INTEGRATED DISABILITY PROGRAM WITH FAMILY AND MEDICAL LEAVE ACT AND AUTO NATION VOLUNTARY DISABILITY PLAN
Integrated Disability Program with FMLA

Early intervention when you are injured, ill or pregnant is important for you and AutoNation. You are an important member of the AutoNation family and contribute to Company productivity and results. Therefore, your extended absence has a direct business impact. Missed opportunities occur when you are not at work.

AutoNation, Inc. has an integrated program for time away from work due to a Disability or an approved leave under the Family and Medical Leave Act (FMLA). AutoNation partners with Matrix Absence Management, Inc. and Reliance Standard Life Insurance Company to provide this integrated program.

Working with these companies helps AutoNation provide and track leaves required by federal and state parental/family leave laws, and helps you return to work.

This section of the booklet provides a general description of the Integrated Disability Program with FMLA. It does not represent a guarantee of any income or benefit payment.

The complete Summary Plan Description for the AutoNation Voluntary Disability Plan follows this section.

What Is FMLA

FMLA is a federal law that provides eligible employees with up to 12 weeks within a 52-week period of unpaid, job-protected leave for any of the following reasons:

- Care of a newborn or newly adopted child
- Care of an immediate family member — your legal spouse, dependent children and parents — who have a serious health condition and to make arrangements for his or her care
- Your own serious health condition You are eligible for FMLA leave if you have worked for AutoNation for at least 12 months in the previous 7 years and worked at least 1,250 hours over the previous 12 months.

Any disability leave, sick time, and vacation time count as time toward your FMLA leave, whether or not the leave is related to your job. FMLA provides 12 weeks of job protection. If you are Disabled, the FMLA leave may expire before your disability ends.

For Associates who have worked at least 1,250 hours and reach 12 months of employment with AutoNation during an approved absence (in other words, meet their FMLA eligibility while on the approved leave), your time away from work will be counted as FMLA leave on the 366th day of your employment. This means that only part of your approved leave may be covered under FMLA. Your absence before the 12 months/1,250 hours of employment with AutoNation is not eligible under FMLA.

All periods of Disability — non-work-related and work-related — run concurrently with FMLA leave.

If you have a non-work-related Short- or Long-Term Disability, or work-related Long-Term Disability and are eligible and enrolled in the AutoNation Voluntary Disability Plan, the Disability Case Manager assigned to you collaborates with a team that includes Vocational Rehabilitation Counselors, Physical and Occupational Therapists, Medical Consultants and Social Security Administration Specialists, who will help you apply for Social Security Disability Income (SSDI) benefits. The objective of this coordinated effort is to create a personalized recovery Plan for you that considers your degree of impairment and the demands of your job. The Disability Case Manager will work with you, your Physician and your supervisor throughout your Disability to help you return to work as safely and quickly as possible.
How to Report a Non-Work-Related Disability or FMLA Leave

In the event of a Disability that is not work-related, you must report your absence immediately. For family or medical leave, you must request the leave 30 days in advance if the event is foreseeable, or within two days of your first day of absence from work in the event of an emergency.

You have one place to call — The Benefit Connection whether you are calling to apply for a FMLA leave — if you qualify, or to file a Disability claim under the AutoNation Voluntary Disability Plan.

Whether or not your absence is related to work or you need to request a FMLA leave, it is important to remember that this integrated program does not change or replace your work location’s requirements for reporting your absence.

You must complete the following steps to apply for a FMLA leave or in the event of your absence due to a non-work-related Disability if you are eligible and enrolled in the AutoNation Voluntary Disability Plan:

- Call The Benefit Connection at: 1-877-550-BENE (2363).
- Provide the personal information requested.
- Once you are provided with the reason options for your call, say “FMLA & Disability.”
- You will then be transferred to an Intake Specialist at Matrix Absence Management.
- The Intake Specialist will gather initial information from you which includes but is not limited to:
  — Your last date worked or expected last day of work
  — Your or your family member’s treating Physician’s name, address and telephone number
  — The nature of your Sickness, injury or pregnancy, or request for an FMLA leave
  — Your supervisor’s name and telephone number
  — When your Disability exceeds 13 weeks and is expected to continue beyond 180 days, Reliance Standard Life Insurance Company will notify you in writing of the procedures you need to follow to apply for Long-Term Disability benefits under the AutoNation Voluntary Disability Plan.

Confidentiality

Please be assured that information provided to Matrix Absence Management and Reliance Standard Life Insurance Company about your medical condition remains confidential. The Disability Case Manager assigned to you does not share medical or diagnostic information with your supervisor or Human Resources representative. The Disability Case Manager who will handle your Short- and/or Long-Term Disability will discuss only your physical abilities as they relate to your occupation requirements.

How to Report a Work-Related Disability

If your Sickness or injury is work-related, immediately report the incident to your supervisor. Your supervisor will file an Incident Report with AutoNation’s workers’ compensation third party administrator who will evaluate and decide your workers’ compensation claim. If it is approved, the workers’ compensation administrator will notify Matrix Absence Management for the purpose of handling your FMLA leave. You must also notify Matrix Absence Management to report your FMLA leave if you start losing time from work due to a work-related Injury. Additionally, if your work-related disability exceeds 13 weeks and is expected to continue beyond 180 days, provided you are eligible and enrolled in the AutoNation Voluntary Disability Plan, Reliance Standard Life Insurance Company will notify you in writing of the procedures you need to follow to apply for Long-Term Disability benefits under the AutoNation Voluntary Disability Plan.

If you work in New York and file a FMLA claim under the Plan, the FMLA/Disability Case Manager will process a New York Paid Family Leave subject to the eligibility requirements of New York Paid Family Leave.

If you will not qualify for the minimum amount of time required for eligibility under New York Paid Family Leave you may opt out of this coverage. You must complete a waiver form to opt out of coverage. If the waiver is revoked (by the associate or a change in work schedule), AutoNation may take retroactive deductions for the period of time covered by the waiver and the period of time will count toward eligibility for paid family leave.

Confidentiality

Please be assured that information provided to Matrix Absence Management and Reliance Standard Life Insurance Company about your medical condition remains confidential. The Disability Case Manager assigned to you does not share medical or diagnostic information with your supervisor or Human Resources representative. The Disability Case Manager who will handle your Short- and/or Long-Term Disability will discuss only your physical abilities as they relate to your occupation requirements.
2018 Summary Plan Description for the AutoNation Voluntary Disability Plan for Retail Associates
This booklet is the Summary Plan Description (SPD) of your AutoNation Voluntary Disability Plan. This SPD and the insurance certificates summarize 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 insurance certificates, the insurance certificates will govern for benefit provisions for participation in the Plan. The Plan document is available for review by contacting the Plan Administrator. The insurance certificates are available for review by contacting the Claims Administrator.
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PLAN OVERVIEW

The AutoNation Voluntary Disability Plan ("the Plan") is designed to provide income protection for you and your family if you become Disabled and are unable to work due to an Sickness, injury or pregnancy. There must be appropriate medical evidence to support your Disability claim. As long as your Total Disability, as defined in the Plan, is approved, the Plan provides a continuing source of income for weeks, months or years.

The Plan replaces 65 percent of your Eligible Pay, as defined in the Plan, to a maximum of $1,384.62 per week for the first 26 weeks of a Disability that is not work-related and 50 percent of your Eligible Pay to a maximum of $6,000 per month if you continue to be Totally Disabled after 180 days whether or not your Total Disability is work-related.

The Plan considers income from certain other sources, described in "Other Income Benefits," as reductions against the income benefit provided under the Plan.

Mandatory Return to Work Policy

AutoNation has a Mandatory Return to Work policy for all Disabled Associates whose Physicians release them to perform alternate, modified or Part-Time duty. The purpose of the Mandatory Return to Work policy is to help Associates transition back to Full-Time status.

During your Total Disability, your Physician, the Disability Case Manager and AutoNation will work together to determine when and under what conditions you may return to work. If your Physician and AutoNation approve your return-to-work date, you may start working again as specified in your Physician’s release, whether your return to Active Employment is under work conditions that are the same as those in place prior to your Total Disability or modified.

If AutoNation offers you alternate, modified or Part-Time duty that is consistent with your Physician’s release and you decline such duty, your Disability benefits will end.

If your disabling condition becomes more severe, a Vocational Rehabilitation Specialist may be involved to assess the need for extensive rehabilitation intervention. These interventions may include transferable skills analyses, potential retraining for a new occupation and job placement assistance.
ELIGIBILITY AND ENROLLMENT

Who Is Eligible

You are eligible to participate in the Plan if you are a regular, Full-Time Associate of AutoNation 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.

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.

You will have to satisfy the new hire waiting period for benefits.

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 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 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 benefits that you were enrolled in and had in effect before your termination — if available — based on your Eligible Pay before termination, 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 the Voluntary Disability Plan for Retail Associates upon rehire.

Rehired after 13 weeks: If your rehire occurs more than 13 weeks after your termination or if you were not eligible for benefits at the time of 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 Effective 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.

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 are first Active-at-Work after completion of your Eligibility (Waiting) Period. If you do not enroll, you will be assigned “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). 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.

Who Is Not Eligible

Provided you enroll when you are first eligible to participate in the Plan and are Actively at Work on that date, your 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 benefits eligible
· A leased Associate
· A contract Associate
· Employed by a location that does not participate in the Plan
· You are receiving benefits but do not pay for them while on leave
· 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 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, provided you are Active at Work on that date. 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, provided you are Active at Work on that date.
If you are not Actively at Work due to injury, Sickness, temporary layoff or Leave of Absence on the date your coverage under the Plan normally would begin, coverage will begin on the date you return to Active Employment for one full work day.

If you do not enroll in the Plan when you are first eligible to do so and choose to enroll during a later enrollment period, you will have to provide Evidence of Insurability to the insurance company. See “Evidence of Insurability Requirement” for additional details.

How to Enroll

You may enroll in benefits at the following times:

- **Initial enrollment**, occurs when you are hired or 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 any questions concerning your online enrollment.

The elections you make will be effective the first day of the month following one three (3) months of regular, Full-Time employment. However, if you are hired on the first day of a month your coverage under the Plan is effective on the first day of the third (3) month.

If you do not enroll by the deadline indicated on The Benefit Connection website, you will have to wait until the next Annual Enrollment period to enroll, subject to the Evidence of Insurability requirement, unless you experience a qualifying life event during the Plan Year.

**Annual Enrollment**

Each year during Annual Enrollment, you may add or drop coverage for the next Plan Year, subject to the Evidence of Insurability requirement for Associates who do not enroll when they are initially eligible.

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 any 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, provided you are Actively at Work on that date, subject to the Evidence of Insurability requirement. If not, any changes will be effective on the date you return to Active Employment for one full work day. 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**

You may change your disability coverage under the Plan if you experience certain qualifying life events such as marriage, divorce, legal separation or annulment; birth, adoption or placement for adoption of a child or the death of your spouse or a dependent. 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 in support of it to change your 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.
Any change request must be consistent with your life event. As a result of a qualifying life event, you may elect to add coverage under the Plan, subject to the Evidence of Insurability requirement, or drop coverage.

Your coverage change request, including any increase or decrease in payroll deductions, will be effective on the first day of the month following the date of the insurance company approval, provided you are Actively at Work on that date. If you are not Actively at Work on that date, the new coverage and the required cost will not take effect until you return to Active Employment for one full work day.

By requesting this change, you certify that the information you 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.

Evidence of Insurability Requirement

If you are a new hire and eligible to participate in the Plan or you are newly eligible to participate in the Plan, Evidence of Insurability approval is not required.

If you do not elect coverage as a new hire or newly eligible Associate and later wish to enroll in coverage under the Plan within 31 days of a qualifying life event (within 60 days if you become eligible for Medicare/Medicaid/CHIP and 90 days for divorce) or you wish to enroll during Annual Enrollment, Evidence of Insurability approval is required.

In all situations, if you were previously denied Plan coverage under the Evidence of Insurability requirement, current Evidence of Insurability must be submitted to the insurance company for review and approval before new coverage will become effective.

You must submit complete Evidence of Insurability to the insurance company within 90 days of making your election. Complete Evidence of Insurability includes providing the insurance company with any and all additional requested information within 90 days of making your benefit election. Failure to provide complete Evidence of Insurability will result in you not being covered under the Voluntary Disability Plan for Retail Associates.

If coverage is approved by the insurance company, the new coverage and the required contribution will become effective on the first day of the month following the date of the insurance company approval or on the date you are approved if you are approved on the first day of the month, provided you are Actively at Work on that date. If you are not Actively at Work on that date, the new coverage and the required contribution will not take effect until you return to Active Employment for one full work day.

Your Cost for Coverage

You pay the full cost for coverage under the Plan with after-tax contributions. Since you pay for coverage with after-tax dollars, should you receive any benefits directly from the Plan in the event of your approved Total Disability, they will not be taxable when received under current tax regulations. The cost may increase or decrease at any time to meet the full cost of the Plan. Refer to The Benefit Connection website at www.KnowYourBenefits.org for the required contributions.

Since your disability payment is not taxable income, you will not receive a W-2 for tax purposes.

If you are enrolled in benefits and then are approved for a Leave of Absence, your coverage under the Plan continues for the period of your approved leave but your period of coverage continuation will not exceed six months. You will be billed directly by The Benefit Connection. The bills will be mailed to your home address that is on file with 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 retroactively to the last date you paid in
full. For the period you are on leave you must pay your required contribution in full by the due date specified on the direct bill (partial payments are not accepted).

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

**SHORT-TERM DISABILITY**

In the event of your Total Disability that occurs while you are covered under the Plan, benefits begin after you satisfy the required elimination (or waiting) period.

The elimination (or waiting) period is seven consecutive calendar days during which you are unable to work due to Disability.

**If Your Sickness or Injury Is Work-Related**

If your Sickness or injury is work-related, immediately notify your supervisor. Your supervisor will file an Incident Report with AutoNation’s workers’ compensation third party administrator.

**If You Have a Pre-Existing Condition**

There is no Pre-Existing Condition limitation for Short-Term Disability; there is, however, a Pre-Existing Condition limitation for Long-Term Disability, which is explained in the “Long-Term Disability” section of this Summary Plan Description.

**How to Qualify for Disability Benefits**

To qualify for Short-Term Disability benefits under the Plan, you must meet the following criteria:

· You must be enrolled in the Plan at the time you become Disabled.

· You become Disabled due to a non-work-related Sickness or Injury for more than seven consecutive calendar days.

· You are unable to perform the Material and Substantial Duties of your Regular Occupation.
You are under the direct care of a Physician who is not a family member. The Physician must be licensed to practice medicine or legally qualified as a medical practitioner under state law.

You report and file a claim for non-work-related Short-Term Disability with the Disability Intake Specialist immediately or as soon as is reasonably possible if you expect to be away from work for more than seven days.

You and your Physician submit proof of your Total Disability, including, but not limited to, medical records, X-rays and other documentation as requested by the Disability Case Manager assigned to you.

You continue to pay for your benefits while you are on your Short-Term Disability leave.

How to Apply for Disability Benefits

To apply for Short-Term Disability benefits, you must follow these steps:

- Call The Benefit Connection at: 1-877-550-BENE (2363).
- Provide the personal information requested.
- Once you are provided with the reason options for your call say “FMLA & Disability.”
- You will then be transferred to an Intake Specialist at Matrix Absence Management.
- The Intake Specialist will gather initial information from you which includes but is not limited to:
  - Your last date worked
  - Your treating Physician’s name, address and telephone number
  - The nature of your Sickness, injury or pregnancy
  - Your supervisor’s name and telephone number
  
Following your call, a Medical Release form will be sent to you to sign. When the insurance company receives the completed release form, a Disability Case Manager will be assigned to you. He or she will contact your Physician to obtain the necessary medical information to evaluate and decide your claim. You and your Physician must provide the information by the date specified in the Disability Case Manager’s request or your claim may be denied.

If you work in New York and file a claim under the Plan, the Disability Case Manager will process a New York Short-Term Disability claim. If you are enrolled in the Plan, any claim benefit paid from the Plan will be offset by the New York Short-Term Disability claim benefit. Your total Short-Term Disability benefit will never exceed the Short-Term Disability Benefit Plan benefit.

If you work in California, you must file a claim under the Plan and also directly with the state of California. To assist you with filing your state of California claim, the Claims Administrator will provide you a form in your initial claim packet which you must complete and send it to the state. Your Short-Term Disability Benefit will never exceed the Short-Term Disability Plan benefit. The Claims Administrator will withhold the maximum state benefit and deduct it from the Plan benefit. Once you receive the state Disability Benefit award letter, the Claims Administrator will make any applicable adjustments.

Disability and Family and Medical Leave

Your Total Disability and medical leave under the Family and Medical Leave Act (FMLA) run concurrently. Early in your Total Disability, whether or not it is related to your job, the Disability Case Manager will notify you of your rights under FMLA.

Time Limit to Apply for Benefits

An application filed more the six (6) months after the date benefits may become payable, will not be accepted by the Claim or Plan Administrator.

How Your Disability Claim Is Decided

The Disability Case Manager makes a determination of the length of your Total Disability based on the impairment level and severity of your Sickness or injury, and takes into consideration any restrictions provided by your treating Physician.

In certain situations, you may be asked to have an independent medical examination or a functional capacity examination to assist the Disability Case Manager in determining the appropriate length of your Total Disability. The cost of any required examination is paid for by AutoNation or the Plan. If you refuse to have an examination when one is requested, your claim may be suspended or denied.
If there is insufficient evidence of a Disability severe enough to warrant your absence from work, your claim will be denied.

**How Your Benefit Is Calculated**

Your Short-Term Disability benefits are based on your Eligible Pay as of the date you are Disabled. Eligible Pay is based on earnings from the prior August 1 through July 31. For example, Eligible Pay in 2018 is based on earnings from August 1, 2016 through July 31, 2017. Eligible Pay is not adjusted for bonuses, transfers, rehires within 30 days, overtime, promotions, demotions or salary changes that occur during the Plan Year. Refer to “Eligible Pay” under “Important Definitions.”

The Plan reduces your Short-Term Disability benefit based on your other sources of income as described in “Reduction of Benefits” so that your total income equals 65 percent of your Eligible Pay to a maximum of $1,384.62 per week up to 26 weeks of an approved Short-Term Disability that is not work-related. Your Disability Benefits income is subject to the provisions of the Plan described in “Reduction of Benefits.”

The following example shows how a Short-Term Gross Disability benefit is calculated under the Plan. In this example, Eligible Pay is $45,000.

**Gross short-term Disability benefit**

<table>
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<tr>
<th>Weekly Eligible Pay ($45,000/52)</th>
<th>$865.38</th>
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<td>Multiply by 65%</td>
<td>.65</td>
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<tr>
<td>Gross Weekly Benefit equals</td>
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**How Benefits Are Paid**

Short-Term Disability benefits under the Plan are paid on a weekly basis, up to a maximum of 26 weeks, for your Total Disability that is not related to your job.

AutoNation has a Mandatory Return to Work policy. This applies when you are receiving Disability Benefits for a non-work-related injury or Sickness, and are released by your Physician to return to alternate or modified duty or to your own position on a Part-Time basis.

If during the first 26 weeks of disability, you refuse or decline alternate, modified or Part-Time duty that is provided by AutoNation, you will no longer be considered Disabled. **Disability benefits will end.**

If you do accept such duty, AutoNation will supplement your Disability Benefits an additional 15 percent of your Eligible Pay until you return to work Full-Time. However, if you are in a position that pays a commission while you are on alternate, modified or Part-Time duty, your commission will be factored in to the total amount paid to you in Disability Benefits and supplemental pay. Your Disability Benefits and supplemental pay will be offset by the commission to the extent that your Disability Benefits, supplemental pay and commission will not exceed 80 percent of your Eligible Pay. It is possible that no Disability Benefits or supplemental pay may be due to you in cases where your earnings exceed 80 percent of your Eligible Pay.
Reduction of Benefits

Short-Term Disability benefits will be reduced by any of the following that are available to you for the same period Disability Benefits are payable under the Plan:

* No-fault automobile insurance policy
* Income/wages from AutoNation
* State-mandated disability plan
* Social Security Disability program
* Disability or retirement benefits under any other AutoNation-sponsored or AutoNation-funded Plan, unless you were receiving it prior to becoming Totally Disabled or immediately transfer the payment to another plan qualified by the United States Internal Revenue Service.

Acts of Third Parties

In the event that you are injured through the acts or omissions of another person or organization, benefits under the Plan will be provided only on condition that you agree in writing to the following:

* to reimburse the Plan for the full amount of payments made under the terms of the Plan immediately upon receipt of the proceeds of any settlement;
* to provide the Plan with a lien on the proceeds to the extent of the full amount of payments made under the terms of the Plan; and
* to provide the Plan with a credit against payments to be made in the future under the Plan equal to the proceeds less any amount paid to the Plan by way of reimbursement.

If You Have Recurrent Periods of Disability

If your initial Disability lasts less than 26 weeks and a second period of disability is due to the same or related cause(s), the second period of disability will be considered as a continuation of the initial disability provided that your return to Full-Time Active Employment does not exceed 14 consecutive days. If so, you will not be required to satisfy a second seven-day elimination (or waiting) period if your claim is approved.

If You Have Successive Periods of Disability

If the second Disability is unrelated to the initial Disability or if your return to Active Employment exceeds fourteen (14) consecutive days, the second period of Disability will be considered as a separate Disability. In this case, you must file a new claim and if approved, benefits will be payable after you satisfy a second seven-day elimination (or waiting) period.

When Disability Benefits End

Your Short-Term Disability benefits under the Plan will end if any of the following events occurs:

* You are no longer Totally Disabled as defined in the Plan.
* You have been released to return to work on a Full-Time basis with no restrictions.
* You fail to provide satisfactory proof of your Total Disability when requested by the disability case manager.
* You decline alternate, modified or Part-Time duty that is consistent with any medical restrictions as defined by your Physician.
· You are in a commissionable alternate, modified or Part-Time position, and your commission exceeds 65 percent of your Eligible Pay. In this case your Disability Benefits would be reduced or eliminated for the period that your commission exceeded 65 percent of Eligible Pay.

· Your earnings while you are on disability exceed the amount allowable under the Plan.

· You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition.

· Your period of Total Disability reaches 26 weeks.

· You do not pay the required contributions that are billed to your home address on file with The Benefit Connection.

· You die.

Exclusions

Disability benefits will not be paid for disabilities caused by or resulting from any of the following:

· Intentionally self-inflicted Injury or attempted suicide committed while sane or insane

· Active participation in a riot

· War or any act of war (declared or undeclared)

· An attempt to commit or the commission of a crime, or as a result of such crime conviction under state or federal law

· Work-related injury or Sickness

· Cosmetic surgery except surgery required as a result of an accidental Injury that occurs while covered under the Plan

· Not under the regular and continuous care and treatment of a Physician

· Any period of disability that occurs while you are incarcerated

· Any period of disability that begins when you were not a Participant in the Plan

· Period of disability that follows a claimant’s failure to pay required contributions during the Short-Term Disability period
**LONG-TERM DISABILITY**

The required elimination (or waiting) period for Long-Term Disability is 180 consecutive days during which you are unable to work due to a Total Disability. If your Long-Term Disability stops and starts again during the Elimination Period, the insurance company will treat your Total Disability as continuous if the break is less than 30 days. The days that you are not Totally Disabled will not count toward the required Elimination Period.

**If You Have a Pre-Existing Condition**

Benefits will not be paid for a Total Disability caused by, contributed to by, or resulting from a Pre-Existing condition unless you have been Actively at Work for one (1) full day following the end of:

- Six consecutive months during which you receive no consultation with a Physician; or received medical care, treatment or services, including diagnostic procedures or took prescription drugs or medicines for such condition; or
- Twelve (12) consecutive months from the date you became insured.

**How to Qualify for Disability Benefits**

To qualify for Long-Term Disability benefits under the Plan, you must meet the following criteria:

- You must be enrolled in the Plan at the time you become Disabled.
- You have been continuously Disabled due to a work-related or non-work-related Sickness or injury for 180 days.

- You are under the direct care of a Physician who is not a family member. The Physician must be licensed to practice medicine or legally qualified as a medical practitioner under state law.

- You report and file a claim for Long-Term Disability that is work-related or non-work-related with the disability Intake Specialist within 180 days of your last date worked if you expect to be away from work for more than 180 days.

- You and your Physician submit proof of your Total Disability, including, but not limited to, medical records, X-rays and other documentation as requested by the disability case manager assigned to you.

**How to Apply for Disability Benefits**

If your Total Disability is expected to continue beyond 180 days, the Disability Case Manager will notify you in writing of the procedures you need to follow to apply for Long-Term Disability benefits under the Plan.

If your Sickness or Injury is work-related and you are receiving workers’ compensation Indemnity Benefits, the Disability Case Manager will notify you in writing of the procedures you need to follow to apply for Long-Term Disability benefits under the Plan if all of the following occur:

- Your Total Disability exceeds 13 weeks.
- Your Total Disability is expected to continue beyond 180 days.
- You are eligible and enrolled in coverage under the Plan.
How Your Disability Claim Is Decided

The Disability Case Manager makes a determination of the length of your Total Disability based on the impairment level and severity of your Sickness or injury, and takes into consideration any restrictions provided by your treating Physician.

In certain situations, you may be asked to have an Independent Medical Examination or a Functional Capacity Examination to assist the Disability Case Manager in determining the appropriate length of your Total Disability. The cost of any required examination is paid for by the insurance company. If you refuse to have an examination when one is requested, your claim may be suspended or denied.

If there is insufficient evidence of a disability severe enough to warrant your absence from work, your claim will be denied.

How Your Benefit Is Calculated

Your Long-Term Disability benefits are based on your Eligible Pay as of the date you are Disabled. Eligible pay is based on earnings from the prior August 1 through July 31, for example, your Eligible Pay in 2018 is based on earnings from August 1, 2016, through July 31, 2017. Eligible Pay is not adjusted for bonuses, transfers, rehires within 30 days, overtime, promotions, demotions or salary changes that occur during the Plan Year. Refer to “Eligible Pay” under “Important Definitions.”

The Plan supplements your other sources of income as described in “Other Income Benefits” so that your total income equals 50 percent of your Eligible Pay to a maximum of $6,000 per month after 180 days of an approved Disability whether or not it is work-related, subject to the provisions of the Plan described in “Other Income Benefits.”

If you accept alternate, modified or Part-Time duty that is consistent with your Physician’s release, AutoNation supplements your Disability Benefits an additional 15 percent of your Eligible Pay until you return to work Full-Time. If you are in a position that pays a commission while you are on alternate, modified or Part-Time duty, your commission will be factored in to the total amount paid to you in Disability Benefits and supplemental pay. Your Disability Benefits and supplemental pay will be offset by the commission to the extent that your Disability Benefits, supplemental pay and commission will not exceed 80 percent of your Eligible Pay. It is possible that no Disability Benefits or supplemental pay may be due to you in cases where your earnings exceeds 80 percent of your Eligible Pay.

However, no matter how much you receive from the other income benefits, the Plan will pay a minimum Monthly Benefit of the greater of $100 or 10 percent of your Gross Monthly Benefit, as defined in the Plan.

The following example shows how a Long-Term Gross Disability benefit is calculated under the Plan. In this example, Eligible Pay is $45,000.

<table>
<thead>
<tr>
<th>Gross long-term Disability benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assuming the disability is approved, to calculate the gross Long-Term Disability benefit, Eligible Pay is converted to a monthly rate. The gross Long-Term Disability benefit is based on 50 percent of Eligible Pay up to the Maximum Benefit Period not to exceed $6,000 per month.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monthly Eligible Pay</th>
<th>$3,750</th>
</tr>
</thead>
<tbody>
<tr>
<td>($45,000/12)</td>
<td></td>
</tr>
<tr>
<td>Multiply by 50%</td>
<td>X .5</td>
</tr>
<tr>
<td>Gross Monthly Benefit equals</td>
<td>$1,875</td>
</tr>
</tbody>
</table>

How Benefits Are Paid

If you continue to be Disabled beyond 180 days due to a non-work-related or work-related disability and the Disability Case Manager approves you for Long-Term Disability benefits under the Plan, your benefits will be paid on a monthly basis. Payments are issued at the beginning of a month for the previous month.
For example, if the last day of the initial 180-day disability period falls on June 30, after you receive your last Short-Term Disability Weekly Benefit check, your Long-Term Disability Monthly Benefit check will be issued August 1 for the month of July, September 1 for the month of August and so on.

Maximum Benefit Period

Your benefits under the Plan will end if you reach the Maximum Benefit Period, as defined in the Plan. The Maximum Benefit Period that follows is based on your age at the time you become Totally Disabled.

<table>
<thead>
<tr>
<th>Your Age on the Date Your Disability Begins</th>
<th>Maximum Benefit Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 61</td>
<td>60 months</td>
</tr>
<tr>
<td>Age 61</td>
<td>54 months</td>
</tr>
<tr>
<td>Age 62</td>
<td>48 months</td>
</tr>
<tr>
<td>Age 63</td>
<td>42 months</td>
</tr>
<tr>
<td>Age 64</td>
<td>36 months</td>
</tr>
<tr>
<td>Age 65</td>
<td>30 months</td>
</tr>
<tr>
<td>Age 66</td>
<td>27 months</td>
</tr>
<tr>
<td>Age 67</td>
<td>24 months</td>
</tr>
<tr>
<td>Age 68</td>
<td>21 months</td>
</tr>
<tr>
<td>Age 69 or older</td>
<td>18 months</td>
</tr>
</tbody>
</table>

If You Have Recurrent Periods of Total Disability

If your initial Total Disability exceeds 180 days and the second period of Total Disability is due to the same or related cause(s), the second period of Total Disability will be considered as a continuation of the initial Total Disability provided that your return to Full-Time Active Employment does not exceed six consecutive months. If so, you will not be required to satisfy a second 180-day elimination (waiting) period if your claim is approved.

If You Have Successive Periods of Total Disability

If the second Total Disability is unrelated to the initial Total Disability or if your return to Active Employment exceeds six consecutive months, the second period of Total Disability will be considered as a separate Total Disability. In this case, you must file a new claim and if approved, benefits will be payable after you satisfy a second 180-day elimination (waiting) period.

The Long-Term Disability Limitation

Long-Term Disability benefits payable under the Plan due to a condition of Mental or Nervous Disorder and Substance Abuse are limited to a total of 24 months from the onset of Long-Term Disability, or the initial 26-week period of Short-Term Disability if it applies.

However, you may continue to receive Long-Term Disability benefits beyond 24 months of the onset of your Total Disability if you are hospitalized or institutionalized at the end of the 30-month period as a result of the Disability.

If you are still Disabled when you are released from the hospital or institution, you will receive benefit payments under the Plan for up to a day recovery period. If you are readmitted during this 90-day recovery period for a confinement of at least 14 consecutive days, you will continue to receive benefits during your confinement and after your second discharge from the facility for up to a second 90-day recovery period.

Other Limited Benefits

You may be eligible for a monthly benefit for all Total Disabilities caused by or contributed to chronic fatigue syndrome, environmental allergic or reactive illness, self-reported conditions, musculoskeletal and connective tissue disorders of the neck and back, including any disease, disorder, sprain and strain of the joints and adjacent muscles of the cervical, thoracic & lumbosacral regions and surrounding soft tissue. You may be limited to 24 months in your lifetime for all Total Disabilities outlined above.
If You Die During a Period of Total Disability

If you die during a period of Total Disability, your survivor may be eligible to receive a lump sum payment equal to three months of your Gross Monthly Benefit under the Plan. The benefit will be paid if, on the date of your death, the following have occurred:

- Your Total Disability was approved by the insurance company and continued for 180 days or more.
- You were eligible to receive or were actually receiving a monthly Long-Term Disability benefit under the Plan.

Your survivor is considered to be your legal spouse. However, if your spouse predeceases you or you are single at the time of your death, any surviving children will receive the benefit. If you have no surviving natural, legally adopted or step children under age 25, the benefit will be paid to your estate.

When Disability Benefits End

Your Long-Term Disability benefits under the Plan will end if any of the following events occurs:

- You are no longer Totally Disabled as defined in the Plan.
- You fail to provide satisfactory proof of your Total Disability when requested by the Disability Case Manager.
- You decline alternate, modified or Part-Time duty that is consistent with any medical restrictions as defined by your Physician.
- You are in a commissionable alternate, modified or Part-Time position, and your commission exceeds 65 percent of your Eligible Pay. In this case your Disability benefits would be reduced or eliminated for the period that your commission exceeded 65 percent of Eligible Pay.
- You are able to work and choose not to work in your Regular Occupation on a Part-Time basis during the first 18 months of your Total Disability as measured from the onset of your Total Disability. For purposes of the Plan, “Part-Time basis” means the ability to work and earn 20 percent or more of your Indexed Monthly Earnings, as defined in the Plan.
- You are able to work and choose not to work in any Gainful Occupation on a Part-Time basis after an 18-month period as measured from the onset of your Total Disability.
- Your earnings while you are on Disability exceed the amount allowable under the Plan.
- You refuse to receive recommended treatment that is generally acknowledged by Physicians to cure, correct or limit the disabling condition.
- You reach the Maximum Benefit Period under the Plan.
- You die, except as provided under “If You Die During a Period of Disability.”

Exclusions

Voluntary Disability benefits will not be paid for disabilities caused by any of the following:

- Intentionally self-inflicted Injury or attempted suicide
- Active participation in a riot
- War or any act of war (declared or undeclared)
- Committing a felony
· Cosmetic surgery except surgery required as a result of an accidental injury that occurs while covered under the Plan

· Any period of disability that occurs while you are confined in any penal or correctional institution.

**OTHER INCOME BENEFITS**

Your Disability benefits under the Plan may vary from time to time depending on income benefits you are eligible to receive from other sources.

The other sources of income that count toward your disability income under the Plan include, but are not limited to, those described in the following provisions.

“Other income benefits” means the amount of any benefit for loss of income, provided to you or to your family, as a result of the period of Total Disability for which you are claiming benefits under the Plan. This includes any such benefits for which you or your family are eligible or that are paid to you, to your family or to a third party on your behalf, pursuant to any of the following:

· Temporary or permanent workers’ compensation Indemnity Benefits including any damages or settlements made in place of such benefits (whether or not liability is admitted).

· Temporary or permanent Disability Benefits under the Jones Act, occupational disease law or similar law including any damages or settlements made in place of such benefits (whether or not liability is admitted).

· Government law or program that provides disability or unemployment benefits as a result of your job with AutoNation

· Individual insurance policy where the premium is wholly or partially paid by AutoNation

· “No-fault” automobile insurance plan

· Disability benefits under the United States Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan, or similar plan or act that you, your spouse and/or children are eligible to receive because of your Total Disability
“Other income benefits” also means any of the following payments you are entitled to receive:

· Any formal salary continuance plan

· Wages or income or other compensation not part of the supplemental Disability Benefits paid by AutoNation under the Mandatory Return to Work policy

· Commissions or monies, including vested renewal commissions, but excluding commissions or monies that you earned prior to disability which are paid after your disability has begun

“Other income benefits” also means any such payments that are made to you, your family or to a third party on your behalf, pursuant to any of the following:

· Disability benefit under AutoNation’s Retirement Plan

· Portion of a settlement or judgment, minus associated costs, of a lawsuit that represents or compensates for your loss of earnings

· Retirement benefit from a retirement plan that is wholly or partially funded by AutoNation contributions, unless:

   1. You were receiving it prior to becoming Totally Disabled, or

   2. You immediately transfer the payment to another plan qualified by the United States Internal Revenue Service.

Benefits will not include the portion, if any, of such retirement benefit that was funded by your after-tax contributions.

· Retirement benefits under the United States Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan, or similar Plan or act that you, your spouse and/or children receive because of your retirement, unless you were receiving them prior to becoming Totally Disabled

If you are paid other income benefits in a lump sum, the insurance company will prorate the lump sum in accordance with either of the following:

· over the period of time it would have been paid if not paid in a lump sum; or

· if such period of time cannot be determined, the insurance company will use tables based on the expected duration of disability

The insurance company may make a retroactive allocation of any retroactive other income benefits payments.

The amount of any increase in benefits paid under any federal or state law will not be included as other income benefits if such increase:

· takes effect after the date benefits become payable under the Plan, and

· is a general increase that is required by law and applies to all persons who are entitled to such benefits.

"Eligible to receive" means that the other sources of income benefits will count toward your disability income under the Plan if it is deemed by the insurance company that you would be eligible for the other benefits if you make proper application for them, whether or not you actually choose to apply and receive the other income benefits. For this reason, you should receive the most income if you apply for and receive every income benefit available to you.

If you work in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island, you may be eligible for a state or territory Disability Benefit for a sickness or injury that is not work-related. State disability programs normally provide a benefit for up to 180 days. California and Rhode Island may provide Disability Benefits for a period beyond 180 days.
If You Receive a Lump Sum Payment

If you receive Disability Benefits in a lump sum payment from any sources described in “Other Income Benefits,” the lump sum payment amount will be converted to a weekly amount if the other benefits are payable for the first 180 days of your Total Disability. Or, the lump sum payment amount will be converted to a monthly amount if other benefits are payable beyond the first 180 days of your Total Disability. The purpose is to reduce your gross weekly or monthly disability income benefits under the Plan.

Coordination With Social Security and Other Income Benefits

If you are Totally Disabled beyond 180 days and become eligible for Social Security Disability Income (SSDI) benefits, your Gross Monthly Benefit under the Plan will be reduced by the amount of income you receive or are eligible to receive.

Estimating Income From Social Security and Other Income Benefits

The insurance company may determine that you are eligible for benefits from Social Security or another source. If this occurs, benefits under the Plan will be reduced based on an estimate of what you would be eligible to receive from the other income benefits if any of the following occurs:

· You have not applied for benefits for which you may be eligible.

· You have applied for benefits and have not received the payment as yet.

· You have applied and were denied benefits, and you are appealing or have appealed the denial.

Your Disability Benefits will not be reduced by other income benefits described previously if either of the following occurs:

· The other income benefits sources have denied both your application for benefits and your appeal.

· You sign a repayment form for reimbursement to the insurance company for Plan recovery of any overpayment made by the Plan as a result of benefit payments made to you from another source. If the insurance company withholds a benefit under the Plan while a claim from another source is under appeal, the withheld portion of the Plan benefit will be paid to you in a lump sum if your appeal subsequently is denied.

If You Recover Disability Payments From Another Party

If you receive benefits as a result of an Sickness or injury for which you have asserted or will assert any claim or right of recovery against any 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 Disability benefits paid by the Plan for the Sickness or injury.

When this provision applies to your Disability 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.”
**WHAT IF YOUR CLAIM IS DENIED — INITIAL DECISION**

The Claims Administrator or insurance company will notify you in writing of its initial determination within a reasonable period of time, but not later than 45 days after your claim is received by the Plan.

If the Claims Administrator or insurance company does not respond to your claim within 45 days, you immediately should contact the Claims Administrator or insurance company. For circumstances beyond the control of the Plan, the Claims Administrator or insurance company is allowed an additional period (up to 30 days) within which to notify you of its decision. If such an extension is required, the Claims Administrator or insurance company 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 or insurance company 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 or insurance company notifies you prior to the expiration of the first 30-day extension, and relates the circumstances requiring the extension and the date by which the final decision will be rendered.

If the Claims Administrator or insurance company needs additional information from you to make its initial determination, you will receive written notice describing the required information and you will have at least 45 days to supply the additional information. If additional information is required, the period within which the initial determination is required to be made is tolled (put on hold) until you supply the additional information or the time allowed for you to do so runs out.

If the Claims Administrator or insurance company determines after a periodic review that you are no longer Disabled and terminates your Disability Benefits under the Plan, such determination constitutes an adverse benefit determination that triggers these claims procedures.

The Claims Administrator’s or insurance company’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.
How to Appeal a Denied Claim for Benefits

If 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’s or insurance company’s notice of denial. You have the following rights:

* To submit a request for review in writing to the Claims Administrator or insurance company

* To review pertinent documents

* To submit issues and comments in writing to the Claims Administrator or insurance company

The Claims Administrator or insurance company will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such review.

A decision on the review shall be made no later than 45 days following receipt of the written request for review.

If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision shall be made not later than 90 days following receipt of the request for review. The decision shall be furnished in writing and shall include the reasons for the decision with reference to the policy provisions upon which the decision is based.

How to Appeal a Denied Claim for Eligibility

If your appeal pertains to eligibility write to:

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

or fax to:
1-847-554-1245

Any request for an eligibility related appeal MUST be accompanied by a fully completed and executed Authorization for Release of Information form in this Summary Plan Description. Any request for an eligibility related appeal that does not include a fully completed and executed authorization form will be delayed in processing until such form is received.

Your appeal must be submitted within 180 days after you receive the Claims Administrator’s or insurance company’s notice of denial. If your initial appeal is not approved, you have the right to request a second level of appeal. All second level appeals must be submitted within 60 days from the initial appeal decision.

Second Review of a Denied Claim

The Claims Administrator and insurance company have the discretionary authority to interpret the terms and application of the Plan as they relate to Evidence of Insurability, Pre-Existing Conditions, and your request for benefits and benefit payments; and to make a final determination on all claims.

You will be notified in writing of the Claims Administrator’s decision within 45 days or 90 days if there are special circumstances. If the Claims Administrator denies your claim on review, you will receive written notice of the specific reasons for denial with specific references to applicable Plan provisions. All decisions of the Claims Administrator are final and binding.
If You Are Granted a Leave of Absence

If AutoNation grants you a Leave of Absence, your 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 for your coverage. You will be direct billed by The Benefit Connection. The bill will be mailed to your home address that is on file with Payroll. You will be billed on an after tax basis the same amount you would have paid as a contribution from your paychecks if you were an 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 the 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, and premiums were paid, 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.

If You Terminate

If you terminate employment with AutoNation, your coverage under the Plan ends on your termination date. It is your responsibility to request a refund of any premiums paid beyond your termination date from your payroll representative.

If You Decline Alternate Duty

AutoNation has a Mandatory Return to Work policy. If AutoNation offers you alternate, modified or Part-Time duty that is consistent with your Physician's release and you decline such duty, your Disability benefits will end.

At Other Times

Plan 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.
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 of Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 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 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 (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, 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 — Short Term Disability

When you receive disability payments 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 Sickness or injury, you must notify the Plan Administrator and agree to subrogation.

The Plan is entitled to reimbursement for any payment which you may receive (or may be entitled to receive) from any 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 disability income payments) and regardless of whether you have been “made whole” by the settlement or fully compensated for your Injury. The Plan is not subject to any state laws or equitable doctrine, including but not limited to the make whole or common fund doctrines, which would purport to require the Plan to reduce its recovery by any portion of a covered person’s attorney’s fees or costs. The Plan’s right of first priority shall not be reduced due to the covered person’s own negligence. The Plan requires all covered persons and their representatives to cooperate (including in any litigation) in order to guarantee reimbursement to the Plan from third-party benefits. Failure to comply with this request will entitle the Plan to withhold benefits due to you or your covered dependents under the Plan.

The Plan’s reimbursement will not be reduced by any attorney’s fees.
By accepting benefits under this Plan, you agree to subrogate the Plan, and acknowledge the Plan’s rights to be reimbursed for expenses for which you 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 are obligated to cooperate in pursuit of any recovery. If you fail to cooperate, or if the Plan becomes aware that you have received a third-party payment and not reported such payment, the Plan may suspend all further benefit payments on any account to you until the subrogated portion is returned to the Plan or offset against amounts which would otherwise be paid to you.

The cost of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The cost of legal representation for you shall be borne by you.

Subrogation & Reimbursement — Long Term Disability

When you suffer a Total Disability because of the act or omission of a third party; and become entitled to Long Term Disability benefits under this Plan; and you do not initiate legal action for the recovery of such benefits from the third party in a reasonable period of time; then the insurance company will subrogate any rights you may have against the third party and may bring legal action to recover any payments the insurance company made in connection with such Total Disability.

Legal Action

No legal action may be filed for benefits less than 60 days or more than five years from the time proof of claim is required, unless otherwise provided under federal law.
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:

- 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.
- You are on a scheduled Company observed holiday or vacation day, provided you are an Active Employment on the preceding schedule work day.

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

**Actively At Work**
You are “Actively at Work,” when performing on a Full-Time basis, the material duties pertaining to your job in the place where and in the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of Injury or Sickness.

**Affiliate/Affiliated Employer**
Each subsidiary of AutoNation, Inc. that participates in the Plan.

**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 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.

**Claims Administrator**
Any insurance company or third-party administrator designated by AutoNation, Inc. to administer Plan benefits.

**Company**
AutoNation, Inc. and certain of its Affiliates.

**Disability Benefit**
A benefit that is paid to you during an approved disability period.

**Disabled**
The Associate is unable to do the Material and Substantial Duties of his/ her occupation, is not doing any work for payment, and is under the regular care of a Physician. If during the first 26 weeks of disability, the Associate refuses or declines alternate, modified or Part-Time duty that is provided by AutoNation, the Associate will no longer be considered Disabled under the Plan.
Important Definitions

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

Eligibility (Waiting) Period
A continuous period of time that an Associate must be in Active Employment in an eligible group before the Associate becomes eligible for coverage under the Plan.

Eligible Pay
Eligible Pay is determined once a year and is not adjusted for bonuses, transfers, rehires within 30 days, overtime, promotions, demotions or salary changes that occur during the Plan Year. Each year the amount of your Eligible Pay is based on earnings from the prior August 1 through July 31. For example, your Eligible Pay in 2018 is based on earnings from August 1, 2016, through July 31, 2017. Eligible Pay for the upcoming Plan Year is determined between August 1 and September 30 each year.

Associates on a commission or incentive pay structure and service technicians paid by flag hours
Your Eligible Pay is based on earnings from the prior August 1 through July 31, before taxes and any deductions made for pretax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, overtime pay, any other extra compensation (except annual and quarterly bonuses) or income received from sources other than AutoNation, Inc.

Hourly Associates
Your regular work earnings received for the prior August 1 to July 31. Includes wages paid for high productivity or motivational incentives. Overtime pay is not included.

Salaried Associates on base pay structure
Your gross annual income, received for the prior August 1 to July 31 before taxes and any deductions made for pretax contributions to a qualified deferred compensation plan, Section 125 plan or flexible spending account. It does not include income received from commissions, overtime pay, any other extra compensation (except annual and quarterly bonuses) or income received from sources other than AutoNation, Inc.

New Hires
Until you have been continuously employed for a complete Eligible Pay measurement period, your Eligible Pay will be based on a projected earning target specific to your job category, as determined by AutoNation. This amount is based upon the average Eligible Pay for your job category and may not reflect your actual earnings.

Elimination Period
The number of consecutive days at the onset of disability for which no benefits are payable under the Plan. It begins on the first day of disability.

Employer
AutoNation, Inc. and its Affiliates
### Important Definitions

#### Evidence of Insurability
A statement of your medical history that the insurance company will use to determine if you are approved for coverage. This may include having a medical exam or having a doctor verify your medical history.

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

#### Gainful Occupation
A job or position of employment that is or can be expected to provide you with an income at least equal to your gross disability payment within 12 months of your return to work.

#### Gross Monthly Benefit
After the first 180 days of Total Disability, the amount of your Monthly Benefit under the Plan before any reductions for other income benefits and earnings.

#### Gross Weekly Benefit
During the first 26 weeks of disability, the amount of your Weekly Benefit under the Plan before any reductions for other income benefits and earnings.

#### Indexed Covered Monthly Earnings
Your monthly earnings adjusted on each anniversary of benefit payments by the lesser of 10 percent or the current annual percentage increase in the Consumer Price Index (CPI-W). Your Indexed Monthly Earnings may increase or remain the same, but will not decrease. The CPI-W is published by the U.S. Department of Labor. The insurance company reserves the right to use some other similar measurement if the Department of Labor changes or stops publishing the CPI-W.

Indexing is only used to determine your percentage of lost earnings while you are Totally Disabled and working.

#### Injury
Bodily Injury resulting from an accident that is the direct and independent cause of loss, including all related conditions and recurrent symptoms. The Injury must cause disability that begins while your coverage is in effect.

#### Insured
Any person covered under the Plan.

#### 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, approved personal leave, or workers’ compensation.

#### Mandatory Return to Work
AutoNation has a Mandatory Return to Work policy for all Disabled Associates whose Physicians release them to perform alternate, modified or Part-Time duty. The purpose of the return to work policy is to help Associates transition back to Full-Time status.

When a location is able to accommodate the release, your Disability Case Manager will advise you of the duty that is available. If you decline such duty, or begin and then refuse to continue such duty, your Disability Benefits will end without regard to the minimum
Monthly Benefit. Your Disability Benefits will resume when you accept such duty. Benefits will not be retroactive to the time you initially refused such duty.

If you accept such duty in a noncommissioned position, you will receive a supplemental payment from your location of 15 percent of your Eligible Pay in addition to your Disability Benefits.

If you are in a commissionable alternate, modified or Part-Time position and are receiving commissions, the combination of your commissions, the supplemental 15 percent of your Eligible Pay and your Disability Benefits cannot exceed 80 percent of your Eligible Pay. If that would happen, your Disability Benefits will be reduced by the amount that would have exceeded 80 percent.

Material and Substantial Duties
Duties that are material and substantial not incidental, are fundamental or inherent to the occupation and cannot be reasonably omitted or changed.

Maximum Benefit Period
The maximum period for which Long-Term Disability benefits are payable for any one period of continuous disability. The Maximum Benefit Period starts when the Elimination Period of 180 days ends. A Monthly Benefit is not payable after the end of the Maximum Benefit Period even if disability continues.

Mental or Nervous Disorders
Mental or Nervous Disorders include:
- Bipolar Disorder (manic depressive syndrome)
- Schizophrenia
- Delusional (paranoid) Disorders
- Psychotic Disorders
- Depressive Disorders
- Anxiety Disorders
- Somatoform Disorder (psychosomatic Illness)
- Eating Disorders
- Mental Illness

Monthly Benefit
After 180 days of a disability, the benefit payable monthly under the Plan after any reductions for other income benefits and earnings.

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

Participant
An Associate who has been properly enrolled in the Plan and whose contributions for coverage are current.

Physician
Means a duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which claim is made. The Physician may not be you or a member of your immediate family.
Important Definitions

Plan
The AutoNation Voluntary Disability 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.

Plan Year
The 12-consecutive-month period beginning January 1 and ending December 31.

Regular Occupation
The job or position routinely performed when the disability begins.

Self-Reported Condition
Those conditions which, when reported by your Physician, cannot be verified using generally accepted standard medical procedures and practices. Examples of such conditions include, but are not limited to, headaches, dizziness, fatigue, loss or energy or pain.

Sickness
Illness or disease causing disability, including pregnancy, childbirth, miscarriage or abortion, and any complications from these conditions/procedures.

Substance Abuse
Substance abuse means the pattern of pathological use of a substance which is characterized by:

- Impairment in a social and/or occupational functioning;
- Debilitating physical condition;
- Inability to abstain from or reduce consumption of a substance; or
- The need for daily substance use for adequate functioning.

Total Disability (Totally Disabled)

- During the initial 18 months from the onset of your disability, as a result of a Sickness or injury you cannot perform the material and substantial duties of your regular occupation.
- After that 18-month period, you must be so prevented from performing the material and substantial duties of any occupation for which you are qualified by education, training or experience.
- During the first 180 days of disability and after, you have lost 20% or more of your Indexed Covered Monthly (as defined in “Important Definitions”) Earnings due to the same injury or Sickness.
- If during the first 180 days of disability, the Associate refuses or declines alternate, modified or Part-Time duty that is provided by AutoNation, the Associate will no longer be considered Disabled under the Plan.
- If you require a license to perform your occupation, the loss of such license for any reason does not in and of itself constitute a Total Disability.

Weekly Benefit
During the first 26 weeks of a disability, the weekly benefit payable under the Plan after any reductions for other income benefits and earnings.
As a Participant in the AutoNation Voluntary Disability 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.

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. 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.
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:

   __________________________________________________________________________________________

1. 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
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   Phone Number: __________________________  __________________________
   Email: __________________________  __________________________

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

The following is important identification and administration information about the AutoNation Voluntary Disability 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 Voluntary Disability 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 financial protection in case of a short- or long-term disability.</td>
</tr>
<tr>
<td>Plan Number</td>
<td>519</td>
</tr>
</tbody>
</table>
| Plan Sponsor, Administrator and Agent for Service of Legal Process | AutoNation, Inc.  
c/o AutoNation Benefits Company  
200 Southwest First Avenue, 14th Floor  
Fort Lauderdale, FL 33301  
954-769-6000  

The Plan is administered by the Employee Benefits Committee (the “Plan Administrator”). The Plan Administrator makes all determinations as to the administration and interpretation of the Plan. The Plan Administrator is the agent for service of legal process.

<table>
<thead>
<tr>
<th>Controlling Law</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employer Identification Number</td>
<td>73-1105145</td>
</tr>
<tr>
<td>Plan Year</td>
<td>January 1 – December 31</td>
</tr>
</tbody>
</table>
Short-Term Disability benefits under the Plan are self-insured. Long-Term Disability benefits under the Plan are fully insured and governed by a policy issued by Reliance Standard Life Insurance Company (RSLI). RSLI administers all claims under the Plan and provides other administrative services as described throughout this Summary Plan Description. The certificate, which confirms your Long-Term Disability benefits under the Plan, is available for review by contacting the Plan Administrator.

<table>
<thead>
<tr>
<th>Type of Financing</th>
<th>Associate contributions.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Company</td>
<td>AutoNation, Inc. and certain of its Affiliates.</td>
</tr>
</tbody>
</table>

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.