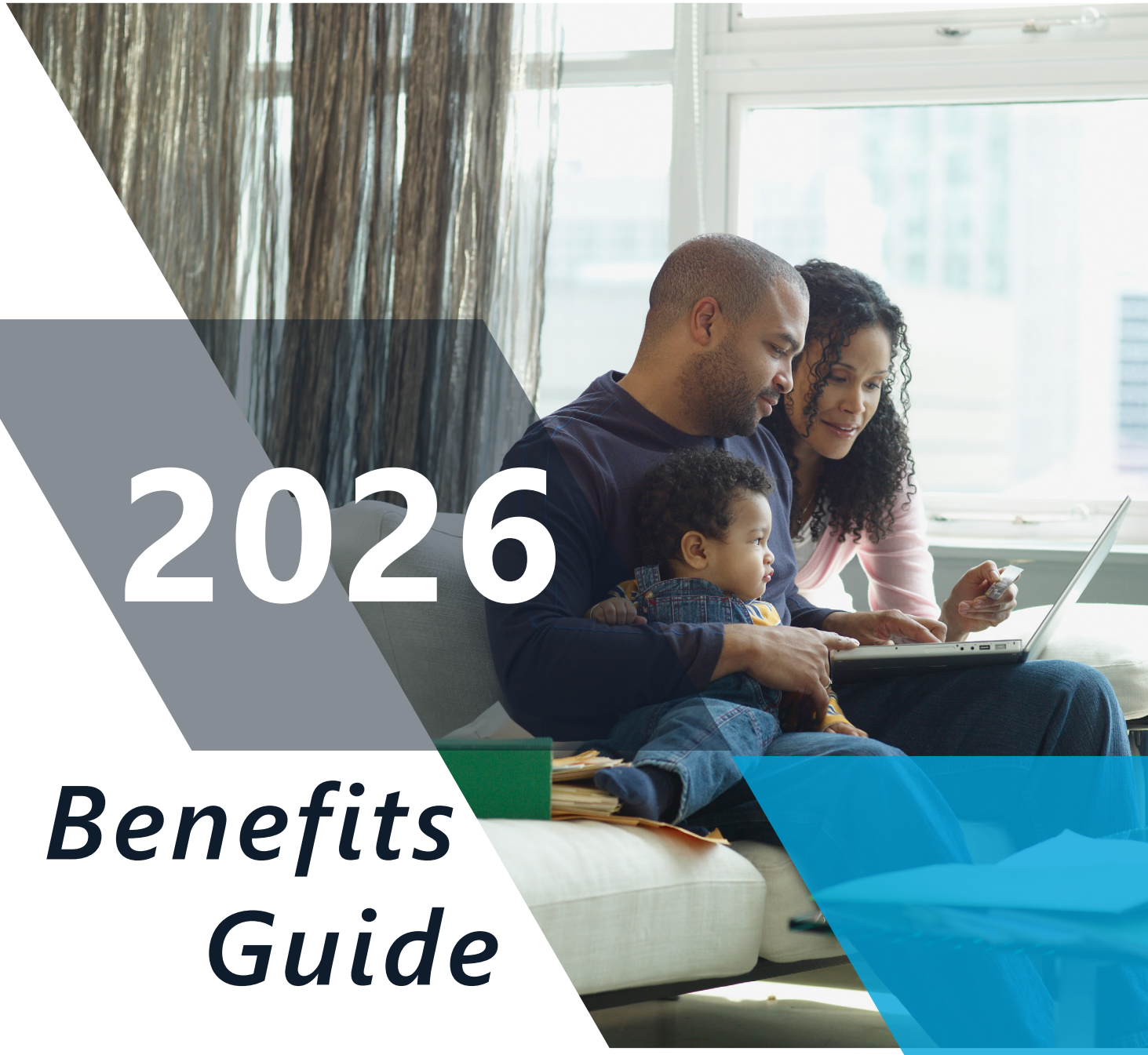
The Dealer Tire Family of Companies

AMI Automated Media, Inc. | DealerTire | Dent Wizard Smart Repairs
Sentric | SimpleTire | Sonsio Vehicle Protection



# 2026 Benefits Guide

**Visite dtfamilybenefits.com para obtener su guía de beneficios.**

This publication contains important information about your employee benefit program.

**Please read thoroughly.**

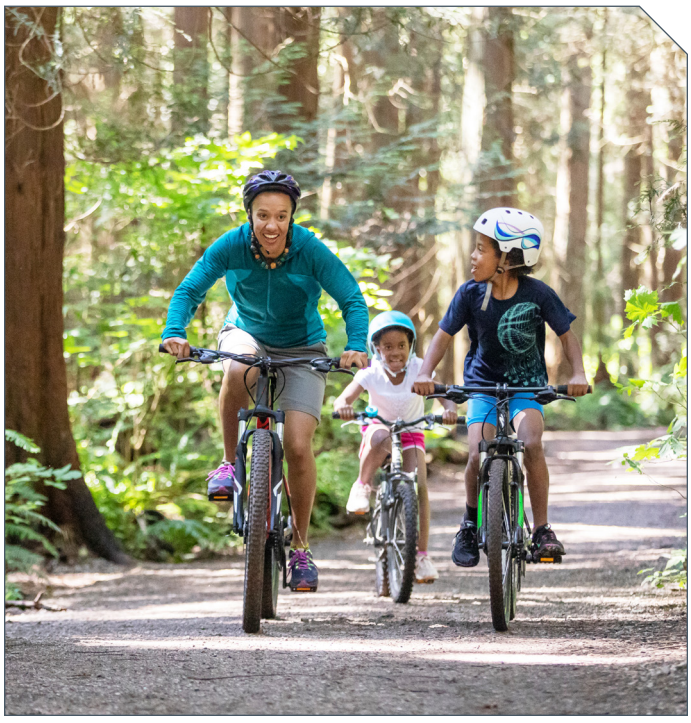
2026

# What's Inside



### Enrollment Reminders:

- If you enroll in the HDHP plan and do not make an employee contribution to your Health Savings Account, you will not receive the company contribution.
- Download your Alight Digital ID card- it lists all of your benefit enrollments conveniently on one card!
- Insurance ID Cards: Only newly enrolled employees or employees making changes to their medical or dental plan will be receiving new cards. You can always download an ID card through the carrier website.
- This is a great time to name your life insurance beneficiaries!



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# *Prioritize Your Health and Wellbeing*

## A MESSAGE FROM MATT BITTNER, PARTNER AND CHIEF PEOPLE OFFICER

Our people are our most precious resource and represent our future potential as an organization. Accordingly, we invest in you in many ways including through a robust benefits offering. We want to make it easy for you to prioritize life both in and outside of work, and we strive to keep your benefits competitive and affordable despite rising healthcare costs. Dealer Tire's holistic support platform and long term resources can help you plan for your year ahead and support you no matter where you are on your wellbeing journey.

Take advantage of the tools and resources provided to help you navigate the benefits and programs available to you and your family. This enrollment guide and the **DTFOC Benefits Resource Website** make it easier to explore your options, allowing you to make more informed decisions now and throughout the year!

Your benefits are a key part of our commitment to supporting your health, wellbeing, and financial security.

Thank you for being proactive and engaged. We are proud to offer benefits, programs, and resources that reflect the value we place on each of you.

### *Have Questions About Your Benefits?*

1. Visit **dtfamilybenefits.com**. Your one-stop-shop for benefits information.
2. During your enrollment window, schedule an appointment with an Alight Benefits Education Center Counselor by visiting the following link: **https://dtfoc.myenrollmentinfo.com**.
3. Visit the Contacts section of this guide to find key contacts and reach out directly to the vendors.

# *When You Can Enroll*

## New Hire Enrollment

Welcome to our team! As a new employee, you could be eligible for coverage as soon as the first of the month following date of hire. You must enroll in benefits within 30 days of your date of hire.

Upon separation from employment, regardless of the reason, your benefits will end at midnight on the date of termination.

## Annual Open Enrollment

Annual open enrollment is your yearly opportunity to review your current benefits and make changes for the upcoming plan year. During annual enrollment, you can add, change, or decline coverage. You can also add and/or drop family members for coverage during this time.

## Changing Your Benefits Mid-Year

Once you make your elections, you will not be able to make changes until next year's annual open enrollment unless you experience a qualifying life event. Examples of qualifying events include the following:

- Change of legal marital status (e.g., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (e.g., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status
- Employee or dependent coverage gain or loss from another plan

You must make changes to your benefits within 30 days of your qualifying life event. If you do not make changes during this time, you may have to wait until next year's open enrollment to make your change.

If your coverage was effective in the past, you will be charged for benefit changes retroactively in your next paycheck.

# *Benefits Eligibility*

## Covering Yourself

Full-time employees who are actively working a minimum of 30 hours per week are eligible for coverage. Part-time employees who are regularly scheduled to work less than 30 hours per week can elect medical, dental, and vision benefits; however, they will pay the full benefit premium (not reflected in this document).

**Note:** Dent Wizard part-time employees are not eligible to participate in the DTFOC healthcare benefit plans.

## Covering Your Family Members

Eligible dependents generally include your legally married spouse and children up to age 26. Some age limitations may apply to specific insurance programs. Children may include natural, adopted, step-children, or children obtained through court-appointed legal guardianship.

## Eligibility Documentation

Please be prepared to share dependent eligibility information during enrollment including date of birth and Social Security Numbers. Other documentation may be required depending on your elections.

As part of our ongoing commitment to maintaining the integrity and affordability of our benefits program, we will be conducting a Dependent Eligibility Verification Audit (DEVA) through Alight. This audit ensures that only eligible dependents are enrolled in our health insurance plans.

## What Is DEVA?

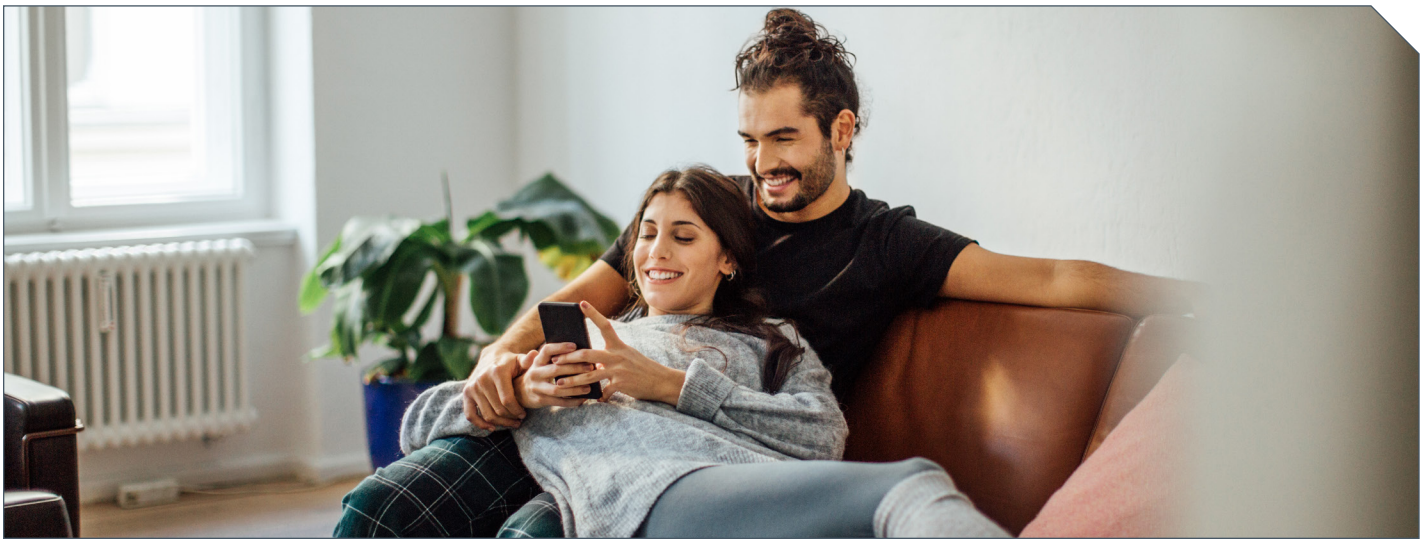
A Dependent Eligibility Verification Audit is a formal review process that verifies whether individuals enrolled as dependents under the DTFOC medical, dental, and vision plans meet the eligibility criteria. This includes spouses, children, and other dependents as defined by our plan rules and applicable regulations.

## Why Are We Doing This?

- Cost Containment: Covering ineligible dependents increases healthcare costs for everyone. Audits help reduce unnecessary expenses and protect the plan's financial health.
- Compliance: Ensuring that our benefits program complies with federal and state regulations is essential. Covering ineligible individuals can lead to tax issues and personal liability for plan fiduciaries.
- Fairness: This process helps maintain fairness for all employees by ensuring that benefits are provided only to those who qualify.

## What to Expect

- Communication Campaign: You'll receive instructions from our audit partner, Alight, explaining what documentation is required.
- Required Documents: You may be asked to submit items such as marriage certificates, birth certificates, or other proof of relationship.
- Timeline: Alight will provide a timeline for submission of required documents.



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# *How to Enroll*

## Online DTFOC Benefits Resource Website

- **www.dtfamilybenefits.com**
- Houses all your benefit information, plan documents, and contacts
- Access to important employee notices
- Learn more about Carrum and Alight

## Alight Benefits Education Center

### Get Personalized Enrollment Guidance

Alight provides you with a personalized enrollment experience. Licensed Benefits Counselors who know the ins and outs of our benefits will be available to answer your specific questions. Counselors are knowledgeable and trained to provide you with the best program and plan recommendations for your situation.

### Make an Appointment

Appointments are available on a first come, first served basis. Time slots will be available throughout the enrollment period, and signing up now will ensure you find a time that fits your schedule.

Go online to **https://dtfoc.myenrollmentinfo.com** (or scan the QR code). Be sure to:

- Provide the phone number the counselor should use to call you
- Opt in for text messages so you get a reminder
- Enter your email address so you get a confirmation of your appointment

### Be Prepared

It's important to be prepared for your meeting! During the one-on-one enrollment meeting, the Counselor can answer your benefit related questions. Be sure to have the following with you so you're ready to go:

- Full names, birth dates, and Social Security Numbers of any dependents you are adding
- Full names for those you want listed as beneficiaries
- Any questions you may have!

## Workday

Visit Workday to validate your benefits and make your benefit elections.
**www.wd5.myworkday.com/wday/authgwy/dealertire/login.htmld**

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# *Carrum Health*

## What is Carrum Health?

Carrum Health is a specialty healthcare benefit available for employees and family members (18+) enrolled in any of our Aetna Medical Plans.

With Carrum Health, you and your covered dependents age 18+ will have access to top surgeons, cancer specialists, and alcohol and substance use treatment centers across the country—providers with better outcomes and strong patient reviews.

And when you receive care through Carrum Health, all care and treatment costs, including travel, if needed, are covered. This is with the exception of second opinions and individuals enrolled in a High Deductible Plan, deductible must be met first.

### Better Outcomes

The providers in Carrum Health's program achieve better outcomes and have exceptional bedside manner.

### No Surprise Bills

When you receive care through Carrum Health, Dealer Tire Family of Companies covers most, if not all, of the medical costs.*

### Dedicated Support

You or your loved one will receive personalized support throughout your journey so you can focus on your health.

For more information, visit **carrum.me/DTFOC**, call **888.855.7806**, or scan the QR code:

* With the exception of second opinions, individuals enrolled in a high-deductible plan must first meet their deductible, but oftentimes copays and coinsurance will be waived. Second opinions are typically provided at no cost to members and do not require payment of any deductible. Per IRS rules, a portion of any covered travel expenses will be reported as taxable income to the covered member.

# *Alight Navigation*

Navigating healthcare can be complex and confusing. As part of your benefits, you have access to online resources and experts who can help you make the most of your health coverage and guide you towards informed clinical decisions. This valuable benefit is available at no cost to you and your eligible dependents.

You will have a dedicated Health Pro for all your benefit-related questions. **Instead of calling Aetna, reach out to your Alight Health Pro.** Your Health Pro will advocate and work with Aetna and providers on your behalf. Let your Health Pro do the heavy lift, giving you back more time in your day! **Health Pro Connection is a mobile-friendly platform where you can:**

- View information about your health plan coverage
- Choose in-network, top-notch, medical, dental, and vision professionals
- Compare costs and make informed healthcare decisions
- Connect with highly trained professionals who can help you work through questions about your insurance and medical options
- Find which lower-cost medications are available
- Set up medical appointments that fit your schedule
- Confirm benefits coverage was properly applied
- Solve billing issues
- Connect you with other benefits offered by your employer
- Connect with a Medical Ally to understand a diagnosis and all available treatment options

Your Medical Ally can help you with any medical condition, and if you need surgery, can help you understand the risks and benefits, alternative and non-surgical treatment options, and pain management techniques. Additionally, if your doctor recommends elective lower back surgery, hip or knee replacement, weight loss surgery, or hysterectomy, you may even qualify for a $400 prepaid card just for learning more (terms and conditions may apply).

Take advantage of your benefits today. Log in to Health Pro Connection to view your benefits information or connect with your Health Pro or Medical Ally at **worklife.alight.com/DTFOC**.

**What happens when I connect with my Health Pro?** A representative will greet you and may request your name, employer, DOB, and the last 4 digits of your SSN to confirm your identity and locate you in the system. Once the message or call has been secured, your Health Pro will gather details around your need. Many cases can be handled on the first exchange, but if your service requires additional research, they will triage your request and let you know when you can expect to receive an update. Your Health Pro interaction is 100% confidential and your Health Pro will never share your personal information.

# Medical and Prescription Drugs

The Dealer Tire Family of Companies partners with Aetna to offer Medical and Prescription Drug insurance.

## Plan Highlights

You have the option of choosing one of four plans through Aetna. Our plans offer coverage for most healthcare services. When you receive care in-network you benefit from our negotiated discounts with Aetna.

## Aetna Member Site

Visit **www.aetna.com** or download the Aetna App to take advantage of all the helpful tools and resources available including the following:

- In-network provider and pharmacy searches
- A list of prescription drugs covered by our plans
- Access to temporary ID cards and means to order another ID card
- Information regarding paid and pending claims

## Spousal Surcharge

A spousal surcharge of $100 per month will apply to your 2026 medical contributions if you have a spouse on the plan who is offered coverage through their employer.

### *What is a Network?*

A network is a group of providers your plan contracts with at discounted rates. You will almost always pay less when you receive care in-network.

If you choose to see an out-of-network provider, you may be balance billed, which means you will be responsible for charges above Aetna's reimbursement amount.

Your plan network is the Aetna Choice POS II (Open Access) Network.

### *Important Insurance Terms*

- **Deductible**: The amount of money you are responsible for paying up-front before your plan shares your costs
- **Coinsurance**: The percentage you and the plan pay; in our plans, you pay a smaller percentage and the plan pays a larger percentage
- **Copay**: A fixed amount for certain services you pay in some of our plans
- **Out-of-pocket maximum**: The limit on your expenses; once you reach this limit, the plan covers all eligible expenses for the remainder of the plan year
- **Formulary**: List of prescription drugs covered by your plan. Your Aetna plans access the Aetna Standard Open Formulary listing.

## Employee Bi-Weekly Medical Contributions

| | PPO 1 | PPO 2 | PPO 3 | HSA |
|---|---|---|---|---|
| Employee Only | $146.38 | $102.15 | $52.22 | $78.40 |
| Employee and Spouse | $313.30 | $224.31 | $140.80 | $174.08 |
| Employee and Child(ren) | $278.23 | $197.01 | $130.72 | $152.94 |
| Family | $414.44 | $312.30 | $213.76 | $236.90 |

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# Medical Plan Details

| | Aetna | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | PPO 1 | | PPO 2 | | PPO 3 | | HSA Plan | |
| Coverage | In-Network | Non-Network | In-Network | Non-Network | In-Network | Non-Network | In-Network | Non-Network |
| Deductible (embedded)* | | | | | | | | |
| Individual | $1,200 | $1,800 | $1,500 | $2,250 | $1,800 | $4,100 | $3,400 | $5,100 |
| Family | $3,600 | $5,400 | $4,500 | $6,750 | $5,400 | $12,300 | $6,800 | $10,200 |
| Coinsurance | 85% | 70% | 80% | 60% | 70% | 40% | 80% | 60% |
| Maximum Out-of-Pocket (embedded)* | | | | | | | | |
| Individual | $5,000 | $7,500 | $6,000 | $9,000 | $7,500 | $11,600 | $4,500 | $6,750 |
| Family | $10,000 | $15,000 | $12,000 | $18,000 | $15,000 | $34,800 | $9,000 | $13,500 |
| Preventive Care | | | | | | | | |
| | No cost | Ded+30% | No cost | Ded+40% | No cost | Ded+60% | No cost | Ded+40% |
| Office Visits | | | | | | | | |
| Primary Care | $25 copay | Ded+30% | $30 copay | Ded+40% | $75 copay | Ded+60% | Ded+20% | Ded+40% |
| Specialists | $35 copay | Ded+30% | $40 copay | Ded+40% | $100 copay | Ded+60% | Ded+20% | Ded+40% |
| Hospital Care | | | | | | | | |
| Inpatient Coverage | Ded + 15% | Ded + 30% | Ded + 20% | Ded + 40% | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 40% |
| Outpatient Surgery | Ded + 15% | Ded + 30% | Ded + 20% | Ded + 40% | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 40% |
| Outpatient Short-Term Therapy (limited to 60 visits per year) | | | | | | | | |
| Speech | $35 copay | Ded + 30% | $40 copay | Ded + 40% | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 40% |
| Physical | $35 copay | Ded + 30% | $40 copay | Ded + 40% | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 40% |
| Occupational | $35 copay | Ded + 30% | $40 copay | Ded + 40% | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 40% |
| Mental Health Services | | | | | | | | |
| Inpatient | Ded + 15% | Ded + 30% | Ded + 20% | Ded + 40% | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 40% |
| Office Visits | $35 copay | Ded + 30% | $40 copay | Ded + 40% | $100 copay | Ded + 60% | Ded + 20% | Ded + 40% |
| Emergency Room | | | | | | | | |
| | $500 copay | $500 copay | $500 copay | $500 copay | Ded + 30% | Ded + 60% | Ded + 20% | Ded + 20% |
| Urgent Care | | | | | | | | |
| | $50 copay | Ded + 30% | $75 copay | Ded + 40% | $150 copay | Ded + 60% | Ded + 20% | Ded + 40% |
| Prescription Drug | | | | | | | | |
| Deductible | N/A | N/A | N/A | N/A | $150/$450 waived for Tier 1 | $150/$450 | Included in medical | Included in medical |
| Retail | | | | | | | | |
| Tier 1 | $15 copay | Not covered | $15 copay | Not covered | $10 copay | Not covered | Ded + 20% | Not covered |
| Tier 2 | $25 copay | Not covered | $30 copay | Not covered | $50 copay | Not covered | Ded + 20% | Not covered |
| Tier 3 | $45 copay | Not covered | $50 copay | Not covered | $75 copay | Not covered | Ded + 20% | Not covered |
| Tier 4 | 20% up to $200 | Not covered | 20% up to $200 | Not covered | Not applicable | Not applicable | Ded + 20% | Not covered |
| Mail Order (after 2 fills required to fill 90-day supply through CVS Mail Service) | | | | | | | | |
| Tier 1 | $30 copay | Not covered | $30 copay | Not covered | $20 copay | Not covered | Ded + 20% | Not covered |
| Tier 2 | $50 copay | Not covered | $60 copay | Not covered | $100 copay | Not covered | Ded + 20% | Not covered |
| Tier 3 | $90 copay | Not covered | $100 copay | Not covered | $150 copay | Not covered | Ded + 20% | Not covered |
| Tier 4 | 20% up to $200 | Not covered | 20% up to $200 | Not covered | Not applicable | Not applicable | Ded + 20% | Not covered |

* Embedded means if covering a dependent on the plan each individual enrolled is capped at the individual level.

This is a high level summary of your benefit coverage. Full coverage details and summaries are available at **www.dtfamilybenefits.com/medical-plan/**. In the event there is a discrepancy between what is reflected in this guide and what is communicated in your summaries, the terms of your summaries will prevail.

# *Aetna Resources*

To explore the Aetna resources listed below, log in to your account at **aetna.com** or visit **dtfamilybenefits.com**.

## CVS HealthHUB

CVS HealthHUB and Minute Clinic locations offer you access to a professional care team including nurse practitioners, physician assistants, and pharmacists who work together to help you get the best care for your needs. Whether you need treatment for a sudden illness like the flu or managing a chronic condition like diabetes. The best part is if you are on our Aetna PPO 1, PPO 2, or PPO 3 plan your visit is $0!

## Aetna Transform Diabetes Care Program

Transform Diabetes Care is a FREE program that provides a personalized, comprehensive approach to diabetes management. For more information on how to access this free program, contact Aetna.

## Aetna Back and Joint Care Program

Suffering from back or joint pain? Aetna members age 18+ have access to Hinge Health Coaches for education and guidance in dealing with pain. Plus you get access to online therapy that is convenient and effective in reducing pain, all from the comfort of your own home. For more information on how to enroll in this FREE program, contact Aetna.

## Transform Oncology Program

A cancer diagnosis is life-changing. Aetna is here for you with resources and support you may need to manage your care, understand your benefits, and locate the right providers.

## CVS Weight Management Program

Managing your health is important to you which is why we have partnered with the CVS Weight Management Program to help get you more from your medication. **If you are prescribed a weight loss medication, we do require enrollment in this program before you can receive your script.** Learn more online by logging into your Aetna member portal.

## 24-Hour Nurse Line

Talk to a registered nurse anywhere, anytime! This free resource is available to all members and covered family members. Nurses are available 24/7 to answer any of your healthcare questions or point you in the right direction.

## Discounts

Did you know just for being an Aetna member, you have access to healthy lifestyle discounts? It's true! Aetna's partners provide you and your family savings on eyewear and exams, healthy lifestyle choices, natural products and services, gym memberships, and even options on hearing aids and exams. Once enrolled, shop around at **www.aetna.com**.

## App

Your health... there's an app for that! Download the Aetna Health app today by texting AETNA to 90156 or searching for the Aetna Health app at your app store. This app allows you to view your health plan summary and claims, find an in-network provider, receive cost estimates, and easily download your ID card. Find many more resources on the app today!

# CVS Virtual Primary Care

Access to virtual care is included for members covered under an Aetna medical plan. Get access to convenient and affordable care whenever and wherever you need it. Copays may apply. This includes:

- Primary care appointments—See your selected virtual primary care provider within days of scheduling for preventive care, annual wellness visits, sick visits, prescriptions, and chronic disease management
- 24/7 on-demand medical care—Connect quickly and easily with a licensed physician virtually for minor illnesses and injuries
- Mental health services—Schedule talk therapy visits with licensed therapists and get access to mental health counseling for things like anxiety, stress, and depression

# What to Expect with Virtual Primary Care

When you schedule your first virtual primary care appointment, CVS will mail you a welcome kit that includes a device to measure your blood pressure and heart rate and instructions on how to use it.

Once you have your first visit, your dedicated Care Team will help you create a plan to manage your health. Your Care Team will be available every day during business hours and you can securely message them 24/7. Visit CVS Virtual Care at **CVS.com/virtual-care** to register and select your virtual primary care provider.

## *Enhanced Women's Health Resources*

### MAVEN ENHANCED MATERNITY PROGRAM

Maven provides 24/7 virtual care at no cost for Aetna members and their partners for fertility and family building such as IVF, IUI, egg-freezing; adoption and surrogacy; pregnancy; and 3 months of postpartum. You can use Maven to book unlimited coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, doulas, lactation consultants, nutritionists, mental health specialists, and sleep coaches. Plus you get access to Maven's library of virtual and on-demand classes covering everything from infant CPR to stress management and prenatal yoga, along with content personalized to your journey. Learn more and register at **mavenclinic.com/join/takecare**.

### MIDI

Midi is a virtual care clinic created by specialists in perimenopause and menopause to provide a path to symptom relief. Midi treatment is personalized, evidence-based, and fine-tuned to deliver real results. Join Midi and create your account to meet with your Midi clinician who will listen to your concerns, symptoms, and medical history, then create your personalized Care Plan. If you need tests, Midi's care coordinators will send you to a convenient local lab. Get started today by visiting **joinmidi.com**.

### GENNEV

This virtual menopause clinic led by board-certified OB/GYNs and Registered Dietitian Nutritionists is available in all 50 states. Visit **gennev.com** to get started today.

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# *HealthWi$e Wellbeing Program*

Powered by Personify Health, this program helps you get active, improve your health, and focus on your overall wellbeing.

## Earn Premium Credits with Ease

Complete **all** required actions to receive:

- ▶ $400 in premium credits toward your 2027 DTFOC medical plan
- ▶ $100 in Rewards Cash

Required actions for employees:

- ☑ Complete Health Risk Assessment
- ☑ Complete Annual Physical Exam/Biometric Screening
- ☑ Complete One Additional Preventive Exam
- ☑ Earn 200 points from Additional Wellness Activities

## Spouse Incentives

Your spouse can earn up to:

- ▶ $75 in additional premium credits
- ▶ $25 in Rewards Cash

By completing three or more of the following actions:

- ☑ Health Risk Assessment
- ☑ Biometric Screening
- ☑ Preventive Care Verification Form
- ☑ Telephonic Coaching Call

Engage with Alight Navigation Support and earn additional points!

### *Getting Started with the HealthWi$e Wellbeing Program*

**ENROLL ANYTIME**

Log into Workday and enroll in the HealthWi$e Wellbeing Program at your convenience. Keep an eye out for a welcome email with step-by-step login instructions to get started.

**NEED MORE INFORMATION?**

Visit **dtfamilybenefits.com** for program details and helpful resources.

# Dental

We partner with Delta Dental of Ohio to offer you and your family members Dental insurance. Visit **www.deltadentaloh.com** to find in-network providers and access a variety of online tools and programs.

**If you are enrolling in dental for the first time, or making a change, an ID card will be mailed. Your Dental ID card is also available online at www.deltadentaloh.com or on the app.**

Please Note: If both spouses work for The Dealer Tire Family of Companies, dual coverage is not offered.

## Finding In-Network Providers

Remember to visit in-network dentists to receive the deepest level of discount on your services.

To find a participating in-network dentist in your area, go to **www.deltadentaloh.com** or call **800-524-0149**.

## Orthodontia Services Note

The lifetime maximum illustrated is different from the calendar year maximum. For orthodontia services, this limit does not reset each year, this is the most your plan will cover for your child's services for the lifetime of your participation in this program.

## Examples of Services

- **Preventive**—exams, cleanings, fluoride, X-rays, and sealants
- **Basic**—fillings, extractions, periodontics, repairs, and oral surgery
- **Major**—crowns, inlays, dentures, and dental implants

| | Low PPO | | High PPO | |
|---|---|---|---|---|
| | In-Network | Out-of-Network* | In-Network | Out-of-Network* |
| **Calendar Year Deductible** | | | | |
| Individual | $50 | $75 | $50 | $50 |
| Family | $150 | $225 | $150 | $150 |
| **Calendar Year Maximum** | | | | |
| | $1,000 | $1,000 | $1,500 | $1,500 |
| **Coinsurance** | | | | |
| Preventive | 100% | 90% | 100% | 100% |
| Basic | 80% | 60% | 90% | 80% |
| Major | 50% | 40% | 60% | 50% |
| **Orthodontia—Child(ren) up to age 19 only are eligible** | | | | |
| Coinsurance | N/A | N/A | 60% | 50% |
| Lifetime Maximum | N/A | N/A | $1,200 | $1,200 |

This is a high level summary of your benefit coverage. Full coverage details are available in your Certificate of Insurance (COI). In the event there is a discrepancy between what is reflected in this guide and what is communicated in your COI, the terms of your COI will prevail.

* When you receive services from a non-participating dentist, the percentages in this column indicate the portion of Delta Dental's non-participating dentist Fee that will be paid for those services. This amount may be less than what the dentist charges and you are responsible for that difference.

# Employee Bi-Weekly Dental Contributions

| | Low Plan | High Plan |
|---|---|---|
| Employee Only | $5.40 | $9.20 |
| Employee and Spouse | $9.92 | $19.33 |
| Employee and Child(ren) | $14.11 | $17.49 |
| Family | $20.15 | $25.69 |

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# Vision

We partner with VSP to offer you and your family members Vision insurance. Visit **www.vsp.com** to find in-network providers and access to a variety of online tools and programs.

| | In-Network |
|---|---|
| **Copay** | |
| Exam | $10 |
| Materials | $25 |
| **Frames** | |
| Frames Allowance | $175 |
| Featured Frames Allowance (check out **vsp.com/offers**) | $195 |
| Frequency Limitations | Every 12 months |
| **Lenses** | |
| Single Vision, Lined Bifocal, and Lined Trifocal | Copay included in materials |
| Anti-Glare Coating | $0 copay |
| Tints/Light-Reactive | $0 copay |
| Standard Progressive Lenses | $0 copay |
| Premium Progressive Lenses | $95-$105 |
| Custom Progressive Lenses | $150-$175 |
| Frequency Limitations | Every 12 months |
| **Contacts (instead of glasses)** | |
| Contacts Allowance | $175 |
| Contact Lens Exam (fitting and evaluation) | Up to $60 |
| Frequency Limitations | Every 12 months |
| **Out-of-Network Benefits** | |
| Exam | Up to $45 |
| Frame | Up to $70 |
| Single Vision Lenses | Up to $30 |
| Lined Bifocal Lenses | Up to $50 |
| Lined Trifocal Lenses | Up to $65 |
| Progressive Lenses | Up to $50 |
| Contacts | Up to $105 |

This is a high level summary of your benefit coverage. Full coverage details are available in your Certificate of Insurance (COI). In the event there is a discrepancy between what is reflected in this guide and what is communicated in your COI, the terms of your COI will prevail.

## Employee Bi-Weekly Vision Contributions

| | Vision Plan |
|---|---|
| Employee Only | $3.95 |
| Employee and Spouse | $5.72 |
| Employee and Child(ren) | $6.80 |
| Family | $10.87 |

**If you are enrolling in Vision, no ID card is mailed. Your Vision ID card is available online at www.vsp.com or on the app.**

### *Finding In-Network Providers*

Remember to visit in-network providers to receive the deepest level of discount on your services.

To find a participating in-network provider in your area, go to **www.vsp.com** or call **800.877.7195**.

# Health Savings Account (HSA)

The Dealer Tire Family of Companies partners with Fidelity to administer our Health Savings Account. A Health Savings Account (HSA) is a tax-favored personal savings account which works with your High Deductible Health Plan. HSA dollars can be used to pay for qualified medical expenses such as deductibles, copays, dental, and vision care. For a complete list of qualified medical expenses visit **www.irs.gov** in **IRS Publication 502**. HSA elections do not rollover from year to year. An election will need to be made each year during open enrollment.

To be eligible for the DTFOC HSA employer contribution, you are required to make an annual minimum contribution of $52 to your Health Savings Account. Dealer Tire Family of Companies will be contributing the following, incrementally per pay period.

- Employee only: Up to $500 annually
- Employee and spouse: Up to $1,000 annually
- Employee and child(ren): Up to $1,000 annually
- Family: Up to $1,000 annually

## HSA Major Benefits

- Funds always belong to you
- Funds always roll over from year to year
- Lowers your taxable income
- Helps you build a healthcare nest egg for emergencies or retirement

## HSA Triple Tax Savings

- Tax deduction when you contribute to your account
- Tax-free earnings through investment
- Tax-free withdrawal for qualified medical expenses

| 2026 HSA Funding Limits | |
|---|---|
| Coverage Level | Limit |
| Individual Coverage | $4,400 |
| Family Coverage | $8,750 |
| Age 55 or Older | Contribute an additional $1,000 on top of these amounts |

## Opening an HSA

We partner with Fidelity to administer our HSA program. You can find information about your HSA by visiting **netbenefits.com** or calling **800.544.3716**. In enrolling in an HSA for the first time, you will receive a Welcome Kit in the mail which will include your new HSA debit card. If you do not receive this, please reach out to Fidelity for further instructions. HSA dollars will be available in your account once deposits have occurred. Employer and employee contributions are pulled each paycheck.

### *HSA Eligibility*

You may open and contribute pre-tax to an HSA under the following circumstances.

- Enrolled in an IRS qualified High Deductible Health Plan (HDHP)
- Not enrolled in a traditional PPO Plan through your spouse or other employer sponsored plan options
- Not enrolled in a Government sponsored program (Medicare, Medicaid, Tricare, etc.)
- Have not received VA benefits within the last three months (unless receiving benefits for a service related disability)
- Not claimed as a dependent on someone else's tax return
- Cannot be enrolled in a Healthcare FSA, your spouse also cannot have a Healthcare FSA through his/her own employer

# *Flexible Spending Account (FSA)*

We partner with Fidelity to offer three types of FSA programs. A Flexible Spending Account (FSA) allows you to set aside pre-tax dollars from your paycheck to cover qualified expenses you would normally pay out of your pocket. FSA elections do not roll over from year to year. An election will need to be made each year during our annual open enrollment.

## Healthcare FSA

The Healthcare FSA helps you pay for certain IRS-approved medical expenses not covered by your insurance plan with pre-tax dollars. The maximum contribution to the Healthcare FSA is $3,400 per plan year.

If any funds remain in your Healthcare FSA at the end of the current plan year, you can carryover up to $680 into the next year. Your carryover balance can be used at any time for expenses incurred in the new plan year (in addition to the elected payroll deductions).

Funds you elect to contribute to the Healthcare FSA are available in full on the first day of the plan year. For example, if you elect to contribute $1,000, the full election is available to you on day one. You'll continue to pay for the election pre-tax from your paycheck throughout the plan year.

## Limited Purpose FSA

The Limited Purpose FSA lets you set aside pre-tax dollars only for qualified dental and vision care. The maximum you may contribute to the Limited Purpose FSA is $3,400 per plan year, and you are allowed to carry over up to $680 into the next year. This spending account is intended for employees enrolled in the HSA compatible health plan. By providing pre-tax funds for dental and vision expenses, it allows you to further reduce taxable income and save more of your HSA funds for medical expenses. You cannot enroll in a Limited Purpose FSA and a Healthcare FSA in the same year.

## Dependent Care FSA

The Dependent Care FSA lets you set aside pre-tax dollars to use toward qualified dependent care. The maximum amount you may contribute to the dependent care FSA is $5,000 (or $2,500 if married and filing separately) per plan year. Your FSA funds via your payroll contributions. FSA funds are only available once they are deducted from your paycheck and credited to your FSA account.

Dependent Care FSA contributions may be subject to change based on required annual IRS non-discrimination testing.

## Use It or Lose It

Carefully consider your FSA contribution amounts for the plan year. At the end of the year, you may lose some unused dollars. Your plan has a rollover provision in place. This means you can roll over up to $680 to be used in next plan year. This rollover amount is in addition to the annual maximum.

## *Eligible Expenses*

### HEALTHCARE FSA

- Doctor's visit copays
- Prescription drug copays
- Medical and dental deductibles
- Certain over-the-counter medications (with a written prescription)
- Hearing aids
- Eyeglasses

### DEPENDENT CARE FSA

- Cost of child or adult day care*
- Nursery school
- Preschool (excluding kindergarten)

### LIMITED PURPOSE FSA (HSA MEDICAL PLAN ONLY)

- Dental and vision copays
- Dental and vision deductibles
- Eyeglasses

* An eligible dependent is a tax dependent child under age 13 or a tax dependent spouse, parent, or child unable to care for themselves.

### WHO IS A QUALIFIED DEPENDENT UNDER THE DEPENDENT CARE FSA?

Dependent under the age of 13.

Dependent or spouse of employee who is mentally or physically disabled and whom the employee claims as a dependent on their federal income tax return.

### DOES MY DAY CARE PROVIDER HAVE TO BE LICENSED?

No. However, you are required to submit their Tax Identification Number or Social Security Number when filing your federal income tax return.

### MY CHILD ATTENDS CAMP DURING THE SUMMER. IS THIS ELIGIBLE?

Generally, no. However, if the camp is a day camp and your dependent attends to allow you and your spouse (if married) to work, look for work or attend school Full-time, then yes, this would be an eligible expense. Overnight camps are specifically excluded.

### DOES MY DAY CARE PROVIDER HAVE TO BE 18?

No, but the individual must claim the money as income on their tax return.

# *Life and Disability Insurance*

Life and Disability insurance is provided through Reliance Matrix.

## Basic Life and Accidental Death and Dismemberment (AD&D)

The company automatically provides you a benefit of one times your annual salary (up to $300,000), at no cost to you, for Life insurance and Accidental Death and Dismemberment insurance.

## Employee Voluntary Life Insurance

You are eligible to purchase additional Life insurance in increments of $25,000 up to a maximum of $500,000, not to exceed five times your annual salary. The guaranteed issue amount is $250,000.

## Spouse and Dependent Voluntary Life Insurance

You must elect Voluntary Life Insurance for yourself in order to elect it for your dependents.

- Spouse: $12,500 increments to a maximum of $250,000, not to exceed 50% of employee's Voluntary Life Benefit; spouse rates are based on the employee's age; guaranteed issue amount is $50,000
- Child (birth to limiting age): $10,000; child limiting age is 26.

### *Naming a Beneficiary*

Naming a beneficiary for your life insurance ensures that they will distribute the policy proceeds the way you want after your death. Without beneficiary designations set, in the event of your death, benefits would be paid according to plan rules, which might be different from the designation you would choose.

| Supplemental Life—EE Only*<br>(per $1,000 of Covered Volume)<br>All Active Full-Time Employees** | |
|---|---|
| Less than 30 | $0.062 |
| 30-34 | $0.080 |
| 35-39 | $0.090 |
| 40-44 | $0.106 |
| 45-49 | $0.151 |
| 50-54 | $0.230 |
| 55-59 | $0.434 |
| 60-64 | $0.665 |
| 65-69 | $1.285 |
| 70+ | $2.083 |

| Supplemental Dependent Life*<br>(per $1,000 of Covered Volume)<br>All Active Full-Time Employees and Spouse** | |
|---|---|
| Less than 30 | $0.062 |
| 30-34 | $0.080 |
| 35-39 | $0.090 |
| 40-44 | $0.106 |
| 45-49 | $0.151 |
| 50-54 | $0.230 |
| 55-59 | $0.434 |
| 60-64 | $0.665 |
| 65-69 | $1.285 |
| 70+ | $2.083 |
| Child | $0.135 |

Age Reduction*: The Employer is responsible for making sure that the offer of insurance to its Employees under the program described complies, if applicable, with the Age Discrimination in Employment Act of 1967, as amended, ("ADEA"), and the regulations thereunder. The Employer should seek the advice of counsel as to whether ADEA applies to the program and, if so, whether it is in compliance with ADEA and other applicable laws. Reliance Matrix is required to comply with insurance age discrimination laws where applicable.

* The rates listed above are monthly.

** All reductions are applied to the original benefit amount.

### *What is Evidence of Insurability (EOI)?*

If EOI is required, this means you must provide certain information about your health in order for the insurance company to review your information and approve you for coverage. If you are electing coverage as a new hire, you do not have to submit EOI as long as you elect coverage below the guaranteed issue amount. You will, however, be required to submit EOI if you have previously waived this coverage, are a late entrant, are increasing your amount by more than one level increment, or you elect an amount above the guaranteed issue amount.

# Additional Voluntary Coverage

Regular expenses, big and small, can add up. Think about your ability to pay for those expenses if you or your family member experienced a covered accident or are diagnosed with an unexpected illness. Aetna's Accident, Critical Illness, and Hospital Indemnity Plans can supplement your health plan and provide you and your family with the additional financial protection you may need. These plans pay benefits directly to you and you decide how to use the benefit. To learn more about your plans, download the My Aetna Supplemental app or log into the member portal at **MyAetnaSupplemental.com** to view plan documents, submit and track claims, and sign up for direct deposit. Aetna Medical members can also visit **aetna.com** to access the member portal.

# Accident Coverage

Accidents can happen in an instant. When they do, medical bills can pile up quickly. Our Accident insurance pays you a tax-free benefit after a covered accident so you can focus on what's truly important—getting better. More than 150 events resulting from non-work-related injuries or accidents are covered by this plan.

| Coverage Level | Low Plan | | | High Plan | | |
|---|---|---|---|---|---|---|
| Category | Employee | Spouse | Child | Employee | Spouse | Child |
| Basic Accidental Death | $25,000 | $12,500 | $5,000 | $50,000 | $25,000 | $10,000 |
| Accidental Death Common Carrier | $75,000 | $37,500 | $15,000 | $150,000 | $75,000 | $30,000 |
| Basic Dismemberment/Functional Loss Benefit | $750-$10,000 | $750-$10,000 | $750-$10,000 | $1,000-$15,000 | $1,000-$15,000 | $1,000-$15,000 |
| Catastrophic Dismemberment/ Functional Loss Benefit | $20,000 | $20,000 | $20,000 | $40,000 | $40,000 | $40,000 |
| Paralysis Benefit | $10,000-$20,000 | $10,000-$20,000 | $10,000-$20,000 | $20,000-$40,000 | $20,000-$40,000 | $20,000-$40,000 |
| Fracture Benefit (closed) | $100-$4,000 | $100-$4,000 | $100-$4,000 | $200-$5,000 | $200-$5,000 | $200-$5,000 |
| Fracture Benefit (open) | $200-$8,000 | $200-$8,000 | $200-$8,000 | $400-$10,000 | $400-$10,000 | $400-$10,000 |
| Dislocation Benefit (closed) | $100-$4,000 | $100-$4,000 | $100-$4,000 | $200-$5,000 | $200-$5,000 | $200-$5,000 |
| Dislocation Benefit (open) | $200-$8,000 | $200-$8,000 | $200-$8,000 | $400-$10,000 | $400-$10,000 | $400-$10,000 |
| Burn Benefit | $75-$10,000 | $75-$10,000 | $75-$10,000 | $100-$15,000 | $100-$15,000 | $100-$15,000 |
| Concussion | $250 | $250 | $250 | $500 | $500 | $0 |
| Coma | $7,500 | $7,500 | $7,500 | $10,000 | $10,000 | $10,000 |
| Laceration | $50-$400 | $50-$400 | $50-$400 | $75-$700 | $75-$700 | $75-$700 |
| Broken Tooth | $25-$200 | $25-$200 | $25-$200 | $50-$300 | $50-$300 | $50-$300 |
| Eye Injury | $300 | $300 | $300 | $400 | $400 | $400 |
| Ground/Air Ambulance | $300-$1,000 | $300-$1,000 | $300-$1,000 | $400-$1,250 | $400-$1,250 | $400-$1,250 |
| Surgery | $150-$1,500 | $150-$1,500 | $150-$1,500 | $200-$2,000 | $200-$2,000 | $200-$2,000 |
| Health Screening Benefit | $50 | $50 | $50 | $50 | $50 | $50 |

| | Bi-Weekly Rates | |
|---|---|---|
| | Low Plan | High Plan |
| Employee | $3.07 | $4.40 |
| Employee + Spouse | $6.07 | $8.65 |
| Employee + Child(ren) | $7.07 | $10.02 |
| Family | $8.64 | $12.26 |

2026

# *Hospital Indemnity Plan*

It's scary enough being admitted into the hospital, so why worry about whether you'll be able to cover unexpected expenses? Hospital Indemnity insurance is a supplemental insurance plan designed to pay for the costs of a hospital admission that may or may not be covered by your insurance. The plan covers employees and their family members (based on enrollment) who are admitted to a hospital or ICU for a covered sickness or injury.

## Bi-Weekly Contributions

| | Low Plan | High Plan |
|---|---|---|
| Employee Only | $3.45 | $6.02 |
| Employee + Spouse | $9.19 | $16.51 |
| Employee + Children | $6.14 | $10.74 |
| Employee + Spouse and Children | $11.88 | $21.24 |

| Subcategory | Benefit Limits (Applies to Subcategory) | Benefit | Low Plan | High Plan |
|---|---|---|---|---|
| Hospital Benefits | | | | |
| Admission Benefit | 4 time(s) per calendar year | Admission | $500 | $1,000 |
| | | ICU supplemental admission (benefit paid concurrently with the admission benefit when a covered person is admitted to ICU) | $500 | $1,000 |
| Confinement Benefit | 15 days per calendar year ICU Supplemental Confinement will pay an additional benefit for 15 of those days | Confinement | $100 | $200 |
| | | ICU supplemental confinement (benefit paid concurrently with the confinement benefit when a covered person is admitted to ICU) | $100 | $200 |
| Confinement Benefit for Newborn Nursery Care | 2 day(s) per confinement | Confinement benefit for newborn nursery care | $25 | $50 |
| Other Benefits | | | | |
| Health Screening Benefit | 1 time(s) per calendar year per covered person | Health screening | $50 | $50 |

# Critical Illness Coverage

There are a lot of expenses associated with a critical illness, and a major medical plan usually won't cover them all. Critical Illness coverage helps you focus on recuperation instead of being distracted by the extra expenses you may be facing. Similar to Life insurance, which pays your beneficiary a lump-sum benefit upon death, a Critical Illness plan pays you a cash benefit upon a diagnosis of a covered illness. Covered diagnoses include but are not limited to the following.

- Cancer
- Heart attack
- Organ Failure
- Stroke

| Carrier | Aetna |
|---|---|
| Covered Condition | Initial Benefit |
| Benign Brain Tumor | 100% of benefit amount |
| Cancer Category | |
| Invasive Cancer | 100% of benefit amount |
| Non-Invasive Cancer | 25% of benefit amount |
| Skin Cancer | 5% of benefit amount, but not less than $250 |
| Cardiovascular Disease Category | 50% of benefit amount |
| Childhood Disease Category | 100% of benefit amount |
| Functional Loss Category | 100% of benefit amount |
| Heart Attack Category | 100% of benefit amount |
| Infectious Disease Category | 25% of benefit amount |
| Kidney Failure Category | 100% of benefit amount |
| Major Organ Transplant Category | 100% of benefit amount |
| Progressive Disease Category | 100% of benefit amount |
| Severe Burn Category | 100% of benefit amount |
| Stroke Category | 100% of benefit amount |
| Health Screening Benefit | Payable if an eligible covered person takes one of the screening/prevention measures—$50 |

| Critical Illness $15,000 Benefit Amount Bi-Weekly Rates | | | | |
|---|---|---|---|---|
| Age | Employee | Employee + Spouse | Employee + Child(ren) | Family |
| <25 | $1.86 | $3.00 | $2.86 | $4.05 |
| 25-29 | $2.16 | $3.48 | $3.19 | $4.56 |
| 30-34 | $2.74 | $4.48 | $3.90 | $5.59 |
| 35-39 | $3.44 | $5.54 | $4.63 | $6.73 |
| 40-44 | $4.73 | $7.47 | $5.88 | $8.63 |
| 45-49 | $6.73 | $10.43 | $7.96 | $11.66 |
| 50-54 | $10.35 | $15.41 | $11.55 | $16.61 |
| 55-59 | $15.07 | $21.72 | $16.35 | $22.99 |
| 60-64 | $21.65 | $30.59 | $22.87 | $31.80 |
| 65-69 | $30.85 | $42.92 | $32.08 | $44.21 |
| 70+ | $41.45 | $58.06 | $42.75 | $59.29 |

| Critical Illness $30,000 Benefit Amount Bi-Weekly Rates | | | | |
|---|---|---|---|---|
| Age | Employee | Employee + Spouse | Employee + Child(ren) | Family |
| <25 | $3.72 | $6.00 | $5.72 | $8.10 |
| 25-29 | $4.32 | $6.97 | $6.38 | $9.12 |
| 30-34 | $5.48 | $8.96 | $7.80 | $11.17 |
| 35-39 | $6.89 | $11.09 | $9.26 | $13.46 |
| 40-44 | $9.45 | $14.95 | $11.76 | $17.26 |
| 45-49 | $13.46 | $20.86 | $15.93 | $23.33 |
| 50-54 | $20.69 | $30.81 | $23.10 | $33.22 |
| 55-59 | $30.15 | $43.44 | $32.69 | $45.98 |
| 60-64 | $43.30 | $61.17 | $45.73 | $63.61 |
| 65-69 | $61.70 | $85.85 | $64.15 | $88.41 |
| 70+ | $82.91 | $116.11 | $85.50 | $118.59 |

## Wellness Benefit

This benefit pays $50 per calendar year per insured individual if a covered health screening test is performed, including blood tests, chest X-rays, stress tests, mammograms, and colonoscopies. Please contact Aetna regarding the full list of covered tests.

## Critical Illness Plan Options

- You have the choice of a $15,000 or $30,000 benefit amount.
- Spouses will be offered 50% and dependent child(ren) will be offered 50% of the employee benefit amount.
- Benefits are paid directly to you based on the benefit schedule.

# Short Term Disability (STD)

The company provides Short Term Disability (STD) insurance to help provide financial security until you get back on your feet and return to work. After meeting the required eligibility period, the plan covers 100% for first 6 weeks; max $2,500 per week; 60% for next 20 weeks; max $1,500 per week. There is a 7-day waiting period for illnesses and accidents.

| Carrier | Reliance Matrix |
|---|---|
| **Payment % and Weekly Benefit** | 100% for first 6 weeks; Max $2,500 per week 60% for next 20 weeks; Max $1,500 per week |
| Elimination Period | |
| Accident | 7 days |
| Illness | 7 days |
| **Benefit Duration** | 26 weeks |

**If you are a Dent Wizard employee classified as a Technician,** you are not eligible for company-paid Short Term Disability (STD). You can, however, elect Voluntary STD to help provide financial security until you get back on your feet and return to work. The plan covers 60% up to $1,500 per week. There is a 7-day waiting period for illnesses and accidents.

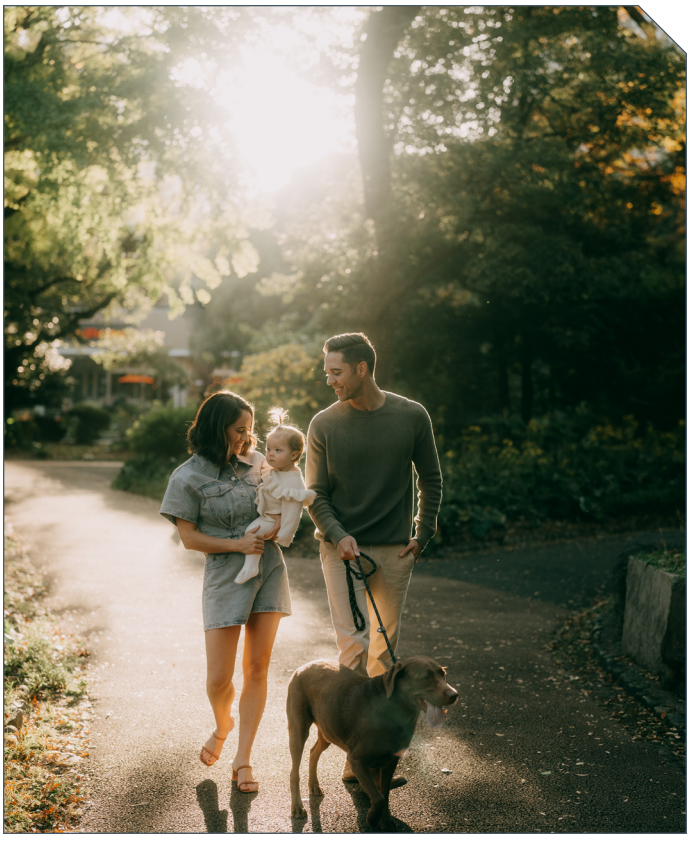
| Carrier | Reliance Matrix |
|---|---|
| **Payment % and Weekly Benefit** | 60% up to $1,500 |
| Elimination Period | |
| Accident | 7 days |
| Illness | 7 days |
| **Benefit Duration** | 26 weeks |

# Long Term Disability (LTD)

The company provides Long Term Disability (LTD) insurance to offer you financial assistance in the event you are unable to work for an extended period of time due to serious illness or non-work related injury. The plan covers 60% of your pre-disability earnings.

| Carrier | Reliance Matrix |
|---|---|
| **Payment %** | 60% |
| **Maximum Monthly Benefit** | Class 1 and 2: $6,000<br>Class 3: $12,000 |
| **Elimination Period** | 180 days |

| | Class Description |
|---|---|
| Class 1 | Full-time exempt and non-exempt employees working 30 hours |
| Class 2 | Full-time Warehouse employees working 30 hours |
| Class 3 | Full-time Directors, Vice Presidents, Senior Vice Presidents, and Partners working 30 hours |



# *Employee Assistance Program (EAP)*

We partner with Reliance Matrix to provide an Employee Assistance Program to help you and your family members find solutions and resources to tackle life's challenges. From simple questions such as quick ways to de-stress or how to find more time in your schedule, to more difficult issues such as finding support after the loss of a loved one, your program is there to work with you and offer suggestions, options, and information.

EAP specialists will confidentially discuss challenges you and your family may be facing and provide you with consultation, information, action plans, and resources within your community. Reliance Matrix's work-life balance Employee Assistance Program (EAP) offers online tool and resources. In addition, members receive up to 5 free counseling sessions per issue, per calendar year either in person or virtually.

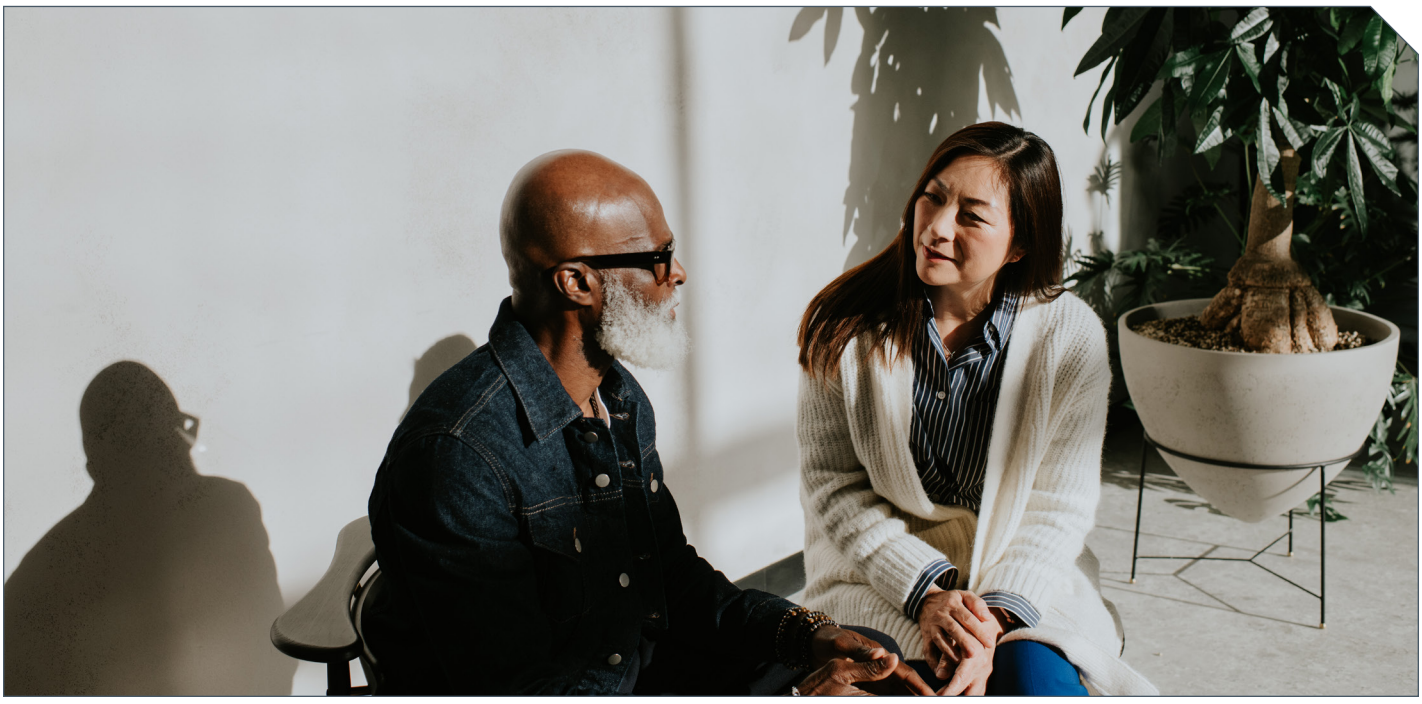
## Accessing the EAP

- Phone consultations: **855.775.4357**; unlimited calls, 24/7
- Online tools and resources: visit **https://reliance-matrix.mylifeexpert.com/**
- Log in or create an account using your work email address and company code: RSLI859

There are strict standards of confidentiality in place to protect your privacy. Treatment information is not shared with anyone without your written permission.

### *Counseling and Work-Life Services*

- Stress management
- Work and home relationships
- Depression and grief
- Alcohol and substance abuse
- Child, adult, and elder care
- Legal and financial consultations
- Identity theft



# *401(k) Savings Retirement Plan*

Dealer Tire LLC offers a 401(k) Savings Plan with Fidelity Investments, which includes a Roth 401(k) option.

- The Company Match is $0.50 on the dollar to a maximum of 7% of employee contributions.
- All employees, except for Interns, are eligible to participate.
- All employees must opt out or make an election within the 30-day window or they will be auto enrolled in the plan at 3% upon hire.
- The employee's deferral will automatically increase 1% on March 1 of every year (up to 10% maximum deferral). Employees may opt out of the auto-increase annually.

| Years of Vesting Service | Vesting Percentage |
|---|---|
| Less Than 1 Year | 0% |
| 1 Year | 0% |
| 2 Years | 50% |
| 3 Years or More | 100% |

## Savings Plan—401(k) Enhancements

The Savings Plan offers the following features. Review the information below and go to **www.401k.com** if you have any questions.

- **Super "Catch-up" Contributions:** The 401(k) plan now includes an increased catch-up contribution limit of $11,250 for employees who attain ages 60 to 63 by the end of the applicable tax year.
- **Mandatory Roth Catch-Up Contributions:** Effective January 1, 2026, if you are turning 50 or older and earn more than $145,000 in FICA wages in 2025 from Dealer Tire, any catch-up contributions must be made to a Roth after-tax account. This applies to both the standard catch-up for those age 50 and the super catch-up for those age 60 to 63.
- **Medicare Services:** A free resource for Medicare education, guidance and enrollment assistance. Fidelity's licensed insurance agents help you compare Medicare options and enroll—whether you are new to Medicare, want to adjust your existing Medicare coverage, or are helping a loved one. If you or a loved one is 64 or older, or eligible for Medicare due to disability, Fidelity can help. Call **833.886.0033** (TTY: 711), Monday-Friday, 8:30 a.m.-8 p.m. ET. Or visit **medicare.fidelity.com**.

# *Work-Life Harmony—Paid Time Off*

We know it's extremely important for our employees to maintain work-life harmony to reduce stress, prevent burnout, and enjoy their personal and professional lives. The DTFOC offers several programs to enhance work-life harmony, including a generous paid time off package, ability to work remotely, and paid holidays.

## Family Medical Leave Act (FMLA)

The DTFOC is committed to a workplace culture that helps employees balance their work and family responsibilities by allowing them to take unpaid leave for certain family and medical reasons. Family and medical leave provides eligible employees with up to 12 weeks of leave per year for the following reasons:

- The birth and care of a newborn child of an employee
- The placement with the employee of a child through adoption or foster care
- To care for an immediate family member (e.g., spouse, child or parent) with a serious health condition
- When the employee is unable to work because of a serious health condition

Employees are eligible for leave under FMLA if they have worked for the DTFOC at least 1,250 hours over the past 12 months. Military family leave provisions afford FMLA protections specific to the needs of military families. Employees should contact the Leave Team for additional information or to request Family Medical Leave.

## Holidays

The DTFOC observes 6 paid holidays* and provides 6 floating holidays as well. The DTFOC designated holidays are:

- New Year's Day
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day

* If one of these holidays falls on a Sunday, it will be observed on the following Monday. If the holiday falls on a Saturday, the company will select the following Monday or the preceding Friday as a substitute holiday.

## Paid Parental Leave (PPL)

Paid Parental Leave is available to all full-time employees to take time off to bond with their new child immediately following the birth, adoption, or other eligible circumstance. Please review your Company-specific Employee Handbook for eligibility requirements.

## Other Paid Time Off

Additional paid time off programs are available to employees of the DTFOC. For specific program eligibility, requirements (e.g., waiting periods) and schedule of benefits, please review your Company-specific Employee Handbook for more information.

# Contacts

## MEDICAL

Aetna
Group # 170220
Pre-enrollment number: **866.979.0237**
Customer service: **866.979.0237**
**www.aetna.com**

CVS Health Virtual Primary Care
**CVS.com/virtual-care**

## PRESCRIPTION

Aetna
Group # 170220
Rx Member Services and Mail Order:
**888.792.3862**
Specialty Pharmacy: **866.782.2779**
**www.aetna.com**

## HEALTH SAVINGS ACCOUNT (HSA)

Fidelity
**800.544.3716**
**www.netbenefits.com**

## FSA AND DEPENDENT CARE FSA

Fidelity
FSA: **833.299.5089**
**www.netbenefits.com**

## DENTAL

Delta Dental of Ohio
Group # 11210
**800.524.0149**
**www.deltadentaloh.com**

## VISION

VSP
Group # 300100243
**800.877.7195**
**www.vsp.com**

## DTFOC BENEFITS RESOURCE WEBSITE

**www.dtfamilybenefits.com**

## ACCIDENT, CRITICAL ILLNESS, AND HOSPITAL INDEMNITY

Aetna
**800.607.3366**
**www.myaetnasupplemental.com**

## LIFE AND DISABILITY

Reliance Matrix
**Customer.care@rsli.com**
**800.351.7500**
**www.reliancematrix.com**

Dealer Tire Family of Companies Leave Team
**800.933.2537 x36550**
**leaveofabsence@dealertire.com**

## 401(K)

Fidelity
Plan Number: 08723
**800.835.5097**
**www.401k.com**

## EMPLOYEE ASSISTANCE PROGRAM

Reliance Matrix—AllOne Health Company Code : RSLI859
**855.775.4357**
**https://reliance-matrix.mylifeexpert.com/**

## WELLBEING PROGRAM

HealthWi$e through Personify Health
**888.671.9395**
**support@personifyhealth.com**
**app.personifyhealth.com**

## ALIGHT NAVIGATION AND SUPPORT

**worklife.alight.com/DTFOC**

## CARRUM HEALTH

**888.855.7806**
**carrum.me/DTFOC**

## ALIGHT BENEFITS EDUCATION CENTER

**dtfoc.myannualenrollment.com**

**IMPORTANT NOTICE FROM DEALER TIRE 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 Dealer Tire 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. 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. Dealer Tire has determined that the prescription drug coverage offered by the Dealer Tire Employee Health Care Plan ("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 15 through December 7. 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 percent 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 19 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 Dealer Tire 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 Dealer Tire Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the Dealer Tire 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 Dealer Tire 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, or call (216)432-7401. **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 Dealer Tire 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). **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).**

Date: January 1, 2026
Name of Entity/Sender: Kellye Khas
Address: 7012 Euclid Ave
Cleveland, OH 44103
Phone Number:(216)432-7401

**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.**

**DEALER TIRE 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:
**Dealer Tire Benefits and Welfare Plan***
* This notice pertains only to healthcare coverage provided under the plan.
For the remainder of this notice, Dealer Tire is referred to as Company.

1. Introduction: This Notice is being provided to all covered participants in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and is intended to apprise you of the legal duties and privacy practices of the Company's self-insured group health plans. If you are a participant in any fully insured group health plan of the Company, then the insurance carriers with respect to those plans is required to provide you with a separate privacy notice regarding its practices.

2. General Rule: A group health plan is required by HIPAA to maintain the privacy of protected health information, to provide individuals with notices of the plan's legal duties and privacy practices with respect to protected health information, and to notify affected individuals follow a breach of unsecured protected health information. In general, a group health plan may only disclose protected health information (i) for the purpose of carrying out treatment, payment and health care operations of the plan, (ii) pursuant to your written authorization; or (iii) for any other permitted purpose under the HIPAA regulations.

3. Protected Health Information: The term "protected health information" includes all individually identifiable health information transmitted or maintained by a group health plan, regardless of whether or not that information is maintained in an oral, written or electronic format. Protected health information does not include employment records or health information that has been stripped of all individually identifiable information and with respect to which there is no reasonable basis to believe that the health information can be used to identify any particular individual.

4. Use and Disclosure for Treatment, Payment and Health Care Operations: A group health plan may use protected health information without your authorization to carry out treatment, payment and health care operations of the group health plan.

An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
Examples of "payment" activities include billing, claims management, and medical necessity reviews.
Examples of "health care operations" include disease management and case management activities.
The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

5. Disclosure for Underwriting Purposes. A group health plan is generally prohibited from using or disclosing protected health information that is genetic information of an individual for purposes of underwriting.

6. Uses and Disclosures Requiring Written Authorization: Subject to certain exceptions described elsewhere in this Notice or set forth in regulations of the Department of Health and Human Services, a group health plan may not disclose protected health information for reasons unrelated to treatment, payment or health care operations without your authorization. Specifically, a group health plan may not use your protected health information for marketing purposes or sell your protected health information. Any use or disclosure not disclosed in this Notice will be made only with your written authorization. If you authorize a disclosure of protected health information, it will be disclosed solely for the purpose of your authorization and may be revoked at any time. Authorization forms are available from the Privacy Official identified in section 23.

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.
8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:
When required by law; When permitted for purposes of public health activities; When authorized by law to report information about abuse, neglect or domestic violence to public authorities; When authorized by law to a public health oversight agency for oversight activities; When required for judicial or administrative proceedings; When required for law enforcement purposes; When required to be given to a coroner or medical examiner or funeral director; When disclosed to an organ procurement organization; When used for research, subject to certain conditions; When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.
10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.
11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.
12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.
13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.
For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.
14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.
15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.
16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.
17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.
The requested information will be provided within 30 days. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline, provided that you are given a written statement of the reasons for the delay and the date by which the group health plan will complete its action on the request. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.
18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.
19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.
If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.
20. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 23).
21. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.
22. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.
23. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official

**Privacy Official**

The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is: Kellye Khas (216)432-7401 **Effective Date:** The effective date of this notice is: January 1, 2026.

**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 toward 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 (e.g., 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; andLoss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP). Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *30 days* 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 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 toward 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: Kellye Khas (216)432-7401 **** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

**GENERAL COBRA NOTICE**

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. 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 and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. **You may have other options available to you when you lose group health coverage.** For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.
**What is COBRA continuation coverage?** COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called 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 coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
Your hours of employment are reduced, or Your employment ends for any reason other than your gross misconduct.
If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:
Your spouse dies;Your spouse's hours of employment are reduced;Your spouse's employment ends for any reason other than his or her gross misconduct;Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); orYou become divorced or legally separated from your spouse.Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:The parent-employee dies;The parent-employee's hours of employment are reduced;The parent-employee's employment ends for any reason other than his or her gross misconduct;The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);The parents become divorced or legally separated; or The child stops being eligible for coverage under the Plan as a "dependent child." **When is COBRA continuation coverage available?** The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:The end of employment or reduction of hours of employment;Death of the employee;The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

**For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice in writing to the Plan Administrator. Any notice you provide must state the name of the plan or plans under which you lost or are losing coverage, the name and address of the employee covered under the plan, the name(s) and address(es) of the qualified beneficiary(ies), and the qualifying event and the date it happened. The Plan Administrator will direct you to provide the appropriate documentation to show proof of the event.**

**How is COBRA continuation coverage provided?**

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. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

**Disability extension of 18-month period of COBRA continuation coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. If you believe you are eligible for this extension, contact the Plan Administrator.

**Second qualifying event extension of 18-month period of continuation coverage**

If your family experiences another qualifying event during the 18 months 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 the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are there other coverage options besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

**Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?**

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

The month after your employment ends; or The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare. For more information visit https://www.medicare.gov/medicare-and-you.

**If you have questions**

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

**Keep your Plan informed of address changes**

To protect your family's rights, let the Plan Administrator know about 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.

**Plan contact information:** For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below: Kellye Khas (216)432-7401

**WOMEN'S HEALTH AND CANCER RIGHTS NOTICE**

Dealer Tire Employee Health Care Plan 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 Dealer Tire Employee Health Care 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. If you would like more information on WHCRA benefits, please refer to your Policy Booklet or contact your Plan Administrator at:

Kellye Khas

(216)432-7401

**NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS**

Dealer Tire Wellness Program is a voluntary wellness program available to All employees regardless of enrollment. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others.

Details about the wellness program, including criteria and incentives, can be found in the Health Plan Notice Packet.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting at or benefithotline@dealertire.com.

The information from the Biometric Screening the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks,and may also be used to offer you services through the wellness program, such as e.g., education, coaching, or additional testing, or free or reduced diabetes testing supplies.. You also are encouraged to share your results or concerns with your own doctor.

**Protections from Disclosure of Medical Information**

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Dealer Tire may use aggregate information it collects to design a program based on identified health risks in the workplace, the wellness program will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) For example, "a registered nurse," "a doctor," "a health coach," or "business associates of ". in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately. You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate. If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact at or benefithotline@dealertire.com.

**Please read thoroughly.** This publication contains important information about your employee benefit program.

This benefit guide is only intended to highlight some of the major benefit provisions of the company plan and should not be relied upon as a complete detailed representation of the plan. Please refer to the plan's summary plan descriptions for further detail. Should this guide differ from the summary plan descriptions, the summary plan descriptions prevail.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