2018 Summary Plan Description for the Dental Benefits Plan for Retail Associates
This booklet is the Summary Plan Description ( SPD) of your AutoNation Dental Benefits Plan. This SPD summarizes the Plan in nontechnical language so you can understand the benefits available to you. The SPD 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 certificates, the certificate of coverage or insurance certificate will govern for benefit provisions while this booklet will govern for eligibility provisions. The Plan document is available for review by contacting the Plan Administrator. The insurance certificate is available for review by contacting the Claims Administrator.
<table>
<thead>
<tr>
<th>Contents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Overview ...................................................................................</td>
</tr>
<tr>
<td>Eligibility and Enrollment ..................................................................</td>
</tr>
<tr>
<td>Who Is Eligible ..................................................................................</td>
</tr>
<tr>
<td>If You Transfer From One AutoNation Location to Another AutoNation Location</td>
</tr>
<tr>
<td>If You Were Previously Part-Time and Become Full-Time .......................</td>
</tr>
<tr>
<td>If You Were Previously a Benefit Eligible Corporate Associate and Transferred into a Benefit Eligible Retail Associate Position</td>
</tr>
<tr>
<td>If You Were Previously Full-Time and Become Part-Time ........................</td>
</tr>
<tr>
<td>If You Are Rehired After Terminating Employment ..................................</td>
</tr>
<tr>
<td>If Your Company or Location Is Acquired by AutoNation ..........................</td>
</tr>
<tr>
<td>If You Work for More Than One AutoNation Location ................................</td>
</tr>
<tr>
<td>If You and Your Spouse Work for AutoNation .......................................</td>
</tr>
<tr>
<td>If You and Your Dependent Child Work for AutoNation ...............................</td>
</tr>
<tr>
<td>Eligible Dependents ...........................................................................</td>
</tr>
<tr>
<td>Leave of Absence ...............................................................................</td>
</tr>
<tr>
<td>Who Is Not Eligible ............................................................................</td>
</tr>
<tr>
<td>When Coverage Begins ..........................................................................</td>
</tr>
<tr>
<td>How to Enroll .....................................................................................</td>
</tr>
<tr>
<td>Initial Enrollment ...............................................................................</td>
</tr>
<tr>
<td>Annual Enrollment .............................................................................</td>
</tr>
<tr>
<td>Enrollment Change Due to a Qualifying Life Event ..................................</td>
</tr>
<tr>
<td>Your Cost for Coverage ......................................................................</td>
</tr>
<tr>
<td>How the Plan Works ............................................................................</td>
</tr>
<tr>
<td>Your Coverage Options and Levels of Coverage ......................................</td>
</tr>
<tr>
<td>Dental PPO .........................................................................................</td>
</tr>
<tr>
<td>Covered Services Under the Dental PPO ...............................................</td>
</tr>
<tr>
<td>Annual Deductible ...............................................................................</td>
</tr>
<tr>
<td>Coinsurance .......................................................................................</td>
</tr>
<tr>
<td>Maximum Annual Benefit .......................................................................</td>
</tr>
<tr>
<td>Orthodontic Maximum Lifetime Benefit ..................................................</td>
</tr>
<tr>
<td>In-Network Benefits ............................................................................</td>
</tr>
<tr>
<td>Locating a Participating Dental Provider ...............................................</td>
</tr>
<tr>
<td>Out-of-Network Benefits .....................................................................</td>
</tr>
<tr>
<td>Pre-Treatment Review .........................................................................</td>
</tr>
<tr>
<td>Alternate Benefit ..............................................................................</td>
</tr>
</tbody>
</table>
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.

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

If you were previously Full-Time and become Part-Time you will no longer be eligible for benefits as of the date you become Part-Time.

If You Are Rehired After Terminating Employment

Rehired within 13 weeks: If you are rehired after terminating employment at an AutoNation location you will be reinstated in the same dental benefits that you were enrolled in and had in effect before your termination — if available — unless you are rehired by a location with different benefit options. If you terminate your employment at an AutoNation location prior to your benefit Effective Date and are rehired, your benefit Effective Date will be your original benefit Effective Date or your rehire date, whichever is later. If you terminate and are hired in a subsequent plan year, you will be given an opportunity to enroll in a dental Plan upon rehire.

Rehired after 13 weeks: If your rehire occurs more than 13 weeks after your termination, you will be required to satisfy the new hire eligibility (waiting) period before you are eligible for benefits. See “When Coverage Begins.”

If Your Company or Location Is Acquired by AutoNation

If your company or location is acquired by AutoNation, you will be eligible for AutoNation benefits on the date established for the transition to the AutoNation Plan (AutoNation will notify you of your benefit eligibility date).

If You Work for More Than One AutoNation Location

If you work for more than one AutoNation location and you meet the eligibility requirements, you may enroll for benefits only at one location.

If you work Full-Time at one location and Part-Time at another location, you can be covered only by the benefits provided by your Full-Time location.

If you work Part-Time at more than one AutoNation location, the hours from your two Part-Time jobs will be combined to meet the Full-Time eligibility requirements for benefits. You will be offered the benefit Plan of the location that first hired you. It is your responsibility to notify the location that first hired you of your combined Part-Time hours, so that your benefit eligibility status can be updated.

If You and Your Spouse Work for AutoNation

If you and your spouse are eligible for the Plan as Associates and AutoNation employs both of you, either or both of you may enroll as an Associate, or one of you may be covered as a dependent of the other. If both of you enroll as an Associate, one of you may enroll your children, provided they satisfy the definition of “Eligible Dependents.” You cannot be enrolled as an Associate and as a spouse at the same time.

If You and Your Dependent Child Work for AutoNation

If you and your dependent child work for AutoNation your dependent child cannot be enrolled as an Associate and as a dependent at the same time.
Eligible Dependents

Your Eligible Dependents for coverage include your spouse and children who meet the definition of "Eligible Dependents" in "Important Definitions." You must provide the appropriate supporting documentation before coverage for any Eligible Dependent will become effective.

It is your responsibility to certify that each of your enrolled dependents continues to meet all of the eligibility requirements to participate in the Plan as described in "Eligible Dependents" in "Important Definitions." Further, it is your responsibility to recertify your dependent(s) if they are selected for a random dependent audit. You must notify The Benefit Connection of any changes in the status of a dependent prior to or by the change date.

You also certify that you understand that any fraudulent statement, falsification, or material omission of information made in connection with your dependent enrollment under the Plan would violate AutoNation’s ethical code and will be considered an act of fraud or intentional misrepresentation of material fact, as prohibited by the terms of this Plan. The Plan may retroactively rescind coverage as a result. The Plan reserves the right to conduct random claims audits and to seek reimbursement from you for all claims paid on behalf of ineligible dependents or otherwise paid due to fraudulent acts or omissions on your part.

Who Is Not Eligible

You are not eligible for benefits if any of the following applies to you:

- A Part-Time Associate, classified as such upon hire, regularly scheduled to work less than 30 hours each week
- 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 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 the 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 one of these Qualifying Life Events. 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 pre-tax 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.
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 MetLife Preferred Dentist Program (PDP), pre-negotiated fees will apply to you, and covered dental services will be paid subject to the higher 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 Reasonable and Customary Allowance, or Maximum Allowed Charge as defined in the Plan, for the dental procedure or treatment. Amounts in excess of the Reasonable and Customary Allowance or Maximum Allowed 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 MetLife Preferred Dentist Program, you are responsible for the out-of-network Annual Deductible and any amount in excess of the Plan’s out-of-network 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 up to age 19

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

- Medical Necessity
- Not job-related
- Treated or prescribed by a licensed or certified provider acting under applicable state law
- Not specifically excluded by this Plan

Services are covered if they are essential for the necessary care of the teeth provided the treatment

HOW THE PLAN WORKS
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

**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 MetLife. 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 in-network and out-of-network 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 Maximum Lifetime Benefit for covered orthodontia treatment and/or appliances for each covered dependent child up to age 19. Of this maximum, the Maximum Lifetime Benefit for covered out-of-network services may be further reduced. 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 MetLife Preferred Dental 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 MetLife at 1-866-348-9503 or visit its website at www.metlife.com/mybenefits.

**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 MetLife, 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 MetLife online at www.metdental.com or call 1-877-MET-DDS9 (638-3379).

You and your Dentist will receive a statement from MetLife indicating the estimated coverage available under the Plan for the proposed treatment.

Alternate Benefit

There may be more than one way to effectively treat a dental problem. If an adequate method or material that costs less could have been used, benefits under the Plan will be based on the method or material which is less costly and meets generally accepted dental standards as determined by MetLife. You will be responsible for payment of any expense in excess of the benefit payable under the Plan as a result of this provision.
## Schedule of Bronze Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</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>$100</td>
</tr>
<tr>
<td>• Family</td>
<td>None</td>
<td>$300</td>
</tr>
<tr>
<td><strong>Maximum Annual Benefit per covered individual</strong></td>
<td>$1,500</td>
<td>$750</td>
</tr>
<tr>
<td><strong>Preventive and Diagnostic Services</strong></td>
<td>100%</td>
<td>80% after Annual Deductible is met</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 per calendar year for children to age 20, 1 per calendar year for adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Panoramic or full mouth X-rays – 1 set every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fluoride treatment – 1 treatment per calendar year for children up to age 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Space maintainers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sealants – 1 treatment per first or second permanent molar every 5 years for children up to 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</strong></td>
<td>80%</td>
<td>60% after Annual Deductible is met</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>60%</td>
<td>40% after Annual Deductible is met</td>
</tr>
<tr>
<td>• Periodontal maintenance – limited to 2 times per rolling 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontal surgery – flap entry and closure are part of the Allowance, 1 surgery in 36 months per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontal scaling and root planing – 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 anesthesia – covered when Medically Necessary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Schedule of Bronze Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits¹</th>
<th>Out-of-Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major Services</strong></td>
<td>50%</td>
<td>5% after Annual Deductible is met</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 in a 6-year period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fixed bridges⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crowns⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crown repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inlays and onlays – covered only when silver fillings cannot restore the tooth, limited to 1 in a 6-year period⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full dentures⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial dentures⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relining dentures – limited to relining done more than 6 months after initial insertion. Limited to 1 per rolling 12 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 – limited to adjustments done within 12 months after initial installation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Appliances for bruxism, including but not limited to occlusal guards and night guards — limited to 1 in 24 months</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 in 6 years for the same tooth position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repair of implants — limited to 1 in 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
## Schedule of Bronze Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia including appliance therapy for children up to age 19 for the following services:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Orthodontic work-up including:</td>
<td>50% up to a $1,500 combined in-network and out-of-network Maximum Lifetime Benefit</td>
<td>40% after Annual Deductible is met, up to a $750 combined in-network and out-of-network Maximum Lifetime Benefit</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 (1 appliance per child)</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 Reasonable and Customary Allowance as determined by the Claims Administrator are not payable under the Plan.

3. The Maximum Annual Benefit is combined for in-network and out-of-network covered services per covered individual excluding orthodontic services, which are subject to a separate Maximum Lifetime Benefit for children up to age 19.

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

5. Subject to Medical Necessity following six years since initial installation.

6. MetLife does not cover this service for adults. Service is covered for children up to age 20.
# Schedule of Silver Dental PPO Benefits

## Covered Dental PPO Services

<table>
<thead>
<tr>
<th>Claim form required</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>

## Annual Deductible

- **Individual**: None  
- **Family**: None  
  
<table>
<thead>
<tr>
<th>Annual Deductible</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$100</td>
<td>$300</td>
</tr>
</tbody>
</table>

## Maximum Annual Benefit per covered individual

<table>
<thead>
<tr>
<th>Maximum Annual Benefit per covered individual</th>
<th>$1,500</th>
</tr>
</thead>
</table>

## Preventive and Diagnostic Services

- **Oral exams** – 2 per calendar year
- **Cleaning of teeth (oral prophylaxis)** – 2 per calendar year
- **Bitewing X-rays** – 2 per calendar year for children to age 20, 1 per calendar year for adults
- **Panoramic or full mouth X-rays** – 1 set every 5 years
- **Fluoride treatment** – 1 treatment per calendar year for children up to age 20
- **Space maintainers**
- **Sealants** – 1 treatment per first or second permanent molar every 5 years for children up to age 16
- **Palliative (emergency) treatment of dental pain**, if no other services other than X-rays and exam were done during the visit

<table>
<thead>
<tr>
<th>Preventive and Diagnostic Services</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>100%</td>
<td>80% after Annual Deductible is met</td>
</tr>
</tbody>
</table>

## Fillings and General Anesthesia

- **Amalgam filling** – primary and permanent teeth
- **Composite/resin filling**
- **General anesthesia** – covered when Medically Necessary

<table>
<thead>
<tr>
<th>Fillings and General Anesthesia</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>60% after Annual Deductible is met</td>
</tr>
</tbody>
</table>

## Basic Services

- **Periodontal maintenance** – limited to 2 times per rolling 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement
- **Periodontal surgery** – flap entry and closure are part of the Allowance, 1 surgery in 36 months per quadrant
- **Periodontal scaling and root planing** – 1 per quadrant per rolling 24 months
- **Surgical extraction**, including impacted teeth
- **Root canal therapy**
- **Simple extractions**
- **Surgical removal of erupted tooth**

<table>
<thead>
<tr>
<th>Basic Services</th>
<th>In-Network Benefits</th>
<th>Out-of-Network Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>60%</td>
<td>40% after Annual Deductible is met</td>
</tr>
</tbody>
</table>
# Schedule of Silver Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</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>50%</td>
<td>40% after Annual Deductible is met</td>
</tr>
</tbody>
</table>

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 in a 6-year period.

- Fixed bridges\(^4\)
- Crowns\(^4\)
- Crown repair
- Inlays and onlays – covered only when silver fillings cannot restore the tooth, limited to 1 in a 6-year period\(^4\)
- Full dentures\(^4\)
- Partial dentures\(^4\)
- Relining dentures – limited to relining done more than 6 months after initial insertion. Limited to 1 per rolling 12 months
- Repairs to dentures, partial dentures, crowns and bridges
- Adjustments to dentures, partial dentures, crowns and bridges\(^5\) – limited to adjustments done within 12 months after initial installation.
- Appliances for bruxism, including but not limited to occlusal guards and night guards — limited to 1 in 24 months
- Implant services, implant supported cast restorations and implant supported fixed and removable dentures — no more than 1 in 6 years for the same tooth position
- Repair of implants — limited to 1 in 12 months
### Schedule of Silver Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits¹</th>
<th>Out-of Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia including appliance therapy for children up to age 19 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 (1 appliance per child)</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 Reasonable and Customary Allowance as determined by the Claims Administrator are not payable under the Plan.

³ The Maximum Annual Benefit is combined for in-network and out-of-network covered services per covered individual excluding orthodontic services, which are subject to a separate Maximum Lifetime Benefit for children up to age 19.

⁴ Subject to Medical Necessity following six years since initial installation.

⁵ Limit does not apply to crowns and bridges for MetLife Members.
## Schedule of Gold Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</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>Annual Deductible³</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>Maximum Annual Benefit per covered individual⁴</td>
<td>$1,500</td>
<td></td>
</tr>
</tbody>
</table>

### Preventive and Diagnostic Services

- Oral exams – 2 per calendar year
- Cleaning of teeth (oral prophylaxis) – 2 per calendar year
- Bitewing X-rays – 2 per calendar year for children to age 20, 1 per calendar for adults
- Panoramic or full mouth X-rays – 1 set every 5 years
- Fluoride treatment – 1 treatment per calendar year for children up to age 20
- Space maintainers⁷
- Sealants – 1 treatment per first or second permanent molar every 5 years for children up to age 16
- Palliative (emergency) treatment of dental pain, if no other services other than X-rays and exam were done during the visit

### Fillings and Simple Extractions

- 80% after Annual Deductible is met

### Basic Services

- 50% after Annual Deductible is met

---

⁠¹ Benefits provided by the plan.
⁠² Benefits are provided by the plan or by an arrangement with another carrier (fully and partially). The amount shown reflects the maximum amount at which the plan reimburses for the service.
⁠³ Deductible applies to all family members.
⁠⁴ Deductible applies to all family members.
⁠⁵ Benefits provided by the plan or by an arrangement with another carrier (fully and partially). The amount shown reflects the maximum amount at which the plan reimburses for the service.
⁠⁶ Benefits provided by the plan or by an arrangement with another carrier (fully and partially). The amount shown reflects the maximum amount at which the plan reimburses for the service.
⁠⁷ Benefits provided by the plan or by an arrangement with another carrier (fully and partially). The amount shown reflects the maximum amount at which the plan reimburses for the service.
# Schedule of Gold Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits¹</th>
<th>Out-of-Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Major Services</strong></td>
<td>50% after Annual</td>
<td>50% after Annual</td>
</tr>
<tr>
<td>High noble (gold) or crown</td>
<td>Deductible is met</td>
<td>Deductible is met</td>
</tr>
<tr>
<td>restorations are covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dental services only when</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the tooth, as a result of</td>
<td></td>
<td></td>
</tr>
<tr>
<td>extensive caries or fracture,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cannot be restored with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>amalgam, or composite/resin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>restoration. Limited to 1 in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a 6-year period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fixed bridges⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crowns⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Crown repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inlays and onlays – covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>only when silver fillings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>cannot restore the tooth,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>limited to 1 in a 6-year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>period⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full dentures⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial dentures⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relining dentures – limited</td>
<td>50% after Annual</td>
<td>50% after Annual</td>
</tr>
<tr>
<td>to relining done more than</td>
<td>Deductible is met</td>
<td>Deductible is met</td>
</tr>
<tr>
<td>6 months after initial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>insertion. Limited to 1 per</td>
<td></td>
<td></td>
</tr>
<tr>
<td>rolling 12 months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repairs to dentures,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>partial dentures, crowns and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bridges</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Adjustments to dentures,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>partial dentures, crowns and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>bridges⁷ – limited to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>adjustments done within 12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>months after initial</td>
<td></td>
<td></td>
</tr>
<tr>
<td>installation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Appliances for bruxism,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>including but not limited to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>occlusal guards and night</td>
<td></td>
<td></td>
</tr>
<tr>
<td>guards — limited to 1 in 24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>months</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Implant services, implant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>supported cast restorations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and implant supported fixed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and removable dentures — no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>more than 1 in 6 years for</td>
<td></td>
<td></td>
</tr>
<tr>
<td>the same tooth position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repair of implants – limited</td>
<td>50% after Annual</td>
<td>50% after Annual</td>
</tr>
<tr>
<td>to 1 in 12 months</td>
<td>Deductible is met</td>
<td>Deductible is met</td>
</tr>
</tbody>
</table>
## Schedule of Gold Dental PPO Benefits

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits¹</th>
<th>Out-of-Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orthodontic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia including appliance therapy for children up to age 19 for the following services:</td>
<td>50% after Annual Deductible is met, up to a $1,500 combined in-network and out-of-network Maximum Lifetime Benefit</td>
<td>50% after Annual Deductible is met, up to a $1,500 combined in-network and out-of-network Maximum Lifetime Benefit</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 (1 appliance per child)</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 Reasonable and Customary Allowance as determined by the Claims Administrator are not payable under the Plan.

³ The Annual Deductible is waived for preventive and diagnostic services.

⁴ The Maximum Annual Benefit is combined for in-network and out-of-network covered services per covered individual excluding orthodontic services, which are subject to a separate Maximum Lifetime Benefit for children up to age 19.

⁵ Anesthesia Benefits differ by service. Check with the Plan for details.

⁶ Subject to Medical Necessity following six years since initial installation.

⁷ MetLife does not cover this service for adults. Service is covered for children up to age 20.

⁸ Limit does not apply to crowns and bridges for MetLife Members.
## Schedule of Alternative Gold Dental PPO Benefits
*(Louisiana, Mississippi, Montana, and Texas only)*

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits¹</th>
<th>Out-of-Network Benefits²</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible³</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 individual⁴</strong></td>
<td></td>
<td>$1,500</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></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 per calendar year for children to age 20, 1 per calendar year for adults</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Panoramic or full mouth X-rays – 1 set every 5 years</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fluoride treatment – 1 treatment per calendar year for children up to age 20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Space maintainers⁶</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sealants – 1 treatment per first or second permanent molar every 5 years for children up to 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 Simple Extractions</strong></td>
<td></td>
<td>75% after Annual Deductible is met</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>• Simple extractions</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
<td>50% after Annual Deductible is met</td>
</tr>
<tr>
<td>• Periodontal maintenance – limited to 2 times per rolling 12 months following active and adjunctive periodontal therapy within the prior 24 months, exclusive of gross debridement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontal surgery – flap entry and closure are part of the Allowance, 1 surgery in 36 months per quadrant</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Periodontal scaling and root planing – 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>• Surgical removal of erupted tooth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• General anesthesia – covered when Medically Necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered Dental PPO Services</td>
<td>In-Network Benefits¹</td>
<td>Out-of-Network Benefits²</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Major Services</td>
<td>50% after Annual</td>
<td>50% after Annual</td>
</tr>
<tr>
<td></td>
<td>Deductible is met</td>
<td>Deductible is met</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 in a 6-year period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Fixed bridges⁵</td>
<td>50% after Annual</td>
<td>50% after Annual</td>
</tr>
<tr>
<td>• Crowns⁵</td>
<td>Deductible is met</td>
<td>Deductible is met</td>
</tr>
<tr>
<td>• Crown repair</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inlays and onlays – covered only when silver fillings cannot restore the tooth⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Full dentures⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Partial dentures⁵</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Relining dentures – limited to relining done more than 6 months after initial installation period. Limited to one per rolling 12 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 bridges⁷ – limited to adjustments done within 12 months after initial installation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Appliances for bruxism, including but not limited to occlusal guards and night guards – limited to 1 in 24 months</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 in 6 years for the same tooth position</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Repair of implants — limited to 1 in 12 months</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ In-Network Benefits
² Out-of-Network Benefits
## Schedule of Alternative Gold Dental PPO Benefits
(Louisiana, Mississippi, Montana, and Texas Only)

<table>
<thead>
<tr>
<th>Covered Dental PPO Services</th>
<th>In-Network Benefits ¹</th>
<th>Out-of Network Benefits ²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthodontic Services</td>
<td>50% after Annual Deductible is met, up to a $1,500 combined in-network and out-of-network Maximum Lifetime Benefit</td>
<td>50% after Annual Deductible is met, up to a $1,500 combined in-network and out-of-network Maximum Lifetime Benefit</td>
</tr>
<tr>
<td>Orthodontia including appliance therapy for children up to age 19 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 (1 appliance per child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Active monthly treatment</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

¹ Participants 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 Allowed Charge as determined by the Claims Administrator are not payable under the Plan.

³ The Annual Deductible is waived for preventive and diagnostic services.

⁴ The Maximum Annual Benefit is combined for in-network and out-of-network covered services per covered individual excluding orthodontic services, which are subject to a separate Maximum Lifetime Benefit for children up to age 19.

⁵ Subject to Medical Necessity following six years after initial installation.

⁶ MetLife does not cover this service for adults. Service is covered for children up to age 20.

⁷ Limit does not apply to crowns and bridges for MetLife Members.
Exclusions

Under any Dental PPO option, the Plan does not pay benefits for any of the following services, supplies or Charges, among others:

• Acupuncture, acupressure and other forms of alternative treatment whether or not used as anesthesia

• Attachments to conventional removable prostheses or fixed bridgework

• Charges by a Dentist for completion of dental forms

• Charges for dental procedures or treatment begun prior to the patient’s Effective Date of coverage under the Plan

• Charges for failure to keep a scheduled appointment

• Charges in excess of the Reasonable and Customary Allowance or Maximum Allowed Charge as determined by the Plan

• Charges incurred after the Plan Year’s Maximum Annual Benefit and orthodontic Maximum Lifetime Benefit have been paid under the Plan

• Dental procedures performed solely for cosmetic or aesthetic reasons

• Dental procedures that are not directly associated with dental disease

• Dental services provided in a foreign country unless required due to an emergency

• Dental services rendered after the date coverage ends under the Plan, except as provided in “Extended Coverage for Certain Services”

• Dental services that are not Medically Necessary

• Drugs or medications unless they are dispensed and utilized in the dental office during the patient’s visit

• Experimental, investigational or unproven procedures not accepted by the American Dental Association (ADA) Council on Dental Therapeutics

• Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction

• Hospitalization or other facility Charges

• Occlusal guards specifically used as safety items or to affect performance primarily in sports-related activities (Exclusion does not apply to MetLife members)

• Placement of fixed bridgework solely for the purpose of achieving periodontal stability

• Procedures not performed in a dental setting

• Procedures related to the reconstruction of a patient’s correct vertical dimension or occlusion

• Services which are primarily cosmetic unless the services are

  o Required for reconstructive surgery which is incidental to or follows surgery which results from trauma, an infection or other disease of the involved part; or

  o Required for reconstructive surgery because of a congenital disease or anomaly of a child which has resulted in a functional defect.

• Replacement of complete or partial dentures, crowns, and fixed bridgework previously paid under the Plan within six years of initial or supplemental placement

• Replacement of complete or partial dentures, crowns or fixed bridgework if damage or breakage was directly related to provider error or patient noncompliance
• Services for injuries or conditions paid by workers’ compensation, occupational disease laws, or Employer liability laws and services that are provided without cost to the covered individual by any municipality, county or other political subdivision

• Services related to the temporomandibular joint (TMJ) either bilateral or unilateral, upper or lower jaw bone surgery, orthognathic surgery, jaw alignment or TMJ treatment

• Services rendered by a provider residing in the same residence as the covered individual or who is a member of the covered individual’s family, including spouse, brother, sister, parent or child

• Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue

• Training and/or supplies used to educate an individual on the care of his or her teeth

• Treatment of congenital malformations of hard or soft tissue including excision

• Treatment of malignant or benign neoplasms, cysts or other pathology, except excisional removal

• Treatment rendered other than by a licensed Dentist, dental Physician or dental technician working under the direction of a licensed Dentist

Claims Procedures Under the Dental PPO

Generally, you will not be required to file a claim if you receive covered services from a participating in-network Dentist if available.

If you receive covered services from an out-of-network provider, you may be required to file a claim. 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:
  o Patient’s full name
  o Amount charged
  o Date of service
  o Description of the service or supply
  o Diagnosis or nature of Injury
  o 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:
  MetLife Dental Claims P.O. Box 981282
  El Paso, TX 79998-1282

  Claim forms are available on MetLife’s website at www.metlife.com/mybenefits or by calling 1-866-348-9503.

Explanation of Benefits

When the claim is processed, you will receive an Explanation of Benefits (EOB) statement from MetLife. 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 Reasonable and Customary Allowance or Maximum Allowed 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

MetLife 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 for most of the country is Cigna Dental. In Texas, the Network Manager is MetLife.

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 MetLife at 1-866-348-9503 if you live in Texas. Or, you can access information online at www.cigna.com/dental or www.metlife.com/mybenefits, respectively.

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.

- Treatment for orthodontic services and related care already in progress prior to the Effective Date of the patient’s coverage is not covered under the MetLife DHMO.

Covered Service Limitations

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

- The frequency of certain services, such as cleanings, is limited. Refer to the Network Manager’s Patient Charge Schedule for the limitations.
- Prior treatment authorization is required for specialty care services rendered by a Network specialist.
- Coverage for referral to a pediatric Dentist ends on a child’s seventh birthday (eighth birthday for Texas DHMO). However, exceptions for medical reasons may be considered on an individual basis provided the request is preapproved by the Network Manager. The Network’s general Dentist will provide dental care for a child age 7 or older (8 or older for Texas DHMO).
- The surgical removal of an impacted wisdom tooth is not covered if the tooth is not diseased or if the removal is only for orthodontic reasons.

Selecting a Dental Facility

When you enroll in the Dental HMO option, you and each of your covered dependents must select a participating Dentist from the list of network facilities provided by Cigna Dental or, if it applies, MetLife. If your first choice of a Cigna Dental participating Dentist at a dental facility is not available, you will be notified by the Network Manager of your designated participating Dentist based on your alternate selection.

If you do not select a dental provider the Network Manager will designate one for you.
If you are eligible and enroll for coverage under the Dental HMO option, dental services that are listed in the Patient Charge Schedule are covered provided that the dental service is:

- received from a designated participating dental facility, or
- referred by your participating Dentist to a specialist approved by the Network Manager.

If you want to change participating dental facilities, contact the Network Manager to request the change. Facility transfers will take effect on the first day of the month following the date your request is authorized by the Network Manager.

**Network Benefits**

The Network Manager — Cigna Dental or MetLife in Texas — 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**

When specialized dental care services are required, your participating general Dentist must initiate the referral process. When the Network Manager approves a referral to an endodontist, oral surgeon, orthodontist (MetLife DHMO only), pedodontist or periodontist, you or your covered dependents will be responsible for any fee, including fees for any dental service rendered but not listed in the Patient Charge Schedule. All fees correspond to the Patient Charge Schedule in effect on the date the procedure is initiated.

You must be covered under the Plan when treatment by a specialist is rendered. Such treatment must occur within 90 days of the Network Manager’s approval. Any X-rays taken by the patient’s participating general Dentist must be sent to the specialist with the referral form.

**Complex Rehabilitation**

Complex rehabilitation is extensive dental restoration involving seven or more teeth or units of a crown and/or bridge within the same treatment plan. The crown and bridge Charges listed in the Patient Charge Schedule are for each unit. An additional amount is charged for each unit when complex rehabilitation is performed.

**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, or an agreed upon rate if you participate in the Texas network, 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.

For emergency dental treatment received after regular office hours, a fee will be charged as indicated in the Patient Charge Schedule.

"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):

Cigna DHMO

• Charges for or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society

• Charges for or in connection with bone grafting and/or guided tissue regeneration when performed at the site of a tooth extraction or in conjunction with an apicoectomy or periradicular surgery, unless specifically listed on the Patient Charge Schedule

• Charges that the patient would not be legally required to pay

• Completion of implant supported prosthesis (including crowns, bridges and dentures) already in progress on the Effective Date of your coverage, unless specifically listed in the Patient Charge Schedule

• Completion of crown and bridge, dentures or root canal treatment already in progress on the date the patient becomes covered under the Dental HMO option

• Cosmetic Dentistry or cosmetic dental surgery (dentistry and/or dental surgery performed solely to improve appearance) unless specifically listed on your Patient Charge Schedule

• Crowns, bridges and/or implants supported prosthetics used solely for splinting

• Endodontic treatment and/or periodontal surgery of teeth exhibiting a poor or hopeless periodontal prognosis

• General anesthesia and sedation except when performed by a periodontist or oral surgeon when Medically Necessary for a covered procedure

• Hospitalization including any associated incremental Charges for dental services performed in a hospital

• If Charges would not have been made if the patient had no dental coverage or insurance

• Intentional root canal treatment in the absence of Injury or disease to solely facilitate a restorative procedure

• Localized delivery of antimicrobial agents when performed alone or in the absence of traditional periodontal therapy

• Prescription medications
• Procedures, appliances or restorations if the main purpose is to: (a) change vertical dimension (degree of separation of the jaw when teeth are in contact); or (b) diagnose or treat conditions or dysfunction of the temporomandibular joint, except as specified in the Patient Charge Schedule

• Recementation of any implant supported prosthesis, inlay, onlay, crown, post and core or fixed bridge within 180 days of initial placement

• Replacement of a bridge, crown or denture within six years of its original installation

• Replacement of fixed and/or removable prosthodontic appliances that have been lost, stolen or damaged due to patient abuse, misuse or neglect

• Resin bonded retainers and associated pontics

• Services not listed in the Patient Charge Schedule

• Services performed by a prosthodontist

• Services provided or paid by or through a federal or state government agency, or authority, political subdivision or public program other than Medicaid

• Services related to an injury or illness covered under workers’ compensation, occupational disease or similar laws

• Services related to injuries that are self-inflicted

• Services required while serving in the armed forces of any country or international authority, or relating to a declared or undeclared war or acts of war

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

• Services to the extent the covered person is compensated for under any group medical plan, no-fault insurance policy or insured motorist policy

• Surgical placement of a dental implant; repair, maintenance, or removal of a dental implant; implant abutments(s); or any services related to the surgical placement of a dental implant, unless specifically listed on the Patient Charge Schedule

• To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received

• Treatment rendered by a pedodontist on a covered dependent child who has attained age 7, except as may be preapproved by the Network Manager due to medical reasons

• Treatment, services and/or supplies that are not deemed necessary

**Safeguard DHMO**

• Implants and services associated with the placement of implants, prosthodontic restoration of dental implants, and specialized implant maintenance services

• Inpatient/outpatient hospital Charges of any kind including Dentist and/or Physician Charges, prescriptions or medications

• Orthodontic repair or replacement of lost or broken appliances, retreatment of orthodontic cases, maxillofacial surgery, myofunctional therapy, cleft palate, micrognathia, macroglossia, hormonal imbalances or other factors affecting growth or developmental abnormalities, treatment of temporomandibular joint disorders, composite or ceramic brackets, lingual adaptation of orthodontic bands and brackets, lingual adaptation of orthodontic bands and specialized or cosmetic alternatives to standard fixed removable orthodontic appliances
• Orthognathic surgery

• Procedures, appliances, or restorations whose primary purpose is to change the vertical dimension of occlusion, correct congenital, developmental, or medically induced dental disorders

• Procedures or treatment unable to be performed in the dental office due to the general health or physical limitations of the member

• Replacement of dentures, crowns, appliances or bridgework that have been lost, stolen or damaged due to abuse, misuse, or neglect

• Services or appliances which are determined to be not reasonable and/or necessary for maintaining or improving the member’s dental health

• Services for or paid by a federal or state government agency or authority, political subdivision, or other public program other than Medicaid or Medicare

• Services required while serving in the Armed Forces of any country or international authority

• Services considered experimental in nature

• Services related to pathology laboratory fees

• Treatment of malignancies, cysts, or neoplasms, unless specifically listed as a covered benefit on the Patient Charge Schedule

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.

What If Your Dental HMO Claim Is Denied

Each of the Network Managers — Cigna Dental or MetLife — has a three-step appeals procedure for coverage decisions. To initiate an appeal with Cigna Dental, you must submit a request for an appeal in writing to the address provided on your initial denial letter within one year of receipt of a denial notice. You should state the reason why you feel your claim should be reviewed and include any information supporting your claim. If you are unable or choose not to write, you may call the toll-free number on your identification card. To initiate an appeal with MetLife, you must submit a request for an appeal within fifteen (15) days after receiving notice of your initial denial. Your request must be in writing and directed to the MetLife Dental Claims department.
To initiate an appeal, you must submit a request within 180 days from the receipt of an adverse benefit determination.

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 to:
1-847-554-1245

Dental Benefit Appeals

If your dental claim is denied and you are not satisfied with the explanation, you have the legal right to appeal the denial.

If you or your authorized representative appeals a denied claim, it must be submitted within 180 days after you receive the Claims Administrator or insurance company’s notice of denial under any Dental PPO option or within one year after you receive the Network Manager’s notice of denial under the Dental HMO option. You have the following rights:

• To submit a request for review in writing to the Network Manager or the Claims Administrator and insurance company
• To review pertinent documents
• To submit issues and comments in writing to the Network Manager or the Claims Administrator and insurance company

If your appeal concerns your eligibility to apply for enrollment under the Plan, write to AutoNation Benefit Connection, P.O. Box 1407 Lincolnshire, IL 60069-1407 or fax to: 1-847-554-1245. If your appeal concerns benefits and/or benefit payments, write or call the Network Manager or the Claims Administrator and insurance company. All review requests must be made within 180 days after you receive the Network Manager’s or the Claims Administrator and insurance company’s notice of denial of your claim.

Your appeal to the Network Manager or the Claims Administrator and insurance company will be reviewed and the decision made by someone not involved in the initial claim decision. Appeals involving Medical Necessity will be considered by a health and/or dental care professional. For level-one appeals, the Network Manager or the Claims Administrator and insurance company will respond in writing with a decision normally within 30 calendar days (within 15 calendar days if the appeal concerns Pre-Treatment Review authorization by CIGNA Dental) after the appeal is received. If the review cannot be completed within that time frame, The Benefit Connection, or the Network Manager or the Claims Administrator and insurance company will notify you in writing of the reason for the delay, and the review will be completed within 15 calendar days after that.

If your appeal is directed to the Network Manager or the Claims Administrator and insurance company, you may request that the appeal process be expedited if the time frame under this process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum functionality. In consultation with the treating Physician or Dentist, the Network Manager’s director or the Claims Administrator and insurance company will decide if an expedited appeal is necessary. When an appeal is expedited, an oral decision will be made within 72 hours, followed by a written response.

Second Review of a Denied Claim

If you are dissatisfied with the level-one appeal decision, you may request a second review.

The Plan Administrator has the discretionary authority to interpret the terms and application of the Plan as they relate to your eligibility to apply for enrollment under the Plan and to make a final determination on all eligibility appeals. The Network Manager or the Claims Administrator and insurance company have the discretionary authority to interpret the terms and application of the Plan as they relate to your request for benefits and benefit payments, and to make a final determination on all claims. If your appeal concerns eligibility, write to the Plan Administrator. All second level eligibility appeals to the Plan Administrator must be submitted within 60 days from the initial appeal decision.

If your appeal concerns benefits and/or benefit payments, write or call the Network Manager or the Claims Administrator and insurance company. All review requests must be made within 180 days of the date your benefits are denied.
Most requests for a second review by the Network Manager or the Claims Administrator and insurance company will be conducted by an Appeals Committee, which consists of a minimum of three people. Anyone on the Appeal Committee involved in the prior decision may not vote on the appeal. For appeals involving Medical Necessity or clinical appropriateness, the committee will consult with at least one Physician or Dentist in the same or similar specialty as the care under consideration, as determined by the Network Manager or the Claims Administrator and insurance company.

You may represent your situation to the Appeals Committee by conference call.

For level-two appeals, the Network Manager or the Claims Administrator and insurance company will acknowledge in writing that your request has been received. If the Network Manager or the Claims Administrator and insurance company cannot complete the review within 30 calendar days, you will be notified in writing on or before the 15th calendar day, and the review will be completed no later than 45 calendar days after receipt of your request. You will be notified in writing of the decision.

If your appeal is directed to the Network Manager or the Claims Administrator and insurance company, you may request that the appeal process be expedited if the normal time frame under this process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum functionality. When an appeal is expedited, you will receive an oral decision followed by a written response within 72 hours.

All decisions of the Plan Administrator, and the Network Manager or the Claims Administrator and insurance company are final and binding.

Final Review of a Denied Claim for Benefits

Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this section.

If you are not fully satisfied with the decision by the Network Manager or the Claims Administrator and insurance company following completion of the level-two appeal process and your claim is denied based upon lack of Medical Necessity or because it was an Experimental/Investigational Treatment, you may request that your claim be reviewed by an external independent review organization. The independent review organization is composed of persons who are not employed by the Network Manager or the Claims Administrator and insurance company, or any of its Affiliates. There is no charge for you to initiate this independent review process. The Network Manager or the Claims Administrator and insurance company will abide by the decision of the independent review organization.

To request a review, you must notify the Network Manager’s Appeals Coordinator or the Claims Administrator and insurance company within 180 days of your receipt of the level-two appeal review denial. You will be provided with additional information on external review at that time and asked to provide any new information relating to your appeal. The Appeals Coordinator or the Claims Administrator and insurance company then will forward the file to the independent review organization. The independent review organization will render an opinion within 30 days upon receipt of all information. When requested and when a delay would be detrimental to your medical or dental condition, as determined by the Network Manager or the Claims Administrator and insurance company, the external review shall be completed within three days. The decision of the independent review organization is binding upon the Network Manager or the Claims Administrator and insurance company.
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.

### How to Determine Which Dental Plan Pays First

<table>
<thead>
<tr>
<th>Dental expense is for:</th>
<th>AutoNation Plan is:</th>
<th>Spouse’s plan is:</th>
</tr>
</thead>
<tbody>
<tr>
<td>You</td>
<td>Primary</td>
<td>Secondary</td>
</tr>
<tr>
<td>Your spouse</td>
<td>Secondary</td>
<td>Primary</td>
</tr>
<tr>
<td>Your children¹</td>
<td>Primary if your birthday (month/day only) occurs first in the year</td>
<td>Secondary if your spouse’s birthday (month/day only) is later in the year than yours</td>
</tr>
<tr>
<td>Your children¹</td>
<td>Secondary if your birthday (month/day only) is later in the year than that of your spouse</td>
<td>Primary if your spouse’s birthday (month/day only) occurs first in the year</td>
</tr>
</tbody>
</table>

¹If 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.”
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.
- You 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:

- Crown, inlay or onlay if the Dentist prepares the tooth for the crown, inlay or onlay while the patient is covered under the Plan and installs the crown, inlay or onlay within three calendar months after coverage ends (or within 90 days for MetLife members)

- Prosthetic device, such as a full or partial denture, and fixed bridgework if the Dentist takes the initial impressions and prepares the abutment teeth while the patient is covered under the Plan, and delivers and installs the device within three calendar months after coverage ends (or within 90 days for MetLife members)

- Root canal therapy if the Dentist opens the pulp chamber of the tooth while the patient is covered under the Plan and completes the treatment within three calendar months after coverage ends (or within 90 days for MetLife members)

There is no extended coverage for any other dental treatment, services and/or supplies that are not described above.

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.¹</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.¹</td>
<td></td>
</tr>
<tr>
<td>· You die.¹</td>
<td>36 months for your covered dependents</td>
</tr>
<tr>
<td>· Your child loses eligibility for any reason²</td>
<td></td>
</tr>
<tr>
<td>· You become entitled to Medicare.²,³</td>
<td></td>
</tr>
<tr>
<td>· You divorce or legally separate from your spouse.⁴</td>
<td></td>
</tr>
</tbody>
</table>

¹AutoNation will notify the COBRA administrator of these qualifying events.

²You 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.

³You 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.

**E lecting 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.AutoNationBenefits.com 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.

• You (or your qualified dependent) becomes entitled to Medicare refer to “COBRA and Medicare” for details.

• AutoNation ceases to provide any group health Plan for its employees.

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 may delegate its authority and responsibility for certain parts of the Plan administration to other persons.

You can receive additional information about the Plan and the Plan Administrator by contacting The Benefit Connection at 1-877-550-BENE (2363).

Privacy

To the extent required under applicable law, all medical records and other individually identifiable health information shall be kept confidential and shall not be used for any purpose other than payment, treatment and health care operations under the Plan. AutoNation and the Plan shall establish such practices and procedures as they deem necessary to ensure such confidentiality and to comply with all such applicable laws.

The Plan may disclose protected health information to the Plan Sponsor for the purposes of Plan administration functions, as permitted by law. The Plan only may disclose such information upon the receipt of a HIPAA Plan Sponsor Privacy Certification ("Certification"), as required by the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164. This Certification shall be incorporated by reference as a part of this Plan document.

Only persons involved with Plan administration functions shall have access to any information disclosed under this section. If the persons to whom information is disclosed violate this section, or applicable law, the Plan shall cease disclosing such information.

The Plan is required by law to: (1) make sure that medical information that identifies you and your covered dependents is kept private; (2) give you the HIPAA Privacy Notice outlining the legal duties and privacy practices with respect to medical information about you and your covered dependents; and (3) follow the terms of the HIPAA Privacy Notice that is currently in effect.

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; and
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 subrogate.

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.

#### Active Employment

You are in Active Employment when you are working for AutoNation, Inc.:

- On a Full-Time basis and paid regular earnings, and
- At AutoNation’s usual place of business, or
- At a location to which Company business requires you to travel.

Or, you are in Active Employment when you are regularly scheduled to work the number of hours specified by the Plan.

#### Affiliate/Affiliated Employer

Each subsidiary of AutoNation, Inc. that participates in the Plan.

#### Allowance

The limit on a charge for a covered service, which is determined by MetLife based on dental practices in your region. The benefits under the Plan are based on the amounts charged up to these Allowances.

#### Amendment (Amend)

A formal document signed by the representatives of AutoNation, Inc. and the insurance company. The Amendment adds, deletes or changes the provisions of the Plan and applies to all eligible Participants, including those covered before the Amendment becomes effective, unless otherwise specified.

#### Annual Deductible

The amount you must pay in a Plan Year before the Plan starts sharing in the cost of your care.

#### Annual Enrollment

A designated period of time before the beginning of each Plan Year when you have an opportunity to enroll in benefits or change your benefit elections.

#### Associate

An employee of AutoNation, Inc.

#### Charges

The actual billed amount for services performed.

#### Cigna Dental

Cigna Dental Health Organization contracts with participating general Dentists for the provision of dental care.

#### Claims Administrator

The company that processes dental claims under the Plan. The Claims Administrator for the Plan is subject to change.

#### COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which provides that group dental Plans must offer continuation of dental coverage to certain Associates and/or their covered dependents beyond the date that this coverage might otherwise terminate.

#### Coinsurance

The percentage of reasonable and customary Charges you must pay for covered services after any applicable Annual Deductible has been satisfied.
### Important Definitions

**Company**

AutoNation, Inc. and certain of its Affiliates.

**Coordination of Benefits**

If you or any covered dependents are also covered under another dental plan, your benefits under the Plan and the other plan will be coordinated to determine how much the Plan pays toward your expenses.

**Cosmetic Surgery**

A medically unnecessary surgical procedure performed primarily to preserve or improve appearance rather than to restore the dental functions that are lost or impaired due to illness or injury.

**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.

**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.

**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.

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.

### 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 diagnoses.

• 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.
Full-Time
An Associate who is regularly scheduled to work at least 30 hours each week.

Incurred Expense
The cost of a dental treatment, service or supply when provided.

Injury
Bodily damage other than sickness, including all related conditions and recurrent symptoms.

Injury (Accidental)
An unforeseen and unavoidable event caused by an externally violent force or occurrence resulting in bodily harm or damage, independent of an illness or sickness that is not the fault (as defined by the industry) of the Participant and requires initial necessary care provided by a Physician or Dentist within 90 days after the occurrence.

In-Network Benefits
Benefits under the Plan for covered dental treatment, services and supplies provided by a Dentist who is a participating MetLife Preferred Dentist Program (PDP) provider.

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.

Maximum Allowed Charges
The maximum amount participating Dentists have agreed to accept as payment in full for services provided.

Maximum Annual Benefit
The dollar limit the Plan pays in dental benefits in a Plan Year for each covered person.

Maximum Lifetime Benefit
The dollar limit the Plan pays in dental benefits in a lifetime for orthodontic services for a covered child up to age 19 under the Dental PPO option.

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.
Important Definitions

**MetLife**
MetLife contracts with participating Dentists for the provision of dental care. Participating Dentists are providers under the MetLife Preferred Dentist Program.

**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 any Dental PPO option is MetLife. Under the Dental HMO option, the Network Managers are Cigna Dental on a national basis, where available, and SafeGuard in Texas.

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

**Out-of-Network Benefits**
Benefits under the Plan for covered dental treatment, services and supplies provided by a Dentist who is not a participating MetLife Preferred Dentist Program 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 MetLife for inclusion in the PPO program; or accepted by Cigna Dental, and SafeGuard in Texas, for inclusion in the HMO programs.

**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 sole fiduciary of the Plan who exercises all discretionary authority and control over the administration of the Plan, and the management and disposition of Plan assets. The Plan Administrator shall have the sole discretionary authority to determine eligibility for Plan benefits or to construe the terms of the Plan. The Plan Administrator has the right to Amend, modify or terminate the Plan in any manner, at any time, regardless of the health status of any Plan Participant or beneficiary.

The Plan Administrator may hire someone to perform claims processing and other specified services in relation to the Plan. Any such contractor will not be fiduciary of the Plan and will not exercise any of the discretionary authority and responsibility granted to the Plan Administrator as described above.

**Plan Sponsor**
AutoNation, Inc.
Important Definitions

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 $250 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.

Reasonable and Customary Allowance

The maximum amount determined by the Claims Administrator to be eligible for consideration of payment for a particular service, supply or procedure. The amount is determined from the range of the Charges most frequently made in the same or similar dental service area for the service or procedure as billed by other Dentists.

SafeGuard Health Plans, Inc.

A MetLife company, contracts with participating general Dentists for the provision of dental care.
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

In order to track the type of inquiries and turnaround response time, please complete the following form and email to:
Maureen Redman at RedmanM@autonation.com or fax to: 954-861-4588.

In order to maintain a log please do not email to anyone else in the Benefits Department.

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 1-877-550-BENE (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:

   First Name
   Last Name

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:
   [____________________________________, ________________________________________]
   Last Name
   First Name

   Phone Number: __________________________

   Date: [__________________________________________]
   Month / Day / Year

   Email: __________________________

   This request is
   □ Urgent (48 hour turn around time required)
   □ Immediate (5-7 business days)
   □ Regular (7-10 business days)

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

Page 1 of 2
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):

Maureen Redman

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.

<table>
<thead>
<tr>
<th>Official Plan Name</th>
<th>AutoNation Dental Benefits Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Type</td>
<td>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.</td>
</tr>
<tr>
<td>Plan Number</td>
<td>511</td>
</tr>
<tr>
<td>Plan Sponsor, Administrator and Agent for Service of Legal Process</td>
<td>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.</td>
</tr>
<tr>
<td>Controlling Law</td>
<td>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.</td>
</tr>
<tr>
<td>Employer Identification Number</td>
<td>73-1105145</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 – December 31</td>
</tr>
<tr>
<td>Network Managers, Claims Administrators and Insurance Companies</td>
<td><strong>MetLife and SafeGuard</strong> MetLife Dental Claims P.O. Box 981282 El Paso, TX 79998-1282 1-866-348-9503 <a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a> <strong>Cigna Dental</strong> Cigna Dental P.O. Box 188046 Chattanooga, TN 37422 1-800-244-6224 <a href="http://www.cigna.com/dental">www.cigna.com/dental</a> Dental PPO and Dental HMO benefits under the Plan are fully insured, and governed by policies issued by MetLife, Cigna Dental and SafeGuard. MetLife, Cigna Dental and SafeGuard administer 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.</td>
</tr>
<tr>
<td>Type of Financing</td>
<td>Associate contributions.</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Company</td>
<td>AutoNation, Inc. and certain of its Affiliates.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>