is to diagnose or treat jaw joint problems, including dysfunction of the temporomandibular joint and craniomandibular disorders, or other conditions of the joints linking the jawbone and skull, including the complex muscles, nerves and other tissues related to that joint;
• occlusal adjustment or the alteration or restoration of occlusion;
• the restoration of teeth which have been damaged by erosion, attrition, abfraction or abrasion;
• bite registration or bite analysis;
• porcelain, ceramic, resin, or acrylic materials on crowns or pontics on, or replacing the upper or lower first, second and/or third molars;
• services to correct congenital malformations, including the replacement of congenitally missing teeth;
• procedures, restorations, appliances or services to stabilize periodontally involved teeth;
• fixed or removable space maintainers for patients on or after their 20th birthday;
• myofunctional therapy;
• the recementation and/or repair of any inlay, onlay, crown, post and core, or fixed bridge within 6 months of initial placement by the same Dentist or a different Dentist in the same office. We consider recementation and/or repair within this timeframe to be incidental to and part of the charges for the initial restoration;
• replacement of a partial denture or complete denture which can be made serviceable;
• prescription drugs;
• treatment of jaw fractures and/or orthognathic surgery;
• the treatment of cleft lip and cleft palate;
• charges for sterilization of equipment, infection control processes and procedures, disposal of medical waste or other requirements mandated or recommended by the Centers for Disease Control and Prevention (CDC), OSHA or other regulatory agencies; We consider these to be incidental to and part of the charges for services provided and not separately chargeable;
• charges for travel time; transportation costs; or professional advice given on the phone;
• temporary, transitional or interim dental services;
• personal supplies, including but not limited to toothbrushes, rotary toothbrushes, floss holders, and water irrigation devices;
• charges for broken appointments; completion of claim forms; duplication of x-rays and/or exams required by a third party;
• services that are deemed to be medical services;
• any charges, including ancillary charges, for services and supplies received from a hospital, outpatient facility, ambulatory surgical center or similar facility;
• charges for treatment or surgery that does not meet plan guidelines;
• general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management;
• indirect pulp capping on the same date of service as a permanent restoration, We consider this to be incidental to and part of the charges for services provided and not separately chargeable;
• additional/incremental costs associated with optional/elective orthodontic materials including but not limited to ceramic, clear, or lingual brackets, or other cosmetic appliances including clear aligners; orthognathic surgery and associated incremental costs; appliances to guide minor tooth movement; and services which are not typically included in orthodontic treatment. These services will be identified on a case-by-case basis. This exclusion applies when orthodontics is covered under the Plan;
• endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis;

• intentional root canal treatment in the absence of injury or disease solely to facilitate a restorative procedure;

• services to the extent you or your enrolled Dependent(s) are compensated under any group medical plan;

• house/extended care facility calls; hospital calls; office visits for observation (during regularly scheduled hours) when no other services are performed; office visits after regularly scheduled hours; and case presentations;

• procedures performed by a Dentist who is a member of the covered person’s family except in the case of a dental emergency when no other Dentist is available. (Covered person’s family is limited to a spouse, siblings, parents, children, grandparents, and the Spouse’s siblings and parents);

• dental services that do not meet commonly accepted dental standards;

• replacement of teeth beyond the normal adult dentition of thirty-two (32) teeth;

• services not included in the list of Covered Services, unless Cigna agrees to accept such expense as a Covered Dental Expense, in which case payment will be made consistent with similar services which would provide the least expensive professionally satisfactory result;

• to the extent that you or any of your covered Dependents are in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;

• charges in excess of the Maximum Reimbursable Charge allowances;

• procedures for which a charge would not have been made if the person had no insurance or for which the person is not legally required to pay. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of the Copayment, Deductible, and/or Coinsurance amount(s) You are required to pay for a Covered Service without Cigna’s express consent, Cigna shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the Copayment, Deductible, and/or Coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that the Plan does not cover. Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a non-participating provider who has agreed to charge you or charged you at an In-Network benefits level or some other benefits level not otherwise applicable to the services received;

• charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law;

• Covered Services to the extent that payment is unlawful where the covered person resides when the expenses are incurred;

• charges for or in connection with experimental procedures or treatment methods not recognized and approved by the American Dental Association or the appropriate dental specialty organization;

• charges which would not have been made in any facility, other than a hospital or a correctional institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;

• services for which benefits are not payable according to the certificate of coverage;

• procedures which are not included in the list of Covered Dental Expenses;

• procedures which are not necessary and which do not have uniform professional endorsement;

• for charges for unnecessary care, treatment or surgery;
Claims Procedures Under the Dental PPO

There’s no paperwork to submit for Covered Services received from a Participating Provider. Your provider will submit a claim to Cigna Dental for reimbursement. Claims for services received from a Non-Participating Provider can be submitted by the provider if the provider is able and willing to file on your behalf.

If the provider is not submitting on your behalf, you must send a completed claim form and itemized bills to the claims address listed below.

Follow the steps below to ensure that your claim will be processed for payment consideration as efficiently as possible. Cancelled checks, cash register receipts or personal itemizations are not acceptable.

- Know your Plan benefits to determine if the services you receive are eligible for dental coverage.
- Obtain an original, itemized bill that includes the following:
  - Patient’s full name
  - Amount charged
  - Date of service
  - Description of the service or supply
  - Diagnosis or nature of Injury
  - Name, address, tax identification number and signature of the dental service provider
- If you have already paid for the services received, submit proof of the payment with your claim.
- Make a copy for your records.
- Complete the claim form, including your signature and date, attach your itemized bills and mail to:

Cigna Dental
P.O. Box 188037
Chattanooga, TN 37422

Claim forms are available on Cigna’s website at https://www.cigna.com/individuals-families/member-resources/claims-authorizations-eob/how-to-file or by calling 1-800-CIGNA24.

Explanation of Benefits

When the claim is processed, you will receive an Explanation of Benefits (EOB) statement from Cigna. The EOB will include the provider’s charge, allowable amount(s), Coinsurance amount(s) and Annual Maximum if they apply, total benefits paid and the amount you owe to the provider. You are responsible for any applicable Annual Deductible, Coinsurance and any amount over the Maximum Reimbursable Charge, if applicable, plus any Charges for services that are not covered under the Plan.

Claim-Filing Deadline

Dental claims must be filed under the Plan within one year of the date the services are performed.

If you fail to do so, the claim will be denied even if the services otherwise would have been covered under the Plan.

Refund of Overpaid Benefits

Cigna has the right to obtain a refund from you for overpayment of benefits if it is found that it has paid more benefits than should have been paid for expenses incurred by you or a covered dependent.

The amount of the refund will be the difference between the amount of benefits paid under the Plan for the expenses and the amount of benefits that should have been paid under the Plan for those same expenses.

What If Your Dental PPO Claim Is Denied

The Claims Administrator will notify you in writing of the initial determination within a reasonable period of time, but no later than 45 days after your claim is received by the Plan.

If the Claims Administrator does not respond to your claim within 45 days, you immediately should contact the Claims Administrator. For circumstances beyond the control of the Plan, the Claims Administrator is allowed an additional period (up to 30 days) within which to notify you of their decision. If such an extension is required, the Claims Administrator will send written notice before the original 45 days expire indicating the reason for the delay and the date you may expect a final decision. If prior to the end of the first 30-day extension period, the Claims Administrator determines that a decision cannot be rendered within the first extension period due to circumstances beyond the control of the Plan, the determination period may be extended for up to an additional 30 days if the Claims Administrator notifies you prior to the expiration of the first 30-day extension, and relate the...
circumstances requiring the extension and the date by which the final decision will be rendered.

The Claims Administrator’s notice of denial shall include the following information:

- Specific reason or reasons for denial with reference to those policy provisions on which the denial is based
- Description of any additional material or information necessary to complete the claim and why that material or information is necessary
- Description of the Plan’s review procedures and applicable time limits, and a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA)

In addition, the following information concerning the denial shall be provided free of charge upon request:

- If an internal rule, guideline, protocol or similar criteria are relied upon in making the denial, either the rule, guideline, protocol or similar criteria or a copy of the rule, guideline or protocol will be provided
- If the denial is based on a Medical Necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or such explanation will be provided

For details about how to appeal a denied claim, refer to “How to Appeal a Denied Claim.”

Dental HMO

Under the Dental HMO option, Dentists contract with the Network Manager to provide dental services to patients for a fixed charge. You will receive a Patient Charge Schedule when you are eligible and enroll for coverage under this option. This schedule will let you know how much you will pay for dental procedures that are covered under this option.

The Dental HMO option is available in most parts of the country. Where available, the Network Manager is Cigna Dental.

This option pays a higher level of benefits for most preventive care services. To receive any covered dental services, you must have all of your dental treatment performed by your preselected network Dentist or a dental provider to whom he or she refers you. To request a dental HMO network directory, a list of participating network Dentists in your area and a Patient Charge Schedule, call Cigna Dental at 1-800-244-6224. Or, you can access information online at www.cigna.com/dental

If you enroll in the Dental HMO option, the appropriate Network Manager will issue an identification card to you.

Covered Services Under the Dental HMO

The Dental HMO option provides coverage for the following dental treatment:

- Preventive care, including routine oral exams, cleanings and X-rays (every six months)
- Basic restorative services, including amalgam fillings, root canals and simple extractions, which are covered at a fixed charge amount as indicated in the Network Manager’s Patient Charge Schedule
- Major restorative services, including crowns, complete dentures and appliances, which are covered at a fixed charge amount as indicated in the Network Manager’s Patient Charge Schedule
- Orthodontic services, which are covered at a fixed charge amount as indicated in the Network Manager’s Patient Charge Schedule

Covered Service Limitations

The following are covered service limitations under the Dental HMO option:

- Frequency - The frequency of certain Covered Services, like cleanings, is limited. Your Patient Charge Schedule lists any limitations on frequency.
- Pediatric Dentistry - Coverage for treatment by a Pediatric Dentist ends on your child’s 7th birthday. Effective on your child’s 7th birthday, dental services must be obtained from a Network General Dentist however, exceptions for medical reasons may be considered on an individual basis.
- Oral Surgery - The surgical removal of an impacted wisdom tooth may not be covered if the tooth is not diseased or if the removal is only for orthodontic reasons. Your Patient Charge Schedule lists any limitations on oral surgery.
- Periodontal (gum tissue and supporting bone) Services – Periodontal regenerative procedures are limited to one regenerative procedure per site (or per tooth, if applicable), when covered on the Patient Charge Schedule. Localized delivery of antimicrobial agents is
limited to eight teeth (or eight sites, if applicable) per 12 consecutive months, when covered on the Patient Charge Schedule

- Clinical Oral Evaluations – When this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.

- Surgical Placement of Implant Services – When covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.

- Prosthesis Over Implant - When covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

Selecting a Dental Facility

You may select a Dentist from the list provided by Cigna. If your first choice of a Dentist is not available, you will be notified by Cigna of your designated Dentist, based on your alternate selection. No dental benefits are covered unless the dental service is received from your designated Dentist, referred by a Network General Dentist at that facility to a specialist approved by Cigna, or otherwise authorized by Cigna, except for emergency dental treatment.

A transfer from one Dentist to another Dentist may be requested by you through Cigna by calling 1-800-CIGNA24. Any such transfer will take effect on the first day of the month after it is authorized by Cigna. A transfer will not be authorized if you or your eligible dependent has an outstanding balance with the Dentist.

Network Benefits

The Network Manager — Cigna Dental— will pay for covered dental services received by you or your covered dependents, except for your cost for each dental procedure as indicated in the Patient Charge Schedule.

Covered dental services under the Dental HMO option are the services listed in the Network Manager’s Patient Charge Schedule that meet all of the following requirements:

- They are performed by or under the direction of the preselected participating dental facility, or upon referral by the participating general Dentist to an approved specialist as authorized by the Network Manager
- They are essential for the necessary care of the teeth and supporting structure (gums)
- The treatment begins and ends while the person is covered under the Plan

Dental service begins when the actual service is performed, except for any of the following procedures:

- Treatment for fixed bridgework and full or partial dentures; service begins when the initial impressions are taken, and/or the abutment teeth are prepared
- Treatment for a crown, inlay or onlay; service begins when the tooth is prepared for the crown, inlay or onlay
- Root canal therapy; service begins when the pulp chamber of the tooth is opened

Specialty Referrals

Upon referral from a Network General Dentist, your Network Specialty Dentist will submit a specialty care treatment plan to Cigna Dental for payment authorization, except for Pediatrics, Orthodontics and Endodontics, for which prior authorization is not required. You should verify with the Network Specialty Dentist that your treatment plan has been authorized for payment by Cigna Dental before treatment begins.

When Cigna Dental authorizes payment to the Network Specialty Dentist, the fees or no-charge services listed on the Patient Charge Schedule in effect on the date each procedure is started will apply. Treatment by the Network Specialty Dentist must begin within 90 days from the date of Cigna Dental's authorization. If you are unable to obtain treatment within the 90-day period, please call Cigna (1-800-CIGNA24) to request an extension. Your coverage must be in effect when each procedure begins.
HOW THE PLAN WORKS (CONTINUED)

For non-Covered Services or if Cigna Dental does not authorize payment to the Network Specialty Dentist for Covered Services, including Adverse Determinations, you must pay the Network Specialty Dentist directly. If you have a question or concern regarding an authorization or a denial, contact Cigna at 1-800-CIGNA24.

After the Network Specialty Dentist has completed treatment, you should return to your Network General Dentist for cleanings, regular checkups and other treatment. If you visit a Network Specialty Dentist without a referral or if you continue to see a Network Specialty Dentist after you have completed specialty care, it will be your responsibility to pay for treatment.

Refer to the certificate of coverage for additional information regarding Specialty Referrals.

Complex Rehabilitation

Complex rehabilitation is extensive dental restoration involving 6 or more “units” of crown, bridge and/or implant supported prosthesis (including crowns and bridges) in the same treatment plan. Using full crowns (caps), fixed bridges and/or implant supported prosthesis (including crowns and bridges) which are cemented in place, your Network General Dentist will rebuild natural teeth, fill in spaces where teeth are missing and establish conditions which allow each tooth to function in harmony with the occlusion (bite). The extensive procedures involved in complex rehabilitation require an extraordinary amount of time, effort, skill and laboratory collaboration for a successful outcome.

Complex rehabilitation will be covered when performed by your Network General Dentist after consultation with you about diagnosis, treatment plan and charges. Each tooth or tooth replacement included in the treatment plan is referred to as a “unit” on your Patient Charge Schedule. The crown, bridge and/or implant supported prosthesis (including crowns and bridges) charges on your Patient Charge Schedule are for each unit of crown or bridge. You pay the per unit charge for each unit of crown, bridge and/or implant supported prosthesis (including crowns and bridges) PLUS an additional charge for each unit when 6 or more units are prescribed in your Network General Dentist’s treatment plan.

Note: Complex rehabilitation only applies for implant supported prosthesis, when implant supported prosthesis are specifically listed on your Patient Charge Schedule.

Emergency Dental Treatment

If you or your covered dependents receive emergency dental treatment by a Dentist other than your participating general Dentist, the Dental HMO option will pay for Covered Expenses up to $50, or at the usual and customary rate for each such emergency, less any amount listed in the Network Manager’s Patient Charge Schedule, provided that:

- The need for treatment occurs at least 50 miles from the patient’s home, or
- The patient is unable to contact his or her designated participating dental facility, and
- Treatment is performed during regular office hours and is not received in a hospital

“Emergency dental treatment” means diagnostic and palliative procedures administered in the event of a dental emergency that causes acute pain requiring immediate treatment.

Benefits under the Dental HMO are payable if the dental service is received from your designated participating dental facility, referred by a participating general Dentist at that facility to a specialist approved by the Network Manager or otherwise authorized by the Network Manager, except as described previously.

Exclusions

Under the Dental HMO option, the Plan does not pay benefits for any of the following services, supplies or Charges, among others (refer to your certificate of coverage for additional information):

- services not listed on the Patient Charge Schedule.
- services provided by a non-Network Dentist without Cigna Dental’s prior approval
- services to the extent you, or your Dependent, are compensated for them under any group medical plan.
- services considered to be unnecessary or experimental in nature or do not meet commonly accepted dental standards.
- surgical placement of a dental implant; repair, maintenance or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant, unless specifically listed on your Patient Charge Schedule.
• cosmetic dentistry or cosmetic dental surgery (dentistry or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule. If bleaching (tooth whitening) is listed on your Patient Charge Schedule, only the use of take-home bleaching gel with trays is covered; all other types of bleaching methods are not covered.

• prescription medications.

• hospitalization, including any associated incremental charges for dental services performed in a hospital. (Benefits are available for Network Dentist charges for Covered Services performed at a hospital. Other associated charges are not covered and should be submitted to the medical carrier for benefit determination. If special circumstances arise where a Network Dentist is not available, the Plan will make special arrangements for the provision of covered benefits as necessary for the dental health of the customer.)

• procedures, appliances or restorations if the main purpose is to: change vertical dimension (degree of separation of the jaw when teeth are in contact); restore asymptomatic teeth where loss of tooth structure was caused by attrition, abrasion, erosion and/or abfraction and the primary purpose of the restoration is: to change the vertical dimension of occlusion; or for cosmetic purposes.

• procedures or appliances for minor tooth guidance or to control harmful habits.

• charges by dental offices for failing to cancel an appointment or canceling an appointment with less than 24 hours’ notice (i.e. a broken appointment). You will be responsible for paying any broken appointment fee unless your broken appointment was unavoidable due to emergency or exigent circumstances.

• consultations and/or evaluations associated with services that are not covered.

• infection control and/or sterilization. Cigna Dental considers this to be incidental to and part of the charges for services provided and not separately chargeable.

• services to correct congenital malformations, including the replacement of congenitally missing teeth.

• there is no coverage for crowns, bridges used solely for splinting. This exclusion will not apply if a crown or bridge is determined by Cigna Dental to be the treatment most consistent with professionally accepted standards of care.

• there is no coverage for implant supported prosthesis used solely for splinting unless specifically listed on your Patient Charge Schedule.

• there is no coverage for resin bonded retainers and associated pontics.

• general anesthesia, sedation and nitrous oxide are not covered, unless specifically listed on your Patient Charge Schedule. There is no coverage for general anesthesia or intravenous sedation when used for the purposes of anxiety control or patient management.

• replacement of fixed and/or removable orthodontic appliances (including fixed and removable orthodontic appliances) that have been lost, stolen, or damaged due to patient abuse, misuse or neglect.

• endodontic treatment and/or periodontal (gum tissue and supporting bone) surgery of teeth exhibiting a poor or hopeless periodontal prognosis.

• the recementation of any inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration.

• the recementation of any implant supported prosthesis (including crowns, bridges and dentures) within 180 days of initial placement. Cigna Dental considers recementation within this timeframe to be incidental to and part of the charges for the initial restoration unless specifically listed on your Patient Charge Schedule.

• the replacement of an occlusal guard (night guard) beyond one per any 24 consecutive month period, when this limitation is noted on the Patient Charge Schedule.

• intentional root canal treatment in the absence of injury or disease to solely facilitate a restorative procedure.

• bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction, unless specifically listed on your Patient Charge Schedule.

• bone grafting and/or guided tissue regeneration when performed in conjunction with an apicoectomy or periradicular surgery.

• localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy.
### Limitations

No payment will be made for expense incurred or services received:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit;
- for charges which would not have been made in any facility, other than a Hospital or a Correctional Institution owned or operated by the United States Government or by a state or municipal government if the person had no insurance;
- to the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- for the charges which the person is not legally required to pay;
- for charges which would not have been made if the person had no insurance;
- due to injuries which are intentionally self-inflicted;
- when this limitation is noted on the Patient Charge Schedule, periodic oral evaluations, comprehensive oral evaluations, comprehensive periodontal evaluations, and oral evaluations for patients under 3 years of age, are limited to a combined total of 4 evaluations during a 12 consecutive month period.
- when covered on the Patient Charge Schedule, surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutment(s); or any services related to the surgical placement of a dental implant are limited to one per year with replacement of a surgical implant frequency limitation of one every 10 years.
- when covered on the Patient Charge Schedule, a prosthetic device, supported by an implant or implant abutment is considered a separate distinct service(s) from surgical placement of an implant. Replacement of any type of prosthesis with a prosthesis supported by an implant or implant abutment is only covered if the existing prosthesis is at least 5 calendar years old, is not serviceable and cannot be repaired.

### Claims Procedures Under the Dental HMO

You pay the required copayment at the Dentist’s office. The Dentist is responsible for submitting a claim to the Network Manager for payment.
HOW TO APPEAL A DENIED CLAIM

If your appeal concerns verification of your dependent(s) (i.e., your dependent’s verification documentation was not submitted timely), send your appeal letter to:

Claims and Appeals Management
P.O. Box 1434
Lincolnshire, IL 60069-1434

or fax it to: 1-855-769-5781

Eligibility Appeals

If your appeal concerns your eligibility to apply for enrollment under the Plan, write to:

AutoNation Benefit Connection Claims
and Appeals Management
P.O. Box 1407
Lincolnshire, IL 60069-1407

or fax it to: 1-847-554-1245

Dental Benefit Appeals

Appointment of Authorized Representative

You may appoint an authorized representative to assist you in submitting a claim or appealing a claim denial. However, Cigna may require you to designate your authorized representative in writing using a form approved by Cigna. At all times, the appointment of an authorized representative is revocable by you. To ensure that a prior appointment remains valid, Cigna may require you to re-appoint your authorized representative, from time to time.

Cigna reserves the right to refuse to honor the appointment of a representative if Cigna reasonably determines that:

- the signature on an authorized representative form may not be yours, or
- the authorized representative may not have disclosed to you all of the relevant facts and circumstances relating to the overpayment or underpayment of any claim, including, for example, that the billing practices of the provider of medical services may have jeopardized your coverage through the waiver of the cost-sharing amounts that you are required to pay under your plan.

If your designation of an authorized representative is revoked, or Cigna does not honor your designation, you may appoint a new authorized representative at any time, in writing, using a form approved by Cigna.

Appeals Procedure

Cigna has a two-step appeals procedure for coverage decisions. To initiate an appeal, You must submit a request for an appeal in writing to Cigna within 365 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask Cigna to register your appeal by telephone by calling 1-800-CIGNA24.

Level-One Appeal

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medically Necessary or clinical appropriateness will be considered by a health care professional.

For level-one appeals, Cigna will respond in writing with a decision within 30 calendar days after it receives an appeal for a post-service coverage determination. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Requests for a level-two appeal regarding the Medically Necessary or clinical appropriateness of your issue will be conducted by committee, which consists of one or more people not previously involved in the prior decision. The committee will consult with at least one dental care provider in the same or similar specialty as the care under consideration. You may present your situation to the committee by conference call.
HOW TO APPEAL A DENIED CLAIM (CONTINUED)

In the event any new or additional information (evidence) is considered, relied upon or generated by Cigna in connection with the level-two appeal, this information will be provided to you as soon as possible and sufficiently in advance of the committee’s decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Cigna, Cigna will provide the rationale to you as soon as possible and sufficiently in advance of the committee’s decision so that you will have an opportunity to respond.

You will be notified in writing of the committee’s decision within five business days after the committee meeting, and within the committee review time frames above if the committee does not approve the requested coverage.

Notice of Benefit Determination on Appeal

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: the specific reason or reasons for the adverse determination; reference to the specific plan provisions on which the determination is based; 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 Relevant Information as defined; a statement describing any voluntary appeal procedures offered by the plan and the claimant’s right to bring an action under ERISA section 502(a); upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding Your appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a Medically Necessary, experimental treatment or other similar exclusion or limit.

You also have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the decision on review. You or the Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your State insurance regulatory agency. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record or other information which: was relied upon in making the benefit determination; was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

You have the right to bring a civil action under section 502(a) of ERISA if you are not satisfied with the outcome of the appeals procedure. In most instances, you may not initiate a legal action against Cigna until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action. However, no action will be brought at all unless brought within 3 years after a claim is submitted for In-Network Services or within three years after proof of claim is required under the Plan for Out-of-Network services.

The Following Will Apply To Residents Of Texas When You Have A Complaint Or An Adverse Determination Appeal:

When You Have a Complaint

If you have a complaint regarding a person, a service, the quality of care, or contractual benefits not related to Medical Necessity, you can call Cigna at 1-800-CIGNA24 and explain Your concern to one of Cigna’s Customer Service representatives. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by Cigna by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider’s dissatisfaction or disagreement with an adverse determination. You can also express that complaint in writing.
Cigna will do its best to resolve the matter on your initial contact. If Cigna needs more time to review or investigate your complaint, Cigna will send you a letter acknowledging the date on which it received your complaint no later than the fifth working day after it receives your complaint. Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

If you are not satisfied with the results of a coverage decision, you can start the complaint appeals procedure.

**Complaint Appeals Procedure**

To initiate an appeal of a complaint resolution decision, you must submit a request for an appeal in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask to register your appeal by telephone by calling Cigna at 1-800-CIGNA24.

Your complaint appeal request will be conducted by the Complaint Appeals Committee, which consists of at least three people. Anyone involved in the prior decision may not vote on the Committee. You may present your situation to the Committee in person or by conference call.

Cigna will acknowledge in writing that it has received your request within five working days after the date Cigna receives your request for a Committee review and schedule a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, Cigna will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee’s decision within five working days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

**When You have an Adverse Determination Appeal**

An Adverse Determination is a decision made by Cigna that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary or clinically appropriate. An Adverse Determination also includes a denial by Cigna of a request to cover a specific prescription drug prescribed by your Dentist. If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination orally or in writing. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. Cigna will acknowledge the appeal in writing within five working days after receiving the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. Cigna will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination Appeal request.

You may request that the appeal resolution be expedited if the time frames under the above process would seriously jeopardize your life or health or would jeopardize your ability to regain the dental functionality that existed prior to the onset of your current condition.

A dental professional, in consultation with the treating Dentist, will decide if an expedited review is necessary. When a review is expedited, Cigna will respond orally with a decision within 72 hours, followed up in writing.

In addition, your treating Dentist may request in writing a specialty review within 10 working days of Cigna’s written decision. The specialty review will be conducted by a Dentist in the same or similar specialty as the care under consideration. The specialty review will be completed and a response sent within 15 working days of the request. Specialty review is voluntary. If the specialty reviewer upholds the initial adverse determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization.

**Retrospective Review Requirements**

Notice of adverse determinations (denials only) of retrospective reviews must be made in writing to the patient within a reasonable period, not to exceed 30 days from the date of receipt.
The term retrospective review is a system in which review of the medical necessity and appropriateness of health care services provided to an enrollee is performed for the first time subsequent to the completion of such health care services. Retrospective review does not include subsequent review of services for which prospective or concurrent reviews for medical necessity and appropriateness were previously conducted.

**Independent Review Procedure**

If you are not fully satisfied with the decision of Cigna’s Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an Independent Review Organization. In addition, your treating Dentist may request in writing that Cigna conduct a specialty review. The specialty review request must be made within 10 days of receipt of the Adverse Determination appeal decision letter. Cigna must complete the Specialist review and send a written response within 15 days of its receipt of the request for specialty review. If the Specialist upholds the initial Adverse Determination, You are still eligible to request a review by an Independent Review Organization. The Independent Review Organization is composed of persons who are not employed by Cigna or any of its affiliates. A decision to use the voluntary level of appeal will not affect the claimant’s rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process and the decision to use the process is voluntary. Cigna will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by Cigna. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process. You will receive detailed information on how to request an Independent Review and the required forms you will need to complete with every Adverse Determination notice.

The Independent Review Program is a voluntary program arranged by Cigna.

**Appeal to the State of Texas**

You have the right to contact the Texas Department of Insurance for assistance at any time for either a complaint or an Adverse Determination appeal. The Texas Department of Insurance may be contacted at the following address and telephone number:

Texas Department of Insurance
333 Guadalupe Street
P.O. Box 149104
Austin, TX 78714-9104
1-800-252-3439
The Plan may pay benefits if you, your spouse or your covered dependent children are eligible for benefits under more than one group dental plan. This is called “Coordination of Benefits.” Benefits under the Plan are coordinated with benefits from any of the following:

- Other employers’ plans
- Government plans
- Motor vehicle plans required by law, including no-fault plans

When an individual is covered by two group dental plans, one plan pays benefits first (the “primary plan”), while the other (the “secondary plan”) considers what the primary plan paid and pays benefits as the secondary plan if any are payable. Benefits from the secondary plan are coordinated so that payments from all group plans do not exceed 100 percent of the total allowable expense.

If You Are Covered by Another Group Dental Plan

If the other Plan does not have a Coordination of Benefits provision, that Plan is always the primary Plan. Benefits paid or payable by the other group Plan will be taken into account to determine if any benefits will be paid under the AutoNation Dental Benefits Plan.

If the other Plan has a Coordination of Benefits provision, there are several guidelines for determining the primary Plan.

When you and your spouse are legally separated or divorced, the following order applies:

1. If the parent with custody of the child has not remarried, the Plan of the parent with custody pays first; the other parent’s Plan is secondary
2. When a divorced parent with custody has remarried, the Plan of the parent with custody pays first; then, the stepparent’s Plan pays before the Plan of the parent who does not have custody
3. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child’s dental expenses, the Plan of that parent pays first. The Plan of the other natural parent is secondary, and the Plan of the stepparent, if any, pays third

<table>
<thead>
<tr>
<th>How to Determine Which Dental Plan Pays First</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Dental expense is for:</strong></td>
</tr>
<tr>
<td>You</td>
</tr>
<tr>
<td>Your Spouse</td>
</tr>
<tr>
<td>Your children¹</td>
</tr>
<tr>
<td>Your children¹</td>
</tr>
</tbody>
</table>

¹ If your birthday and your spouse’s birthday occur on the same day, the plan covering the children for the longer period of time is the primary plan.
When none of the above circumstances apply, the Plan in effect for the longest period of time pays first provided that:

- The Plan has a provision regarding laid-off or retired employees. If so, the coverage of that Plan covering the employee or a dependent of the employee is primary before the benefits of the Plan covering a laid-off or retired employee, or a dependent of such person.

- If the other Plan does not have a provision regarding laid-off or retired employees, and, as a result, the benefits of each Plan are determined after the other, then the preceding provision does not apply.

- Under the Coordination of Benefits provision, if the Plan pays more than it should have as a result of benefits coordination, you are expected to repay any overpaid amount to the Plan.

If You Recover Dental Payments From Another Party

If you receive benefits as a result of an illness or Injury for which you have asserted or will assert any claim or right of recovery against a third party or parties, Plan benefits will be paid to you provided that you execute a written agreement with the understanding that you will reimburse the Plan when you receive the recoverable amount from the third party or parties.

Only the amount recovered from the third party or parties in a settlement or judgment will be subject to this provision, up to a maximum of the total dental benefits paid by the Plan for the illness or Injury.

When this provision applies to your dental benefit claim under the Plan, you must comply with the following:

- You assign your right of recovery to the Plan.

- You repay to the Plan the recovery received from the third party or parties, or the third party's insurance company.

- You execute and deliver any instruments and papers requested by the Plan when a right of recovery exists and do whatever is necessary to fully execute and protect the Plan's rights. In addition, you must not prejudice the Plan's right of recovery to such reimbursement.

For additional information concerning this provision, refer to “Subrogation.”
WHEN COVERAGE ENDS

If You Are Granted a Leave of Absence

If AutoNation grants you a Leave of Absence, your personal and, if it applies, dependent coverage under the Plan continues for the period of your approved leave, not to exceed six months, provided that you continue to pay the required contributions on an after-tax basis for your personal coverage and if it applies, dependent coverage. You will be billed directly to your address on file with Payroll. You will be billed on an after-tax basis the same amount that you would have paid as a contribution from your paycheck if you were an Active Associate. If you do not make any after tax payments while you are on leave, your benefits will be terminated retroactive to your Leave of Absence start date. If you fail to continue to make timely after-tax payments via direct bill, your benefits will be terminated retroactive to the last date you paid in full. For the period you are on leave you must pay your required contributions in full by the due date specified on the direct bill (partial payments will not be accepted).

Loss of coverage due to nonpayment is not considered a qualifying event under the federal law (known as COBRA) concerning continuation of coverage.

When you return from an approved leave, your coverage and if it applies, dependent coverage will be reinstated, as of your return to work date, even if you lost coverage due to nonpayment.

Payments for benefits for the dates you were on leave will not be automatically deducted from your paycheck upon your return to work.

After you have been on an approved leave for six months and if you had coverage immediately prior to or during your leave, COBRA continuation coverage will be offered to you.

If You Terminate

If you terminate employment with AutoNation, your personal and, if it applies, dependent coverage under the Plan ends on your termination date unless you elect COBRA and pay for COBRA coverage. It is your responsibility to request a refund of any premiums paid beyond your termination date from your payroll representative.

At Other Times

Plan coverage including your personal coverage and, if it applies, dependent coverage will end when any of the following events occurs:

- You are no longer eligible for coverage, including going from Full-Time to Part-Time status
- You fail to make the required contributions for coverage
- You elect to waive coverage for the next Plan Year. Coverage will end on the last day of the current Plan Year
- You die
- The Plan is terminated

In addition to the above, dependent coverage under the Plan will end if any of the following events occur:

- Your child is no longer an Eligible Dependent
- Your spouse no longer meets the definition of an Eligible Dependent due to divorce, legal separation or your marriage has been annulled
- Your dependents are selected for a random dependent audit, and you do not re-certify them by the deadline noted. If you do not re-certify they will be dropped from coverage and offered COBRA. Dependents can be re-added to coverage during the next Annual Enrollment period provided they meet the definition of an eligible dependent at that time

Extended Coverage for Certain Services

The Plan does not pay for services or supplies after your coverage ends, even if the Network Manager or the Claims Administrator and insurance company predetermine the payments for a treatment plan that is submitted before your coverage stops. However, the Plan will pay benefits for the following services that begin while coverage under the Plan is in effect:

- the course of treatment was recommended in writing by the Dentist and began while the Associate or Eligible Dependents were covered under the Plan; and
- the Dental Service is other than a routine examination, prophylaxis, x-ray, or sealants or orthodontic services;
- for Orthodontic Services, the treatment commenced while the person was insured and the expenses are incurred within 60 days after coverage ceases.
- and the Dental Service is performed within 90 days after coverage ceases.

The terms of Extended Coverage will not apply to a person who becomes insured under another group policy for similar dental benefits.
If you and/or your Eligible Dependent participation in the Plan ends due to certain events, you may be able to continue coverage under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). Under COBRA, you may have the right to extend participation at your own expense for a period of time. If you or your Eligible Dependents, choose COBRA continuation coverage, AutoNation is required to offer you or your dependents the same coverage that is offered at that time to similarly situated active employees.

Any qualified person may elect coverage for a newly acquired dependent (e.g., your spouse or a newborn child) under the Plan’s HIPAA special enrollment rules, described in the Qualifying Events section. You must notify the COBRA administrator to add coverage for a newly acquired dependent within 31 days of the event (e.g., marriage, birth, adoption, or placement for adoption) and submit proper documentation.

In addition, a child who is born to or placed for adoption with a covered Associate during a period of COBRA continuation coverage will be considered to be a COBRA qualified beneficiary and will be eligible to elect further continuation coverage if the Associate has a second qualifying event.

The COBRA administrator is The Benefit Connection. Contact The Benefit Connection online at www.KnowYourBenefits.org or call 1-877-550-BENE (2363).

**COBRA Qualifying Events and Length of Coverage**

The length of COBRA coverage for you and/or your covered dependents varies, depending on the qualifying event that occurs. The COBRA qualifying events and length of continuation coverage are shown in the chart on the next page.

If your qualified dependent experiences a second qualifying event while receiving COBRA coverage, he or she may be entitled to extend COBRA to a maximum of 36 months. The qualified dependent must notify the COBRA administrator as described in the chart.

**COBRA and Medicare**

The following explains how COBRA and Medicare impact coverage.

- If a qualified beneficiary is on COBRA and then becomes entitled to Medicare, his/her COBRA coverage will terminate. Other covered qualified beneficiaries may continue coverage for the remainder of their COBRA period.

Your Medicare entitlement is not a second qualifying event for your qualified dependent and will not extend his or her COBRA coverage.

- If a COBRA qualifying event occurs within 18 months after you become entitled to Medicare, that is your termination of employment or reduction in hours, you will be entitled to 18 months of COBRA from the date of the qualifying event. Your Eligible Dependents will be entitled to COBRA until the later of: (1) 18 months from your COBRA qualifying event, or (2) 36 months from your date of Medicare entitlement.

**If You Are on Military Leave**

If you are on a military leave, you will be billed at the address on file for benefits for the first six months of your leave. After six months, you will be offered COBRA continuation coverage for an additional 18 months.

**If You or Your Dependent Is Disabled**

If you or a covered dependent is determined by the Social Security Administration to have been disabled on the date of your qualifying event that is a termination of employment or a reduction in hours or at any time during the first 60 days of COBRA continuation coverage, you or your qualified dependent may apply for an additional extension of 11 months to the 18-month period of COBRA continuation coverage. You must furnish a copy of the disability certification to the COBRA administrator within 60 days of the date of the certification and before your original 18-month continuation period ends.
### COBRA Qualifying Events and Length of Coverage

<table>
<thead>
<tr>
<th>Qualifying Events (if cause loss of coverage)</th>
<th>Length of Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Your employment ends for any reason except gross misconduct&lt;sup&gt;1&lt;/sup&gt;</td>
<td>18 months for you and/or your covered dependents</td>
</tr>
<tr>
<td>- You and your covered dependents lose your eligibility because of a reduction in your working hours&lt;sup&gt;1&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>- You die&lt;sup&gt;1&lt;/sup&gt;</td>
<td>36 months for your covered dependents</td>
</tr>
<tr>
<td>- Your child loses eligibility for any reason&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>- You become entitled to Medicare&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>- You divorce or legally separate from your spouse&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
</tr>
</tbody>
</table>

<sup>1</sup> AutoNation will notify the COBRA administrator of these qualifying events.

<sup>2</sup> You or your dependent must contact The Benefit Connection by telephone at 1-877-550-BENE (2363) and ask to speak to a representative within 60 days of an initial or second qualifying event. You or your qualified dependent also must notify The Benefit Connection to request a disability extension.

<sup>3</sup> You or your spouse must contact The Benefit Connection by telephone at 1-877-550-BENE (2363) and ask to speak to a representative within 90 days of an initial or second qualifying event. Written notification will not be accepted by The Benefit Connection and will be returned as unsolicited mail. Failure to notify The Benefit Connection by telephone within the 90-day time period could result in legal action and recovery of benefits paid after the Qualifying Life Event.
If the individual is no longer disabled, as determined by Social Security Administration, you must notify the COBRA administrator within 30 days of such determination. Nondisabled qualified beneficiaries may continue COBRA continuation coverage for the full 29 months even if the disabled person declines to do so.

**Electing COBRA**

The COBRA administrator will send you an election notice and information about COBRA continuation coverage and payment methods. You have 60 days to inform the COBRA administrator that you want to elect COBRA continuation coverage. Your notice will provide instructions on election procedures. This 60-day election period starts on the date you would otherwise lose coverage because of the qualifying event or when you were sent the election notice, whichever is later.

In order to protect your family’s COBRA rights, you should notify The Benefit Connection of any changes in the addresses of your family members.

**Your Cost for COBRA**

A qualified beneficiary must pay 100 percent of the cost of coverage, plus a 2 percent administrative fee. Full payment of the initial premium is required by the 45th day after the election. Payment must be made directly to the COBRA administrator and the contribution will be on an after-tax basis.

If approved for an 11-month disability extension, the disabled person and any other qualified beneficiaries will be charged 150 percent of the cost of coverage for the extension period.

If the disabled person declines COBRA coverage for the additional 11 months, the nondisabled qualified beneficiaries may still elect to continue COBRA coverage for the full 29-month period at a cost of 102 percent of the cost of coverage.

**COBRA Continuation Coverage Payments**

The first COBRA premium payment is due no later than 45 days from the date COBRA coverage is elected. Although COBRA coverage is retroactive to the date of the initial qualifying event, no benefits will be paid until the full premium payment is received. The due date for each month’s premium is prior to the first day of the month of coverage. You are responsible for making timely payments.

COBRA premium payments should be mailed to the address indicated on your premium notice. If you do not receive your premium notice, visit www.KnowYourBenefits.org to access information about your COBRA coverage, or contact the COBRA administrator. Do not contact your medical Network Manager as it does not administer COBRA nor bill you for COBRA coverage.

If you fail to make the first full payment within 45 days of your COBRA election or subsequent full payments within 30 days of the due date, COBRA continuation coverage will be permanently cancelled retroactive to the last date for which premiums were paid. Partial payments will not be accepted for coverage.

Other important information you need to know about the required COBRA continuation coverage payments is shown below:

- COBRA continuation coverage cannot be reinstated once it is terminated
- COBRA premium payments that are returned by the bank for insufficient funds will result in termination of your COBRA continuation coverage if a replacement payment in the form of a cashier’s check, certified check or money order is not made within the grace period
- COBRA premium payments should be mailed to the address indicated on your premium notice. If you do not receive your premium notice, contact the COBRA administrator
- COBRA premiums paid for a month in which you gain other coverage will not be refunded
- You may be eligible for state or local assistance to pay the COBRA premium. For more information, contact your local Medicaid office or the office of your state insurance commissioner
- You or your Eligible Dependents extended COBRA coverage to 29 months due to disability, but are no longer considered disabled

**When COBRA Continuation Coverage Ends**

A qualified beneficiary’s COBRA continuation coverage will end when any of the following occurs:

- The premium for COBRA continuation coverage is not paid on a timely basis
- The maximum period for COBRA continuation coverage expires as it applies to the qualifying event
- The later of the end of the month you become covered under another group dental Plan, provided that you paid for that month, or the end of the month you last paid in full
<table>
<thead>
<tr>
<th>COBRA CONTINUATION COVERAGE (CONTINUED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• You (or your qualified dependent) becomes entitled to Medicare refer to “COBRA and Medicare” for details</td>
</tr>
<tr>
<td>• AutoNation ceases to provide any group health Plan for its employees</td>
</tr>
</tbody>
</table>
OTHER IMPORTANT INFORMATION

No Guarantee of Employment

The Plan booklet and the benefits described in it do not create a contract of employment or a guarantee of employment between AutoNation and any Associate. Further, there is no guarantee that benefit levels will not be changed in the future or that the Plan will continue indefinitely.

Future of the Plan

AutoNation reserves the unfettered and unrestricted right to change, Amend or terminate the Plan for any reason at any time. AutoNation, pursuant to written action of its Board of Directors, is empowered to Amend the Plan or any benefit under the Plan. The Employee Benefits Committee (“the Committee”), which is established by the Board of Directors of AutoNation, is empowered to make Amendments to the Plan or any benefit under the Plan at any time by a written resolution, so long as the Amendment does not significantly increase or affect AutoNation’s liability. Any Amendment which terminates the Plan or any portion of the Plan or the application of the Plan to any class of Associate must be approved by written action of the Board of Directors of AutoNation. If the Plan is terminated, the rights of covered persons to benefits are limited to claims incurred up to the date of termination. The benefits under the Plan are not vested and shall not become vested as a result of any oral representations or statements or written document by an AutoNation representative or agent unless such written document is adopted pursuant to the Amendment procedure set forth above.

Statements Made by AutoNation

Any oral representations or statements made to an Associate by an AutoNation representative or agent about benefits coverage under the Plan that conflict with Plan provisions will not be considered as representations or statements made by, or on behalf of AutoNation or the Plan, and will not bind AutoNation or the Plan for benefits under the Plan.

Plan Administrator

The Plan Administrator has overall responsibility for the operation of the Plan and controls the administration of the Plan. The Plan Administrator’s authority shall include (not by way of limitation) the authority to construe, in its discretion, all terms, provisions, conditions, and limitations of the Plan.

The Plan Administrator may delegate its authority and responsibility for certain parts of the Plan administration to other persons. The Plan Administrator shall be deemed to have delegated its responsibilities for determining benefits and eligibility for benefits to a Claims Administrator where such person has been appointed to make such determinations.

In such case, such other person shall have the duties and powers as the Plan Administrator, including the complete discretion to interpret and construe the provisions of the Plan.

HIPAA Compliance

Disclosures to AutoNation

The Plan may disclose participant information to AutoNation, as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 (“HIPAA Privacy Regulations”). In addition, the Plan may disclose protected health information to AutoNation as necessary to allow AutoNation to perform plan administration functions, within the meaning of the HIPAA Privacy Regulations.

Use of PHI

The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

Access to Medical Information

The following employees or individuals under the control of AutoNation shall have access to the Plan’s protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

- The Plan Administrator;
- Members of the benefits, legal, finance, information system, audit, accounting, and human resources departments of the AutoNation to the extent they perform functions with respect to the Plan; and
- Such other individuals or classes of individuals identified by the Plan’s Privacy Officer as necessary for the Plan’s administration.
**AutoNation Agreement to Restrictions**

The Plan will not disclose protected health information to AutoNation until AutoNation has certified to the Plan that it agrees to:

- Not use or disclose protected health information other than as permitted or required by law or as specified above;
- Not use or disclose the protected health information in any employment-related decisions or in connection with any other benefit or employee benefit plan of AutoNation;
- Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which AutoNation becomes aware;
- Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;
- Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;
- Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;
- Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for determining compliance;
- Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;
- Ensure that any agents, including a subcontractor, of AutoNation to whom AutoNation provides protected health information shall also agree to these same restrictions;
- Ensure that adequate separation between AutoNation and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of employees or individuals identified in this section; and
- Restrict the use of protected health information by those employees identified in this section for plan administration functions within the meaning of the HIPAA Privacy Regulations.

**Permitted Disclosure to AutoNation**

Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the AutoNation the following types of information:

- Summary health information may be disclosed to AutoNation if AutoNation requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.
- Information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.
- Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.
- De-identified information, as defined under the HIPAA Privacy Regulations.

**Noncompliance**

In the event of noncompliance with the restrictions of this section by a designated employee or other individual receiving protected health information on behalf of AutoNation, the employee or other individual shall be subject to discipline in accordance with AutoNation’s disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan’s Privacy Officer.

**HIPAA Security Standards**

**Safeguards**

AutoNation shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the “HIPAA Security Standards”).


**Agents**

AutoNation shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

**Security Incidents**

AutoNation shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

**Adequate Separation**

AutoNation shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and AutoNation, in support of the requirements described in this section.

**Application**

The provisions of this section shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

**Security Measures**

When AutoNation receives electronic protected health information from the Plan (beyond summary health information or enrollment information), it must comply with the HIPAA security terms in the Plan. The Plan document requires AutoNation, by the HIPAA Security Rule Effective Date, to:

1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic protected health information;
2. Ensure that the firewall required by the privacy rule is supported by reasonable and appropriate security measures;
3. Ensure that any agent or subcontractor to whom AutoNation provides electronic protected health information agrees to implement reasonable and appropriate security measures;
4. Report to the Plan any security incident of which AutoNation becomes aware.

**Right to Recover Overpayment**

Payments are made in accordance with the provisions of the Plan. If it is determined that payment was made for benefits that are not covered by the Plan, for a Participant who is not covered by the Plan, when other insurance is primary or other similar circumstances, the Plan has the right to recover overpayment. The Plan will try to collect the overpayment from the party to whom the payment was made. However, the Plan reserves the right to seek overpayment from you and/or your covered dependents.

Failure to comply with this request will entitle the Plan to withhold benefits due you and/or refer to an outside collection agency if internal collection efforts are unsuccessful. The Plan may also bring a lawsuit to enforce its right to recover overpayments.

**Subrogation & Reimbursement**

When you and/or your covered dependents incur medical expenses, which are payable under workers’ compensation, any statute, any insurance policy or other Plan of benefits (including, but not limited to, no-fault insurance), or because legal action is brought against any third party or parties to recover damages for an illness or Injury, you and/or your covered dependents must notify the Plan Administrator within 30 days and agree to subrogation.

The Plan is entitled to reimbursement for any payment which you and/or your covered dependents may receive (or may be entitled to receive) from a third party or parties if the Plan has paid benefits. The Plan shall have a superior right in equity and first priority in any recovery to 100 percent reimbursement of the Plan’s outlay regardless of the manner in which the recovery is structured or worded (e.g., the recovery may seek to limit the Plan’s reimbursement by stating that amounts paid do not represent medical, dental or vision expenses) and regardless of whether you and/or your covered dependents have been “made whole” by the settlement or fully compensated for your Injury. You and/or your covered dependents expressly covenant not to bring make whole, common fund or other apportionment actions, or raise any such legal or equitable defenses against the Plan’s reimbursement rights in contravention of the Plan’s reimbursement terms. In addition, you and/or your covered dependents expressly covenant not to raise jurisdiction and procedures issues and affirm the Plan’s fiduciary right to bring
reimbursement recovery action under ERISA Section 502.

The Plan’s reimbursement will not be reduced by any attorney’s fees incurred by you and/or your covered dependents or any person acting on your or their behalf.

By accepting benefits under this Plan, you and your covered dependent agree to subrogate the Plan and acknowledge the Plan’s right to be reimbursed for expenses for which you and/or your covered dependents are entitled to payment from a third party or parties. The Plan may pursue these subrogation rights independently of you or on your behalf, and you and/or your covered dependents are obligated to cooperate in pursuit of any recovery. If you or your covered dependents fail to cooperate, or if the Plan becomes aware that you and/or your covered dependents have received a third-party payment and not reported such payment, the Plan may suspend all further benefit payments on any account to you and/or your covered dependents until the subrogated portion is returned to the Plan or offset against any amounts which would otherwise be paid to you and/or your covered dependents.

The cost of legal representation of the Plan in matters related to subrogation will be borne solely by the Plan. The costs of legal representation for you or your covered dependents shall be borne by you or your covered dependents.
## IMPORTANT DEFINITIONS

These words and phrases have special meaning when used to describe your benefits under the Plan.

<table>
<thead>
<tr>
<th>Definition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Employment</td>
<td>You are in Active Employment when you are working for AutoNation, Inc.:</td>
</tr>
<tr>
<td></td>
<td>• On a Full-Time basis and paid regular earnings, and</td>
</tr>
<tr>
<td></td>
<td>• At AutoNation’s usual place of business, or</td>
</tr>
<tr>
<td></td>
<td>• At a location to which Company business requires you to travel</td>
</tr>
<tr>
<td></td>
<td>Or, you are in Active Employment when you are regularly scheduled to work</td>
</tr>
<tr>
<td></td>
<td>the number of hours specified by the Plan.</td>
</tr>
<tr>
<td>Affiliate/Affiliated Employer</td>
<td>Each subsidiary of AutoNation, Inc. that participates in the Plan.</td>
</tr>
<tr>
<td>Allowance</td>
<td>The limit on a charge for a covered service, which is determined by</td>
</tr>
<tr>
<td></td>
<td>CIGNA based on dental practices in your region. The benefits under the Plan</td>
</tr>
<tr>
<td></td>
<td>are based on the amounts charged up to these Allowances.</td>
</tr>
<tr>
<td>Alternate Benefit Provision</td>
<td>If more than one Covered Service will treat a dental condition, payment</td>
</tr>
<tr>
<td></td>
<td>is limited to the least costly service provided it is a professionally</td>
</tr>
<tr>
<td></td>
<td>accepted, Medically Necessary and/or Dentally Necessary, and appropriate</td>
</tr>
<tr>
<td></td>
<td>treatment. If the Covered Person requests or accepts a more costly Covered</td>
</tr>
<tr>
<td></td>
<td>Service, he or she is responsible for expenses that exceed the amount</td>
</tr>
<tr>
<td></td>
<td>covered for the least costly service. Therefore, We recommend Predetermination</td>
</tr>
<tr>
<td></td>
<td>of Benefits before major treatment begins.</td>
</tr>
<tr>
<td>Amendment (Amend)</td>
<td>A formal document signed by the representatives of AutoNation, Inc. and the</td>
</tr>
<tr>
<td></td>
<td>insurance company. The Amendment adds, deletes or changes the provisions</td>
</tr>
<tr>
<td></td>
<td>of the Plan and applies to all eligible Participants, including those</td>
</tr>
<tr>
<td></td>
<td>covered before the Amendment becomes effective, unless otherwise specified.</td>
</tr>
<tr>
<td>Annual Deductible</td>
<td>The amount you must pay in a Plan Year before the Plan starts sharing in</td>
</tr>
<tr>
<td></td>
<td>the cost of your care.</td>
</tr>
<tr>
<td>Annual Enrollment</td>
<td>A designated period of time before the beginning of each Plan Year when you</td>
</tr>
<tr>
<td></td>
<td>have an opportunity to enroll in benefits or change your benefit elections.</td>
</tr>
<tr>
<td>Associate</td>
<td>An employee of AutoNation, Inc.</td>
</tr>
<tr>
<td>Charges</td>
<td>The actual billed amount for services performed.</td>
</tr>
<tr>
<td>Cigna Dental</td>
<td>Cigna Dental Health Organization that contracts with participating general</td>
</tr>
<tr>
<td></td>
<td>Dentists for the provision of dental care.</td>
</tr>
<tr>
<td>Claims Administrator</td>
<td>The company that processes dental claims under the Plan. The Claims</td>
</tr>
<tr>
<td></td>
<td>Administrator for the Plan is subject to change.</td>
</tr>
<tr>
<td>COBRA</td>
<td>The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which</td>
</tr>
<tr>
<td></td>
<td>provides that group dental Plans must offer continuation of dental coverage</td>
</tr>
<tr>
<td></td>
<td>to certain Associates and/or their covered dependents beyond the date that</td>
</tr>
<tr>
<td></td>
<td>this coverage might otherwise terminate.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>The percentage of reasonable and customary Charges you must pay for</td>
</tr>
<tr>
<td></td>
<td>covered services after any applicable Annual Deductible has been satisfied.</td>
</tr>
<tr>
<td>Company</td>
<td>AutoNation, Inc. and certain of its Affiliates.</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>If you or any covered dependents are also covered under another dental plan,</td>
</tr>
<tr>
<td></td>
<td>your benefits under the Plan and the other plan will be coordinated to</td>
</tr>
<tr>
<td></td>
<td>determine how much the Plan pays toward your expenses.</td>
</tr>
<tr>
<td>Copayment</td>
<td>Copayments are the dollar amounts you must pay to the provider at the time</td>
</tr>
<tr>
<td></td>
<td>services are rendered for in-network services.</td>
</tr>
<tr>
<td>Cosmetic Surgery</td>
<td>A medically unnecessary surgical procedure performed primarily to preserve</td>
</tr>
<tr>
<td></td>
<td>or improve appearance rather than to restore the dental functions that are</td>
</tr>
<tr>
<td></td>
<td>lost or impaired due to illness or Injury.</td>
</tr>
</tbody>
</table>
These words and phrases have special meaning when used to describe your benefits under the Plan.

**Covered Expenses**
Charges for dental treatment, services and supplies that are eligible for reimbursement under the Plan.

**Covered Percentage**
The percentage shown in the respective Dental PPO benefits schedule.

**Covered Service**
A dental service used to treat a covered person’s dental condition and which is:
- Prescribed or performed by a Dentist while coverage is in effect
- Medically Necessary and/or Dentally Necessary to treat the covered person’s condition

**Dentist**
A person practicing dentistry or oral surgery within the scope of his or her license, including a Physician operating within the scope of his or her license when he or she performs any of the dental services described in the Plan.

**Deductible**
Expenses to be paid by you or your covered dependents before benefits are paid under the Plan.

**Effective Date**
The date the Participant’s coverage begins under the Plan.

**Eligible Dependents**
Dependants eligible for coverage under the Plan include the following:
- Your spouse is an individual who is lawfully married to a Participant and not legally separated. An individual shall be considered lawfully married regardless of where the individual is domiciled if either of the following are true: (i) the individual is married in a state, possession or territory of the U.S. and the individual is recognized as lawfully married in that state, possession or territory of the U.S.; or (ii) the individual was married in a foreign jurisdiction and the laws of at least one state, possession or territory of the U.S. would recognize him/her as lawfully married. (Also excludes a Common Law Spouse not covered or certified by the Plan prior to January 1, 2014.)
- Your children up to the end of the month in which they turn age 26.
- Your children of any age who were continuously covered under the Plan up to the end of the month in which they turn age 26, who are physically or mentally disabled, and unable to work and are supported by you. (A disabled dependent certification is required.) Eligibility will continue if you provide proof of the disability when the child reaches the age at which coverage otherwise would end; coverage then will remain in effect as long as the disability continues, the dependent continues to be principally supported by you and you maintain dependent coverage under the Plan.
- Your children up to the end of the month in which they turn age 26.
- Your children of any age who were continuously covered under the Plan up to the end of the month in which they turn age 26, who are physically or mentally disabled, and unable to work and are supported by you. (A disabled dependent certification is required.) Eligibility will continue if you provide proof of the disability when the child reaches the age at which coverage otherwise would end; coverage then will remain in effect as long as the disability continues, the dependent continues to be principally supported by you and you maintain dependent coverage under the Plan.

For the purpose of the Plan, “children” include the following:
- Your biological children
- Legally adopted children (effective on the date of placement in your home)
- Stepchildren of your current spouse as defined above
- Any other child for whom you have legal custody or are the legal guardian, provided: 1) the child is related to you or is living in your household, and 2) you provide over half the child’s support
- Dependents who are eligible as a result of a qualified medical child support order (QMCSO). You will be notified if you are subject to a QMCSO

Supporting documentation, such as a marriage license or birth certificate, must be submitted to and approved by The Benefit Connection within the required time frame before dependent coverage will become effective.

No person may be covered both as an employee and a dependent, and no person may be covered as a dependent of more than one employee.

Your dependents do not include any person, whether related to you or not, who resides outside of the United States and any person not previously specified.

**Eligible Expenses**
Charges for dental treatment, services and supplies that are eligible for reimbursement under the Plan.

**Emergency Services**
A service required immediately to either alleviate pain or to
treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

**Employer**
AutoNation, Inc. and its Affiliates and subsidiaries.

**Experimental/Investigational**
Expenses for medical, surgical, diagnostic, other dental care technologies, supplies, treatments, procedures, drug therapies or devices that the Network Manager or the Claims Administrator and insurance company determine, in the exercise of their discretion, to be experimental or done primarily for research. Treatments, procedures, devices or drugs are excluded under the Plan at the time it makes a determination regarding coverage in a particular case unless:

- Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law
- Reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis
- Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnoses. Reliable evidence includes anything determined to be such by the Network Manager or the Claims Administrator and insurance company, within the exercise of their discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authorized by the national medical or dental professional community

**In-Network Benefits**
Benefits under the Plan for covered dental treatment, services and supplies provided by a Dentist who is a participating Total Cigna DPPO network.

**Leave of Absence**
Approved period of time away from work. Types of leaves are limited to the following: Company, disability, leave under the Family and Medical Leave Act (FMLA), military service, personal, or workers’ compensation.

**Medically Necessary (Medical Necessity)**
Services or supplies that the Network Manager or the Claims Administrator and insurance company determine, in the exercise of their discretion, are generally accepted by the national medical or dental professional community as being safe and effective in treating a covered illness or Injury, consistent with the symptoms or diagnoses, furnished at the most appropriate medical or dental level and not primarily for the convenience of the patient, a medical or dental care provider or anyone else.
The Plan has the right to exclude certain procedures, within the bounds of applicable laws, even if they are Medically Necessary. Because a provider has prescribed, ordered or recommended a service or supply does not, in itself, mean that it is Medically Necessary as defined above.

**Network Manager**
The organization that credentials, evaluates and contracts with dental providers to establish a network of participating dental providers and/or participating dental facilities. The Network Manager for all dental plans is Cigna Dental.

**Not Job-Related**
Injury for which you are not entitled to benefits under workers’ compensation or occupational disease laws or similar laws.

**Non-Participating Provider**
A Dentist, or professional corporation, professional association, partnership, or other entity that has not entered into a contract with Cigna Dental to provide dental services. Services received from Non-Participating Providers are considered Out-of-Network.

**Orthodontic Treatment (Services)**
The corrective movement of the teeth through the alveolar bone by means of active appliance to correct a handicapping malocclusion of the mouth.

**Out-of-Network Benefits**
Benefits under the Plan for covered dental treatment, services and supplies provided by a Dentist who is not a participating Total Cigna DPPO network provider.

**Part-Time**
An Associate who is regularly scheduled to work less than 30 hours each week.

**Participant**
An Associate or an Associate’s Eligible Dependent who is enrolled in the Plan and whose contribution for coverage is current.

**Participating Provider**
A Dentist who has been accepted by Cigna for inclusion in the Dental PPO or Dental HMO program.

**Physician**
A licensed medical practitioner who is practicing within the scope of his or her license and who is licensed to prescribe and administer drugs or perform surgery. The term includes any other licensed practitioner operating within the scope of his or her license and performing a covered service, and whose services are required by law in the locality where the service is rendered.

**Plan**
The AutoNation Dental Benefits Plan.

**Plan Administrator**
The Plan Administrator has overall responsibility for the operation of the Plan and controls the administration of the Plan. The Plan Administrator’s authority shall include (not by way of limitation) the authority to construe, in its discretion, all terms, provisions, conditions, and limitations of the Plan.

The Plan Administrator may delegate its authority and responsibility for certain parts of the Plan administration to other persons. The Plan Administrator shall be deemed to have delegated its responsibilities for determining benefits and eligibility for benefits to a Claims Administrator where such person has been appointed to make such determinations. In such case, such other person shall have the duties and powers as the Plan Administrator, including the complete discretion to interpret and construe the provisions of the Plan.

**Plan Sponsor**
AutoNation, Inc.

**Plan Year**
The 12-consecutive-month period beginning January 1 and ending December 31. All Annual Deductibles and benefit maximums accumulate during the Plan Year.

**Pretax Contributions**
Contributions that are deducted from your pay before federal, state (in most cases) and Social Security taxes are calculated. Because your taxable pay is reduced, you pay less in taxes.

**Pre-Treatment Review**
A proposed course of treatment estimated to be more than $300 that is submitted by your Dentist for review prior to the actual performance of services. Evaluation of the course of treatment is subject to alternate procedures and does not guarantee payment of benefits when the actual services are performed.
**Qualified Medical Child Support Order (QMCSO)**
Any court order, judgment or decree (including a judicially approved settlement) that: (1) provides for child support with respect to a Plan Participant’s child or directs the Participant to provide coverage under a benefits Plan under a state domestic relations law; or (2) enforces a law described in the Social Security Act, Section 1908, with respect to a group Plan. You will be notified if you are subject to a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of the Plan's QMCSO procedures from the Plan Administrator.

**Qualifying Life Event**
A change in your family, work or life status that can have an impact on your benefits as described in the “Enrollment Change Due to Qualifying Event” section of this document.

**Specialist**
A Dentist who focuses on a specific area of dentistry, including oral surgery, endodontia, periodontia, orthodontia, pediatric dentistry or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.
As a Participant in the AutoNation Dental Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as Amended (ERISA). ERISA provides that you, as a Plan Participant, are entitled to the following:

- Examine all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, without charge at either the Plan Administrator’s office or at other specified locations.

- Obtain copies of all documents governing the operation of the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) and an updated summary Plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. By law, the Plan Administrator must furnish each Participant with a copy of this summary annual report.

- Continue dental coverage for yourself, spouse 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 and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan Participants, ERISA imposes duties on the people who are responsible for operating this Plan. The people who operate your Plan, called “fiduciaries,” have a duty to do so prudently and in your interest and that of other Plan Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial and you have the right to obtain copies of documents relating to the decision without charge within certain time schedules. You have the right to have the Plan Administrator review and reconsider your claim within certain time schedules. Under ERISA, there are steps you can take to enforce these rights.

For instance, if you request a copy of Plan documents or the latest annual report from the Plan Administrator 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 Plan Administrator’s control. If you have a claim for benefits that 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 Administrator’s decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If the 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.

If you have any questions about your 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 the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.
BENEFIT INQUIRY & HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION FROM AN AUTONATION PLAN

Please complete section A regarding your benefit inquiry and only complete section B if your inquiry is in regard to a medical, prescription drug, dental, vision or Flexible Spending account claim, disability leave, personal medical information or medical information regarding a dependent.

SECTION A. BENEFIT INQUIRY

1. Did you contact The Benefit Connection first to try to resolve your inquiry? If yes, date called ______/_____/______. If no, please call The Benefit Connection first at 1-877-650-SENE (2363).

2. If you called The Benefit Connection and still have an issue outstanding did you or your HR representative contact The Benefit Connection to resolve the inquiry? If yes, list name of representative you spoke to:

3. If steps 1 and 2 are answered “yes” please complete the following:

PLEASE PRINT EMPLOYEE’S NAME (LAST, FIRST):

Employee’s Social Security Number:

Nature of Inquiry

Completed By: ________________________

Date: ________________________

Phone Number: ________________________

Email: ________________________

This request is: [ ] Urgent (48 hour turnaround time required) [ ] Immediate (5-7 business days) [ ] Regular (7-10 business days)

Proprietary: Cannot be copied or reproduced without written authorization of AutoNation.
SECTION B. HIPAA AUTHORIZATION FOR RELEASE OF INFORMATION FROM AN AUTONATION PLAN

I. Authorization: I hereby authorize the (Place an X next to the box that applies — one or more of the following):

- AutoNation Medical Benefits Plan/AutoNation Medical Wraparound Medical Plan
- AutoNation Dental Benefits Plan
- AutoNation Flexible Spending Accounts Plan
- AutoNation Vision Benefits Plan

(the “Plan”) to disclose my health information as follows: (if you need more space for any item, please use the back of the form)

1. Information to be Disclosed:

2. Person(s) to whom the Plan May Disclose the Above Information (list the specific person(s) or class of persons):
   Michelle Cotton

3. Purpose of Use or Disclosure (either list purpose or state "at the request of individual", if applicable):

4. Expiration of Authorization (must be specific date, not open ended such as “until resolved” or “indefinitely”):

   / / /
   Month Day Year

I understand that:

- I have the right to revoke this Authorization at any time for future disclosures the Plan may make, unless the Plan has taken action in reliance upon this Authorization. I must revoke this Authorization by completing and executing Section II to this Authorization and submitting it to the Plan’s Office of Privacy Governance, 200 Southwest 1st Avenue, 14th Floor, Fort Lauderdale, FL 33301. I understand that the revocation will not be effective until received by the Plan. I also understand that a revocation is not needed for the Expiration Date in Paragraph 4 above to be effective.
- This authorization does not encompass or include the use or disclosure of any psychotherapy notes, unless specifically stated.
- The Plan may not condition my treatment, payment, enrollment, or eligibility for benefits upon whether I sign this Authorization.
- Once my information has been disclosed, as permitted under this Authorization, it no longer will be protected under the federal privacy regulations of the Health Insurance Portability and Accountability Act (“HIPAA”), so there is a possibility that the party to whom my information is being disclosed may re-disclose the information without my permission.
- The Plan will not receive any direct or indirect remuneration from a third party as a result of this use or disclosure.

Signature: ____________________________ Date: ____________________________

/ / /
Month Day Year

* If this Authorization is being signed by the individual’s personal representative, describe below your authority to act on the individual’s behalf. If there is a legal document that evidences your authority to act (power of attorney, court order, etc.), you must attach a copy of such document when you submit this Authorization. If the documentation is not presented, the Plan will not proceed until it is presented to the Plan.

II. Revocation: I hereby revoke the Authorization granted in Section I above. I understand that this revocation will only become effective when the Plan receives it.

Signature: ____________________________ Date: ____________________________

/ / /
Month Day Year

Proprietary: Cannot be copied or reproduced without written authorization of AutoNation.
ADMINISTRATIVE INFORMATION

The following is important identification and administration information about the AutoNation Dental Benefits Plan. The Plan number identifies the Plan with the Internal Revenue Service and the U.S. Department of Labor.

Official Plan Name
AutoNation Dental Benefits Plan

Plan Type
This Plan is a “welfare plan” as defined in Section 3(1) of the Employee Retirement Income Security Act of 1974, as Amended. It provides dental coverage and certain dental preventive care benefits.

Plan Number
511

Plan Sponsor, Administrator and Agent for Service of Legal Process
AutoNation, Inc.
c/o AutoNation Benefits Company
200 Southwest First Avenue, 14th Floor Fort Lauderdale, FL 33301
954-769-6000

The Plan is administered by the Employee Benefits Committee (the “Plan Administrator”). The Plan Administrator makes all determinations as to the eligibility of any person to dental benefits under the Plan, and determines all questions arising out of the administration and interpretation of the Plan. The Plan Administrator is the agent for service of legal process.

Controlling Law
The laws of the state of Florida shall be the controlling state law in all matters relating to the Plan and shall apply to the extent not preempted by the laws of the United States of America.

Employer Identification Number
73-1105145

Plan Year
January 1 – December 31

Network Manager
Cigna Dental
P.O. Box 188046
Chattanooga, TN 37422
1-800-244-6224
www.cigna.com/dental

Dental PPO and Dental HMO benefits under the Plan are fully insured, and governed by policies issued by Cigna Dental. Cigna Dental administers all claims under the Plan and provide other administrative services as described throughout this Summary Plan Description. The certificate of coverage, which confirms your benefits under the Plan, is available for review by contacting the Network Manager or the Plan Administrator.

Type of Financing
Associate contributions.

Company
AutoNation, Inc. and certain of its Affiliates. You can obtain a copy of the complete listing of companies or divisions participating in the Plan by writing to the Plan Administrator. The list is available for examination by Participants and beneficiaries.