Employee **Benefits** Summary | 2018

BENEFITS

Think Young Commitment

Young
AUTOMOTIVE GROUP

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Contact Information

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local Human Resources Department.

Benefit	Administrator	Phone	Website
Medical	SelectHealth	801.442.5000	www.selecthealth.org
Dental	Dentist Direct	866.696.6527	www.usdentistdirect.com
Life and AD&D Insurance	Cigna	800.362.4462	www.cigna.com
Voluntary Long-Term Disability	Cigna	800.362.4462	www.cigna.com
Voluntary Vision	Opticare of Utah	801.869.2020	www.opticareofutah.com
Voluntary Life and AD&D Insurance	Cigna	800.362.4462	www.cigna.com
Voluntary Short-Term Disability	Cigna	800.362.4462	www.cigna.com
Legal Insurance	ARAG	800.247.4184	ARAGLegalCenter.com
Pet Insurance	ASPCA	877.343.5314	www.aspcapetinsurance.com/youngautomotive
Critical Illness and Hospital Indemnity	Aflac	800.433.3036	www.aflacgroupinsurance.com
Human Resources	HR Department	801.927.1755	hr@youngauto.net
Goldenwest Insurance Services Broker	Casey Bangerter	801.786.8168	cbangerter@gwcu.org
Goldenwest Insurance Services Account Executive	Stacie Eyring	801.786.8164	seyring@gwcu.org
Goldenwest Insurance Services Account Executive	Felicia Muñoz	801.786.8166	fmunoz@gwcu.org
401(k) Raymond James	Jon Hooiman	801.525.9800	jon.hooiman@raymondjames.com
401(k) Raymond James	Ryan Poll	801.525.9800	ryan.poll@raymondjames.com

Young Automotive Group Utah Business 2014 - 2017 Best Companies to Work For

Top Workplaces The Salt Lake Tribune www.sltrib.com

Davis Education Foundation Learning today. Leading tomorrow.

Utah Business 50 Fast

What is HIPAA?

The Health Insurance Portability and Accountability Act (HIPAA) establishes a set of standards for protecting certain health information or PHI (Protected Health Information). If you have any questions or would like additional information regarding HIPAA, please contact your Human Resources Department or Goldenwest Insurance Services.

Monthly Cost for Benefits

Medical SelectCare			
Status	Employee Monthly Premium	Young Auto Monthly Cost	Young Auto Monthly HSA Contribution
Single	$122.26	$330.54	$50.00
Two Party	$384.75	$384.75	$65.00
Family	$563.91	$612.69	$85.00

Dental Dentist Direct	
Status	Employee Monthly Premium
Employee	$28.17
Two Party	$59.65
Family	$97.46

Vision Opticare	
Status	Employee Monthly Premium
Single	$7.45
Employee + Spouse	$14.02
Employee + Child(ren)	$17.13
Family	$23.04

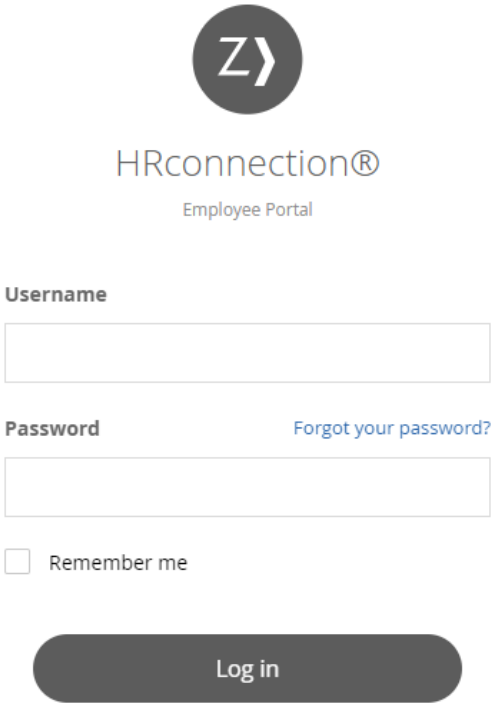
HRconnection – Employee Portal

Administered by Goldenwest Insurance Services

We are excited to announce the rollout of HRconnection® to our employees. HRconnection is a one-stop shop for human resources-related communications, specifically for benefit enroll communications, and document summaries. Accessible from the Internet, you can visit it anytime from any computer or mobile device.

How do I access HRconnection?
Simply go to **www.hrconnection.com**. Once you are on the HRconnection website, enter your username and password. To retrieve your credentials, click "Forgot your password" and enter your email address.

Make your open enrollment election with 4 easy steps…..



Step 1. **Log in to HRconnection**

Step 2. **Click on "Time to Enroll"**

Step 3. **Make your enrollment elections**

Step 4. **Confirm your elections**

Benefits Overview

Young Automotive Group is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours or more per week. Coverage will begin on the first day of the month following 60 days of your hire date or your qualifying event. Eligible dependents are your spouse, children under age 26, and disabled dependents of any age.

Benefits Offered

- Medical
- Dental
- Vision
- Basic Life Insurance
- Voluntary Life Insurance
- Long-Term Disability
- Flexible Spending Account (FSA)
- Limited FSA
- Employee Assistance Program (EAP)

Qualifying Events

- Loss of Dependent Coverage (including spousal coverage through employer)
- Marriage
- Divorce
- Legal Separation
- Birth of a Child
- Adoption or Change in Custody
- Death

***If you experience a qualifying event, you must contact HR within 30 days.**

UNDERSTANDING THE PROCESS

1. Present your ID card to your provider at which time they may ask you to pay any applicable copay, deductible, etc.
2. After your visit or procedure, the provider will send the insurance carrier a claim.
3. Claim is processed by the insurance carrier.
4. Payment is sent to the provider's office.
5. Insurance carrier will send you an EOB (Explanation of Benefits) in the mail or a notice via email.
6. The provider will send you a bill for any remaining balance.

UNDERSTANDING YOUR BENEFITS

- Use IN-NETWORK PROVIDERS to make sure you receive the HIGHEST LEVEL OF BENEFIT and to protect against additional excess charges.
- Consult your plan summary BEFORE undergoing any procedure to VERIFY whether or not a CERTAIN PROCEDURE IS COVERED and there are no potential limitations.
- Some services or medications REQUIRE PRIOR AUTHORIZATION and failure to receive prior authorization may result in a DENIAL OF A CLAIM.
- If possible, UTILIZE AN URGENT CARE CENTER for any illness or injury that is not life threatening as opposed to an emergency room.
- Many PRESCRIPTIONS HAVE A GENERIC ALTERNATIVE and are often more cost-effective. These drugs are usually just as safe and effective as the equivalent name brand.

Medical Benefits

For a list of providers please visit: **selecthealth.org/Find-a-Doctor**

	Select Care: High Deductible Health Plan (HDHP)	
	In-Network	Out-of-Network
Lifetime Benefit Maximum	None	
Annual Deductible	$2,000 / $4,000	$2,250 / $4,500
Annual Out-of-Pocket Maximum (deductible)	$3,275 / $6,550	$4,500 / $9,000
Coinsurance	20%	40%
Doctor's Office		
Office Visit	Primary Care-$15 after deductible Secondary Care-$25 after deductible	40% after deductible
ConnectCare	$49	Not covered
Wellness Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	Covered 100%	Not covered
Prescription Drugs		
Tier 1 (30-day supply)	$7 after participating deductible	
Tier 2 (30-day supply)	$21 after participating deductible	
Tier 3 (30-day supply)	$42 after participating deductible	
Tier 4 (30-day supply)	$100 after participating deductible	
Mail Order—Tier 1 (90-day supply)	$7 after participating deductible	
Mail Order—Tier 2 (90-day supply)	$42 after participating deductible	
Mail Order—Tier 3 (90-day supply)	$126 after participating deductible	
Hospital Services		
Emergency Room	$75 after deductible	See participating benefit
Inpatient	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Ambulance Service	20% after deductible	See Participating Benefit
Mental Health and Chemical Dependency		
Inpatient Services	20% after deductible	40% after deductible
Outpatient Services	20% after deductible	40% after deductible
Other Services		
Maternity Services	See Professional, Inpatient and Outpatient	40% after deductible
All other maternity hospital/ physician services	See Professional, Inpatient and Outpatient	40% after deductible
Physical, Occupational and Speech Therapy Services (Up to 20 visits per calendar year for each therapy type)	$25 after deductible	40% after deductible
TMJ and Related Services (lifetime maximum benefit)	See Professional, Inpatient and Outpatient	Not covered
Private Duty Nursing (monthly maximum benefit)	20% after deductible	40% after deductible

Understanding a Health Savings Account (HSA)

Administered by Flex, a service of Goldenwest

Top 5 advantages of having a Health Savings Account (HSA)

1. **Contributions:** You decide the amount of money you will set aside for your healthcare costs. You also get to determine how your money is spent. You, as the consumer, have the advantage to determine your care based on cost and quality.
2. **Tax-deductible/Tax free:** Annual contributions to your HSA (up to the legal limit) are tax-deductible from your gross income. Money used to pay qualified medical expenses (including dental and vision), is not taxed.
3. **Tax-deferred:** Funds in your HSA account earn interest and are accumulated tax-deferred.
4. **HSA funds are yours to keep:** Unlike an FSA, any unused money in your HSA account at the end of the year will roll over as opposed to an FSA where the money is forfeited once the year ends ("use it or lose it"). The unused portion will continue to accumulate tax-deferred.
5. **Simple to use:** You can decide whether to easily swipe your HSA debit card at time of service, or submit your claim to receive a reimbursement at a later date.

HSA Maximum Contributions	
Ages, Status	**2018**
Under 55, Single	$3,450
Under 55, Family	$6,900
Over 55, Single	$4,450
Over 55, Family	$7,900

What type of expenses are covered?

- Acupuncture
- Anesthetist
- Alcohol and Drug Rehab
- Ambulance
- Artificial Limbs
- Birth Control Pills
- Blood Pressure Monitoring Device
- Contact Lenses, Solutions and Cleaner
- Co-payments, Deductibles, Coinsurance
- Chiropractor
- Dental Care
- Diabetic Supplies
- Eye Exams and Eyeglasses
- Guide Dog
- Gynecological/Obstetrics
- Hearing Aids
- Home Healthcare
- Hospital and Skilled Nursing
- Immunizations
- Medical Services
- Orthodontia Benefits
- Physical Exams
- Prescriptions
- Psychiatric Care

What type of expenses are not covered?

- Cosmetic Surgery
- Diapers
- Exercise Equipment
- Hygiene Products
- Home Pregnancy Test
- Toothpaste, etc.
- Teeth Whitening
- Over-the-Counter RX, without a Prescription

Please visit: **www.irs.gov/publications/p502** for a complete listing of Covered/Non-Covered expenses and to review the full definition of each.

LowestMed

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BIN: 610602 GROUP: LOWEST

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www.LowestMed.com
Customer service: info@lowestmed.com
This is not insurance.

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- No enrollment forms or membership required

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- Anyone can use this card
- Valid at virtually all local and national pharmacies
- Use it as many times as you'd like

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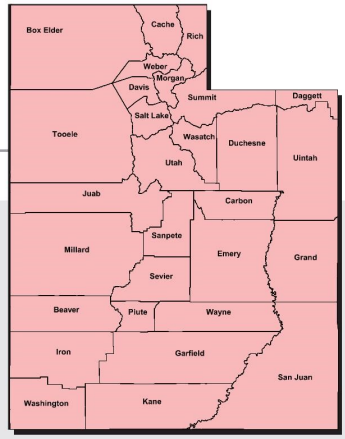
Young Automotive Group

Select Care® Plus



select:care+

Select Care includes high-performing hospitals and clinics, like Primary Children's Hospital, Intermountain Medical Center, Utah Valley Regional Medical Center, and The Orthopedic Speciality Hospital (TOSH®). Additionally, the Huntsman Cancer Institute, University of Utah Hospital, and all U of U clinics are included.

The "plus" means you can see doctors and facilities outside your network.

You can use our provider search tool at **selecthealth.org/providers** to see which doctors and facilities participate in the Select Care network.

Select Care Plus Service Area

36 Participating Hospitals

Over 8,300 Participating Providers

Your network includes providers and facilities throughout Utah. Don't see your hospital? Visit **selecthealth.org/providers** to see all the hospitals included on Select Care.

- Alta View Hospital
- American Fork Hospital
- Cedar City Hospital
- Davis Hospital and Medical Center
- Dixie Regional Medical Center
- Heber Valley Hospital
- Huntsman Cancer Hospital
- Intermountain Medical Center
- LDS Hospital
- Logan Regional Hospital
- McKay-Dee Hospital
- Moab Regional Hospital
- Mountain West Medical Center
- Orem Community Hospital
- Park City Hospital
- Primary Children's Hospital
- Riverton Hospital
- TOSH - The Orthopedic Specialty Hospital
- Utah Valley Hospital
- University of Utah Hospital & Clinics

SELECTHEALTH ALSO INCLUDES:

INTERMOUNTAIN HEALTH ANSWERS℠

A 24/7 nurse line that allows you to speak to a registered nurse who will listen to your concerns, answer medical questions, and help you decide what course of action to take. All you need is your phone. Call **844-501-6600**.

Free!

INTERMOUNTAIN CONNECT CARE®

Use your computer, tablet, or phone to video connect with a doctor or nurse practitioner anytime (24/7 access). Visit **intermountainconnectcare.org** or download the app for Android or iOS.

Never more than $49 per visit. See your schedule of benefits for coverage information.

INTERMOUNTAIN INSTACARE®/KIDSCARE®

They're open late—and are a great choice for sore throats, broken bones, sprains, headaches, stomachaches, earaches, and other urgent medical conditions. With nearly 40 locations, there's a site near you. Use our app to reserve your spot in line!

Approximately doctor's office prices. Much cheaper than the ER!

selecthealth

Convenient, high-quality care— whenever and wherever you need it.

A skilled clinician is just a swipe or click away. With Intermountain Connect Care®, SelectHealth® members can use their smartphone, tablet, or computer to get basic healthcare. Just log in and speak face-to-face with an Intermountain caregiver through on-demand video.

MOBILE APP

With a smartphone or tablet, you can get access through the Connect Care mobile app. Use the app and start your visit in minutes.

WEB

If you'd rather use a larger screen, you can access Connect Care using a video-capable computer at your home or office.

YOUR VISIT

Most visits take less than ten minutes. Your clinician will review your history, answer questions, diagnose, treat, and even prescribe medication.

COVERAGE

Benefits may vary by plan. For details, call Member Services at 800-538-5038 or visit us at selecthealth.org.

GET STARTED

Download the app on Android or iOS, or visit **intermountainconnectcare.org** to register for free.

ANDROID APP ON Google play

Available on the App Store

selecthealth

Young AUTOMOTIVE GROUP

Voluntary Dental Benefits

Administered by Dentist Direct

Benefit	In-Network	Out-of-Network
Deductible	$50 Per person up to $150 per family - Waived for Preventive	
Annual Maximum Benefit	$2,000 Maximum (up to $3,500 with carryover benefit)	
PREVENTIVE: Cleanings & exams (1/6mos), bitewing x-rays, fluoride, etc.	100%	100%
BASIC: Fillings, simple extractions, emergency pain, etc.	90%	80%
MAJOR: Crowns, bridges, dentures, endodontics, periodontics, implants, etc. ***12 month waiting period, unless prior coverage within the last 60 days.**	60%	50%
Specialists	Paid as Specialists	Paid as Specialists
Adult Orthodontics	Discount Only	None
Child Orthodontics Dependents to age 19	50%	50%
Orthodontia Maximum	$1,000 Lifetime	

For a list of providers please visit: **www.usdentistdirect.com**

The Annual Maximum Carryover Benefit Rider allows plan members to 'carryover' a portion of their unused annual maximum benefit into future years. Your dental benefits become more valuable every year and you get to keep a portion of what you don't use!

Base Annual Plan	Threshold Limit	Carryover Amount	Carryover Account Max
$2,000	$800	$400	$1,500

For Example:
A member in their first year of coverage uses $600 of their annual benefit. The paid claims do not exceed the $800 threshold limit therefore; $400 will be credited to the following year. This means in year 2 the member will have an annual maximum benefit amount of $2,400 as oppose to only $2,000.

Voluntary Vision Benefits

Administered by Opticare of Utah

Benefit	Select Network	Broad Network	Out-of-Network
Eye Exam	$10 Copay	$15 Copay	$40 Allowance
Standard Plastic Lenses			
Single Vision	100% Covered	$10 Co-pay	$85 Allowance for lenses, options and coatings
Bifocal	100% Covered	$10 Co-pay	
Trifocal	100% Covered	$10 Co-pay	
Lens Options			
Progressive (Standard plastic no-line)	$30 Co-pay	$50 Co-pay	
Premium Progressive Options	$80 Co-pay	$100 Co-pay	
Ultra Premium Progressive Options	Up to 20% Discount	Up to 20% Discount	
Polycarbonate	$40 Co-pay	25% Discount	
High Index	$80 Co-pay	25% Discount	
Coatings			
Scratch Resistant Coating	100% Covered	$10 Co-pay	
Ultra Violet Protection	100% Covered	$10 Co-pay	
Other Options A/R, Edge Polish, Tints, Mirrors, etc.	Up to 25% Discount	Up to 25% Discount	
Frames			
Allowance Based on Retail Pricing	$130 Allowance	$110 Allowance	$90 Allowance
Contacts			
Contact Benefits in Lieu of Lens and Frame Benefit	$130 Allowance	$110 Allowance	$90 Allowance
Additional Contacts purchases:			
***Conventional	Up to 20% off	Retail	
***Disposables	Up to 10% off	Retail	
Frequency			
Exams, Lenses, Frames, Contacts	Every 12 months	Every 12 months	Every 12 months
Frequency			
LASIK	$250 Off Per Eye	Not Covered	Not Covered

For a list of providers please visit
www.opticareofutah.com

No need for an ID card. To take advantage of your Opticare of Utah vision benefit, simply contact an Opticare of Utah provider and let them know you have Opticare of Utah coverage—they handle the paperwork for you.

Flexible Spending & Limited Flexible Spending Accounts (FSAs)

Administered by Flex, a service of Goldenwest

You can save money on your healthcare and/or dependent daycare expenses with an FSA. You set aside funds each pay period on a pretax basis and use them tax-free for qualified expenses. You pay no federal income or Social Security taxes on your contributions to an FSA. (That's where the savings comes in.) Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

Healthcare Spending Limit—$2,600

Dependent Care Spending Limit—$5,000

Flex, a service of Goldenwest is the **new administrator** of the Flexible Spending Accounts — one for healthcare expenses and one for dependent childcare and elder care expenses. You can enroll in one or both FSAs. You use each account separately, but they work similarly.

Qualified FSA Expenses

- Chiropractic Services
- Copays
- Deductibles
- Dental Treatment
- Eye Glasses
- Lasik
- Orthodontia
- Prescription Copays
- X-Ray
- And More

Here's How an FSA Works

1. You decide the annual amount you want to contribute to either or both FSAs based on your expected healthcare and/or dependent childcare/elder care expenses.
2. Your contributions are deducted from each paycheck before income and Social Security taxes, and deposited into your FSA.
3. You can pay with the Healthcare FSA **debit card** for eligible healthcare expenses. For dependent care, you pay for eligible expenses when incurred, and then submit a reimbursement claim form or file the claim online.
4. You are reimbursed from your FSA. So, you actually pay your expenses with tax-free dollars.
5. File a claim online or check your account balance at www.mybenefitfunds.com/bmsflex

Limited Flexible Spending Account

A limited-purpose flexible spending account is much like a typical health flexible spending account. However, eligible expenses are limited to qualifying dental and vision expenses for you, your spouse, and your eligible dependents.

Life and AD&D Insurance

Insured by Cigna

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump-sum payment if you die while employed by Young Automotive Group. The company provides basic life insurance of $10,000 at no cost to you if you participate in the medical plans offered by Young Automotive Group.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Young Automotive Group provides AD&D coverage of $10,000 at no cost to you. This coverage is in addition to your company-paid life insurance described above.

Voluntary Life and AD&D Insurance

Insured by Cigna

You may purchase life and AD&D insurance in addition to the company-provided coverage. You may also purchase life and AD&D insurance for your dependents if you purchase additional coverage for yourself. You are guaranteed coverage (up to $100,000 and up to $25,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee—Minimum amount you can purchase is $20,000 up to a $500,000 maximum, $5,000 increments.

Spouse—Minimum amount you can purchase is $10,000 up to a $250,000 maximum, $5,000 increments.

Children—$5,000 increments to a maximum of $10,000.

For more information on this benefit and rates please see Human Resources.

Age	Employee and Spouse Smoker Rate per $1,000	Employee and Spouse Non-Smoker Rate per $1,000
<20–29	$0.12	$0.07
30–34	$0.14	$0.08
35–39	$0.20	$0.09
40–44	$0.31	$0.13
45–49	$0.49	$0.22
50–54	$0.74	$0.34
55–59	$1.00	$0.48
60–64	$1.59	$0.82
65–69	$2.91	$1.64
70–74	$5.20	$3.43
75–99	$8.80	$6.28

*AD&D is an additional $0.04 per $1,000 on Employee and an additional $0.025 per $1,000 on Spouse and Children.

To calculate your monthly deduction, use the following formula:

_____ / $1,000 X _____ = _____

Desired Benefit | Rate from the Table | Estimated Monthly Deduction

For Example:
A 32-year-old purchases $100,000 of Voluntary Life Insurance $100,000 / $1,000 X $0.14 = $14/ month or $7/pay period.

Voluntary Short-Term Disability Insurance (STD)

Administered by Cigna

Short-Term Disability (STD) insurance provides income if you become disabled due to an injury or illness. Benefits begin on the fourteenth day of any injury, hospitalization or illness.

Rates: $0.380 Per $10 of Weekly Gross Benefit

Calculate: _____ / $10 X $0.380 =Monthly Rate
(Weekly Gross Income)

Voluntary Short-Term Disability Insurance (STD)	
Benefit Percentage	60% of Wages
Maximum Weekly Benefit	$1,000
Elimination Period	14 Days
Maximum Benefit Duration	11 Weeks

Voluntary Long-Term Disability Insurance (LTD)

Insured by Cigna

Meeting your basic living expenses can be a challenge if you become disabled. Your options may be limited to personal savings, spousal income and possibly Social Security. Disability insurance provides protection for one of your most valuable assets—your ability to earn an income. Young Automotive provides Long-Term Disability insurance (LTD) coverage as a voluntary benefit for all of their employees.

Rates: $0.475 Per $100 of Monthly Covered Payroll

Calculate: _____ / $100 X $0.475 =Monthly Rate
(Monthly Gross Income)

Voluntary Long-Term Disability Insurance (LTD)	
Benefit Percentage	60% of Wages
Maximum Monthly Benefit	$10,000
Elimination Period	90 Days
Maximum Benefit Duration	Social Security Full Retirement Age (SSFRA)

401(k)

Administered by Raymond James

We are excited to announce that beginning January 1, 2018, the following enhancements will be made to the Young Automotive Group 401(k):

For all YAG employees who participate in the 401(k), there will be a predictable company match per pay period. The match will be 25% of the employee's contribution up to the first 4%. YAG will match up to a total of 1% of the employee's annual income.

For example, if John Doe makes $40,000 a year, his semi-monthly gross paycheck would be $1,666.67. The table below shows the dollar amount he and YAG would contribute to the 401(k) based upon different contribution percentages.

Employee contribution percentage	Employee dollar amount per pay period	YAG dollar amount match per pay period
1%	$16.67	$4.17
2%	$33.33	$8.33
3%	$50.00	$12.50
4%	$66.67	$16.67
More than 4%	Varies	$16.67

Eligibility to participate in the 401(k) plan is also being updated. YAG employees must be a full-time employee for 6 months to participate in the plan.

Please contact the financial advisors for questions about the 401(k).

2018 401(k) Contribution Maximum - $18,500

Legal Services

Administered by ARAG

- **In-Office Services:** You receive access to a nationwide network of more than 11,000 **credentialed attorneys** who can advise and represent you.
- **Telephone Advice:** You can call a Network Attorney for **unlimited legal advice** to help prepare documents, letters or a will.
- **Online Resources:** ARAG provides online tools and useful information to learn more about legal issues on your own. Use our **DIY Docs®** to help you create any of 300+ state-specific, legally valid documents online.

Cost to enroll in the Legal Plan is $25.25/month.

Critical Illness

Administered by Aflac

The benefit of an Aflac Group Critical Illness plan can help with the treatment costs of covered critical illnesses, such as heart attack or stroke.

More importantly, the plan helps you focus on recuperation instead of the distraction of out-of-pocket costs. With the Critical Illness plan, you receive cash benefits directly (unless otherwise assigned) – giving you the flexibility to help pay bills related to treatment or to help with everyday living expenses.

The Aflac Group Critical Illness plan benefits include:

- Critical Illness Benefit payable for:
  - Cancer
  - Heart Attack (Myocardial infarction)
  - Stroke
  - Kidney Failure (End-Stage Renal Failure)
  - Major Organ Transplant
  - Bone Marrow Transplant (Stem Cell Transplant)
  - Sudden Cardiac Arrest
  - Coronary Artery Bypass Surgery
  - Noninvasive Cancer
  - Skin Cancer
- Health Screening Benefit

	Nontobacco				Tobacco			
	Employee		Spouse		Employee		Spouse	
Attained Age	$10,000	$20,000	$50,000	$10,000	$10,000	$20,000	$50,000	$10,000
18–25	$3.97	$6.41	$13.75	$3.97	$5.12	$8.72	$19.51	$5.12
26–30	$5.05	$8.58	$19.16	$5.05	$6.61	$11.69	$26.95	$6.61
31–35	$5.75	$9.98	$22.66	$5.75	$8.11	$14.71	$34.49	$8.11
36–40	$7.29	$13.06	$30.36	$7.29	$10.78	$20.05	$47.84	$10.78
41–45	$8.66	$15.81	$37.24	$8.66	$12.87	$24.22	$58.27	$12.87
46–50	$10.22	$18.92	$45.01	$10.22	$15.27	$29.02	$70.26	$15.27
51–55	$15.47	$29.42	$71.26	$15.47	$23.75	$45.97	$112.66	$23.75
56–60	$15.08	$28.63	$69.30	$15.08	$23.99	$46.47	$113.89	$23.99
61–65	$30.54	$59.56	$146.63	$30.54	$47.52	$93.53	$231.54	$47.52
66–70	$53.67	$105.81	$262.25	$53.67	$81.73	$161.94	$402.57	$81.73
71+	$53.67	$105.81	$262.25	$53.67	$81.73	$161.94	$402.57	$81.73

Hospital Indemnity

Administered by Aflac

The Aflac Group Hospital Indemnity plan provides financial assistance to enhance your current coverage. This plan may help you avoid dipping into savings or having to borrow to address out-of-pocket-expenses major medical insurance was never intended to cover. For instance, transportation and meals for family members, help with child care, or time away from work.

The Aflac Group Hospital Indemnity plan benefits include the following:

- Hospital confinement benefit
- Hospital admission benefit
- Hospital intensive care benefit
- Intermediate intensive care step-down unit

Group Hospital Indemnity

Coverage	Monthly (12pp/yr)
Employee	$22.32
Employee + Spouse	$40.54
Employee + Dependent Children	$33.08
Family	$51.30

Accident

Administered by Aflac

In the event of a covered accident, the Aflac Group Accident Advantage Plus plan pays cash benefits fast to help with the costs associated with out-of-pocket expenses and bills — expenses major medical may not take care of, including:

- Ambulance rides
- Wheelchairs, crutches and other medical appliances
- Emergency room visits
- Surgery and anesthesia
- Bandages, stitches and casts

Group Accident Insurance

High Option – Nonoccupational Plan	Monthly (12pp/yr)
Employee	$13.93
Employee + Spouse	$23.30
Employee + Dependent Children	$28.65
Family	$38.02

Pet Insurance

Administered by ASPCA

With ASPCA Pet Health Insurance, you can choose the care you want when your pet is hurt or sick and have the comfort of knowing they have coverage.

Our coverage includes exam fees, diagnostics, and treatments for:

- Accidents
- Illness
- Cancer
- Hereditary Conditions
- Behavioral Issues
- Dental Disease

For more information go to, www.aspcapetinsurance.com/youngautomotive. Priority Code: **EB16YA**

Glossary

Allowed Amount

Maximum amount on which payments is based for covered healthcare services. This may be called “eligible expense”, “payment allowance”, or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing)

Balance Billing

When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you for covered services.

Coinsurance

Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. For example, if the health insurance or plan’s allowed amount for an office visit is $100 and you’ve met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Copayment

A fixed amount (for example, $20) you pay for a covered healthcare service, usually when you receive the service. The amount can vary by the type of covered healthcare service.

Deductible

The amount you owe for healthcare services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1,000, your plan won’t pay anything until you’ve met your $1,000 deductible for covered healthcare services subject to the deductible. The deductible may not apply to all services.

Emergency Medical Condition

An illness, injury, symptom, or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Excluded Services

Healthcare services that your health insurance or plan doesn’t pay for or cover.

Hospital Inpatient Care

Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care

Care in a hospital that usually doesn’t require an overnight stay.

In-Network Copayment

A fixed amount (for example, $20) you pay for covered healthcare services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

Medically Necessary

Healthcare services or supplies needed to prevent, diagnose, or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine.

Network

The facilities, providers, and suppliers your health insurer or plan has contracted with to provide healthcare services.

Out-of-Pocket Limit

The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges, or healthcare your health insurance or plan doesn’t cover. Your health insurance or plan may have an in-network and out-of-network out-of-pocket limit.

Preauthorization

A decision by your health insurer or plan that a healthcare service, treatment plan, prescription drug, or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn’t a promise your health insurance or plan will cover the cost

Primary Care Provider (PCP)

A physician (M.D., Medical Doctor or D.O., Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist, or physician assistant, as allowed under state law, who provides, coordinates, or helps a patient access a range of healthcare services.

Specialist (SCP)

A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

Urgent Care

Care for an illness, injury, or condition serious enough that a reasonable person would seek care right away, but not so severe as to be considered an Emergency Medical Condition.

Important Notices and Disclosures

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of all stages of mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan.

If you would like more information on WHCRA benefits, please contact your plan administrator.

Newborn's Act Disclosure

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

HIPAA Special Enrollment Rights

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

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

To request special enrollment or obtain more information, contact Human Resources.

Qualified Medical Child Support Orders

Coverage will be provided to any of your dependent child(ren) if a Qualified Medical Child Support Order (QMCSO) is issued, regardless of whether the child(ren) currently reside with you. A QMCSO may be issued by a court of law or issued by a state agency as a National Medical Support Notice (NMSN), which is treated as a QMCSO. If a QMCSO is issued, the child or children shall become an alternate recipient treated as covered under the Plan and are subject to the limitations, restrictions, provisions, and procedures as all other plan participants.

CHIP State Premium Assistance

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

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

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance.** If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or by call toll free **866.444.EBSA (3272).**

UTAH – Medicaid and CHIP
Websites:
Medicaid: **http://health.utah.gov/medicaid**
CHIP: **http://health.utah.gov/chip**
Phone: **866.435.7414**

To see if any other states have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866.444.EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877.267.2323, Menu **Option 4, Ext. 61565**

Employee Retirement Income Security Act of 1974 (ERISA)

As a participant in the Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these cost 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.

Assistance with Your Questions

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 N.W., 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.

HIPAA Privacy Notice

This notice describes how medical information about you may be used and disclosed by the employer and its affiliates, if any, and how you can get access to this information as mandated for health plans that are subject to HIPAA. Please review it carefully.

The Health Insurance and Portability and Accountability Act of 1996 (HIPAA) requires certain health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information (45 Code of Federal Regulations parts 160 and 164). Where HIPAA applies to a health plan sponsored by the Employer, this document is intended to satisfy HIPAA's notice requirement for all health information created, received, or maintained by the Employer-sponsored health plans (the plans). The regulations will supersede any discrepancy between the information in this notice and the regulations.

The plans need to create, receive, and maintain records that contain health information about you to administer the plans and provide you with health care benefits. This notice describes the plans' health information privacy policy for your health care, dental, personal spending account and flexible reimbursement account benefits. The notice tells you the ways the plans may use and disclose health information about you, describes your rights, and the obligations the plans have regarding the use and disclosure of your health information. It does not address the health information policies or practices of your health care providers.

Our Commitment Regarding Health Information Privacy

The privacy policy and practices of the plans protect confidential health information that identifies you or could be used to identify you and relates to a physical or mental health condition or the pay-

ment of your health care expenses. This individually identifiable health information is known as “protected health information’ (PHI). Your PHI will not be used or disclosed without a written authorization from you, except as described in this notice or as otherwise permitted by Federal and State health information privacy laws.

Privacy Obligations of the Plans

The plans are required by law to: (a) make sure that health information that identifies you is kept private; (b) give you this notice of the plans’ legal duties and privacy practices for health information about you; and (c) follow the terms of the notice that is currently in effect.

How the Plans May Use and Disclose Health Information about You

The following are the different ways the plans may use and disclose your PHI without your written authorization:

For Treatment. The plans may disclose your PHI to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as the result of an accident, the plans may advise an emergency room physician about the types of prescription drugs you currently take.

For Payment. The plans may use and disclose your PHI so claims for health care treatment, services, and supplies you receive from health care providers may be paid according to the terms of the plans. For example, the plans may receive and maintain information about surgery you received to enable the plans to process a hospital’s claim for reimbursement of surgical expenses incurred on your behalf.

For Health Care Operations. The plans may use and disclose your PHI to enable it to operate or operate more efficiently or make certain all of the plans’ participants receive their health benefits. For example, the plans may use your PHI for case management or to perform population-based studies designed to reduce health care costs. In addition, the plans may use or disclose your PHI to conduct compliance reviews, audits, actuarial studies, and/or for fraud and abuse detection. The plans may also combine health information about many plan participants and disclose it to the Employer and its affiliates, if any, in summary fashion so it can decide what coverages the plans should provide. The plans may remove information that identifies you from health information disclosed so it may be used without the Employer’s learning who the specific participants are.

To the Employer. The plans may disclose your PHI to designated Employer personnel so they can carry out their plan-related administrative functions, including the uses and disclosures descried in this notice. Such disclosures will be made only to the Employer’s Privacy Officer and personnel under the Privacy Officer’s supervision. These individuals will protect the privacy of your health information and ensure it is used only as described in this notice or as permitted by law. Unless authorized by you in writing, your health information: 1) may not be disclosed by the plans to any other employee and 2) will not be used by the Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Employer.

To a Business Associate. Certain services are provided to the plans by third-party administrators known as “business associates.” For example, the plans may input information about your health care treatment into an electronic claim processing system maintained by the business associate so your claim may be paid. In so doing, the plans will disclose your PHI to its business associate so it can perform its claims payment function. However, the plans will require its business associates, through contract, to appropriately safeguard your health information.

Treatment Alternatives. The plans may use and disclose your PHI to tell you about possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services. The plans may use and disclose your PHI to tell you about health-related benefits or services that may be of interest to you.

Individual Involved in Your Care or Payment of Your Care. The plans may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The plans may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

As Required by Law. The plans will disclose your PHI when required to do so by Federal, State, or local law, including those that require the reporting of certain types of wounds or physical injuries.

To the Secretary of the Department of Health and Human Services (HHS). The plans may disclose your PHI to HHS for the investigation or determination of compliance with privacy regulations.

Special Use and Disclosure Situations

The plans may also use or disclose your PHI under the following circumstances:

Lawsuits and Disputes. If you become involved in a lawsuit or other legal action, the plans may disclose your PHI in response to a court or administrative order, a subpoena, warrant, discovery request, or other lawful due process.

Law Enforcement. The plans may release your PHI if asked to do so by a law enforcement official, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime’s location or victims or the identity, description, or location of the person who committed the crime.

Worker’s Compensation. The plans may disclose your PHI to the extent authorized by and to the extent necessary to comply with worker’s compensation laws and other similar programs.

Military and Veterans. If you are or become a member of the U.S. armed forces, the plans may release medical information about you as deemed necessary by military command authorities.

To Avert Serious Threat to Health or Safety. The plans may use and disclose your PHI when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person.

Public Health Risks. The plans may disclose health information about you for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Health Oversight Activities. The plans may disclose your PHI to a health oversight agency for audits, investigations, inspections, and licensure necessary for the government to monitor the health care system and government programs.

Research. Under certain circumstances, the plans may use and disclose your PHI for medical research purposes.

National Security, Intelligence Activities, and Protective Services. The plans may release your PHI to authorized Federal officials: 1) for intelligence, counterintelligence, and other national security activities authorized by law and 2) to enable them to provide protection to the members of the U. S. government or foreign heads of state, or to conduct special investigations.

Organ and Tissue Donation. If you are an organ donor, the plans may release medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank to facilitate organ or tissue donation and transplantation.

Coroners, Medical Examiners, and Funeral Directors. The plans may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or to determine the cause of death. The plans may also release your PHI to a funeral director, as necessary, to carry out his or her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the plans maintain about are as follows:

Right to Inspect and Copy. You have the right to inspect and copy your PHI. This includes information about your plan eligibility, claim and appeal records, and billing records, but does not include psychotherapy notes. To inspect and copy health information maintained by the plans, submit your request in writing to the Privacy Officer. The plans may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the plans may deny your request to inspect and coy your PHI. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that health information the plans have about you is incorrect or incomplete, you may ask to amend it. You have the right to request an amendment for as long as the information is kept by or for the plans. To request an amendment, send a detailed request in writing to the Privacy Officer. You must provide the reason(s) to support your request. The plans may deny your request if you ask to amend health information that was: accurate and complete, not created by the plans; not part of the health information kept by or for the plans; or not information that you would be permitted to inspect or copy.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures". This is a list of disclosures of your PHI that the plans have made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; disclosures made prior to this effective date at the end of this notice; or in certain other situations. To request an accounting of disclosures, submit your request in writing to the Privacy Officer. Your request must state a time period, which may not be longer than six years prior to the date the account was requested.

Right to Request Restrictions. You have the right to request a restriction on the health information the plans use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the plans disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. For example, you could ask that the plans not use or disclose information about a surgery you had. To request restrictions, make your request in writing to the Privacy Officer. You must advise us: 1) what information you want to limit; 2) whether you want to limit the plans' use, disclosure, or both; and 3) to whom you want the limit(s) to apply. Note: The plans are not required to agree to your request.

Right to Request Confidential Communications. You have the right to request that the plans communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the plans send you explanation of benefits (EOB) forms about your benefit claims to a specified address. To request confidential communications, make your request in writing to the Privacy Officer. The plans will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

A Note About Personal Representatives

You may exercise your rights through a personal authorized representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your PHI or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- An individual who is the parent of a minor child.

The plans retain discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Change to this Notice

The plans reserve the right to change this notice at any time and to make the revised or changed notice effective for health information the plans already have about you, as well as any information the plans receive in the future. The plans will post a copy of the current notice in the Employer's office. All individuals covered under the Plan will receive a revised notice within 60 days of a material revision to the notice.

Notice of Breach of PHI

You have a right to receive a notice when there is a breach of your unsecured PHI.

Complaints

If you believe your privacy rights under this policy have been violated, you may file a written complaint with the Privacy Officer at the address listed below. Alternatively, you may file a complaint with the Secretary of the U. S. Department of Health and Human Services (Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington D.C. 20201), generally within 180 days of when the act or omission complained of occurred. Note: The plans, the Employer, and nay of its affiliates will not retaliate against you for filing a complaint.

Other Uses and Disclosures of Health Information

A plan must obtain your written authorization to use or disclose psychotherapy notes, to use PHI for marketing purposes, or to sell PHI. An authorization for a use or disclosure of psychotherapy notes may only be combined with another authorization for a use and disclosure of psychotherapy notes.

Plans (excluding long-term care plans) are prohibited from using or

disclosing PHI that is genetic information for underwriting purposes.

Other uses and disclosures of health information not covered by this notice or by the laws that apply to the plans will be made only with your written authorization. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you authorize the plans to use or disclose your PHI, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the plans will no longer use or disclose your PHI for the reasons covered by your written authorization; however, the plans will not reverse any uses or disclosures already made.

Contact Information: If you have any questions about this notice, please contact the Privacy Officer at the Employer, Attention: Privacy Officer.

Updated and effective March 26, 2013

Prescription Drug Coverage and Medicare

Date of this Notice: October 2017

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Young Automotive Group and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Young Automotive Group has determined that the prescription drug coverage offered by Young Automotive Group is, on average, for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Young Automotive Group coverage will be affected. If you do decide to enroll in a Medicare prescription drug plan and drop your Young Automotive Group prescription drug coverage, be aware that you may not be able to get this coverage back.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. In addition, your current coverage pays other health expenses in addition to prescription drugs, and you will still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Young Automotive Group and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join. For more information about this notice or your current prescription drug coverage, please contact Human Resources.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare and You handbook. You will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans. For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov.**
- Call your State Health Insurance Assistance Program (see inside back cover of your copy of the Medicare and You handbook for their telephone number) for personalized help.
- Call **800.MEDICARE** (800.633.4227). TTY users should call **877.486.2048**.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 800.772.1213.

Remember to keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Mental Health Parity Notice

The Mental Health Parity Act (MHPA) provides for parity in the application of aggregate lifetime and annual dollar limits on mental health benefits with dollar limits on medical/surgical benefits. In

general, group health plans offering mental health benefits cannot set annual or lifetime dollar limits on mental health benefits that are lower than any such dollar limits for medical/surgical benefits.

A plan that does not impose an annual or lifetime dollar limit on medical/surgical benefits may not impose such a dollar limit on mental health benefits under the plan. MHPA's provisions, however, do not apply to benefits for substance abuse or chemical dependency.

For more information about mental health coverage under your plan, please refer to the plan's Summary Plan Description

(SPD). You may obtain a copy of the SPD by contacting Human Resources

Family & Medical Leave Act (FMLA)

FMLA is designed to help employees balance their work and family responsibilities by allowing them to take reasonable unpaid leave for certain family and medical reasons. It also seeks to accommodate the legitimate interests of employers and promote equal employment opportunity for men and women.

FMLA applies to all public agencies, all public and private elementary and secondary schools, and companies with 50 or more employees.

There may be times when you need an extended leave of absence. The company has a Family and Medical Leave Policy that is in compliance with The Family and Medical Leave Act of 1993 (FMLA), as amended. FMLA provides an entitlement of up to 12 weeks, which protects employees' jobs and benefits in the event of a medical or family circumstance, which requires the employee to take time off from work without pay. In general, the employee must have worked for at least 12 months and at least, 1,250 hours within the last 12 months immediately prior to the first day of leave.

Circumstances Permitting Family and Medical Leave

- Birth of an employee's child (within 12 months after birth)
- Adoption of a child by an employee (within 12 months after placement)
- Placement of a child with the employee for foster care (within 12 months after placement)
- Care of a child, spouse or parent having a serious health condition
- Incapacity of the employee due to a serious health condition.
- Military Leave

Additional leave laws may apply to you depending upon your specific state and if you or a dependent or a military member. Whenever possible leave must be requested in advance. If you have questions about FMLA or any leave requests, please contact Human Resources.

Continuation of Coverage During an Approved Leave of Absence Granted to Comply With Federal Law

This continuation of coverage section applies only for the period of any approved family or medical leave (approved FMLA leave) required by Family and Medical Leave Act of 1993 (FMLA). If your Employer grants you an approved FMLA leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by your Employer.

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Benefits summary prepared by:

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