AUTOMOTIVE WHOLESALERS ASSOCIATION OF NEW ENGLAND, INC.

d/b/a

NATIONAL AUTOMOTIVE ROADS AND FUEL ASSOCIATION ("NARFA")

HEALTH AND WELFARE BENEFIT PLAN

AND

SUMMARY PLAN DESCRIPTION

January 1, 2021

Contents

INTRODUCTION

Effective as of January 1, 2021, the Automotive Wholesalers Association of New England, Inc. d/b/a National Automotive Roads & Fuel Association (“NARFA”) or (the "Association") hereby restates the Automotive Wholesalers Association of New England Health and Welfare Benefit Plan (the "Plan") as a multiple employer welfare arrangement ("MEWA") for the benefit of eligible employees and their dependents. This Plan Document and Summary Plan Description explains the provisions of the Plan and provides a general overview of the operating rules under the Plan that are applicable to each available benefit under the Plan. In order to be eligible for the benefits described herein, your employer must participate in the Plan pursuant to the rules and procedures established by the Plan Administrator.

The purpose of this Plan is to provide eligible employees and their dependents with certain welfare benefits under certain terms and conditions (the "Component Benefit Programs"). Certain benefits are fully-insured and provided through policies with insurance carriers and others are self-funded by the employer. The cost of the Component Benefit Programs is paid either through employer contributions, pre-tax or after-tax contributions by participants or a combination of both. The Component Benefit Programs are listed on Appendix A attached hereto.

HOW TO READ THIS DOCUMENT

In addition to this document, specific information about each Component Benefit Program is contained in a separate subscriber Certificate (in the case of fully-insured benefits) or benefit booklet (in the case of self-funded benefits) (collectively hereafter referred to as "Certificates") that describes the covered expenses, exclusions, limitations and other rules that are specific to each Benefit. Separate Certificates are available for the Medical Benefits, the Life Insurance Benefits, the Short Term Disability Benefits, and the Long Term Disability Benefits, and each Certificate is incorporated herein by reference. Dental Benefits are discussed in detail in Appendix B attached hereto. The Health Rewards Program is described in Appendix C attached hereto. This document together with the applicable Certificates and Appendices, incorporated herein by reference, are intended to constitute the written Plan document and SPD for the benefits provided under the Plan. In addition to this document, Certificates and Appendices, the Association and certain third-party administrators may have entered into one or more separate agreements that define the scope of the obligations and responsibilities of each of the parties to those contracts in relation to the management and administration of the Plan. Those contracts also form part the governing documents of the Plan.

This document should be read in conjunction with the applicable insurance Certificates. In general, this document contains information about eligibility requirements and your rights as a participant in the Plan. The Certificates are issued by an insurance company for fully-insured Benefits and contain Benefit specific information. To the extent that this document refers you to a Certificate or your questions are not answered in this document, please refer to the applicable Certificate. In the event that information in this document conflicts with information in a Certificate that is specific to the Benefit covered under the Certificate, the terms and conditions in the Certificate for that Benefit govern.

Every attempt has been made to be informative about the Benefits available under the Plan and when eligibility to participate in the Plan or to obtain a Benefit under the Plan may be lost or denied. Every effort has been made to describe the information herein as clearly as possible with minimal use of technical words and phrases.

The Association intends that, for purposes of the Form 5500 annual reporting requirement, this document is considered a "wrap" plan and the terms of the underlying Component Benefit programs listed on Appendix A as contained in the applicable Certificates and Appendix B and Appendix C are hereby incorporated by reference. This document is not intended to give any substantive rights or benefits to employees that are not already provided under the terms of the applicable insurance policy and/or

benefit plan document that governs each Component Benefit Program. Copies of such insurance policies and benefit plan documents are incorporated by reference herein and considered to be part of this Plan.

VESTING

Benefits under the Plan do not become vested at any time.

RESERVATION OF RIGHTS

The Association reserves the right to amend, suspend or terminate, in whole or in part, the Plan or any or all of its individual Benefits at any time. Each Participating Employer also reserves the right to change the Benefits it offers to its Employees and their Dependents or terminate its participation in the Plan at any time.

If this Plan is terminated, any remaining assets will be used to pay any outstanding legitimate benefit claims and for administrative expenses attendant with payment of claims and winding up the affairs of the Plan. Nothing herein is intended to restrict the use of any remaining Plan assets in a manner consistent with any applicable federal or state laws, to the extent state law is not preempted by ERISA.

GENERAL INFORMATION

Participating Employer

A Participating Employer is any entity or organization that is a member of the Association (as determined by the Plan Administrator) and that has executed a Participating Employer Adoption Agreement.

Plan Type, Name and Number

The Plan is an employee welfare benefit plan governed by the Employee Retirement Income Security Act of 1974, as amended, ("ERISA"), that provides medical (including the Health Rewards Program), dental, life insurance, short-term disability, and long-term disability benefits. The Plan's name is the Automotive Wholesalers Association of New England Health and Welfare Benefit Plan, Plan Number 506.

Employer Identification Number (E.I.N.) of Plan Sponsor

04-2279821

Plan Year

The financial records of the Plan are maintained on the basis of a Plan Year. Each Plan Year commences on January 1 and ends the following December 31.

Name, Business Address and Telephone Number of the Plan Sponsor and Plan Administrator

The name, address and telephone number of the Plan Sponsor and the Plan Administrator is as follows:
Automotive Wholesalers Association of New England, Inc.
d/b/a National Automotive Roads & Fuel Association
4 Main Street, P.O. Box 838
Peterborough, NH 03458
1-800-258-5318

The Plan Administrator is the "named fiduciary" with respect to the Plan.

Agent for Legal Service

The agent for service of legal process is the Plan Administrator and service may be made at the above address.

Plan Administrator

The Association is the "named fiduciary" (as defined in ERISA) of the Plan and Plan Administrator. In general, the Association is the sole judge of the application and interpretation of the Plan and has the sole discretionary authority to construe the provisions of the Plan, to resolve disputed issues of fact, and to make determinations regarding eligibility for benefits. The Association has delegated certain of these duties to third-party administrators or insurance companies. As the Association's delegates, these administrators and insurers have the authority to make decisions under the Plan relating to the benefit claims they administer. The decisions of the Association or its delegates in all matters relating to the Plan (including, but not limited to, eligibility for benefits, Plan interpretations, and disputed issues of fact) will be final and binding on all parties and generally will not be overturned by a court of law. Benefits under this Plan will be paid only if the Association or its delegate decides in its discretion that the applicant is entitled to them.

Association Board of Directors of the Health and Welfare Funds

The Association has delegated some responsibility for administering the Plan to the Board of Directors for the Health and Welfare Benefits Plan ("the Board"). The Board has all of the powers, rights and duties that the Association delegates to the Board. The Board's duties can change from time to time and include, but are not limited to, the following:

- To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- To exercise discretion, in conjunction with the Plan Administrator, in deciding all questions concerning the Plan and the eligibility of any person to participate in the Plan, with any such decision to be reviewed under the arbitrary and capricious standard;
- To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administrating the Plan;
- To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan to the extent permitted under ERISA, any such allocations, delegations or designations to be in writing; and
- To decide if a participant or other claimant is entitled to payment of benefits under the self-funded Benefits.

Each individual appointed to the Board will remain a member upon acceptance of appointment until he or she resigns or is removed from the Board by a simple majority of the remaining Board members. Upon request, the Association will provide the name and contact information of the current members of the Board.

Contract Administrator

For each Benefit, the Plan Administrator has delegated authority to a third-party administrator or insurance company (hereafter referred to the "Contract Administrator" or collectively as the "Contract Administrators") to administer and determine certain eligibility and benefit claims for a specific Benefit. The Contract Administrator for each Benefit is identified in the applicable Certificate and listed on Appendix A attached hereto.

Each Contract Administrator is generally responsible only for paying benefit claims in accordance with the terms of the applicable Certificate or insurance contract. With respect to its area of responsibility, the Contract Administrator has discretionary authority to interpret the terms of the Certificate, insurance contract, or other documents that describe the terms of coverage, construe unclear terms in those documents, and otherwise make all decisions and determinations, including factual determinations, to enable the Contract Administrator to decide the claim. As a result, Benefits will be paid only if the applicable Contract Administrator decides, in its discretion, that the claimant is entitled to the Benefit.

Plan Funding

The Benefits included in the Plan are funded in different ways depending upon whether the Benefits are fully-insured or self-funded. Fully-insured Benefits are funded through insurance contracts paid for by premiums set by the insurers in conjunction with the Plan's actuary, which premiums include fees to offset the cost of administering the Plan. In the case of self-funded Benefits, such Benefits are funded through contributions to a trust based on the total cost of providing coverage, which includes fees to offset the cost of administering the Plan.

Health and Welfare Benefits Trust- Dental Benefits, if you employer offers this benefit to you, and the Health Rewards Program, if you participate in a high deductible health plan, are self-funded through

contributions to the Health and Welfare Benefits Trust (“the Trust”) and paid by the Trust. Medical

Benefits for groups in New Hampshire, Maine, and Connecticut are also funded through contributions to the Trust and paid by the Trust.

Medical Benefits offered in Massachusetts are fully-insured and funded through contracts of insurance with an insurance company to which premium payments are made. The Association is responsible for collecting the premium and ensuring that the premiums for the Medical Benefits are timely paid to the appropriate insurance company. Premiums are placed in the Trust until the time that the full premium is paid to the appropriate insurance company.

Contributions and premiums to the Trust are made by the Participating Employers and include the employees' designated portion of the contribution or premium.

Insurance premiums for the fully-insured Life Insurance Benefits, Short Term Disability Benefits, and Long Term Disability Benefits also are deposited into the Trust. The administrative fee included in the premium payment is kept in the Trust and used to offset the cost of administering the fully-insured Benefits. Premium payments for fully-insured Benefits include the Participating Employers' and the employees' designated portion of the premium.

The Plan Administrator is responsible for the funding policy of the Trust and reserves the right to change the level of Participating Employer contributions at any time and from time to time. Each Participating Employer is responsible for determining the employee paid portion of the total contribution or premium, if any, for the Benefit coverage. In all cases, the Participating Employer is responsible for ensuring that the employee portion of the contribution is properly paid to the Trust. The Trust is intended to qualify as a tax-exempt Code Section 501(c)(9) voluntary employees' beneficiary association.

Trustees of the Trust:

Robert York, 4 Northside Lane, Skowhegan, ME 04976
Joseph Wallier, 195 Winchester Street, Keene, N.H. 03431
Bill O'Neill, 36 Oakland Street, W. Springfield, MA 01089
Leonard Hebert, 15 Old Farm Road, Bedford, N.H. 03110
John Ambler, 3384 Perry Hill Road, Waterbury, VT 05676
Charles Slotnick, 288 Hyde Park Ave, Jamaica Plain, MA 02130
Don Kliska, 16 Meredith Drive, Hampstead, N.H. 03841
Robert Kelley, 102 Fairhaven Road, Mattapoisett, MA 02739
George Mengold, 75 Main Street, Monroe, CT 06468
David Segal, 18 Laurel Drive, Bow, N.H. 03304
Peter Ignatovich, 25 Loudville Road, Westhampton, MA 01027
Chad Walier, 195 Winchester Street, Keene, N.H. 03431
Jesse Kaplan,7 Griffin Way, Chelsea, MA 02150
Andrew Pelkey,53 Grafton Road, Bedford, N.H. 03110
Benjamin Loizides, 94 Condor Street, East Boston, MA 02128
Ken Plante, Route 108 #189, Somersworth, N.H. 03878
Richard Delaney, 331 Mayflower Circle, Hanover, MA 02339

Misrepresentation

If a Plan Participant makes any misrepresentation or uses fraudulent means in applying for coverage or filing a claim for benefits under the Plan, his or her (and/or, as applicable, his or her Dependent's or Eligible Domestic Partner's) coverage will be immediately terminated, including possible retroactive

rescission depending on the type of misrepresentation, if permitted by applicable federal and state laws. The Certificates for each of Benefits may have additional language regarding termination, cancellation or rescission of the insurance coverage in the event of any misrepresentations or fraud. Any misrepresentation or fraud committed with respect to coverage under a contract of insurance for Benefits offered under the Plan will be governed by the appropriate provision in each Certificate. If no such provision is included in the Certificate or Medical Benefits Booklet, then the SPD provision will govern, and the Plan Administrator will make the termination determination.

Limitations on Actions for Self-Funded Medical Benefits and Dental Benefits

Any claim or action filed in court against the Plan, the Plan Administrator or a Contract Administrator with respect to a claim involving any benefit paid under self-funded medical Plan or the self-funded dental plan cannot be brought until the participant or beneficiary has first

completed all of the steps in the claims procedure. After completing all the steps in applicable claims procedure, including all available appeals, a legal action may be commenced in court, but the action must be brought within one year of the date you are notified of the final decision on your appeal. If you do not bring a legal action within that one-year period, then you will lose any rights to bring an action against the Plan, the Plan Administrator, the Association or any applicable Contract Administrator.

NOTICE: THE ONE-YEAR LIMITATION PERIOD DESCRIBED ABOVE SUPERSEDES ANY OTHER LONGER OR SHORTER LIMITATION PERIOD IN ANY MEDICAL BENEFIT BOOKLET OR CERTIFICATE RELATING TO ANY SELF-FUNDED BENEFIT UNDER THE PLAN.

Any claim or action filed in court with respect to any Benefit under the Plan that is fully insured must be filed within the time period specified by the insurance company in the applicable Certificate. PLEASE REVIEW THE APPLICABLE CERTIFICATE FOR MORE INFORMATION.

Any claim or action not commenced within the above timeframes will be time-barred under the applicable Limitations of Action provision.

ELIGIBILITY AND PARTICIPATION

ELIGIBLE EMPLOYEES

General. Any individual who (1) is classified as a regular Full-Time Employee or owner of a Participating Employer (but not including independent contractors or sub-contractors), (2) is regularly scheduled to work at least the number of hours per week established by the applicable Participating Employer but in no event less than 30 hours per week, and (3) is paid from the payroll of the Participating Employer will be eligible for coverage when he/she has completed the Participating Employer's minimum age and service requirements, if any. To be eligible for coverage you must be working (a) at your customary place of employment, or (b) at some location to which that employment requires you to travel.

You are not considered an "Eligible Employee," and you are not eligible to participate in the Plan if you are:

- a temporary Employee, defined as an Employee who is hired for a limited period of time, up to six months,
- a seasonal Employee, defined as an Employee whose customary annual employment with a Participating Employer is a period of up to six months,
- a leased employee, who performs services for a Participating Employer under a contract between the Participating Employer and a leasing or other temporary service organization,
- an independent contractor, who performs services for the Participating Employer, or
- a nonresident alien who receives no income from employment in the U.S.

Please see the applicable Certificate for additional eligibility requirements. The Plan Administrator's determination that an individual is not an Employee will be final and that individual will not be eligible to participate in the Plan regardless of whether a court or tax or regulatory authority determines that the individual is an Employee.

Reclassification. It is expressly intended that individuals not treated as eligible Employees under the Plan are to be excluded from participation under all circumstances until the Plan Administrator changes their classification. Therefore, an independent contractor or any other ineligible individual who is reclassified by a court, administrative agency or other party, as an eligible Employee will not be considered an eligible Employee for periods before the Plan Administrator implements the reclassification the same Medical Benefits and Dental Benefits as you were receiving immediately before the start of your FMLA leave. If you do not wish to receive some or all of the coverage during your FMLA leave that you were receiving just prior to your leave, you must inform your Participating Employer before the start of your leave. If you wish to continue your coverage and you must make Employee contributions for your coverage, you must make arrangements with your Participating Employer to pay the required contributions for the coverage you wish to maintain during the course of your FMLA leave. Your eligibility to continue any coverage that has required contributions may be cancelled if you do not pay the required contributions during the period of your FMLA leave, unless you have made other arrangements in advance with your Participating Employer.

Short-Term Absences Due to Illness or Injury Outside of FMLA. Any Employee who is a Participant in this Plan and who is unable to work the minimum number of hours per week necessary to maintain Plan eligibility due to illness or injury, **may** be eligible to maintain Medical and Dental Benefit coverage for up to 12 weeks from the date of the start of the absence. No Participating Employer may keep an Employee on the Plan beyond this 12-week extension of coverage, if that Employee is not working the required minimum number of hours per week. At the end of this 12-week period, the Employee would then become eligible for COBRA continuation coverage, if the Employee experienced a qualifying event and otherwise meets the requirements for COBRA continuation coverage.

ELIGIBILITY AND PARTICIPATION

Life Insurance Benefits may be continued only if allowed by the terms of the Life Insurance Certificate. Please consult the Life Insurance Certificate for further information.

ELIGIBLE DEPENDENTS

For purposes of Medical and Dental Benefits, eligible Employees may choose to cover their eligible Dependents and Eligible Domestic Partners under the Plan. For purposes of Life Insurance Benefits, eligible Employees may only cover their eligible Dependents and Eligible Domestic Partners to the extent authorized in the Life Insurance Certificate. Dependents and Eligible Domestic Partners may not be covered for purposes of Short-Term Disability and Long-Term Disability Benefits. Please see the definition of "Dependent" in the Plan Definition section as to the types of Dependents that may be covered under the Plan.

PLEASE NOTE:

If a child is born to an enrolled Dependent child, the newborn is covered from the date of birth for 30 days. The newborn child may be enrolled in the Plan as a dependent and benefits continued only if the Employee (i.e., grandparent) provides legal documents within 30 days of birth proving the Employee has full financial responsibility for such newborn.

Any enrolled female Plan Participant is entitled to receive maternity related benefits.

If a mother of a child is not enrolled in the Plan, and if the Employee is enrolled in the Plan and is the legal father of the child, the Employee may apply for Plan coverage for the newborn within 30 days of the newborn's date of birth.

EFFECTIVE DATE OF COVERAGE

All enrollment documents must be received and approved in the Plan Administrator's office by the fifteenth of the month in order for coverage to become effective as of the first day of that month. This includes the Group Application for the Employee and any Dependents or Eligible Domestic Partner. ***NOTE:*** An eligible Employee and his or her Dependents MUST enroll for coverage effective when the Employee and the Dependents first become eligible for coverage OR THE EMPLOYEE AND THE DEPENDENTS WILL NOT BE ELIGIBLE TO ENROLL UNTIL THE NEXT OPEN ENROLLMENT PERIOD OR SPECIAL ENROLLMENT PERIOD, OR AFTER A QUALIFYING CHANGE IN STATUS.

HIPAA SPECIAL ENROLLMENT RULES

An eligible Employee or Dependent who has not applied for coverage on the earliest date he or she was initially eligible may elect to participate in the Plan during a Special Enrollment Period. The Special Enrollment Rules do not apply to Short-term or Long-term Disability Benefits or the Life Benefit.

Special Enrollment for Employees. The effective date of coverage will be the date of the qualifying event causing the Special Enrollment Period if written application for coverage is made within 30 days of that event. Employees will be eligible for a Special Enrollment Period through either of the two qualifying events:

Change in Family Status: An Employee will be eligible for a Special Enrollment Period if he/she gets married, divorced, or has a child born to or placed for adoption with his/her family; or

Loss of Coverage: An Employee will be eligible for a Special Enrollment Period if each of the following conditions is met:

- the Employee had other coverage at the time that he or she was first eligible for coverage under this Plan;
- the Employee waived coverage under this Plan due to being covered under the other plan;
- the coverage of the other plan is terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment), employer contributions towards such coverage terminated, or, if coverage was due to COBRA continuation, as a result of such coverage being exhausted; and
- the individual that originally declined coverage certified in writing that he or she was covered by another health plan when he or she declined coverage under this Plan.

Special Enrollment for New Dependents. If someone first becomes an Employee's Dependent after the Plan has received and approved the Employee's application for enrollment, coverage for that new Dependent will become effective as follows, provided that the Employee submits a new application within 30 days following the qualifying event and the conditions specified for new Employees above are met.

For the Employee's Spouse, coverage will become effective on the first day of the month following the date of marriage.

For a child of the Employee, coverage will become effective on the date of:

Placement for a child placed with the Employee by a licensed child placement agency for purposes of adoption or for an adopted child on the date of legal adoption, until the 30th day after placement or adoption; coverage continues after the first 30 days only if proof of placement or legal adoption is submitted within 30 days of the date of placement or adoption.

Birth, for a newborn child, until the 30th day after birth (whether or not any of the Employee's Dependents are currently enrolled); coverage continues after the first 30 days only if the Employee submits application for coverage within 30 days of the date of birth.

Special Enrollment for Employees and Dependents. The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA") requires a special enrollment right for Employees and their eligible Dependents. An eligible Employee or Dependent who loses coverage under a State Children's Health Insurance Program ("SCHIP") or Medicaid, or becomes eligible for premium assistance under a SCHIP or Medicaid with respect to coverage under the Plan, may elect to participate in the Medical or Dental Benefit. If written application for coverage is made within 60 days of that event, the effective date of coverage will be the date of the loss of coverage under the SCHIP or Medicaid or the date of determination of eligibility for premium assistance, as applicable.

Late Enrollee

Late Enrollee means an Eligible Employee or Dependent that requests coverage after the initial enrollment period. A Late Enrollee may be eligible to enroll in the Plan before the next Open Enrollment Period if the Late Enrollee qualifies for enrollment in the Plan during a HIPAA Special Enrollment Period or a Change in Status.

Changes in Status for Health Care Coverage

You may be able to change your Health Care elections during the Plan Year if you experience a Change in Status. Please note that in order to change your elections due to a Change in Status, you may be

required to show proof verifying that these events have occurred (e.g., copy of marriage or birth certificate, or divorce decree, etc.) The following is a list of Changes in Status that may allow you to make a change to your elections (as long as you meet the consistency requirements, as described below).

Marital status: Any event that changes your legal marital status, including marriage, divorce, death of a Spouse, and annulment;

Number of eligible dependents: Any event that changes your number of eligible dependents including birth, death, adoption, legal Guardianship, and placement for adoption;

Employment status: Any event that changes your or your eligible dependents' employment status that results in gaining or losing eligibility for coverage. Examples include:

- Beginning or ending employment;
- Starting or returning from an unpaid leave of absence;
- Changing from part-time to full-time employment or vice versa; and
- A change in work shift or location;

Dependent status: Any event that causes your dependents to become eligible or ineligible for coverage because of age;

Change in legal custody: A change in legal custody (including the issuance of a Qualified Medical Child Support Order) that affects your dependent's eligibility for coverage under this Plan or the plan of the child's other parent and that is consistent with IRS rules;

Residence: A change in the place of residence for you or your eligible dependents if the change results in your or your eligible dependents living outside the Medical or Dental Plan's Network service area;

Medicare/Medicaid: If you or your eligible dependents become entitled to or lose entitlement to Medicare or Medicaid;

Changes in coverage under another employer plan: If your Spouse or dependent child(ren) is employed and his or her employer's plan allows for a change in your family member's coverage (either during that employer's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code);

HIPAA Special Enrollment: If you or an eligible dependent have a "Special Enrollment" event as defined under HIPAA and described in the preceding section;

Other events: Any other event the Plan Administrator determines permits revocation of an election without violating the Internal Revenue Code. Any election change must be on account of and correspond with the Change in Status event that affects eligibility for coverage.

Note that pursuant to emergency temporary regulations issued by jointly by the U.S. Department of Labor and the Internal Revenue Service on May 4, 2020, the any deadline to submit a written application for coverage following a qualifying event, set forth above, is suspended for the duration of the COVID-19 National Emergency. Therefore the deadline to submit a written application for coverage will extend to not less than 30 days (and in specified instances, 60 days) following the conclusion of the declared COVID-19 National Emergency. This extension of deadlines shall exist while the aforementioned temporary regulations remain in effect, and shall cease to be available when such temporary regulations are no longer in effect.

Consistency Requirements for Changes in Status

In order to change your election due to a Change in Status, you must meet the following requirements:

Effect on eligibility: The Change in Status event must affect eligibility for coverage under the Plan or under a plan sponsored by your dependent's employer. This includes any time you become eligible (or ineligible) for coverage or if the event results in an increase or decrease in the number of your dependent child(ren) who may benefit from coverage under the Plan.

Corresponding election change: The election change must be consistent with the Change in Status event. For example, if you add a dependent child for coverage under the Plan, you may change your Health Care elections to add the new dependent.

To make a coverage change election based on a Change in Status, the eligible Employee must request the change in writing within 30 days from the date of the Change in Status of event. The Plan Administrator may require the Employee to provide appropriate proof that the Change in Status event occurred (such as a copy of a judgment of divorce); the Employee will be notified if proof is required.

The coverage change election will ordinarily take effect on the first day of the month following the date that the Change in Status event occurred, but not earlier than the date the coverage change election is submitted and the Plan Administrator determines that the coverage change election is permissible under the terms of the Plan. However, coverage change elections resulting from the birth, adoption or placement for adoption of a child will be effective as of the date of the birth, adoption or placement for adoption.

REENROLLMENT IN THE PLAN FOR ELIGIBLE EMPLOYEE

If an eligible Employee leaves the Plan to enroll in another group health plan that is not sponsored or administered by the Association, whether at an Open Enrollment Period or because of a Change in Status, the Employee:

Will be ineligible to re-enroll in the Plan for a minimum period of one (1) year, unless the Employee experiences an event that results in a HIPAA Special Enrollment Period or a Change in Status; and

May be subject to the Participating Employer's minimum age and service requirements, if any, as determined by the Participating Employer and the Plan Administrator.

WHEN COVERAGE ENDS

Your coverage under the Plan will end on the earliest of the following:

The date that your coverage is terminated by amendment of the Plan;

The date you cease to be an Eligible Employee (as described herein) or in the case of an Employee who received coverage while on an approved leave of absence, the date the approved leave ceases if you do not otherwise qualify for coverage under the Plan. This includes your death, reduction in hours, or termination of active employment or in certain other situations as determined by the Plan Administrator;

The date you elect to discontinue coverage;

The last date that you or your Employer failed to make a required contribution to the Plan.

The effective date that the covered Employee's Participating Employer no longer participates in the Plan or in a specific Benefit pursuant to the terms of the Plan and the Adoption Agreement.

Termination of Coverage for Dependents and Eligible Domestic Partners. A Dependent's or Eligible Domestic Partner's coverage under the Plan will terminate on the earliest of the following dates:

- The date the coverage of the Employee, through whom the Dependent or Eligible Domestic Partner has coverage, is terminated.

- The date ending the period for which contribution is made, if a required contribution is not made by the Employee, Dependent, Eligible Domestic Partner, or the Participating Employer when due.

- The first of the month following the date the Dependent or Eligible Domestic Partner ceases to be eligible for coverage under the Plan as provided in this SPD.

- The date the Dependent or Eligible Domestic Partner becomes eligible to participate in the Plan as an Employee.

- For a newborn child, the 31st day after the date of birth unless the Plan receives written application to enroll the newborn child before that date.

- For an adopted child, the 31st day after the date of adoption or placement for adoption unless the Plan receives written application to enroll the adopted child before that date.

- The date that this Plan is amended or terminated, in whole or in part, so that the individual ceases to be eligible for coverage as a Dependent or Eligible Domestic Partner.

TERMINATION OF PARTICIPATING EMPLOYER

If a Participating Employer leaves the Plan to subscribe to another group health plan, which is not sponsored or administered by the Association, each of the following occurs (as applicable):

The Participating Employer is not eligible to re-subscribe to the Plan for a minimum period of one (1) year.

Any Participating Employer who does not provide written notification of its termination request at least 30 days prior to its requested termination date, will have its reserve refund (if any) reduced by the administration fees paid by the Association to its third party administrators for their covered Employees.

A Participating Employer that leaves the Plan to subscribe to a group health plan that is not sponsored or administered by the Association is not eligible to re-subscribe to the Plan for a 2-year period.

If a Participating Employer leaves the Plan, re-subscribes to the Plan, and then leaves the Plan a second time, the Participating Employer is not eligible to re-subscribe to the Plan.

SPECIAL ELIGIBILITY RULES

Filing of Information with the Plan: It is the sole duty and responsibility of the Participant to submit to the Plan any information relevant to the eligibility, continued eligibility, or termination of eligibility affecting the Participant or any of their Dependents. The Plan will not be liable for any injury, economic or otherwise, caused as a direct or indirect result of the Participant's failure to submit such information.

Increases and Decreases: An increase or decrease in the benefits or the amount of coverage for a Participant and/or his or her covered Dependents will become effective on the date provided in the Plan amendment containing the increase or decrease, unless otherwise prohibited by applicable law.

Changing between Benefit Coverage Options: If more than one option is offered under a Benefit, Participants may only switch from one option to another during an Open Enrollment Period or a Special Enrollment Period (as applicable). In addition, the Plan Administrator will determine those groups of Participants who qualify to enroll in each Benefit option, if any.

Return to Work following Active Military Duty (applies to voluntary or involuntary military

service, in peacetime or wartime): If an Employee returns to active full-time employment following active military duty, any minimum age and service requirements and any waiting period applicable to new Employees will not apply. All benefits provided by this Plan will be restored to their status as of the Employee's last day worked provided the Employee applies for reinstatement within the time period required by the Uniform Services Employment and Reemployment Rights Act. Coverage under this Plan will be effective on the date the Employee returns to full-time active employment.

PLAN DEFINITIONS

As used in this SPD, the following words and phrases have the meanings ascribed to them below:

Benefit - Each program of benefits that is offered under this Plan. Specifically, Medical (including the Health Rewards Program), Vision, Dental, Life Insurance, Short-Term Disability, and Long-Term Disability Benefits are offered under this Plan. The Health Rewards Program and Dental Benefits are covered in this SPD, while the details of the other Benefits are covered in separate Certificates issued by the applicable insurance company.

Calendar Year - A period of 12 months commencing each January 1 and ending on the following December 31.

Certificate -The policy, certificate or contract of insurance prepared and issued by the applicable insurance company that discusses the details of each fully-insured Benefit that is offered under this Plan. Specifically, one or more Certificates exist for Medical, Life Insurance, Short-Term Disability, and Long- Term Disability Benefits.

Contract Administrator - The applicable third-party administrator or insurance company that determines claims for certain Benefits under the Plan. Each Benefit's applicable Contract Administrator(s) are listed in the applicable Certificate.

Dependent: Unless otherwise defined or modified in a state specific attachment, Dependent means any individual as follows:

1. the covered Employee's Spouse; and
2. each of the covered Employee's children up to age 26.

The term "Dependent" does not include a person who is: (1) eligible as a covered Employee; or (2) on full-time active duty in the armed forces of any country.

The term "children" as used above includes:

1. Natural children.
2. Legally adopted children.
3. Stepchildren (children of the Employee's Spouse).
4. Children placed with the covered Employee by a licensed child placement agency for purposes of adoption.
5. Children of whom the covered Employee has legal guardianship.

Beginning 2014, the term "dependent" for groups over 50 employees includes foster children.

Eligible Domestic Partner -An individual in an exclusive mutual relationship with the Employee where both the Eligible Domestic Partner and the Employee satisfy all of the following (as supported by an affidavit or any other evidence required by the Plan Administrator):

1. At least 18 years of age

2. One of only two people in the relationship ;

3. Not married to each other, not married to any other person, and not in a domestic partnership or civil union with any other person;

4. Not related to the other person by blood so that state law would prohibit marriage to the other person;

5. Living together for at least 6 months;

6. Share a relationship of mutual support, caring, fiscal responsibility and commitment, and have assumed responsibility for each other's welfare; and

7. Intend to continue in the relationship indefinitely.

Employee - Any Employee of a Participating Employer who is eligible for coverage under the Plan as provided in this SPD.

Enroll - - An eligible Employee and his/her eligible Dependents are considered to have enrolled in a Benefit offered under the Plan when the applicable completed and signed enrollment form is presented to the Participating Employer and transmitted to the Plan Administrator.

Enrollment Date - The first day of coverage or, if there is a waiting period, the first day of the waiting period.

ER/SA - The Employee Retirement Income Security Act of 1974, as amended from time to time.

Full-Time - The term used herein will mean individuals regularly employed by the Participating Employer in the usual course of business and regularly scheduled to work at least the number of hours per week established by the Participating Employer as the normal work week, but in no event less than 30 hours per week.

Medicare - the health insurance benefit program established under Title XVIII of the Social Security Act of 1965, as amended.

Participant - An Employee, Dependent or Eligible Domestic Partner who is properly enrolled for coverage under this Plan.

Participating Employer - An entity or organization that is a member in good standing of the Association (as determined by the Plan Administrator), that has executed a Participating Employer Adoption Agreement and that makes the required periodic monetary contributions toward the cost of the Plan.

Plan - The Automotive Wholesalers Association of New England Health and Welfare Benefit Plan, Plan Number 506.

Spouse -Spouse means an individual having a valid legal marriage with the covered Employee in the jurisdiction where the marriage was entered into.

CLAIMS AND APPEALS PROCEDURES

Claims for Medical, Life Insurance, Short-Term Disability and Long-Term Disability benefits must be filed using the procedures listed in the applicable Certificate or Medical Benefit Booklet. All disputes regarding those claims (i.e., appeals) must be resolved in accordance with the procedures associated with the individual Benefit as set forth in the applicable Certificate or Medical Benefit Booklet. Your Benefits are ERISA covered benefits. The Certificates have a supplemental claims procedure section for ERISA covered benefits. Be sure to review the claims procedures included in the "ERISA Rights" section of the Medical Benefit Certificates.

Claims and appeals for Dental Benefits must be filed using the procedures listed in Appendix B.

Claims and appeals regarding Plan eligibility issues (i.e., eligibility to participate in the Plan) will be determined by the Plan Administrator in accordance with the "Claims Related to Eligibility to Participate in the Plan" below.

A Contract Administrator offering a Plan Benefit has the exclusive discretionary authority to construe and to interpret the Plan with respect to that Benefit, construe unclear terms and otherwise make all decisions and determinations, including factual and eligibility determinations. The Contract Administrator's decisions and determinations on these matters are final and conclusive. As a result, Plan Benefits will be paid only if the Contract Administrator decides in its discretion that the claimant is entitled to the Benefits. In the case of a disagreement between a Participant and a Contract Administrator, the Participant may not bring legal action against the Plan or the Contract Administrator until he/she has first completed the claims and appeal procedures described in the applicable Certificate or in this SPD.

Claims Related to Eligibility to Participate in the Plan

Within 90 days after receipt of your initial claim for eligibility to participate in the Plan, the Plan Administrator will send you a notice of the granting or denying, in whole or in part, of your claim, unless special circumstances require an extension of time for processing the claim. The extension may not exceed 90 days from the end of the initial 90-day period.

If an extension is necessary, you will be given a written notice to this effect indicating the special circumstances prior to the expiration of the initial 90-day period and the date by which a determination will be made. The Plan Administrator has full discretion to deny or grant a claim in whole or in part.

If your claim is denied, the Plan Administrator will provide you a written notice setting forth the following information in a manner calculated to be understood by you:

a) The specific reason or reasons for the denial;

b) Specific reference to pertinent Plan provisions on which the denial is based;

c) A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material is necessary;

d) An explanation of the Plan's claim review procedure;

e) A statement of your rights to bring a civil action under Section 502 of the ERISA following an adverse determination on review;

f) in certain situations, a statement in non-English language(s) that future notices of claim denials and certain other benefit information may be available in such non-English language(s); and

g) if required, contact information for the applicable office of health insurance consumer assistance or ombudsman.

You will receive, free of charge, any new or additional evidence considered, relied upon, or generated by the Plan in connection with the claim. Such evidence will be provided as soon as possible and sufficiently in advance of the date on which the notice of final determination is required to be provided, to give you a reasonable opportunity to respond prior to such determination. Before the Plan can issue a final determination based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final determination is required to be provided, to give you a reasonable opportunity to respond prior to such determination.

Within 60 days after you receive written notification of the denial (in whole or in part) of your claim, you or your duly authorized representative may make a written application to the Plan Administrator, in person or by certified mail, postage prepaid, to be afforded a review of the denial. You may review pertinent documents and may submit issues and comments in writing. Upon request, and free of charge, you or your authorized representative will be provided reasonable access to, and copies of, documents, records and other information relevant to your claim.

Your claim for review must be given a full and fair review. The Plan Administrator's review will take into account all comments, documents, records and other information submitted as part of your request for a review, without regard for whether the information was submitted or considered in the initial benefit determination. The decision upon review will be made no later than 60 days after the Plan Administrator receives your request for a review, unless special circumstances require an extension of time for processing. In that case a decision will be rendered not later than 120 days after receipt of a request for review. If an extension is necessary, you will be given written notice, prior to the end of the initial 60-day period, indicating the special circumstances requiring an extension and stating the date by which a decision will be made. The decision will be written in a manner calculated to be understood by you, will include specific reasons for the decision, specific references to the pertinent Plan provisions on which the decision was based, a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim, and a statement of your rights to bring a civil action under ERISA Section 502(a) and the availability of other voluntary alternative dispute resolution options.

PROVISIONS APPLICABLE TO CERTAIN HEALTH BENEFITS

HIPAA PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Background: The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires every health plan to notify Participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This notice is intended to satisfy certain HIPAA notice requirements with respect to health information created, received, or maintained by the Automotive Wholesalers Association of New England Health and Welfare Benefit Plan (the "Plan"), as sponsored by the Automotive Wholesalers Association of New England d/b/a National Automotive Roads & Fuel Association (the "Association").

The Plan may create, receive, and maintain records that contain health information about you to administer the Plan and provide you with health care benefits. This notice describes the Plan's health information privacy policy. The notice tells you the ways the Plan may use and disclose health information about you, describes your rights, and the obligations the Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

Association's Pledge Regarding Health Information Privacy

The privacy policy and practices of the Plan 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 payment 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 Plan

The Plan is required by law to:

- make sure that health information that identifies you is kept private;
- give you this notice of the Plan's legal duties and privacy practices with respect to health information about you; and
- give you, the U.S. Department of Health and Human Services, and, in some cases, certain media outlet(s) notice in the event of a breach of your unsecured PHI; and
- follow the terms of the notice that is currently in effect.

How the Plan May Use and Disclose Health Information About You

The following are the different ways the Plan may use and disclose your PHI:

- For Treatment. The Plan 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 Plan may advise an emergency room physician about the types of prescription drugs you currently take.

- **For Payment.** The Plan 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 Plan's terms. For example, the Plan may receive and maintain information about surgery you received to enable the Plan to process a hospital's claim for reimbursement of surgical expenses incurred on your behalf.

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

- **To the Association.** The Plan may disclose your PHI to designated Association personnel so they can carry out their Plan-related administrative functions, including the uses and disclosures described in this notice. These disclosures will be made only to the Association's Privacy Officer, Karyn Barretto (the "Privacy Officer") and/or the members of the Association's Human Resources Department. 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 Plan to any other Association employee or department and (2) will not be used by the Association or any Participating Employer for any employment-related actions and decisions or in connection with any other employee benefit plan sponsored by the Association or any Participating Employer.

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

- **Treatment Alternatives.** The Plan 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 Plan 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 Plan may disclose PHI to a close friend or family member involved in or who helps pay for your health care. The Plan 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 Plan 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.

Special Use and Disclosure Situations

The Plan 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 Plan 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 Plan 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.

- **Workers' Compensation.** The Plan may disclose your PHI to the extent authorized by and to the extent necessary to comply with workers' compensation laws other similar programs.

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

- **To Avert Serious Threat to Health or Safety.** The Plan 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 Plan may disclose health information about you for public heath 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.

- **Abuse, Neglect or Domestic Violence.** The Plan may disclose your PHI to a government authority under certain circumstances if the Plan reasonably believes that you are a victim of abuse, neglect or domestic violence.

- **Health Oversight Activities.** The Plan 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 Plan may use and disclose your PHI for medical research purposes.

- **National Security, Intelligence Activities, and Protective Services.** The Plan 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 Plan 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 Funerals Directors.** The Plan 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 Plan may also release your PHI to a funeral director, as necessary, to carry out his/her duty.

Your Rights Regarding Health Information About You

Your rights regarding the health information the Plan maintains about you 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 Plan, submit your request in writing to the Privacy Officer. The Plan may charge a fee for the cost of copying and/or mailing your request. In limited circumstances, the Plan may deny your request to inspect and copy 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 Plan has about you is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is kept by or for the Plan.

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 Plan may deny your request if you ask the Plan to amend health information that was: accurate and complete, not created by the Plan; not part of the health information kept by or for the Plan; or not information that you would be permitted to inspect and 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 Plan has made to others, except for those necessary to carry out health care treatment, payment, or operations; disclosures made to you; 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 accounting was requested.

- **Right to Request Restrictions.** You have the right to request a restriction on the health information the Plan uses or disclosures about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information the Plan discloses about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan 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 Plan's use, disclosure, or both; and (3) to whom you want the limit(s) to apply.

Note: The Plan is not required to agree to your request.

- **Right to a Paper Copy.** You have the right to obtain a paper copy of this notice upon request by contacting the Privacy Officer at the address listed below.

- **Right to Request Confidential Communications.** You have the right to request that the Plan communicate with you about health matters in a certain way or at a certain location. For example, you can ask that the Plan 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 Plan will make every attempt to accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Changes to this Notice

The Plan reserves the right to change this notice at any time and to make the revised or changed notice effective for health information the Plan already has about you, as well as any information the Plan receives in the future.

Complaint

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 complain to the Secretary of the U.S. Department of Health and Human Services, generally, within 180 days of when the act or omission complained of occurred.

Note: You will not be penalized or retaliated against for filing a complaint.

Other Uses and Disclosures of Health Information

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

Contact Information

If you have any questions about this notice, please contact:

Automotive Wholesalers Association of New England Health and Welfare Benefit Plan
Automotive Wholesalers Association of New England
d/b/a National Automotive Roads & Fuel Association
2-4 Main Street, P.O. Box 838
Peterborough, NH 03458
800-258-5318

Notice Effective Date: April 14, 2003
Most recently revised: January 1, 2013

HIPAA PRIVACY AND SECURITY COMPLIANCE

This subsection applies only to those portions of the Plan that are group health plans within the meaning of the Privacy Rule (defined below) and to the extent required by HIPAA.

Privacy Compliance. To the extent required by the HIPAA rules regarding the privacy of PHI (the "Privacy Rule") that govern the manner in which the Plan must handle PHI, the Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;

- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

- not use or disclose any PHI for any employment-related action or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

- report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- make available PHI in accordance with Section 164.524 of the Privacy Rule (related to access of individuals to PHI related to them);

- make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Rule;

- make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Rule;

- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Rule;

- if feasible, return or destroy all PHI received from the Plan and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

- ensure that the adequate separation between the Plan and the Plan Sponsor as required by Section 164.504(f)(iii) of the Privacy Rule is established.

There will be adequate separation between the Plan and the Plan Sponsor to help ensure that only persons involved in Plan administration have access to PHI. Only the Privacy Officer and members of the Plan Sponsor's Human Resources Department will have access to PHI created under the Plan. Access to and use by such persons shall be restricted to the Plan administration functions that the Plan Sponsor and its affiliates perform for the Plan. The Plan or the Plan Sponsor (or an affiliate) has retained one or more third party administrators and others that receive PHI in the ordinary course of business performed on behalf of the Plan. Such persons or entities, known in the Privacy Standards as business associates shall enter into agreements with the Plan governing their obligations under the Privacy Standards.

The improper use or disclosure of PHI by an employee of the Plan Sponsor (or an affiliate) shall be governed by the policies and procedures regarding PHI related to the Plan. The terms of the applicable business associate agreement shall address non-compliance with the Privacy Rule by a business associate.

The Privacy Officer appointed by the Plan Administrator pursuant to the Privacy Rule shall be authorized to make and execute any amendment to this subsection that such Privacy Officer (in consultation with the Security Officer, as applicable) deems necessary or appropriate.

Security Compliance. To the extent required by the HIPAA rules regarding the security of electronic PHI (the "Security Rule"), the Plan Sponsor will reasonably and appropriately safeguard electronic

PHI created, received, maintained or transmitted to or by the Plan Sponsor on behalf of the Plan. To this end, the Plan Sponsor will:

- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- ensure that the adequate separation required by applicable regulations regarding the security of electronic PHI is supported by reasonable and appropriate security measures;

- ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

- report to the Plan any security incident of which it becomes aware.

MATERNITY COVERAGE

Under Federal law, group health plans generally may not 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 delivery by cesarean section. The Plan may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier than 48 hours (or 96 hours as applicable). An "attending provider" would be your physician, nurse midwife, or physician assistant. 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 hospital length of stay not in excess of 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out of pocket costs, you may be required to notify the Plan in advance of your admission.

Also, group health plans may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour or 96-hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

In general, qualified medical child support orders ("QMCSOs") are legal orders requiring a parent to provide medical support to a child (for example, in cases of legal separation or divorce). QMCSOs may require the Plan to make health coverage available to your child, even when there is no other event that would permit a mid-year enrollment. In order to qualify as a QMCSO, the medical support order must be a judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction or by an authorized administrative agency, which does the following:

- Specifies your name and last known address, and the child's name and last known address;
- Provides a reasonable description of the type of coverage to be provided by the Plan, or the manner in which the type of coverage is to be determined;
- States the period to which it applies; and
- Specifies the Benefits to which it applies.

The QMCSO may not require the Plan to provide coverage for any type or form of Benefit, or any option, not otherwise provided under the terms of the Plan. Upon approval of a QMCSO, the Plan must pay benefits directly to the child, or to the child's custodial parent or legal guardian, pursuant to the terms of the order to the extent it is consistent with the terms of the Plan.

You must pay any contribution required for the child's coverage under the Plan resulting from the QMCSO. If you are an eligible Employee but you are not enrolled in the Plan, you will be automatically enrolled in the Plan so that coverage can be provided to the affected child as required by the QMCSO. If the QMCSO does not specify the coverage option in which the child must be enrolled and more than one coverage option is available, the child (and you if you are not enrolled in the Plan) will be enrolled in the coverage option that both has the lowest Employee contribution and under which coverage is available to the child (for example, if the child lives outside of an HMO coverage area, the child will not be enrolled in the HMO).

You and the affected child will be notified if an order is received and will be provided with a copy of the Plan's QMCSO procedures. A child covered under the Plan pursuant to a QMCSO will be treated as an eligible Dependent.

MASTECTOMY COVERAGE

Federal law requires a group health plan to provide coverage for the following services to an individual receiving Plan benefits in connection with a mastectomy:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prosthesis; and
- treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The Plan must determine the manner of coverage in consultation with the attending physician and patient. Coverage for breast reconstruction and related services will be subject to deductibles and coinsurance amounts that are consistent with those that apply to other Medical Benefits under the Plan.

LEAVE UNDER FAMILY MEDICAL LEAVE ACT (FMLA)

If you take a leave of absence for your own serious health condition or to care for a family member with a serious health condition or to care for your newborn or adopted child, you may be able to continue your health coverage under the Plan. Additionally, if you take qualifying exigency leave or military caregiver leave under the military leave provisions of the FMLA, you may be able to continue your health coverage under the Plan. If you drop your health coverage during the leave, you can also have your health coverage reinstated on the date you return to work, provided that you pay any contributions required for the coverage.

CHOICE OF PROVIDER

If your Medical Benefit coverage requires or allows you to designate a primary care provider, you have certain rights under federal law. You have the right to designate any primary care provider who participates in the applicable network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, consult your Certificate for Medical Benefits or contact the Plan Administrator at 1-800-258-5318.

ACCESS TO OBSTETRIC OR GYNECOLOGICAL CARE

Under federal law, you do not need prior authorization from the Plan or a referral from a primary care provider in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health

care professionals who specialize in obstetrics or gynecology, consult your Certificate for Medical Benefits or contact the Plan Administrator at 1-800-258-5318.

RIGHT OF SUBROGATION AND REIMBURSEMENT

These Subrogation and Reimbursement provisions are applicable to self-funded Dental Benefits only. Similar rights for the Plan's fully-insured and self-funded Benefits are described in the applicable Certificates. When used in this subsection, "Bene fit" refers to the self-funded Dental Benefit only

Defined Terms

"*Recovery"* means monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for any or all losses caused by the accident, illness or injury.

"*Reimbursement'* means repayment to the Plan for all Dental Benefits the Plan has paid as a result of the accident, illness or injury.

"*Subrogation"* means the Plan's right to pursue the Covered Person's claims against the third party.

Our Right of Subrogation. A Covered Person, whether an Employee or enrolled Spouse, Eligible Domestic Partner or Dependent child, may have a legal right to recover some or all of the costs of his or her health care from another person or entity (for example, from a workers' compensation insurer, or from the Covered Person's own, or a third party's, motor vehicle or homeowner's insurer). The Covered Person may have a right to recover such costs because that person or entity caused, or is legally responsible to indemnify the Covered Person for, the Covered Person's illness or injury.

Right to Withhold Payment of Eligible Claims. In acting pursuant to any rights of the Plan, the Plan or its authorized representative may withhold or deny payment of eligible claims during the time that such claims are being researched for potential third party liability. In addition, you may be required to sign a repayment agreement as a condition for receiving Benefits under the Plan. If the agreement is not signed, you will lose your related Benefits. However, in the event any claim is paid prior to the execution of a repayment agreement, the Plan's rights (as provided in the Plan document or otherwise by law), shall not be prejudiced.

Our Right of Reimbursement. In addition to the rights described above, if a Covered Person recovers money by suit, settlement, or otherwise, the Covered Person is required to reimburse the Plan for the cost of dental care services, supplies and expenses for which the Plan paid, or will pay. The Plan has an equitable lien against and the right to be reimbursed from any payment received by the Covered Person, regardless of whether (a) all or part of the payment to the Covered Person was designated, allocated, or characterized as payment for medical or dental expenses or (b) the payment is for an amount less than that necessary to reimburse the Covered Person Participant fully for the illness or injury. The Plan expressly rejects any rule that the Plan does not have a right of reimbursement or subrogation until the Participant or any of his or her Dependents and/or Eligible Domestic Partner have been fully compensated or made whole. The Plan has the right to recover reasonable attorneys' fees and both pre and post judgment interest if the Plan must initiate legal proceedings to enforce its rights.

If the Plan pays or will pay for the costs of dental care services given to treat the Covered Person's illness or injury, the Plan has the right to recover those costs in the Covered Person's name, with or without the Covered Person's consent, directly from the person or entity. The Plan also has the right to recover in cases where the Covered Person has independently initiated a claim against another person or entity. The Plan may recover against the total amount of any payment, regardless of whether (a) all or part of the payment is designated, allocated or characterized as payment for medical or

dental expenses; or (b) the payment is for an amount less than that necessary to reimburse the Covered Person fully for the illness or injury.

Assignment of Benefits. The Covered Person hereby assigns to the Plan any benefits the Covered Person may be entitled to receive from a person or entity (for example, the Covered Person's own, or a third party's, motor vehicle insurer) which caused, or is legally responsible to indemnify the Covered Person for, the Covered Person's illness or injury up to the cost of dental care services, supplies, and expenses, paid, or to be paid by the Plan, on account of the Covered Person's illness or injury. The Plan has the right to recover reasonable attorneys' fees and both pre and post judgment interest if the Plan must initiate legal proceedings to enforce its rights. The Covered Person is required to sign any and all documents provided by the Plan that allow the Plan to exercise any or all of its rights of subrogation and reimbursement.

Covered Person Cooperation. As a condition to receiving benefits under this Plan, each Covered Person agrees:

- To notify the Plan or Plan Administrator of any circumstances which may give rise to the Plan's subrogation or reimbursement rights, such as injuries or illnesses resulting from an automobile accident or job-related injuries or illnesses that may be covered by workers' compensation;
- To cooperate with the Plan by providing any information concerning any other applicable insurance coverage that may be available (including, but not limited to, automobile, home, and other liability insurance coverage , and coverage under another group health plan), the identity of any other person or entity, and their insurers (if known), that may be obligated to provide payments or benefits because of the same illness or injury for which this Plan made payments;

    - To cooperate fully in the Plan's exercise of its right to subrogation and reimbursement;

    - To do nothing that would prejudice the Plan's right to subrogation and reimbursement (such as settling a claim against another party without notifying the Plan or by not including the Plan as a co-payee);

    - To sign any document deemed by the Plan Administrator to be relevant in protecting the Plan's subrogation and reimbursement rights;

    - To provide relevant information when requested;

    - To authorize the Plan's investigations and to receive and to release information which is necessary to carry out the purposes of the Plan's subrogation and reimbursement rights; and/or

    - To authorize the Plan to take such action as it deems appropriate to protect its subrogation and reimbursement rights.

In this subsection, the term "information" includes any documents, insurance policies, police or other investigative reports as well as any other facts that may be reasonably requested to help the Plan enforce its rights. Failure by you, your spouse, Eligible Domestic Partner or your Dependents to cooperate with the Plan in the exercise of these rights may result, at the discretion of the Plan Administrator, in a reduction of future benefit payments available to the you or your covered Dependents and/or Eligible Domestic Partner under the Plan of an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's right to subrogation and reimbursement , but for which the Plan was not reimbursed.

Participants may have benefits under other group health plans for hospital, medical, dental or other health care expenses. If this applies, the Plan's rights against the other group health plan will be determined by the Coordination of Benefits section, below, rather than this subsection.

Anti-Assignment of Benefits

Plan benefits cannot be assigned, pledged, borrowed against, transferred, or in any way made over to another party, including a provider, by a participant. Nothing contained in this SPD shall be construed to make the Plan or the Company liable to any third-party, including a provider, to whom a participant may be liable for payment of medical care, treatment or services. Moreover, by cooperating with a provider as an "authorized representative" or otherwise in any participant appeal of a denied claim, the Company does not waive this anti-assignment provision.

Nothwithstanding the foregoing, this provision will not prevent direct payments to third party medical providers for the convenience of the Plan, Covered Person or claims administrator. The Plan Administrator reserves the discretionary authority to determine the validity of any arrangement to direct the payment of benefits to a third party and does not guarantee that any arrangement will be valid under the Plan.

COORDINATION OF BENEFITS

If the covered Employee or his or her covered Spouse, Eligible Domestic Partner or Dependent children are covered by another group health plan, there may be duplication of benefit coverage between this Plan and the other group health plan. This Plan contains provisions that coordinate it with other group health plans under which an individual is covered. The total benefits paid from both plans cannot be greater than the benefits payable under the richer plan. Please refer to the applicable Medical Certificate for additional information regarding coordination of benefit rules.

"Plan" means these types of benefit plans:

1. Any hospital or medical service plan for prepaid group health coverage;

2. Labor-management trusteed plans, union welfare plans, employer organization plans, employee organization plans, and professional association plans;

3. Any employee welfare benefit plan as described in the Employee Retirement Income Security Act of 1974, as amended from time to time;

4. Coverage under a governmental program provided or required by statute, including no-fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation, and including, but not limited to, personal injury insurance and medical benefits provisions required by those programs or statutes; and

5. Group insurance or other coverage for a group of individuals including student coverage obtained through an educational institution.

"Plans" will not include benefits under any income replacement coverage.

Coordination of Benefits Rules. This Plan determines the order of benefits using the first of the following rules to apply:

Employee / Dependent - Any Plan in which the Participant is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan in which the Participant is covered as a dependent of the employee will pay second.

Dependent Child - Parents Neither Separated Nor Divorced - For a dependent child who is covered under plans of both parents and the parents are not separated or divorced, any plan in which the child is covered as a dependent of the parent whose birth date occurs earlier in the calendar year will pay first. Any Plan in which the child is covered as a dependent of the parent whose birth date occurs later in

the calendar year will pay second. If the birth dates of the parents are the same the plan, which has covered a parent for the longest time, will pay before the plan of the other parent.

Dependent Child - Separated or Divorced Parents - For a dependent child who is covered under Plans of both parents and the parents are separated or divorced, if there is not a court decree which fixes the responsibility for health care costs of the child, any plan in which the child is covered as a dependent of the parent who has physical custody will pay first. Any plan in which the child is covered as a dependent of the Spouse, if any, of the parent who has physical custody of the child will pay second. Then, any plan in which the child is covered as a dependent of the parent who does not have physical custody will pay third.

Inactive Employee - The benefits of a plan which covers a person as an employee who is neither laid off nor retired or as that employee's dependent are determined before those of a plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Continuation Coverage - If an individual is covered under a plan by reason of a federal or state continuation of coverage rule, and also under another plan, the following shall be the order of benefit determination:

- First, the benefits of a plan covering the person as an employee (or as that employee's dependent);
- Second, the benefits of a plan under which the employee has continued coverage by reason of a federal or state law.

CHIP Coverage - This Plan will be primary to a state Children's Health Insurance Program.

In some cases, the order of payment may be unclear. When this happens, any plan, which covered the eligible person for the longest time, will pay first. Any plan which has covered the eligible person for the shortest time will pay second. Any person who claims benefits must give the Contract Administrator the information needed to coordinate benefit payments.

Payment of Claims. When this Plan pays first, it pays benefits as if it were the only plan. After the Plan pays its benefits, or denies the claim, the Participant may file a claim for any unpaid amounts with the secondary plan.

When this Plan pays second, it coordinates benefits as follows:

- The primary plan determines the benefits paid as if it were the only plan.
- The amount of benefits paid by the primary plan is then subtracted from any benefits paid by this Plan. This means when the Plan pays second, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan.

MEDICARE ELECTION AT AGE 65

If you remain actively employed after reaching age 65, you may choose to drop coverage under this Plan and elect for Medicare to be your **exclusive** source of health insurance coverage. If you choose to remain covered under this Plan and you sign up for Medicare, this Plan will be the primary payor of benefits and Medicare will be a secondary payor. If you do not sign up for Medicare, this Plan will continue to provide you with health coverage.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This section contains your notice of continuation coverage rights under COBRA. You are receiving this notice because you have recently become covered under the Plan. This notice applies only to the Medical and Dental Benefits offered under the Plan. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

There may be other coverage options for you and your family as a result of key parts of the health care law that took effect beginning January 1, 2014, and coverage through the Health Insurance Marketplaces. In the Marketplace, you might be eligible for a tax credit that might lower your monthly premiums depending on your income. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this SPD or contact the Plan Administrator. The terms used in this section will be interpreted so as to permit the Plan to comply with COBRA but will not be construed to provide more continuation coverage than is required by COBRA.

The Plan Administrator is Automotive Wholesalers Association of New England d/b/a National Automotive Roads & Fuel Association. The Plan Administrator's address is 4 Main Street, P.O. Box 838, Peterborough, NH 03458, phone (603) 924-9449, toll free (800) 258-5318, fax (603) 924-4490. The Plan Administrator is responsible for administering COBRA continuation coverage.

COBRA CONTINUATION COVERAGE

COBRA continuation coverage is a continuation of Medical or Dental Benefit coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if Medical or Dental Benefit coverage is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Covered Employees. If you are a covered Employee, you will become a qualified beneficiary if you lose your Medical or Dental Benefit coverage under the Plan because either one of the following qualifying events happens:

(1) Your hours of employment are reduced, or
(2) Your employment ends for any reason other than your gross misconduct.

Covered Spouses. If you are the Covered spouse of an Employee, you will become a qualified beneficiary if you lose your Medical or Dental Benefit coverage under the Plan because any of the following qualifying events happens:

(1) Your spouse (the Employee) dies,
(2) Your spouse's hours of employment are reduced,

(3) Your spouse's employment ends for any reason other than his or her gross misconduct,
(4) Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both), or
(5) You become divorced or legally separated from your spouse.

Covered Dependent Children. Your covered dependent children will become qualified beneficiaries if they lose Medical or Dental Benefit coverage under the Plan because any of the following qualifying events happens:

(1) The parent-Employee dies,
(2) The parent-Employee's hours of employment are reduced,
(3) The parent-Employee's employment ends for any reason other than his or her gross misconduct,
(4) The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both),
(5) The parents become divorced or legally separated, or
(6) The child stops being eligible for coverage under the plan as a "dependent child."

If you are a child born to or placed for adoption with a covered Employee during the continuation coverage period, you may also elect continuation coverage. Your coverage period will be determined according to the date of the qualifying event that gave rise to the covered Employee's COBRA coverage.

YOU MUST GIVE NOTICE OF CERTAIN QUALIFYING EVENTS

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred.

For the qualifying events of divorce or legal separation of the Employee and spouse or a dependent child losing eligibility for coverage as a dependent child, you must notify the Plan Administrator within 60 days after the qualifying event occurs. Your notification must be in writing and must include the following items:

- Type of qualifying event (e.g., divorce, legal separation or losing dependent coverage).
- For a divorce or legal separation, date of the divorce or legal separation.
- For a dependent child losing coverage, date of the event causing the loss of coverage and the nature of the event (e.g., over Plan's age limit, etc.).
- Name and social security number of covered Employee.
- Name, address and telephone number of covered spouse or dependent who is losing coverage.
- Name of person sending the notice and his or her relationship to the covered Employee.
- Signature of person sending the notice and date it is sent.
- A copy of the decree of divorce or legal separation (if the qualifying event is a divorce or legal separation).

Your notification and any supporting documentation must be provided to the Plan Administrator by mail, fax or hand delivery. Electronic or oral notice is not sufficient and will not be accepted. In certain situations, the Plan Administrator may request that you provide additional documentation or information regarding the qualifying event. Once you receive a request, you will have 15 business days (plus reasonable extensions that may be granted by the Plan Administrator) to provide the additional documentation or information.

If the above notification is not made within 60 days after the applicable qualifying event occurs or if you do not timely provide the additional documentation or information (if requested) with

your notification or, if later, within 15 business days (plus reasonable extensions as indicated above) of the Plan Administrator's request, your notification will be rejected and COBRA continuation coverage will not be offered.

For all other qualifying events, such as the end of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), you are not required to notify the Plan Administrator of these events. Rather, your Participating Employer is responsible for notifying the Plan Administrator of these qualifying events.

ELECTION PERIOD

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage for 60 days from the later of the date coverage is lost under the Plan or the date you receive notification or your right to elect continuation coverage. If a qualified beneficiary does not elect continuation coverage within this period, your rights to COBRA continuation coverage will terminate.

Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. If a covered Employee or spouse of a covered Employee elects COBRA continuation coverage without specifying whether the election is for self-only coverage, the election will be considered to be made on behalf of all other qualified beneficiaries with respect to that qualifying event.

If COBRA is elected, the coverage previously in effect will generally be continued. From time to time, some changes in coverage are possible. For example, coverage and cost will be modified as the Plan makes regular changes to the Medical and Dental Benefits, and you will be given the opportunity to make a new election during annual enrollment or when you have a change in family status. Any newly eligible dependents you may have may be enrolled under the same rules that apply to newly eligible dependents of similarly-situated active employees.

Once you make your election, you will have up to 45 days to pay any make-up premiums you missed. COBRA coverage will be effective the day after the qualifying event. Premiums will be equal to the entire cost of the Medical or Dental Benefit coverage (both Employee and Participating Employer portions), with an additional 2% to cover administrative expenses. If you or a dependent are disabled and coverage continues for 29 months as discussed below, during the 19th through 29th month of COBRA participation, you may be required to pay up to 150% of the entire cost of coverage.

LENGTH OF COBRA COVERAGE

COBRA continuation coverage is a temporary continuation of coverage and may only be continued for certain specified time periods depending upon the qualifying event. These time periods are described in general below.

36-Month Period. When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

18- Month Period. When the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18

months. However, if the Employee became entitled to Medicare benefits less than 18 months before the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

In addition, as described below there are two ways in which the general 18-month period of COBRA continuation coverage can be extended.

Disability Extension. If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the regular 18-month period of continuation coverage. **In order to qualify for the extension, you must notify the Plan Administrator of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage.** Your notification must be in writing and must include the following items:

- Name and social security number of covered Employee.
- Name, address and telephone number of disabled qualified beneficiary.
- Date of Social Security Administration's determination of disability.
- Date that the disabled qualified beneficiary became disabled (according to the Social Security Administration).
- Name of person sending the notice and his or her relationship to the covered Employee.
- Signature of person sending the notice and date it is sent.
- A copy of the disability determination made by the Social Security Administration.

Your notification and supporting documentation must be provided to the Plan Administrator by mail, fax or hand delivery. Electronic or oral notice is not sufficient and will not be accepted. In certain situations, the Plan Administrator may request that you provide additional documentation or information regarding your notice of disability. Once you receive a request, you will have 15 business days (plus reasonable extensions that may be granted by the Plan Administrator) to provide the additional documentation or information.

If the above notification is not made within 60 days of the date of the disability determination made by the Social Security Administration and before the end of the 18-month period of COBRA continuation coverage, or if you do not timely provide the additional documentation or information (if requested) with your notification or, if later, within 15 business days (plus reasonable extensions as indicated above) of the Plan Administrator's request, your notification will be rejected and any additional COBRA coverage beyond the original 18-month period will not be offered.

In addition, if there is a final determination that the qualified beneficiary is no longer disabled, you must notify the Plan Administrator within 30 days of the determination that the qualified beneficiary is no longer disabled. Your notification must be in writing and must include the following items:

- Name and social security number of covered Employee.
- Name, address and telephone number of the previously disabled qualified beneficiary.

- Date of Social Security Administration's determination that the qualified beneficiary is no longer disabled.
- Date that the qualified beneficiary was no longer disabled (according to the Social Security Administration).
- Name of person sending the notice and his or her relationship to the covered Employee.
- Signature of person sending the notice and date it is sent.
- A copy of the determination made by the Social Security Administration.

Your notification and supporting documentation must be provided to the Plan Administrator by mail, fax or hand delivery. Electronic or oral notice is not sufficient and will not be accepted. In certain situations, the Plan Administrator may request that you provide additional documentation or information regarding your disability. Once you receive a request, you will have 15 business days (plus reasonable extensions that may be granted by the Plan Administrator) to provide the additional documentation or information. If the qualified beneficiary is no longer considered disabled, any COBRA coverage extended beyond the 18-month limit that would otherwise apply for the qualified beneficiary and all related qualified beneficiaries will be terminated as of the month that begins more than 30 days after a final determination by the Social Security Administration that the individual is no longer disabled.

Secondary Events. If your family experiences another qualifying event while receiving 18 months (or 29 months in case of a disability extension) of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan Administrator. This extension may be available to the spouse and any dependent children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. In no event may a qualifying event give rise to a maximum coverage period that ends more than 36 months after the date of the first qualifying event. **For cases of second qualifying events, the qualified beneficiary must notify the Plan Administrator within 60 days of the date that the second qualifying event occurs.** This notice must be in writing and must include the following items:

- Type of second qualifying event (e.g., divorce, legal separation, losing dependent coverage, or death of covered Employee). For a dependent child losing coverage, also include the nature of the second qualifying event (e.g., over Plan's age limit, etc.).
- The date of the second qualifying event (e.g., date of divorce, date of covered Employee's death, etc.)
- Name and social security number of covered Employee.
- Names, addresses and telephone numbers of the qualified beneficiaries who are the subject of the second qualifying event.
- Name of person sending the notice and his or her relationship to the covered Employee.
- Signature of person sending the notice and date it is sent.
- A copy of the decree of divorce or legal separation (if the second qualifying event is on account of a divorce or legal separation).
- A copy of the death certificate (if the second qualifying event is the covered Employee's death).

Your notification and any supporting documentation must be provided to the Plan Administrator by mail, fax or hand delivery. Electronic or oral notice is not sufficient and will not be accepted. In certain situations, the Plan Administrator may request that you provide additional documentation or information regarding the second qualifying event. Once you receive a request, you will have 15 business days (plus reasonable extensions that may be granted by the Plan Administrator) to provide the additional documentation or information.

If the above notification is not made within 60 days after the second qualifying event occurs or if you do not timely provide the additional documentation or information (if requested) with your notification or, if later, within 15 business days (plus reasonable extensions as indicated above) of the Plan Administrator's request, your notification will be rejected and any additional COBRA coverage beyond the original 18 (or 29) month period will not be offered.

Pursuant to emergency temporary regulations issued by jointly by the U.S. Department of Labor and the Internal Revenue Service on May 4, 2020, any deadline specified above to submit a written notification of election to receive COBRA continuation coverage (contingent upon eligibility) is suspended for the duration of the COVID-19 National Emergency. Therefore the deadline to submit a notification of election of COBRA coverage will extend to not less than 60 days following the conclusion of the declared COVID-19 National Emergency. This extension of deadlines shall exist while the aforementioned temporary regulations remain in effect, and shall cease to be available when such temporary regulations are no longer in effect.

SPECIAL RULE FOR INDIVIDUALS RECEIVING TAA BENEFITS

If you are receiving trade adjustment assistance ("TAA") benefits under the Trade Act of 2002*, and your eligibility for TAA is related to a job elimination that resulted in your right to elect COBRA Continuation Coverage benefits, and you failed to elect COBRA Continuation Coverage during the initial 60-day COBRA Continuation Coverage election period, you may elect continuation coverage during a second 60-day period. This second 60-day period begins on the first day of the month in which you are determined to be TM-eligible, provided you elect COBRA Continuation Coverage within 6 months after the date of the TAA-related loss of coverage. Any COBRA Continuation Coverage elected during the second election period will begin with the first day of the second election period and not on the date on which coverage initially lapsed.

*The Trade Act of 2002 amended the Trade Act of 1974 by, among other things, extending the period for which TAA benefits are available through September 30, 2007. Under the Trade Act of 1974, TAA benefits are available for workers whose employment is adversely affected by international trade (increased imports or a shift in production to another country), primarily in the form of career counseling, up to two years of training, income support during training, job search assistance and relocation allowances. The Trade Act of 2002 also provided for a new tax credit of up to 65 percent of the cost of certain premiums paid for medical coverage, including COBRA continuation coverage for individuals receiving TAA benefits. If you are receiving TAA benefits, you should check with your tax advisor to determine whether you are eligible to claim this tax credit.

TERMINATION OF COBRA

COBRA coverage will terminate before the end of the indicated time period if:

- You or your dependent becomes covered under another group healthcare plan after electing COBRA

- You or certain of your dependents become entitled to Medicare after electing COBRA continuation coverage.

- The first required premium is not paid within 45 days or any subsequent premium is not paid within 30 days of the due date.

- If coverage is extended beyond 18 months because of disability, the date a final determination is made that the individual is no longer disabled.

- All health plans for active employees are terminated by the Association.

COBRA coverage also may terminate for any reason that the Plan would terminate coverage of a Participant not receiving COBRA coverage (such as fraud).

IF YOU HAVE QUESTIONS

Questions concerning the Plan or your COBRA continuation coverage rights should be addressed to the Plan Administrator:

Automotive Wholesalers Association of New England
d/b/a National Automotive Roads & Fuel Association
4 Main Street, P.O. Box 838
Peterborough, NH 03458
1-800-258-5318

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

SPECIAL RULE FOR EMPLOYEES IN THE UNIFORMED SERVICES

YOUR RIGHT TO CONTINUED HEALTH COVERAGE

If you or your dependents lose Medical or Dental Benefit coverage under the Plan as a result of your qualifying service in the uniformed services (your performance of duty on a voluntary or involuntary basis in the Armed Forces (including the Coast Guard and the Reserves), the Army National Guard, the Air National Guard, and the commissioned corps of the Public Health Service) and you provide advance notice of your service (unless such notice is excused), you have the right to elect to continue coverage under USERRA. Your right to continued Medical or Dental Benefit coverage under USERRA is very similar, but not identical, to your right to continued health coverage under COBRA. Your right to COBRA continuation coverage is described in the COBRA section above. In those instances where your rights under COBRA and USERRA are not the same, whichever law gives you the greater benefit will apply.

The administrative policies and procedures that govern your right to COBRA continuation coverage (as described in the COBRA section above) also apply to your right to USERRA continuation coverage, with a few limited exceptions described below.

ELECTION OF USERRA CONTINUATION COVERAGE

The procedures for electing USERRA continuation coverage are the same as the procedures for electing COBRA coverage. (These procedures are described in the COBRA section above.) Any election that you make under COBRA will also be an election to continue your health coverage under USERRA. In other words, if you elect to continue your Medical or Dental Benefit coverage under COBRA by completing and returning a COBRA Election Form within the required time period, you will be deemed to have elected to continue your coverage under USERRA. If, however, you are unable to elect COBRA within the required period because of military necessity or because it is impossible or unreasonable for you to do so, the period for electing USERRA coverage will be suspended until the military necessity is abated or it is no longer impossible or unreasonable for you to make the required election. The period for electing COBRA coverage, however, will not be suspended in this situation.

Only the covered Employee who is called to serve in the uniformed services may make an election under USERRA to continue coverage for the covered Employee or any covered dependents of the covered Employee, or both. The Employee's covered Dependents do not have an independent right to make an election for USERRA continuation coverage. As a result, if you do not elect USERRA/ COBRA coverage on behalf of your covered Dependents, your covered Dependents will still have a right to elect to continue their coverage under COBRA, but they will not be entitled to receive any additional benefits provided under USERRA.

If you elect to continue coverage under USERRA, generally, you will be provided the same coverage that was in effect when your military service began. From time to time, however, some changes in coverage and cost are possible. For example, coverage and cost may be modified as the Plan makes regular changes to its Benefits, and you will be given the opportunity to make a new election during annual enrollment or when you have a qualifying event.

PAYMENT FOR USERRA COVERAGE

If you elect to continue coverage for yourself (and/or your covered Dependents) under USERRA, you will be required to pay 102% of the full premium (Participating Employer and Employee portions) for the coverage elected. This is the same premium rate as COBRA. However, if your uniformed service

period is less than 31 days, you are not required to pay more for coverage than you would be required to pay as an active Employee.

You must make your payments for USERRA coverage at the times and according to the same procedures that apply to payment of COBRA coverage. These time periods and procedures are described in the COBRA section of this SPD. For example, you must make your initial premium payment within 45 days of electing USERRA / COBRA coverage, and thereafter you must make your monthly premium payments within 30 days of the due date.

DURATION OF USERRA COVERAGE

If you elect to continue health coverage for yourself and/or your covered dependents under USERRA and you remit your payment for coverage on time, coverage will begin on the day after health coverage is lost under the Plan. In other words, you will not experience an interruption in coverage. Thereafter, USERRA continuation coverage will terminate upon the earliest of the following events to occur:

- After 24 months of coverage;
- A premium payment is not made within the required time;
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA.

Although COBRA coverage and USERRA coverage begin at the same time, they do not end at the same time. COBRA coverage continues for up to 18 months (although, if certain events occur, it can be extended), while USERRA coverage continues for up to 24 months as described above. On the other hand, there are certain events, like your failure to return to work at the end of your service or a dishonorable discharge, which cause your USERRA coverage to terminate early but which do not cause COBRA coverage to terminate. In that situation, even if your USERRA coverage terminates, you may still be entitled to continued coverage under COBRA.

If you do not elect coverage and you return to employment with the Participating Employer after your service in the uniformed services, you have the right to be reinstated in the Plan. More information about your reinstatement rights under USERRA is available from the Plan Administrator.

USERRA QUESTIONS

If you have any questions regarding your right to continued health coverage under USERRA, please contact:

Automotive Wholesalers Association of New England
d/b/a National Automotive Roads & Fuel Association
2-4 Main Street, P.O. Box 838
Peterborough, NH 03458
800-258-5318

If you have any questions about other rights under USERRA (e.g., USERRA's reemployment provisions after returning from the Uniformed Services) or about USERRA in general, you should contact your Participating Employer.

ERISA RIGHTS

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, 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, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary Plan descriptions. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

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 this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a Plan 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 the Plan documents or the latest summary annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

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

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W.,Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

For Plan Participants who reside in New England and upstate New York, the nearest Employee Benefits Security Administration office is:

Boston Regional Office
JFK Federal Building, Room 575 Boston, MA 02203
(617) 565-9600

IN WITNESS WHEREOF, Automotive Wholesalers Association of New England, Inc., d/b/a National Automotive Roads & Fuel Association, by its duly authorized officer, has executed this Plan and Summary Plan Description as of this 1st day of January, 2021.

AUTOMOTIVE WHOLESALE ASSOCIATION OF NEW ENGLAND, INC.

4849-8175-0363, V. 2

APPENDIX A

COMPONENT BENEFIT PROGRAMS PROVIDED UNDER HEALTH AND WELFARE BENEFIT PLAN

Effective as of January 1, 2021

The underlying Component Benefit Programs that are maintained by the Automotive Wholesalers Association of New England, d/b/a National Automotive Roads & Fuel Association, under this Plan are listed in the first column below; a general description of such benefits is listed in the second column below; any associated Coverage Documents relating to such benefits that are officially cross-referenced and incorporated in this Plan are listed in the third column below (e.g., separate plan documents, descriptions of benefits, certificates of insurance, insurance policies, TPNASO agreements, etc.); the policy or contract identification number along with the contact information of any insurer or service provider are listed in the fourth column below; and a basic summary of the eligibility provisions of such benefits are listed in the remaining columns below.

"Full-Time Employee" means an employee regularly scheduled to work 30 hours or more per week.

Underlying Welfare Benefit	General Description of Benefits Provided	Associated Coverage	Policy Number, Contact Information of Insurer or Service Provider (if applicable)	Employee Eligibility Classification	Employee Eligibility Effective Date
Medical Benefits (Massachusetts)	Fully-insured medical benefits	Certificate of Coverage	Anthem (insurer)	Full-time employees and owners	
Medical Benefits (New Hampshire, Maine, Connecticu	Self-insured medical	Benefits Booklet	Anthem (service	Full-time employees and owners	
Dental Benefits	Self-insured dental benefits	Benefits Booklet	AWANE 1-800-403-5911	Full-time employees and owners	

Underlying Welfare Benefit	General Description of Benefits Provided	Associated Coverage Documents	Policy Number, Contact Information of Insurer or Service Provider (if applicable)	Employee Eligibility Classification	Employee Eligibility Effective Date
Group Life Insurance	Fully insured life insurance coverage	Certificate of Coverage	Lincoln Financial	Full-time employees and owners	
Long-Term Disability Insurance	Fully-insured LTD income coverage	Certificate of Coverage	Lincoln Financial	Full-time employees and owners	
TI ::11 and coverage).	Fully-insured STD income coverage	Certificate of Coverage	Lincoln Financial	Full-time employees and owners	

APPENDIX B - DENTAL BENEFITS

For those Employees and Dependents who are enrolled for Dental Benefits under either the AWANE Dental Plan or the AWANE Dental Industry Plan, this Appendix discusses your Dental Benefits.

SCHEDULE OF BENEFITS

Calendar Year Maximum	AWANE Dental Plan: $1,750 per Covered Person. The calendar year maximum is not applicable to Type IV Expenses. AWANE Dental Industry Plan: $1,250 per Covered Person.
Type I Expenses (Preventive & Diagnostic)	AWANE Dental Plan: Payable at 100% after $50 deductible per person, per year, maximum of 3 deductibles per policy per year, up to calendar year maximum. AWANE Dental Industry Plan: Payable at 100% after $75 deductible per person, per year, maximum of 3 deductibles per policy per year, up to calendar year maximum.
Type II Expenses (Basic Restorative)	Both Plans: Payable at 80% up to calendar year maximum.
Type III Expenses (Major Restorative)	AWANE Dental Plan: Payable at 60% up to calendar year maximum. AWANE Dental Industry Plan: Payable at 50% up to calendar year maximum. **There is a 3 month waiting period for these services, which is waived if prior dental coverage is proven.**
Type IV Expenses, AWANE Dental Industry Plan (Periodontal Expenses)	Payable at 50% up to calendar year maximum.
Type IV Expenses, AWANE Dental Plan (Orthodontic Services)	AWANE Dental Plan: Payable at 60% up to a lifetime maximum of $1,000 per child under age 19. **If orthodontic coverage is elected, there is a 9-month waiting period for these services.**

COVERED DENTAL EXPENSES

The types of dental procedures listed herein are Covered Dental Expenses, provided the procedures are medically necessary and are performed or prescribed by a dentist, as defined herein. Covered Dental Expenses are payable as determined by this SPD and are limited by the General Exclusions section listed later in this SPD.

Date of Service. Benefits will be paid based on the limitations of this Benefit according to the date that services are rendered. Generally, services are considered rendered on the date you receive treatment from your dentist. However, certain services will be paid according to certain dates of service. Payment for the following Covered Dental Expenses are based on the following dates of service.

Dental Expense	Date of Service
An appliance or modification of an appliance (orthodontic benefit only)	The date the impression is taken.
A crown, bridge or gold restoration	The date the tooth is prepared.
Root canal therapy	The date the pulp chamber is opened.
Orthodontic services	The date the appliance or bands are inserted or a one-step orthodontic procedure is performed.

Certain Payment Rules. If a condition is being treated for which two or more services included in the list are suitable under customary dental practices, the benefit will be based on the listed service which, according to a determination made by the Plan Administrator, would produce a professionally satisfactory result at the lowest cost. Further, if a dental service is performed that is not on the list, but the list contains one or more other services that under customary dental practices are suitable for the condition being treated, the listed services that the Plan Administrator determines would produce a professionally satisfactory result will be considered to have been performed.

TYPE I EXPENSES - Preventive and Diagnostic Dental Care

The following expenses are considered Type I Covered Dental Expenses:

Type I Covered Dental Expenses	Limitations / Notes
Routine office exams	One exam is covered in any consecutive six month period.
Prophylaxis (cleaning and scaling)	One cleaning is covered in any consecutive six month period with or without an oral examination.
Fluoride (topical treatments)	One course of treatment is covered in any consecutive 12 month period for a Covered Dependent under age 19.
Space maintainers	Limited to Covered Dependents under age 19.
Bitewing X-rays Occlusal X-rays Extraoral X-rays	One set is covered in any consecutive 12 month period.
Full mouth or panoramic X-rays	One set is covered in any consecutive 36 month period.
Sealants (topical application on a posterior tooth)	Limited to one treatment per tooth in any consecutive 36 month period for a Covered Dependent under age 15. Limited to the first and second permanent molars.

TYPE II EXPENSES - Basic Restorative Care

The following expenses are considered Type II Covered Dental Expenses:

Type II Covered Dental Expenses	Limitations / Notes
Routine extractions	
Emergency Oral Exams	
Palliative Treatment	
Oral surgery	
Periodontal scaling and root planing (AWANE Dental Plan Only)	Limited to once per quadrant every 2 years.
Periodontal prophylaxis (AWANE Dental Plan	Limited to a combined maximum of one prophylaxis in any 6 consecutive month period

Type II Covered Dental Expenses	Limitations / Notes
Only)	Including prophylaxis and periodontal prophylaxis.
Periodontal maintenance following active treatment (AWANE Dental Plan Only)	Limited to once every 3 months.
Root canal therapy	
Pulpotomy	
Apicoectomy	
Amalgam restorations	Multiple restorations on one surface will be paid as a single filling.
Composite restorations	Mesial lingual, distal lingual, mesial buccal and distal buccal restorations on anterior teeth will be considered single surface restorations, and benefits will be paid accordingly.
General anesthesia	Covered only when medically necessary, when administered in connection with oral or dental surgery and if the anesthetic agent produces a state of unconsciousness with absence of pain over the entire body.

TYPE III EXPENSES - Major Restorative

Please Note: Type Ill **Dental Expenses are only payable after a 3-month waiting period that begins on the effective date of your enrollment in the Benefit, which is waived if prior dental coverage is proven.**

The following expenses are considered Type Ill Covered Dental Expenses:

Type III Covered Dental Expenses	Limitations / Notes
Inlays	
Onlays	
Crowns	
Pontics	
Fixed bridgework	

Type III Covered Dental Expenses	Limitations / Notes
Post & Core	Covered only for endodontically treated teeth requiring crowns.
Gingivectomies	
Osseous surgery	
Stainless steel crowns	Limited only to Covered Dependents under age 16.
Denture repairs	Including the addition of a tooth or teeth to an existing denture if the natural teeth are extracted while you are covered under this Benefit.
Prosthondontics (full and partial dentures)	Includes adjustments within 6 months after installation.
Dentures	Includes- • a complete maxillary denture, • a complete mandibular denture, and • a removable bridge (i.e., unilateral partial including a one piece chrome casting, clasp attachments (all types) and panties).

TYPE IV EXPENSES {AWANE DENTAL INDUSTRY PLAN ONLY) - Periodontal

The following expenses are considered Type IV Covered Dental Expenses under the AWANE Dental Industry Plan only:

Type IV Covered Dental Expenses	Limitations / Notes
Periodontal scaling and root planing	Limited to once per quadrant every 2 years.
Periodontal prophylaxis	Limited to a combined maximum of one prophylaxis in any 6 consecutive month period including prophylaxis and periodontal prophylaxis.
Periodontal maintenance following active treatment	Limited to once every 3 months.

TYPE IV EXPENSES (AWANE DENTAL PLAN)- Orthodontia

Type IV Covered Dental Expenses (AWANE Dental Plan) are subject to the following limitations:

- Payable only after a 9-month waiting period that begins on the effective date of your enrollment in the Benefit.
- Available only to Covered Dependents who are under age 19.
- Limited to a lifetime maximum of $1,000 per Covered Dependent.

In order to obtain coverage, you must separately enroll for Type IV Covered Dental Expenses (AWANE Dental Plan). Enrollment instructions are listed on the Dental Benefit Enrollment Form available from your Participating Employer and the Plan Administrator.

The following expenses are considered Type IV Covered Dental Expenses under the AWANE Dental Plan:

Expenses	Limitations / Notes
Comprehensive full-banded orthodontic treatment,	Includes preliminary cephalometric radiographs, diagnostic casts, treatment plan, appliances and treatment.
Appliances for tooth guidance	Limited to one appliance per Covered Dependent.
Retention appliances	Limited to one appliance per Covered Dependent.
Night guards	

GENERAL EXCLUSIONS

Benefits will not be provided for any service that is not medically necessary and appropriate, including the following services, regardless of whether they are provided, performed or prescribed by a dentist. The list below is representative of the exclusions not covered. Any service not listed or specifically identified as a Covered Dental Expense is presumed not covered. To be medically necessary and appropriate, a service must be consistent with accepted dental practice. This Benefit's exclusions include:

1. Services or supplies not described as Covered Dental Expense listed above in the Schedule of Dental Benefits;

2. Care, services, supplies or treatment not prescribed or provided by a dentist (as defined herein) or dental hygienist under the supervision of a dentist;

3. Any treatment or service for a dental condition where any treatment or service was rendered regarding the dental condition prior to the Covered Person's effective date of coverage under this Benefit (including any applicable waiting period);

4. Any procedure begun after termination of coverage or dental appliance installed or delivered more than 30 days after the termination of coverage (as specifically provided herein);

5. Service or supplies which are not medically necessary or do not meet accepted standards of dental practice (including experimental procedures);

6. Any duplicate dental service or appliance including the replacement of lost, missing or stolen devices or appliances;

7. Services for bleaching of teeth or teeth whitening;

8. Bonding, veneers, and any treatment which is elective or primarily cosmetic in nature and not generally recognized as generally accepted dental practice by the American Dental Association;

9. Education or training in and supplies used for dietary or nutritional counseling, oral hygiene or dental plaque control;

10. Fluoride rinses or any "over-the-counter" drug which can be purchased without a prescription; prescribed drugs, premedication, and analgesias;

11. Orthodontic treatment unless specifically elected and otherwise listed as a Type IV Covered Dental Expense;

12. Appliances or restorations relating to: the alteration of vertical dimension; the stabilization of periodontally involved teeth or restoration of occlusion; splinting or replacing tooth structure lost as a result of abrasion or attrition; bite registration; or bite analysis;

13. Personalization or characterization of teeth or dentures;

14. Replacement of bridges unless the bridge cannot be made serviceable;

15. Replacement of full or partial dentures unless the prosthetic appliance is more than five years old and cannot be made serviceable;

16. Replacement of crowns, inlays, or onlays unless the prior placement is more than seven years old and cannot be made serviceable;

17. Cast restorations and crowns for teeth that are not broken down by extensive decay or accidental injury or for teeth that can be restored by other means;

18. Initial placement of any prosthetic appliance or fixed bridge unless such placement is necessitated by the extraction of one or more functioning natural teeth while covered under the Benefit, provided such tooth was not an abutment for a prosthetic appliance installed during the preceding five years or a fixed bridge installed during the preceding seven years. The extraction of a third molar does not qualify. Any such appliance of a fixed bridge must include the replacement of the extracted tooth or teeth;

19. Any charge for failure to keep a scheduled dentist appointment;

20. Any charge for completing a claim form;

21. Diagnosis or treatment of temporomandibular joint (TMJ) dysfunctions, muscular skeletal deficiencies involving TMJ or related structures, myofascial pain;

22. Orthognathic surgery;

23. Treatment of malignancies, cysts or neoplasms;

24. Cone beam x-rays;

25. Any expenses caused by war (declared or undeclared) or any act of war;

26. Any procedure determined by the Plan Administrator which is not necessary, does not offer a favorable prognosis, or does not have a uniform professional endorsement or which is experimental in nature;

27. Services rendered by you or your Spouse, or by a parent, son, daughter, brother or sister of you or of your Spouse or by a member of your household;

28. Any expense incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment (past or present) or which is compensable under any workers' compensation or occupational disease act or law;

29. Any expense included as a covered medical expense under another group medical expense benefit plan, including the Medical Benefit;

30. Any expense provided or paid for by any governmental program or law, except as to charges which the person is legally obligated to pay;

31. Any expense in excess of Annual/Lifetime Maximums as set forth in the Schedule of Benefits;

32. Any expense for medical services, except to the extent herein provided;

33. Any expense suffered while on full-time active duty in the armed forces of any country, countries or international authority;

34. Any expense resulting from or occurring during the commission of a crime by a Covered Person, or while engaged in an illegal act, felonious act or aggravated assault;

35. Any expense for services incurred prior to the effective date of the Covered Person's coverage under this Benefit; and

36. Any expenses for services incurred after the Covered Person's termination of coverage under this Benefit even if the Plan Administrator has predetermined the payment for a treatment plan submitted before the termination date, except that benefits on account of Covered Dental Expenses incurred for the following procedure will be payable as though the coverage had continued in force:

    - a prosthetic device (such as full or partial dentures) if the dentist took impressions and prepared the abutment teeth while the patient was covered under the Benefit, and the dentist delivers and installs the device within 30 days following termination of coverage.

HOW TO FILE A CLAIM FOR DENTAL BENEFITS

Claims for Dental Benefits should be submitted to the Plan Administrator promptly on the appropriate claim form, which can be obtained from the Plan Administrator, if needed. It is recommended that any claim be submitted even if it is not certain whether the expense is covered so that the Plan can make payments whenever necessary and possible.

NOTE: If you have used the debit card that is tied to your Dental Benefits to pay for your Covered Dental Expense, you should not follow these procedures or file a paper claim for Dental Benefits. Rather, you should retain your receipts and follow the substantiation procedures you received with the debit card. If you have any questions, please contact the Plan Administrator.

Mail claims to: AWANE Dental Benefits
PO Box 838
Peterborough, NH 03458-0838
Phone: (603) 924-9449
Toll Free: (800) 258-5318
Fax: (603) 924-4490

PROOF OF LOSS

"Proof of Loss" means a claim for payment along with enough information for the Plan Administrator to accept or reject the claim and to determine the benefits payable. You are encouraged to submit claims within 20 days after the start of any covered service or as soon as reasonably possible, but in no case later than one year after the date of service. Failure to submit claim(s) within the time required, except in the absence of your legal capacity, will invalidate the claim.

When you file your own claim, the following information should be included:

Patient's name;
Date the service was rendered;
Charge for the service rendered;
Diagnosis;
Description of the service rendered or the supply purchased; and Provider's name.

Right to Request Examination. The Plan Administrator at its own expense shall have the right and opportunity to request examination by an appropriate dental professional of any individual whose injury or illness is the basis of a claim.

HOW BENEFIT DETERMINATIONS ARE MADE

Once a claim is filed, it is reviewed and processed. A benefit determination is then issued to the Covered Person or his or her authorized representative. Determinations are made within a reasonable period of time appropriate to the claim's circumstances and in accordance with the following provisions of this section, as applicable. A period of time begins at the time the claim is filed.

For the purposes of Dental Benefits, "days" mean calendar days. Below are other definitions, which are important in understanding how benefit determinations are made.

Adverse benefit determination means a denial, reduction or termination of benefits (in whole or in part), or a failure to provide or pay for benefits.

Post-service claim means any claim that is submitted for benefit determination after dental care services have been provided to a Covered Person and may include review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication of payment.

***Authorized* representative** includes the ordering provider, facility, or attending dentist/physician. Written communication of the need for additional information and the final determination will be sent to the Covered Person or his or her authorized representative..

Determination Making Time Frames

This Plan only processes post-service claims for Dental Benefits. This means that a Covered Person must first incur a claim for a Covered Dental Expense by receiving the services or supplies prior to submitting a claim for Dental Benefits under this Plan.

If additional information is needed to process the claim, the Plan Administrator will notify the Covered Person or his or her authorized representative submitting the claim in writing of the specific information necessary to complete the review within thirty (30) calendar days after receipt of the request. The Covered Person or his or her authorized representative will then have a reasonable amount of time, taking into account the circumstances, but not less than forty-five (45) calendar days from the date of the Plan Administrator's request, to provide the requested information.

Written notice of determinations concerning a post-service claim will be provided to the Covered Person or his or her authorized representative within 30 calendar days of the date the claim was received by the Plan Administrator. If additional review time is needed due to circumstances beyond the control of the Plan Administrator, the Plan Administrator may extend the time period to 45 days after the original review request is received. If the time period is extended, the Plan Administrator will notify the Covered Person and his authorized representative before the expiration of the original 30-day time period.

ADVERSE BENEFIT DETERMINATION LETTERS

If your claim for Dental Benefits is denied, in whole or in part, you will receive a written notice of the adverse benefit determination containing the following information:

1. A statement of the specific reason(s) for the adverse benefit determination;

2. Reference to the specific Plan provisions on which the denial is based, if applicable ;

3. A statement that, upon request and free of charge, the claimant is entitled to receive reasonable access to, and copies of, all documents, records, and other information relevant to his or her claims;

4. A statement of the right to appeal and reconsideration;

5. A description of appeal rights and the time limits applicable to initiating such rights;

6. A statement that the Covered Person has the right to bring a civil action under Section 502(a) of ERISA if the Covered Person's claim is denied upon a subsequent appeal.

7. If an internal rule, guideline, protocol or other similar criteria was relied upon in making an adverse benefit determination, a statement that the specific rule, guideline, protocol or other similar criteria will be provided upon request; and

8. If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request.

APPEAL PROCEDURES

If the Covered Person wishes to appeal a claim denial, a written request must be presented to the Plan Administrator within 180 days from the date appearing on the notice of the adverse benefit determination. The Covered Person may submit written comments, documents, records and other information relating to the claim with his or her appeal.

The Covered Person has the right to review the facts relating to the original determination and any other related information. The Covered Person may also review this information with the Plan Administrator. If the Covered Person so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. A document, record or other information shall be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;

2. Was submitted, considered or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination; or

3. Demonstrates compliance with the certain administrative processes and safeguards in making the benefit determination (i.e., to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently to similarly situated claimants; or

4. Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or Dental Benefit.

The period of time within which a benefit determination on appeal is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing. The Plan Administrator will present the Covered Person with a written determination upon appeal within 60 days after receiving the appeal for the post-service claim.

The review shall take into account all comments, documents, records and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

The written determination will include (i) specific reasons for the determination, (ii) reference to the specific Plan provisions on which the determination is based, if applicable, (iii) a statement that the claimant is entitled to review, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to his or her claim (iv) a statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain information about such procedures, (v) if an internal rule, guideline, protocol or other similar criteria was relied upon in making an adverse benefit determination, a statement that the specific rule, guideline, protocol or other similar criteria will be provided upon request,
(vi) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request, and (vii) a statement indicating that a claimant has a right to file a lawsuit upon completion of the claims process and appeals procedure.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary shall consult with a dental care professional who was not involved in the original benefit determination. This dental care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

The Plan Administrator has the exclusive discretionary authority to construe and to interpret the Plan, to decide all questions of eligibility for benefits and to determine the amount of such benefit. Their decisions on these matters are final and conclusive. As a result, benefits will only be paid if the Plan Administrator decides in its discretion that the applicant is entitled to them. Any interpretation or determination made pursuant to this discretionary authority will be upheld on judicial review, unless it is shown that the interpretation or determination was an abuse of discretion. If the Covered Person is not satisfied with the appeal determination, he or she is entitled to pursue legal remedies under ERISA section 502(a) or other applicable law. However, in no event may a Covered Person file suit in court to recover an alleged benefit without first going through and completing the claims procedures provided above.

PAYMENT OF BENEFITS

Dental Benefits are only payable to the Covered Person. However, Qualified Medical Child Support Order benefits are paid to the child's custodial parent.

Assignment of Benefits. The Covered Person may authorize the Plan Administrator to pay benefits directly to the dentist or other physician providing treatment. Any such payment will discharge the Plan Administrator to the extent of payment made.

Right to Receive and Release Information. To the extent permissible under applicable privacy laws including HIPAA, for the purposes of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for Dental Benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming Dental Benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Right to Make Payments. The Plan Administrator has the right to pay any other organization as needed to properly carry out this "Payment of Benefits" subsection. These payments are made in good faith and are considered Dental Benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability, to the extent that payments are made.

Right to Recovery. If, on behalf of the Plan, the Plan Administrator paid more than it should have, the Plan Administrator has the right to recover the excess amount. This recovery can be from the person for whom the payments were made. It can also be from any other insurance company or other person or organization.

DENTAL DEFINITIONS

As used herein, the following words and phrases have the meanings ascribed to them below. Use of a word or phrase is not intended to imply that coverage for them is provided under the Dental Benefit.

Accident - An immediate, unforeseen event caused by an external trauma to the body.

Anesthesia - Means the following when preceded by the following words -

General - The condition produced by the administration of specific agents to render the patient completely unconscious and completely without conscious pain response.

Local - The condition produced by the administration of specific agents to achieve the loss of conscious pain response in a specific location or area of the body.

Topical - The condition produced by the application of an agent to the skin which diminishes pain response in the treated area.

Anesthetic - A drug that produces loss of feeling or sensation generally or locally.

Anterior Teeth - The six upper and six lower natural teeth in the front of the mouth (central incisors, lateral incisors, and cuspids).

Apicoectomy- A procedure by which a portion of the tooth root is removed.

Bitewing - Dental X-ray showing approximately the coronal (crown) halves of the upper and lower jaw.

Cosmetic Surgery - A procedure performed primarily to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an illness or injury.

Covered Dental Expense - Any expense covered by the Dental Benefit as listed in the Covered Dental Expense section.

Covered Person - An Employee, a Dependent or Eligible Domestic Partner who is enrolled for Dental Benefits and is eligible to receive Dental Benefits.

Dental Hygienist - A person currently licensed to practice dental hygiene by the governmental authority having jurisdiction over the licensing and practice of dental hygiene and who works under the supervision and direction of a dentist.

Dental Services - Procedures involving the teeth, gums or supporting structures.

Dentist - A person licensed to practice dentistry by the appropriate authority in the area where the dental service is given.

Endodontics - That branch of dentistry that involves diagnosis and treatment of the pulp chambers of the teeth.

Fillings -When preceded by the foregoing terms, Fillings means the following:

Silver Amalgam - Material used to fill cavities that is usually placed on the tooth surface that is used for chewing because it is a particularly durable material.

Porcelain, Silicate, Acrylic, Plastic or Composite - Materials used to fill cavities which have less durability, thus they are placed on nonstress-bearing surfaces of front teeth because the color more closely resembles the natural tooth than does the color of Silver Amalgam.

Fluoride - A solution of fluorine which is applied topically to the teeth for the purpose of preventing dental decay.

Gingivae - The gums or soft tissue surrounding the teeth and bone.

Gingivectomy - The cutting away of the diseased gums (gingivae) when the underlying bone is not yet affected.

Injury - Bodily harm which results from an accident occurring while covered under this Plan and which results in a loss covered by the Plan.

Maximum Benefits - The maximum benefits for each Covered Person are shown in the Schedule of Benefits. Not more than the applicable maximum will be payable for expenses incurred for any Covered Person in a calendar year/lifetime.

Medically Necessary - Care and treatment that is:

1. Recommended or approved by a dentist; and
2. Consistent with the patient's condition or accepted standards of good medical practice ;and
3. Medically proven to be effective treatment of the condition; and
4. Not performed mainly for the convenience of the patient or provider; and
5. Not conducted for research purposes.

The Plan Administrator reserves the right to determine medical necessity and may consult with an appropriate health consultant or review group.

Ossseous Surgery - A branch of oral surgery involving procedures performed to eliminate bone deformities, including the removal of diseased bone and infected bone tissue.

Periodontal Disease - A disease that weakens and destroys the gums, bone and membrane surrounding the teeth. Periodontal disease is the principal cause of tooth loss in people over age 30. This disease is sometimes called Vincent's disease, gingivitis or pyorrhea.

Periodontist - A dentist whose practice is limited to the treatment of Periodontal Disease.

Physician -A Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.).

Pantie - The part of a fixed bridge that is suspended between abutments and replacing a missing tooth.

Posterior Teeth - The ten upper and ten lower natural teeth in the back of the mouth (two biscuspids and three molars in each quadrant).

Providers - Any licensed dentist practicing within the scope of his license, any licensed physician performing dental services within the scope of his license or any licensed dental hygienist acting under the supervision and direction of a dentist is a covered provider.

Prophylaxis - The removal of tartar and stains from the teeth. The cleaning of the teeth by a dentist or dental hygienist.

Quadrant - One dental quarter of the mouth, consisting of eight teeth (in an adult) when all natural teeth are present.

Root Canal Therapy - Root Canal Therapy is also known as Endontic Therapy and is treatment of a tooth having a damaged pulp. Usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals and filling the spaces with sealing material.

Scale - To remove calculus (tartar) and stains form the teeth with special instruments.

Topical - Painting the surface of the teeth as in fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.