EARNHARDT

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AUTO CENTERS

EMPLOYEE BENEFITS HANDBOOK

INSURANCE | 2017-2018 PLAN YEAR

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Earnhardt Management Company provides a comprehensive benefits package designed to offer protection for you and your family. We understand your employee benefits package is extremely important to you, and encourage you to evaluate and elect benefits that best suit your personal health care needs. Within this Employee Benefits Handbook you will find important information on the benefits available to you and the costs associated with these benefits.

Please take the time to carefully review your plan options and enroll/make changes as needed. For current benefit-eligible employees, all benefit changes will be effective October 1, 2017. For new employees, benefits will be effective the first of the month following two months of employment.

For more information about your employee benefits, please access our intranet at home.earnhardt.com and click on the HR link. On this site you will find electronic copies of the Benefit Summaries, Summary Plan Descriptions, and helpful links to several of the employee benefit websites.

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YOUR 2017–2018 BENEFITS PACKAGE

Earnhardt Management Company offers an array of benefit plans and coverage levels for you and your family, including:

- Medical and prescription drug coverage
- Dental coverage
- Vision coverage
- Life and accidental death and dismemberment insurance
- Short- and long-term disability insurance

ELIGIBILITY

Active, full-time employees working at least 30 hours per week are eligible for coverage under the Earnhardt Management Company benefit plans the first of the month following two months of employment. If you do not enroll within 30 days of your eligibility date, you will not be able to enroll until the next annual enrollment period unless you experience a qualifying event.

Eligible Dependents

Many of the benefit plans also offer coverage for eligible dependents. Only dependents who meet the definition of an eligible dependent can be enrolled in an Earnhardt Management Company benefit plan.

Your eligible dependents include:

- Your legal spouse
- Your children to age 26 (***for the medical and dental plans***)
- Your children to age 21, or 25 if a full-time student (***for vision and life insurance plans***)
- Your child(ren) of any age who are or become physically or mentally unable to care for themselves while covered by the Earnhardt Management Company benefits program

Children include stepchildren, legally-adopted children, children placed with you for adoption, and children for whom you are the legal guardian.*

Who is NOT an Eligible Dependent?

- An ex-spouse, a parent, a parent-in-law, or a domestic partner
- Grandchildren, siblings, nephews, nieces, cousins, aunts, uncles, and grandparents
- Children of unmarried minor dependents

*A notarized statement from family members is not sufficient to establish legal guardianship. Legal guardianship is established by the court, whereby a minor child is placed under the supervision of a guardian who, under the terms of the legal guardianship, is legally responsible for the care and custody of the child. It allows the guardian to access services for the child, something that would not be possible without the legal guardianship status.

If you have questions regarding benefits eligibility, please contact the Human Resources Department at (480) 813-9009.

PAYING YOUR PREMIUMS ON A PRE-TAX BASIS

If you enroll in the medical, dental, or vision plans, your premium contributions will be deducted on a pre-tax basis from your paycheck and you will not be able to change your benefit elections during the plan year unless you experience a qualifying change in status.

MAKING MID-YEAR BENEFITS CHANGES

After your initial eligibility period, Earnhardt Management Company allows you to make benefit changes once a year during the annual enrollment period. You cannot enroll, change, or terminate your coverage during the year unless you experience a qualifying event, as defined by the Internal Revenue Service (IRS). Election changes must be consistent with your qualifying event/status change.

An IRS-approved qualifying event includes:

- Marriage, divorce, or legal separation
- Birth of a child
- Adoption or placement of a child for adoption
- Court order requiring you to add coverage for a dependent child
- A dependent child reaches the maximum age limit for coverage
- Loss of spouse's group health coverage
- Change in employment status for you or your spouse
- End of COBRA Continuation Coverage through another employer
- You and/or your dependents become entitled to Medicare/AHCCCS
- You are no longer in an eligible class for coverage
- You and/or your dependents become covered by another group health plan
- There is a significant change in the plan or plan cost during the year
- Death of a dependent

You must notify the Human Resources Department within 30 days of the qualifying change in status in order to make a coverage change at any time other than the annual enrollment period or when you are initially eligible for coverage.

If your dependent experiences a qualifying change in status, and you are not currently enrolled, you may be eligible to enroll with the dependent. Any premium change will be made in the month the change occurs. If your dependent(s) have a COBRA qualifying event but you remain on the plan, either you or the dependent must notify the Human Resources Department within 30 days of the event.

MEDICAL COVERAGE

Earnhardt Management Company offers you and your eligible dependents three comprehensive PPO medical plan options through Blue Cross Blue Shield of Arizona: the Red Plan, the White Plan, and the Blue Plan. All three options offer both in-network and out-of-network benefits. You will receive the maximum benefit under any of the plans and pay a smaller amount out of pocket when you seek medical treatment from a network provider. Locate a network provider at www.azblue.com.

How do you determine which plan is right for you and your family?

Each plan has a different employee cost, which is the amount you pay out of your paycheck. As you consider which plan makes the most sense for you, think about whether you prefer to pay more each paycheck but less when you need care, or less per paycheck but more when you need care.

Summary of Benefits	Red Plan		White Plan		Blue Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible *(Does not cross accumulate)*						
Individual	$1,600	$3,200	$3,250	$6,500	$6,000	$12,000
Family	$3,200	$6,400	$6,500	$13,000	$12,000	$24,000
Out-of-Pocket Maximum *(Includes deductible)*						
Individual	$5,500	$8,000	$6,000	$8,000	$8,000	$16,000
Family	$11,000	$16,000	$12,000	$16,000	$16,000	$32,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Coinsurance (Member Pays)	25%	50%	30%	50%	35%	50%
Physician Services						
Adult/Child Preventive Visit	Applic. copay	Ded., 50%	Applic. copay	Ded., 50%	Applic. copay	Ded., 50%
Primary Care Visit	$25 copay	Ded., 50%	$30 copay	Ded., 50%	$35 copay	Ded., 50%
Clinic Visit	$0 copay	N/A	$0 copay	N/A	$0 copay	N/A
Specialist Visit	$55 copay	Ded., 50%	$55 copay	Ded., 50%	$50 copay	Ded., 50%
Annual Eye Exam	$25 copay	Not covered	$25 copay	Not covered	$25 copay	Not covered
Urgent Care Visit	$55 copay	Ded., 50%	$55 copay	Ded., 50%	$50 copay	Ded., 50%
Testing						
Mammogram	100%	Ded., 50%	100%	Ded., 50%	100%	Ded., 50%
Preventive Colonoscopy/ Sigmoidoscopy	100%		100%		100%	
Non-Hospital Lab Services	100%		100%		100%	
Basic Radiology	100%		100%		100%	
MRI, CT, Nuclear Medicine	25%	Ded., 50%	30%	Ded., 50%	35%	Ded., 50%
Hospital Services						
Inpatient or Outpatient (other than ER)	Ded., 25%	Ded., 50%	Ded., 30%	Ded., 50%	Ded., 35%	Ded., 50%
Emergency Room	$250 copay, then 100%	$250 copay, then 100%	$250 copay, then 100%	$250 copay, then 100%	$250 copay, then 100%	$250 copay, then 100%
Prescription Drugs						
Tier 1	$10 copay	Copay + Balance Bill	$10 copay	Copay + Balance Bill	$10 copay	Copay + Balance Bill
Tier 2	$45 copay		$45 copay		$40 copay	
Tier 3	$90 copay		$90 copay		$75 copay	
Mail Order *(90-day supply)*	2x retail copay	N/A	2x retail copay	N/A	2x retail copay	N/A

Prior Notification

Prior notification is required for certain services, including clinical trials, dental (accident only), home healthcare, inpatient hospital stay, outpatient rehab services, skilled nursing facility/inpatient rehab facility services, certain specialty or self-injectable medications, and transplantation services. See coverage booklet for more details.

MEDICAL CLINIC – HEALTHCARE SOLUTIONS CENTERS, LLC

Free onsite clinic available to all employees and family members covered by an Earnhardt Blue Cross Blue Shield medical plan!

Benefits of using Healthcare Solutions:

- 100% HIPAA Compliant
- Completely confidential and voluntary
- Free to visit—no copay or deductible!
- No claims generated
- Located on site to save you time, money, and gas!
- Keeps you healthy through diagnosis and treatment of medical conditions
- Can write prescriptions, order labs, and dispense medications on site
- Offers free smoking cessation and weight loss plans to ensure success with your goals
- Can make specialist referrals quick and easy

Examples of Services Offered:

- Physical exams
- Wellness checks
- Treatment of acute infections (e.g., ear, tonsils, colds, flu)
- Diagnosis and treatment of chronic health conditions (e.g., asthma, diabetes, arthritis, hypertension, depression)
- Order and interpret lab tests and x-rays
- Prescribe and manage medications
- Provide personal health care coordination
- Suture wounds
- Treat sexually transmitted disease and provide counseling
- Phlebotomy

100% HIPAA Compliant and Confidential!

To schedule an appointment:

- Go to www.hcsonsite.com
- In the middle right portion of the home page you will see an "Appointment Request" link. Select a date, time, location, and complete the required fields. Then click submit. Once the form is received, someone will contact you to confirm your appointment.
- Please bring your insurance ID card with you to your first appointment.

Questions?
Please email info@hcsonsite.com
-or-
call (602) 424-2101

On-site clinic locations at Chandler Ford, Mesa Toyota, Avondale Honda, North Scottsdale Hyundai and Gilbert Dodge. Near-site clinic for Camelback Lexus located at 4831 N 11th Street, Phoenix.
(Clinic days and hours vary by location)
-or-

Go to the Healthcare Solutions Camelback location
Hours: Tuesday and Friday 9:00 am—3:00 pm.

DENTAL COVERAGE

Earnhardt Management Company offers you and your eligible dependents two dental plan options through Assurant.

The pre-paid dental plan provides benefits ONLY when you see your primary care dentist or a specialist your primary care dentist has referred you to. Treatment you receive from your primary care dentist will be provided at reduced fees called copayments. Locate a dental provider in the Heritage Series provider network at www.assurantemployeebenefits.com. Click the "Find a dentist" link; select the state of Arizona under the "DHMO or Prepaid Dental Plan" area; then click the "Heritage Series" link. Availability of plan dentists and plan specialists varies depending on location. **This plan is ONLY available in Arizona.**

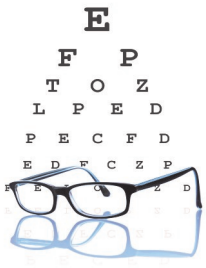
The PPO dental plan allows you the flexibility to select the dentist of your choice. However, you will maximize your benefits and reduce your out-of-pocket expenses if you select an in-network dentist. Out-of-network benefits are paid based on usual and customary charges and balance billing could apply. Locate a network provider at www.assurantemployeebenefits.com. Click the "Find a dentist" link; then click the "Assurant Dental Network" link under the "PPO Plan" heading.

Summary of Benefits	Pre-Paid Plan (AZ only)	PPO Dental Plan	
	DHMO Network	In-Network	Out-of-Network
Plan Year Deductible Individual Family	None	$50 $150	$50 $150
Plan Year Maximum Benefit	Unlimited	$1,500	
Preventive and Diagnostic (Routine cleanings, oral evaluations, topical fluoride application, x-rays, space maintainers, sealants)	Refer to fee schedule	100%	100%
Basic Services (Fillings, root canal, general anesthesia, oral surgery, periodontics)		Ded., 10%	Ded., 20%
Major Services (Crowns, dentures, partials, bridges, bridge or denture repair/rebase/reline)		Ded., 40%	Ded., 50%
Orthodontia (child only)	Ortho Discounts	Not Covered	
Out-of-Network Reimbursement	N/A	N/A	90th percentile

Tips for Managing Your Dental Costs

- See your dentist regularly for cleanings and oral examinations—preventive care is covered at 100% (subject to R&C charges for out-of-network providers).
- Prior to scheduling an appointment with your dentist, make sure he/she is a participating provider so that you receive in-network benefits and minimize your out-of-pocket expenses.

VISION COVERAGE



Earnhardt Management Company offers a PPO vision plan through EyeMed. This plan uses the EyeMed Select network of participating eye care providers. You will receive the maximum benefits under the plan and pay less out of your pocket when you seek care from an EyeMed Select network provider. You do have the option to seek care out of network, but you will pay more out of your pocket for those services. Out-of-network providers will require payment in full at the time of service. You must then submit a claim to EyeMed for partial reimbursement. Locate a network provider at www.eyemedvisioncare.com.

Benefits Snapshot	Vision Plan	
	In-Network	Out-of-Network Reimbursement
Eye Exam with dilation as necessary (Once every 12 months)	$10 copay	Up to $35
Frames (Once every 24 months)	$120 allowance; 80% of balance over $120	Up to $48
Single Vision Lenses (Once every 12 months) **Or**	$25 copay	Up to $25
Contact Lenses (Once every 12 months)	$135 allowance; plus balance over $135	Up to $95

Extra Discounts and Savings at Network Providers

Glasses, Sunglasses, and Contacts

- Members save 40% on a full pair of glasses and 15% on contact purchases if your benefit for the year has already been used.
- 20% off items not covered by the plan.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price from contracted facilities.
- Call 1-877-5LASER6 for locations and discount authorization.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You can purchase life and accidental death and dismemberment insurance for you and your family members without a medical exam.

Guarantee Issue

Guarantee issue amounts refer to the amount of coverage that you can be approved for without completing a health questionnaire. Guarantee issue amounts only apply during your initial eligibility period. Employees must elect coverage within 30 days after meeting the first of the month following two months waiting period. If you wish to enroll in the plan or increase your coverage after this initial eligibility period, you will be required to complete the Evidence of Insurability form. Coverage is contingent upon carrier approval.

Rates are based on your age and the amount of coverage you elect. Refer to the Mutual of Omaha enrollment packet for additional details.

Life and Accidental Death & Dismemberment	
Employee	Benefit Increments: $10,000 (minimum election of $20,000) Benefit Maximum: Lesser of $500,000 or 5 times annual earnings Guarantee Issue: $200,000 (when initially eligible)
Spouse*	Benefit Increments: $5,000 (rounded to the next $10,000) Benefit Maximum: Lesser of 50% of employee election or $250,000 Guarantee Issue: $50,000 (when initially eligible)
Child(ren)*	Benefit: $2,000 to $10,000 (increments of $1,000) Benefit Maximum: $10,000 Guarantee Issue: $10,000 (when initially eligible)

* Dependent coverage only available if employee elects life insurance for himself/herself.

DISABILITY COVERAGE

Short-Term Disability

Earnhardt Management Company offers short-term disability insurance for eligible employees. If enrolled, the benefit begins on the 15th day of the illness or injury and covers 60% of pre-disability earnings for up to 24 weeks (after the 14-day waiting period), or until the employee is able to return to work per a doctor's release.

Long-Term Disability

After short-term disability coverage is utilized, you may be eligible for long-term disability benefits. This plan pays up to 60% of pre-disability earnings to a maximum of $7,500 per month after 180 days of disability.

Refer to the Mutual of Omaha enrollment packet for rate details.

Summary of Benefits	Short-Term Disability	Long-Term Disability
Benefit Amount	60% of weekly earnings	60% of monthly earnings
When are Benefits Payable?	Benefits are payable following a 14-day elimination period	Benefits are payable following a 180-day elimination period
Maximum Benefit	$1,300 per week	$7,500 per month
Maximum Benefit Duration	24 weeks	Later of age 65 or Social Security Normal Retirement Age if disabled prior to age 62; Reduced benefit duration applies if disabled at age 62+

EMPLOYEE CONTRIBUTIONS—PER PAY PERIOD

Medical

Earnhardt Management Company makes a significant contribution towards your portion of medical coverage. The BCBSAZ premium options are listed below and are figured on a per pay period basis.

Coverage Level	If you DO NOT take the HRA			If you DO take the HRA		
	Red Plan	White Plan	Blue Plan	Red Plan	White Plan	Blue Plan
Employee	$112.50	$76.50	$53.50	$102.50	$66.50	$43.50
Employee + Spouse	$460.00	$378.50	$324.00	$450.00	$368.50	$314.00
Employee + Child(ren)	$375.00	$297.50	$249.00	$365.00	$287.50	$239.00
Family	$672.50	$505.00	$435.00	$662.50	$495.00	$425.00

Before you can take the Health Risk Assessment, you must first register for BlueNet Services at www.azblue.com/HealthyBlue. To complete the HRA, please follow the below steps.

Step 1: Once you've logged in to BlueNet, look for the heading, "Health and Wellness" on the left side margin. Under that heading, click on the link, "Try My BluePrint Now."

Step 2: Follow the instruction on the subsequent pages to complete your "My BluePrint" health assessment.

Step 3: Once you have completed the health assessment, be sure to take note of your score and take advantage of one of the many Healthy Living programs available to you.

Dental

Coverage Level	Pre-Paid DHMO Dental Plan	PPO Dental Plan
Employee	$6.93	$20.34
Employee + Spouse	$11.27	$39.78
Employee + Child(ren)	$15.29	$46.30
Family	$17.94	$69.88

Vision

Coverage Level	Vision Plan
Employee	$2.84
Employee + Spouse	$5.38
Employee + Child(ren)	$5.66
Family	$8.32

KEY TERMS

The following terms may be helpful to review as you read this guide.

Term	Definition
Annual Deductible	The amount you are required to pay each calendar year before certain benefits are payable by the plan. Once the deductible has been met, expenses are shared between the plan and the member is a coinsurance arrangement.
Annual Out-of-Pocket Maximum	The most you pay in a calendar year for covered services that are subject to coinsurance/copays. The deductible is included in this amount. If you reach the annual out-of-pocket maximum, the plan pays 100% of covered in-network eligible expenses for the remainder of the plan year. Office visits and prescription copays **are not** included in the annual out-of-pocket maximum.
Balance Billing	When you are billed for the difference between the provider's actual charge and the amount reimbursed under the medical or dental plan. This occurs when services are received out of the preferred provider network.
Coinsurance	The percentage you pay for covered expenses.
Copayments	The flat dollar amount you pay for certain in-network services.
In-Network	A group of doctors, hospitals and other health care providers that contract with a health plan vendor to provide quality health care services at favorable rates.
Explanation of Benefits (EOB)	Provides information about how your claim was processed by the insurer. The EOB outlines what portion of the claim was paid by the insurance plan and what portion is your responsibility.
Preferred Provider Organization (PPO)	A health care arrangement designed to provide health care services at a discounted cost for members who use designated providers (the network), but which also provides coverage (at a lower level) for services received from providers who are not part of the network.
Reasonable & Customary (R&C) Charges	R&C charges are determined by your health plan vendor and are based on the range of fees charged by doctors with comparable training and experience for the same or similar service in your area. When you receive in-network care, R&C charges do not apply. You are responsible for amounts over the R&C charges for out-of-network care.

IMPORTANT NOTICES

Important Notice from Earnhardt Management Company About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Earnhardt Management Company and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

If neither you nor any of your covered dependents are eligible for or have Medicare, this notice does not apply to you or your dependents, as the case may be. However, you should still keep a copy of this notice in the event you or a dependent should qualify for coverage under Medicare in the future. Please note, however, that later notices might supersede this notice.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Earnhardt Management Company has determined that the prescription drug coverage offered by the Blue Cross Blue Shield PPO ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

Because your existing coverage is, on average, at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to enroll in a Medicare drug plan, as long as you later enroll within specific time periods.

Enrolling in Medicare – General Rules
As some background, you can join a Medicare drug plan when you first become eligible for Medicare. If you qualify for Medicare due to age, you may enroll in a Medicare drug plan during a seven-month initial enrollment period. That period begins three months prior to your 65th birthday, includes the month you turn 65, and continues for the ensuing three months. If you qualify for Medicare due to disability or end-stage renal disease, your initial Medicare Part D enrollment period depends on the date your disability or treatment began. For more information you should contact Medicare at the telephone number or web address listed below.

Late Enrollment and the Late Enrollment Penalty
If you decide to *wait* to enroll in a Medicare drug plan you may enroll later, during Medicare Part D's annual enrollment period, which runs each year from October 15th through December 7th. But as a general rule, if you delay your enrollment in Medicare Part D, after first becoming eligible to enroll, you may have to pay a higher premium (a penalty).

If after your initial Medicare Part D enrollment period you go **63 continuous days or longer without "creditable" prescription drug coverage** (that is, prescription drug coverage that's at least as good as Medicare's prescription drug coverage), your monthly Part D premium may go up by at least 1% of the premium you would have paid had you enrolled timely, for every month that you did not have creditable coverage.

For example, if after your Medicare Part D initial enrollment period you go nineteen months without coverage, your premium may be at least 19% higher than the premium you otherwise would have paid. You may have to pay this higher premium for as long as you have Medicare prescription drug coverage. *However, there are some important exceptions to the late enrollment penalty.*

Special Enrollment Period Exceptions to the Late Enrollment Penalty
There are "special enrollment periods" that allow you to add Medicare Part D coverage months or even years after you first became eligible to do so, without a penalty. For example, if after your Medicare Part D initial enrollment period you lose or decide to leave employer-sponsored or union-sponsored health coverage that includes "creditable" prescription drug coverage, you will be eligible to join a Medicare drug plan at that time.

In addition, if you otherwise lose other creditable prescription drug coverage (such as under an individual policy) through no fault of your own, you will be able to join a Medicare drug plan, again without penalty. These special enrollment periods end two months after the month in which your other coverage ends.

Compare Coverage
You should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. See the Plan's summary plan description for a summary of the Plan's prescription drug coverage. If you don't have a copy, you can get one by contacting us at the telephone number or address listed below.

Coordinating Other Coverage with Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the Earnhardt Management

Company Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Earnhardt Management Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

If you do decide to join a Medicare drug plan and drop your Earnhardt Management Plan prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back. To regain coverage you would have to re-enroll in the Plan, pursuant to the Plan's eligibility and enrollment rules. You should review the Plan's summary plan description to determine if and when you are allowed to add coverage.

For more information about this notice or your current prescription drug coverage…
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Earnhardt Management Company changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date:	October 1, 2017
Name of Entity/Sender:	Earnhardt Management Company
Contact--Position/Office:	Human Resources, Benefits Administrator
Address:	2121 N. Arizona Ave, Building B, Chandler, AZ 85225
Phone Number:	(480) 813-9009

Nothing in this notice gives you or your dependents a right to coverage under the Plan. Your (or your dependents') right to coverage under the Plan is determined solely under the terms of the Plan.

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

Earnhardt Management Company
IMPORTANT NOTICE
Comprehensive Notice of Privacy Policy and Procedures

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.

This Notice is provided to you on behalf of:

Earnhardt Management Company Medical Plan
Earnhardt Management Company Dental Care Plan
Earnhardt Management Company Vision Plan

The Plan's Duty to Safeguard Your Protected Health Information.
Individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care is considered "Protected Health Information" ("PHI"). The Plan is required to extend certain protections to your PHI, and to give you this Notice about its privacy practices that explains how, when and why the Plan may use or disclose your PHI. Except in specified circumstances, the Plan may use or disclose only the minimum necessary PHI to accomplish the purpose of the use or disclosure.

The Plan is required to follow the privacy practices described in this Notice, though it reserves the right to change those practices and the terms of this Notice at any time. If it does so, and the change is material, you will receive a revised version of this Notice either by hand delivery, mail delivery to your last known address, or some other fashion. This Notice, and any material revisions of it, will also be provided to you in writing upon your request (ask your Human Resources representative, or contact the Plan's Privacy Official, described below), and will be posted on any website maintained by ABC Company that describes benefits available to employees and dependents.

You may also receive one or more other privacy notices, from insurance companies that provide benefits under the Plan. Those notices will describe how the insurance companies use and disclose PHI, and your rights with respect to the PHI they maintain.

How the Plan May Use and Disclose Your Protected Health Information.
The Plan uses and discloses PHI for a variety of reasons. For its routine uses and disclosures it does not require your authorization, but for other uses and disclosures, your authorization (or the authorization of your personal representative (e.g., a person who is your custodian, guardian, or has your power-of-attorney) may be required. The following offers more description and examples of the Plan's uses and disclosures of your PHI.

Uses and Disclosures Relating to Treatment, Payment, or Health Care Operations.
- **Treatment:** Generally, and as you would expect, the Plan is permitted to disclose your PHI for purposes of your medical treatment. Thus, it may disclose your PHI to doctors, nurses, hospitals, emergency medical technicians, pharmacists and other health care professionals where the disclosure is for your medical treatment. For example, if you are injured in an accident, and it's important for your treatment team to know your blood type, the Plan could disclose that PHI to the team in order to allow it to more effectively provide treatment to you.
- **Payment:** Of course, the Plan's most important function, as far as you are concerned, is that it *pays for* all or some of the medical care you receive (provided the care is covered by the Plan). In the course of its payment operations, the Plan receives a substantial amount of PHI about you. For example, doctors, hospitals and pharmacies that provide you care send the Plan detailed information about the care they provided, so that they can be paid for their services. The Plan may also share your PHI with other plans, in certain cases. For example, if you are covered by more than one health care plan (e.g., covered by this Plan, and your spouse's plan, or covered by the plans covering your father and mother), we may share your PHI with the other plans to coordinate payment of your claims.
- **Health care operations:** The Plan may use and disclose your PHI in the course of its "health care operations." For example, it may use your PHI in evaluating the quality of services you received, or disclose your PHI to an accountant or attorney for audit purposes. In some cases, the Plan may disclose your PHI to insurance companies for purposes of obtaining various insurance coverage. *However, the Plan will not disclose, for underwriting purposes, PHI that is genetic information*.

Other Uses and Disclosures of Your PHI Not Requiring Authorization.
The law provides that the Plan may use and disclose your PHI without authorization in the following circumstances:
- **To the Plan Sponsor:** The Plan may disclose PHI to the employers (such as ABC Company) who sponsor or maintain the Plan for the benefit of employees and dependents. However, the PHI may only be used for limited purposes, and may not be used for purposes of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the employers. PHI may be disclosed to: the human resources or employee benefits department for purposes of enrollments and disenrollments, census, claim resolutions, and other matters related to Plan administration; payroll department for purposes of ensuring appropriate payroll deductions and other payments by covered persons for their coverage; information technology department, as needed for preparation of data compilations and reports related to Plan administration; finance department for purposes of reconciling appropriate payments of premium to and benefits from the Plan, and other matters related to Plan administration; internal legal counsel to assist with resolution of claim, coverage and other disputes related to the Plan's provision of benefits.
- **Required by law:** The Plan may disclose PHI when a law requires that it report information about suspected abuse, neglect or domestic violence, or relating to suspected criminal activity, or in response to a court order. It must also disclose PHI to authorities that monitor compliance with these privacy requirements.
- **For public health activities:** The Plan may disclose PHI when required to collect information about disease or injury, or to report vital statistics to the public health authority.
- **For health oversight activities:** The Plan may disclose PHI to agencies or departments responsible for monitoring the health care system for such purposes as reporting or investigation of unusual incidents.
- **Relating to decedents:** The Plan may disclose PHI relating to an individual's death to coroners, medical examiners or funeral directors, and to organ procurement organizations relating to organ, eye, or tissue donations or transplants.
- **For research purposes:** In certain circumstances, and under strict supervision of a privacy board, the Plan may disclose PHI to assist medical and psychiatric research.
- **To avert threat to health or safety:** In order to avoid a serious threat to health or safety, the Plan may disclose PHI as necessary to law enforcement or other persons who can reasonably prevent or lessen the threat of harm.
- **For specific government functions:** The Plan may disclose PHI of military personnel and veterans in certain situations, to correctional facilities in certain situations, to government programs relating to eligibility and enrollment, and for national security reasons.

Uses and Disclosures Requiring Authorization:
For uses and disclosures beyond treatment, payment and operations purposes, and for reasons not included in one of the exceptions described above, the Plan is required to have your written authorization. Your authorizations can be revoked at any time to stop future uses and disclosures, except to the extent that the Plan has already undertaken an action in reliance upon your authorization.

Uses and Disclosures Requiring You to have an Opportunity to Object:
The Plan may share PHI with your family, friend or other person involved in your care, or payment for your care. We may also share PHI with these people to notify them about your location, general condition, or death. However, the Plan may disclose your PHI only if it informs you about the disclosure in advance and you do not object (but if

there is an emergency situation and you cannot be given your opportunity to object, disclosure may be made if it is consistent with any prior expressed wishes and disclosure is determined to be in your best interests; you must be informed and given an opportunity to object to further disclosure as soon as you are able to do so).

Your Rights Regarding Your Protected Health Information.
You have the following rights relating to your protected health information:

- ***To request restrictions on uses and disclosures:*** You have the right to ask that the Plan limit how it uses or discloses your PHI. The Plan will consider your request, but is not legally bound to agree to the restriction. To the extent that it agrees to any restrictions on its use or disclosure of your PHI, it will put the agreement in writing and abide by it except in emergency situations. The Plan cannot agree to limit uses or disclosures that are required by law.
    - *Effective February 17, 2010, you can restrict disclosure of PHI for payment or health care operations if you pay the health care provider the full out-of-pocket cost.*
- ***To choose how the Plan contacts you:*** You have the right to ask that the Plan send you information at an alternative address or by an alternative means. The Plan must agree to your request as long as it is reasonably easy for it to accommodate the request.
- ***To inspect and copy your PHI:*** Unless your access is restricted for clear and documented treatment reasons, you have a right to see your PHI in the possession of the Plan or its vendors if you put your request in writing. The Plan, or someone on behalf of the Plan, will respond to your request, normally within 30 days. If your request is denied, you will receive written reasons for the denial and an explanation of any right to have the denial reviewed. If you want copies of your PHI, a charge for copying may be imposed but may be waived, depending on your circumstances. You have a right to choose what portions of your information you want copied and to receive, upon request, prior information on the cost of copying.
- ***To request amendment of your PHI:*** If you believe that there is a mistake or missing information in a record of your PHI held by the Plan or one of its vendors, you may request, in writing, that the record be corrected or supplemented. The Plan or someone on its behalf will respond, normally within 60 days of receiving your request. The Plan may deny the request if it is determined that the PHI is: (i) correct and complete; (ii) not created by the Plan or its vendor and/or not part of the Plan's or vendor's records; or (iii) not permitted to be disclosed. Any denial will state the reasons for denial and explain your rights to have the request and denial, along with any statement in response that you provide, appended to your PHI. If the request for amendment is approved, the Plan or vendor, as the case may be, will change the PHI and so inform you, and tell others that need to know about the change in the PHI.
- ***To find out what disclosures have been made:*** You have a right to get a list of when, to whom, for what purpose, and what portion of your PHI has been released by the Plan and its vendors, other than instances of disclosure for which you gave authorization, or instances where the disclosure was made to you or your family. In addition, the disclosure list will not include disclosures for treatment, payment, or health care operations. The list also will not include any disclosures made for national security purposes, to law enforcement officials or correctional facilities, or before the date the federal privacy rules applied to the Plan. You will normally receive a response to your written request for such a list within 60 days after you make the request in writing. Your request can relate to disclosures going as far back as six years. There will be no charge for up to one such list each year. There may be a charge for more frequent requests.

How to Complain about the Plan's Privacy Practices.
If you think the Plan or one of its vendors may have violated your privacy rights, or if you disagree with a decision made by the Plan or a vendor about access to your PHI, you may file a complaint with the person listed in the section immediately below. You also may file a written complaint with the Secretary of the U.S. Department of Health and Human Services. The law does not permit anyone to take retaliatory action against you if you make such complaints.

Notification of a Privacy Breach
A new federal law, the American Reinvestment and Recovery Act of 2009 (ARRA) has made numerous changes to the rules governing PHI that is maintained by the Plan and its service providers (business associates). Effective September 23, 2009, any individual whose unsecured PHI has been, or is reasonably believed to have been used, accessed, acquired or disclosed in an unauthorized manner will receive written notification from the Plan within 60 days of the discovery of the breach. The notice will be provided to you if the breach poses a significant risk of financial, reputational or other harm to you.

If the breach involves 500 or more residents of a state, the Plan will notify prominent media outlets in the state. The Plan will maintain a log of security breaches and will report this information to HHS on an annual basis. Immediate reporting from the Plan to HHS is required if a security breach involves 500 or more people.

Contact Person for Information or to Submit a Complaint.
If you have questions about this Notice please contact the Plan's Privacy Official or Deputy Privacy Official(s) (see below). If you have any complaints about the Plan's privacy practices, handling of your PHI, *or breach notification process,* please contact the Privacy Official or an authorized Deputy Privacy Official.

Privacy Official*.*
The Plan's Privacy Official, the person responsible for ensuring compliance with this Notice, is:
Human Resources, Benefits Administrator—(480) 813-9009.

The Plan's Deputy Privacy Official(s) is: Human Resources, Benefits Administrator; Earnhardt Management Company; P.O. Box 11838; Tempe, AZ 85284; (480) 813-9009

Organized Health Care Arrangement Designation.
The Plan participates in what the federal privacy rules call an "Organized Health Care Arrangement." The purpose of that participation is that it allows PHI to be shared between the members of the Arrangement, without authorization by the persons whose PHI is shared, for health care operations. Primarily, the designation is useful to the Plan because it allows the insurers who participate in the Arrangement to share PHI with the Plan for purposes such as shopping for other insurance bids.

The members of the Organized Health Care Arrangement are: **Earnhardt Management Company Medical Plan, Earnhardt Management Company Dental Care Plan, Earnhardt Management Company Vision Plan**

Effective Date.
The effective date of this Notice is: October 1, 2017

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to later enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

Loss of eligibility includes but is not limited to:

- Loss of eligibility for coverage as a result of ceasing to meet the plan's eligibility requirements (i.e., legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment);
- Loss of HMO coverage because the person no longer resides or works in the HMO service area and no other coverage option is available through the HMO plan sponsor;
- Elimination of the coverage option a person was enrolled in, and another option is not offered in its place;
- Failing to return from an FMLA leave of absence; and
- Loss of coverage under Medicaid or the Children's Health Insurance Program (CHIP).

Unless the event giving rise to your special enrollment right is a loss of coverage under Medicaid or CHIP, you must request enrollment within 30 after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

If the event giving rise to your special enrollment right is a loss of coverage under Medicaid or the CHIP, you may request enrollment under this plan within ***60 days*** of the date you or your dependent(s) lose such coverage under Medicaid or CHIP. Similarly, if you or your dependent(s) become eligible for a state-granted premium subsidy towards this plan, you may request enrollment under this plan within ***60 days*** after the date Medicaid or CHIP determine that you or the dependent(s) qualify for the subsidy.

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

To request special enrollment or obtain more information, contact: Human Resources, Benefits Administrator at (480) 813-9009.

Note: Additional information may be required if the plan requires that persons declining coverage under the plan state, in writing, the reason(s) for declining coverage.
**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

NOTICE OF GRANDFATHERED STATUS

This group health plan believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (480) 813-9009 ERISA plans, insert: You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health and Cancer Rights Notice

Earnhardt Management Company is required by law to provide you with the following notice:

The Women's Health and Cancer Rights Act of 1998 ("WHCRA") provides certain protections for individuals receiving mastectomy-related benefits. Coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

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

The Earnhardt Management Company Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, please see the plan summary for whichever plan you are enrolled in for detailed information on deductibles and coinsurance.

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at (480) 813-9009.

Michelle's Law Notice

(To Accompany Certification of Dependent Student Status)

Michelle's Law is a federal law that requires certain group health plans to continue eligibility for adult dependent children who are students attending a post-secondary school, where the children would otherwise cease to be considered eligible students due to a medically necessary leave of absence from school. In such a case, the plan must continue to treat the child as eligible up to the earlier of:

- The date that is one year following the date the medically necessary leave of absence began; or
- The date coverage would otherwise terminate under the plan.

For the protections of Michelle's Law to apply, the child must:

- Be a dependent child, under the terms of the plan, of a participant or beneficiary; and
- Have been enrolled in the plan, and as a student at a post-secondary educational institution, immediately proceeding the first day of the medically necessary leave of absence.

"Medically necessary leave of absence" means any change in enrollment at the post-secondary school that begins while the child is suffering from a serious illness or injury, is medically necessary, and causes the child to lose student status for purposes of coverage under the plan.

If you believe your child is eligible for this continued eligibility, you must provide to the plan a written certification by his or her treating physician that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary.

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Human Resources, Benefits Administrator (480) 813-9009.

Your Rights Under the Family Medical Leave Act of 1993

Basic Leave Entitlement

FMLA requires covered employers to provide up to 12 weeks of unpaid, job protected leave to eligible employees for the following reasons:

- Incapacity due to pregnancy
- Prenatal medical care or child birth
- To care for the employee's child after birth, or placement for adoption or foster care
- To care for the employ's spouse, son or daughter, or parent, who has a serious health condition
- For a serious health condition that makes the employee unable to perform the employee's job

Military Family Leave Entitlements

Eligible employees with a spouse; son, daughter, or parent on active duty or call to active duty status in the National Guard or Reserves in support of a contingency operation may use their 12-week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible employees to take up to 26 weeks of leave to care for a covered service member during a single 12-month period. A covered service member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty that may render the service member medically unfit to perform his or her duties for which the service member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list.

Benefits and Protections
During FMLA leave the employer must maintain the employee's health coverage under any "group health plan" on the same as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their-original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.

Eligibility Requirements
Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition
A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave
An employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave
Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration off leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

Employer Responsibilities
Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility. Covered employers .must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave entitlement. If the employer determines that the leave is not FMLA protected, the employer must notify the employee.

Unlawful Acts by Employers
FMLA makes it unlawful for any employer to:
- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement
An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures. For additional information: 1-866-4\JS-WAGE (1-866-487-9243) 'ITY: 1-877-889-5627 WWW.WAGEHOUR.DOL.GOV u.s.

NOTES

IMPORTANT CONTACT INFORMATION

Carrier	Member Services	Website
BlueCross BlueShield of AZ Medical	**Claims and Benefits** (602) 864-4400 (800) 232-2345 **Pharmacy Benefits:** (602) 864-4273 (800) 232-2345 ext. 4273 **24/7 Nurse Line:** (866) 422-2729	www.azblue.com
Assurant Dental	**Pre-Paid Dental:** (800) 443-2995 **PPO Dental:** (800) 442-7742 **Help Line** (for plan selection assistance)**:** (303) 927-8734	www.assurantemployeebenefits.com
EyeMed Vision Care Vision	(866) 9-EYEMED	www.eyemedvisioncare.com
Mutual of Omaha Life and Disability	(800) 655-5142	www.mutualofomaha.com
Healthcare Solutions Center Onsite Clinic	(602) 424-2101	**Email:** info@hcsonsite.com
Employee Benefits Help Line Lockton Companies	(602) 735-8923	**Email:** earnhardt@lockton.com

This document is intended to merely highlight or summarize certain aspects of the Earnhardt Management Company benefits program. It is not a summary plan description (SPD) or an official plan document. Your rights and obligations under the program(s) are set forth in the official plan documents. All statements in this summary are subject to the terms of the official plan documents, as interpreted by the appropriate plan fiduciary. In the case of an ambiguity or outright conflict between a provision in this summary and a provision in the plan documents, the terms of the plan documents control. The employer reserves the right to review, change, or terminate the plan, or any benefits under it, for any reason, at any time and without advance notice to any person.

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