VERMONT VEHICLE & AUTOMOTIVE DISTRIBUTORS ASSOCIATION BENEFIT PLAN

Summary Plan Description

Updated January 1, 2021

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VERMONT VEHICLE & AUTOMOTIVE DISTRIBUTORS ASSOCIATION BENEFIT PLAN SUMMARY PLAN DESCRIPTION

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SECTION I. GENERAL INFORMATION

The Vermont Vehicle & Automotive Distributors Association ("VADA") sponsors an employee welfare benefit plan, as that term is defined by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). The plan is called the VADA Benefit Plan (the "Plan"), and is partially governed by a separate written plan document. VADA is referred to as the "Plan Sponsor." The Plan offers various available benefits, referred to as "Benefit Options," that can be elected by eligible employees. Currently, the Plan offers a Dental Benefit Option, a Short-Term Disability Benefit Option, and a Life Insurance Benefit Option.

This document is a summary plan description, as required by ERISA, and is a summary of various general terms of the Plan. It has been incorporated by reference into the Plan. It will be referred to in this document as the "General SPD", and it supersedes and replaces all previous versions of the General SPD.

The third-party administrators or insurers that are involved with each Benefit Option also independently produce summaries of certain features of each Benefit Option. This General SPD works in conjunction with these carrier-produced summaries to form the official summary plan description for purposes of ERISA.

In the event of a conflict between the terms of this General SPD and the official ERISA plan document, the terms of the plan document will control. In the event of a conflict between the terms of this General SPD and any carrier-produced summary, the terms of this General SPD will control. In the event of a conflict between the terms of either the plan document, this General SPD, or a carrier-produced summary and any informal communications about the Plan, the Plan Administrator will be solely responsible for determining the governing provisions.

Below are some items of general information regarding the Plan and its administration.

Plan Sponsor:	VADA 1284 U S Route 302-Berlin, Suite 2 Barre, VT 05641 (802) 461-2655
Named Fiduciary:	VADA
Plan Administrator (for Dental and Short-Term Disability Benefit Options):	Trustees of the Vermont Vehicle & Automotive Distributors Association Dental Benefits Life and Disability Insurance Trust 1284 U S Route 302-Berlin, Suite 2 Barre, VT 05641 (802) 461-2655
Insurance Companies:	UNUM 1 Monument Square Suite 500

	Portland, ME 04101 (207) 228-7425
Plan Year:	Jan 1- Dec 31
EIN:	03-0213537
Plan Number:	502
Participating Companies:	A complete list of the employers whose employees are eligible to participate in the Plan may be obtained by making a written request to the Plan Administrator. Covered employees may also make a written request to the Plan Administrator for information as to whether a particular employer is a Participating Company and, if so, that employer's address.
Benefits Provided:	The Plan provides the following "Benefit Options" to eligible employees and/or their eligible dependents: Dental Benefit Option Short-Term Disability Benefit Option Life Insurance Benefit Option The details of these benefits are more fully set out in the applicable carrier-produced benefits description booklet for each type of benefit. These benefits are funded through the Vermont Vehicle & Automotive Distributors Association Dental Benefits Life and Disability Insurance Trust ("Insurance Trust"). Participating Companies and Covered Employees make contributions to the Insurance Trust. The Insurance Trust purchases an insurance policy for life insurance benefits; all other benefits are self-funded by VADA through the Insurance Trust. The contribution owed by Covered Employees is determined by the Covered Employee's Participating Companies.
Agent for Service of Legal Process:	Service of legal process may be made upon the Plan Administrator.

Plan Trustees:

Robert Cody, II Cody Chevrolet, Cadillac 364 River Street Montpelier, VT 05602	Mitchell Jay Midstate Dodge 1365 US Route 302 Barre, VT 05641

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Twin State Ford
8 Memorial Drive
St. Johnsbury, VT 05819
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Type of Administration: With regard to the self-insured Benefit Options, the Plan Administrator has delegated to various entities the day-to-day ministerial duties regarding participation and claims for benefits and, in some cases, has delegated the authority to determine the amount of benefit under the Plan. These delegations and duties are more fully described in the separate benefits description for the Dental Benefit Option, and the Short-Term Disability Benefit Option.

With regard to the fully-insured Life Insurance Benefit Option, the ERISA plan administrator is the insurance company, rather than the named Plan Administrator.

The Plan Sponsor retains the authority to amend or terminate the Plan at any time, in its sole discretion. Participation in the Plan does not guarantee continued employment with any Participating Company in the Plan.

The Participating Companies must meet certain eligibility and enrollment criteria and procedures in order for their employees to be eligible to participate in the Plan. Those responsibilities are described in a separate agreement between the individual Participating Companies and the Plan Sponsor. An employer's status as a Participating Company will terminate upon certain events, including upon failure to remit full premium payments on employees' behalf.

SECTION II. DEFINITIONS

The following definitions are included to give specific meaning to particular capitalized words used in this document. This list is not intended to include all terms used in this document. Any word or phrase not specifically defined herein will have its usual and customary meaning.

COVERED PERSON: A Covered Employee or Covered Dependent

COVERED EMPLOYEE: An Employee of a Participating Company who is eligible under Section III below and who has taken the required steps to timely enroll for any or all of the benefits offered under the Plan.

COVERED DEPENDENT: A Dependent of an Employee who is eligible under Section III below and who has taken the required steps to timely enroll for any or all of the benefits offered under the Plan.

DEPENDENT: An individual related to an Employee in one of the following ways:

1. the spouse or civil union partner of an Employee;

2. an Employee's natural or adopted child or legal ward who is under the age of 26;

3. an Employee's natural or adopted child or legal ward who is over the age of 26 and who is incapable of self-support because of a physical or mental incapacity which existed prior to age 26 and for whom the Employee provides more than one-half of his or her support; or

4. an individual for whom the Employee is required to cover under the Dental Benefit Option pursuant to a Qualified Medical Child Support Order.

ELIGIBILITY DATE: The date on which an Employee or Dependent becomes eligible to enroll for any or all of the benefits under the Plan as defined in Section III below.

EMPLOYEE: A common-law employee, including an officer, shareholder, or sole proprietor of a Participating Company.

MEDICAL CHILD SUPPORT ORDER: An order, judgment, or decree (including approval of a settlement agreement) that provides for child support with respect to a child of a Covered Employee or provides for health benefit coverage to such a child and is made pursuant to a state domestic relations law or a law relating to medical child support described in section 1908 of the Social Security Act with respect to the Dental Benefit Option.

OPEN ENROLLMENT: A designated period of time before the beginning of each new plan year during which Employees can enroll themselves and their Dependents for coverage under the Benefit Options offered under the Plan.

PARTICIPATING COMPANY: VADA, or any designated related employer that employs Employees, and that fulfills the requirements for continued eligibility as a Participating Company.

PLAN ANNIVERSARY: January 1 of each calendar year.

PPACA: means the Patient Protection and Affordable Care Act of 2010 and guidance issued thereunder.

QUALIFIED MEDICAL CHILD SUPPORT ORDER: A Medical Child Support Order that meets the following conditions:

1. It contains the name and last known mailing address (if any) of the Covered Employee and the name and address of each Dependent covered by the order (the name and mailing address of a government official may be substituted for the mailing address of any child covered by the order).

2. It contains a reasonable description of the type of group health or dental coverage to be provided to each child covered by the order, or the manner in which that type of coverage is to be determined.

3. It states the period to which the order applies.

4. It does not require the Plan to provide any type or form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act.

SECTION III. EMPLOYEE AND DEPENDENT PROVISIONS

A Covered Employee and/or Covered Dependent is eligible for, and may enroll in, only those Benefit Options that the Employee's Participating Company offers.

Upon initial eligibility and then during each subsequent Open Enrollment, the Participating Companies will notify their eligible Employees of the Benefit Options that are available for election.

Employees and Dependents are required to furnish proof of eligibility to participate when requested to do so by the Plan Administrator. Examples of such proof are payroll records, a description of an individual's duties, marriage certificate or evidence of a civil union, adoption records, proof of residency, or medical certification of incapacity. This list is not exhaustive, and the Plan Administrator or its designee may request, and Covered Employees and Covered Dependents must provide, any proof necessary to satisfy the Plan Administrator that the Employee and/or Dependent does, in fact, meet the eligibility criteria set out in this Plan. Failure to timely provide required proof of eligibility may result in loss of coverage under the Plan, as well as disciplinary actions up to and including termination from employment with the Participating Company.

A. ELIGIBILITY

Conditions for Employee Eligibility

An individual can only become a "Covered Employee" if (1) he or she is a common-law employee of VADA or (2) if he or she meets all of the following conditions:

1. The individual must be a common-law employee of a Participating Company or, if the Participating Company is a sole proprietorship or partnership, the individual must be an owner or partner.

2. The individual must: (1) be an employee of a VADA Member Participating Company; (2) be regularly scheduled to work for a minimum of 17 ½ hours per week, or the minimum number of hours per week required by the VADA Member Participating Company for eligibility, whichever is more; (3) have a VADA Member Participating Company as his or her primary place of employment; and (4) perform his/her work at a VADA member Participating Company's business location. "Regularly scheduled to work" means that the individual is scheduled to work every week of the year, disregarding any time the individual is on sick leave, family or medical leave (as defined by Vermont state and federal law). The phrase "perform work at a VADA Member Participating Company" includes the work of employees who are based at the VADA member business location but whose duties require them to travel from the business location, such as tow truck drivers, shuttlers, courtesy van drivers, parts delivery drivers, etc., as well as the

work of employees who regularly work from a remote location, provided that such employees are scheduled for regular hours, actually work such hours, and have specific assigned duties relating to the daily operations of a VADA Member Participating Company.

3. The individual must meet any waiting period imposed by the particular Benefit Option under the Plan.

The Plan Administrator has the sole discretionary authority to construe and interpret these provisions and to determine all questions of eligibility to become a Covered Employee or Covered Dependent, including the question whether an individual is an Employee as defined by the Plan.

If the Plan Administrator determines that a person is not a Covered Employee, that person's benefit coverage shall be terminated retroactive to the date the person ceased to be a Covered Employee. In that instance the Plan Administrator shall return any premiums paid on behalf of such person to the Participating Companies for the period the individual was not a Covered Employee. In addition, to the extent permitted under applicable federal and state laws, the Participating Company shall be liable for the reimbursement to the Plan of any benefits it paid out during such time and shall be liable for the Plan's failure to follow COBRA and any similar Vermont state laws.

Conditions for Dependent Eligibility

A Dependent can only become a Covered Dependent if the Employee to whom the Dependent is related is a Covered Employee, or will become a Covered Person simultaneously with the Dependent. Dependents are eligible only for the Dental Benefit Option.

A child who is covered under a Medical Child Support Order and who a Covered Employee seeks to add as a Dependent is eligible to participate in the Plan if the Medical Child Support Order is a Qualified Medical Child Support Order as determined under the provisions of the "Qualified Medical Child Support Determination Procedures" in place for the Plan.

Eligibility Date

Employees

The Eligibility Date for Covered Employees is the later of:

1. the Covered Employee's date of hire OR

2. the date the Covered Employee completes the waiting period, if any.

Additionally, for purposes of the Dental Benefit Option only, a Covered Employee may have a Special Enrollment Eligibility Date under the following conditions:

1. **Persons previously enrolled in other coverage:** If a Covered Employee or Covered Dependent was enrolled in other coverage at the time the Covered Employee became eligible for benefits through the Plan and that coverage ended because:

   (i) the coverage was provided under the provisions of COBRA and was exhausted;

   (ii) the Covered Employee or Covered Dependent was no longer eligible; or

   (iii) the employer sponsoring the other coverage stopped making contributions,

   then the Covered Employee's Special Enrollment Eligibility Date is the date that other coverage ended, if the reason they did not previously enroll was the existence of the other coverage. *The Covered Employee will be required to submit written proof of the existence and reason for termination (as indicated in items (i)-(iii) above) of that other coverage.*

2. **New dependents:** If the Covered Employee gains a Dependent by marriage, civil union, birth or adoption, the Covered Dependent (if not already enrolled) has a Special Enrollment Eligibility Date. The Special Enrollment Eligibility Date for a marriage or civil union will be the date of notification to the Participating Company. The Special Enrollment Eligibility Date for a birth or adoption will be retroactive to such birth or placement.

SEE THE SECTION IV.B, "ENROLLMENT" REGARDING THE TIME LIMITS FOR SUBMITTING A GROUP ENROLLMENT FORM FOR SPECIAL ENROLLMENT UNDER THESE RULES.

Dependents

The Eligibility Date for Covered Dependents is the Employee's Eligibility Date. For purposes of the Dental Benefit Option only, the Covered Dependent may have a Special Enrollment Eligibility Date under the following circumstances:

1. **Persons previously enrolled in other coverage:** If a Covered Employee or Covered Dependent was enrolled in other coverage at the time the Covered Dependent became eligible for benefits through the Plan and that coverage ended because:

   (i) the coverage was provided under the provisions of COBRA and was exhausted;

   (ii) the Covered Employee or Covered Dependent was no longer eligible; or

   (iii) the employer sponsoring the other coverage stopped making contributions,

then the Covered Dependent's Special Enrollment Eligibility Date is the date that other coverage ended, if the reason they did not previously enroll was the existence of the other coverage. *The Covered Dependent will be required to submit written proof of the existence and reason for termination of that other coverage.*

2. **New dependents:** If the Covered Employee gains a Dependent by marriage, civil union, birth or adoption, the Covered Dependent has a Special Enrollment Eligibility Date. The Special Enrollment Eligibility Date for a marriage or civil union will be the date of notification to the Participating Company. The Special Enrollment Eligibility Date for a birth or adoption will be retroactive to such birth or placement.

SEE THE SECTION IV.B, "ENROLLMENT" REGARDING THE TIME LIMITS FOR SUBMITTING A GROUP ENROLLMENT FORM FOR SPECIAL ENROLLMENT UNDER THESE RULES.

The Plan Administrator has the sole discretionary authority to construe and interpret these provisions and to determine all questions of eligibility for participation.

B. ENROLLMENT

Except for coverage under the Life Insurance Benefit Option, which is automatic, in order for an Employee and/or Dependent to become a Covered Person, he or she must complete the Group Enrollment Form and submit the Group Enrollment Form to the Participating Company, who will then forward it to the Plan Administrator.

Timely Enrollment

All Employees must submit the Group Enrollment Form to the Participating Company no later than 60 days from his or her date of eligibility, even if they are rejecting all coverage (other than coverage under the Life Insurance Benefit Option). If the Participating Company does not have a probationary period, an employee must submit a form within 60 days after his or her date of hire. In either case, the Participating Company must then forward the Group Enrollment Form to the Plan Administrator according to the agreement between the Participating Company and the Plan Administrator. The Group Enrollment Form will explain all enrollment procedures in detail.

Special Enrollment

An Employee or Dependent who has a Special Enrollment Eligibility Date for the Dental Benefit Option may enroll under the Special Enrollment rules if the Plan Administrator receives the Group Enrollment Form no later than 60 days after the event.

C. EFFECTIVE DATE

Except as provided below, the effective date of coverage for a Covered Person will be the first day of the month following date of receipt, if the Employee or Dependent enrolls on a timely basis, but not prior to the completion of any probationary period, if applicable.

Dental Benefit Option

The following exceptions to this rule apply for purposes of the Dental Benefit Option only:

1. If an Employee and/or Dependent becomes eligible for coverage due to the birth or adoption of a child, and Plan Administrator receives the Employee's and/or Dependent's Group Enrollment Form within **31 days** following the birth or adoption, the Employee's and/or Dependent's effective date for coverage is the date of birth or adoption. If the Plan Administrator receives the Employee's and/or Dependent's Group Enrollment Form after **31 days** following the birth or adoption, the Employee's and/or Dependent will have to wait until the next open enrollment period to do so.

2. If an Employee and/or Dependent becomes eligible for coverage due to the loss of other coverage under the "Special Enrollment Eligibility Date" provisions, and the Plan Administrator receives the Employee's and/or Dependent's Group Enrollment Form within **31 days** of the loss of coverage, the Employee's and/or Dependent's effective date for coverage is retroactive to the date of other coverage loss.

3. If an Employee and/or Dependent becomes eligible for coverage due to marriage or civil union, and the Plan Administrator receives the Employee's and/or Dependent's Group Enrollment Form within **31 days** following the marriage or civil union, the Employee's and/or Dependent's effective date of coverage is the first day of the month following the date of marriage or civil union. If the Plan Administrator receives the Employee's and/or Dependent's Group Enrollment Form within **32-60 days** following the marriage or civil union, the Employee's and/or Dependent's effective date for coverage is first of the month following receipt.

Short-Term Disability Benefit Option

If an otherwise Employee is absent from work because of illness or accidental injury on the date upon which coverage would otherwise be effective for him or her, or on the date an increased amount of employee coverage would become effective, the effective date of such original or increased coverage, as the case may be, shall be deferred until the date on which the Employee returns to work.

Life Insurance Benefit Option

When the Participating Company pays all or share's in the cost of life insurance coverage, coverage for a Covered Employee under the Life Insurance Benefit Option is effective at 12:01 a.m. on the later of:

1. the Employee's Eligibility Date; or

2. first of the month following date of receipt (for late enrollees).

D. TERMINATION

A Covered Person's participation in the Plan, including his or her eligibility for all benefits for which he or she is enrolled under the Plan, will terminate on the earliest of the following:

- the date the Plan Sponsor terminates the Plan or a Benefit Option thereunder;

- the date the Covered Person ceases to meet the eligibility criteria set out herein;

- the date on which the employer through whom the Covered Person is eligible ceases to be a Participating Company;

- the last day of the period for which the Covered Person or the Participating Company made the required contribution;

- the death of the Covered Person;

- for a Covered Dependent, the date on which the Covered Employee to whom the Covered Dependent is related ceases to be eligible for participation;

- the last day of the month during which the Plan discovers that a Covered Person made a willful misrepresentation of fact regarding eligibility for participation or for benefits.

Termination of coverage under the Dental Benefit Option is subject to the provisions of COBRA and Vermont state continuation coverage law as set out in the carrier-produced summaries and in Section IV below. COBRA benefits are administered by Business Resource Services. Business Resource Services will send you required continuation coverage information upon certain terminations of such coverage. Coverage for a particular benefit may terminate earlier as provided in the carrier-produced benefits description booklet for that benefit. In no event, however, will you suffer an impermissible rescission of group health plan coverage, in violation of PPACA.

SECTION IV. BENEFITS

The Plan provides a variety of welfare benefits to Covered Persons. Each Participating Company may choose, to a certain extent, from among the various Benefit Options offered under the Plan in determining which benefits to offer its Employees. **The fact that certain benefits are described or referenced in this document should not be interpreted to mean all of the described benefits are available to all Covered Persons.**

General information about all available Benefit Options is contained in this General SPD, and information about the specific Benefit Options is contained in the carrier-produced summaries. The language in this General SPD will control in the event of any inconsistencies in language between a carrier-produced benefits description booklet and this General SPD.

A. DENTAL BENEFIT OPTION

More specific details regarding group dental benefits are set out in the Northeast Delta Dental Plan Description, and subject to future revisions.

COBRA Continuation Coverage (Participating Companies with 20 or more Employees)

Covered Persons may have rights to continue group health benefits, including dental benefits under the Plan should that coverage cease for certain reasons. This coverage will be at the expense of the Covered Person, as indicated below.

The right to continue coverage is governed by a federal law known as "COBRA." COBRA gives qualified beneficiaries the right to elect to continue coverage under the Plan when they experience a qualifying event under the conditions set out below.

Qualified Beneficiary

In order to continue coverage under the Plan, the Covered Person must be a "qualified beneficiary." A **"qualified beneficiary"** is an individual (a covered employee or dependent) who is covered under the Plan on the day prior to the day an event which causes them to lose coverage (known as "qualifying event") occurs. The term "qualified beneficiary" also includes a newborn or child placed for adoption with the Covered Employee while on continuation coverage.

Each qualified beneficiary who loses coverage because of a particular qualifying event may independently elect continuation coverage under these provisions.

Qualifying Event

The Plan will offer qualified beneficiaries the opportunity to elect COBRA continuation coverage when a "qualifying event" occurs that affects the qualified beneficiary. A **"qualifying event"** is one of the following events that would otherwise cause a Covered Person to lose coverage:

a. Termination of the Covered Employee's employment, whether voluntary or involuntary, other than for gross misconduct;

b. Reduction in hours so that the Covered Employee and Covered Dependents are no longer eligible for coverage;

c. Divorce or legal separation of the Covered Employee and Covered Dependent;

d. Death of the Covered Employee; or

e. Loss of Dependent status of a child of the Covered Employee

Notification

When a Covered Employee experiences a **reduction in hours or termination of employment, or when a covered employee dies,** or when the Participating Company becomes aware that a Covered Dependent of a Covered Employee has become ineligible to receive coverage under the Plan, the Participating Company must inform the Plan Administrator that this has occurred.

When a Covered Employee and Covered Dependent spouse are **legally separated or divorced or in the event that a Covered Dependent no longer qualifies as such under the Plan**, the person losing coverage is responsible for notifying the Plan Administrator that the event has occurred. The beneficiary must inform the Plan Administrator that the particular event occurred **within 60 days** of the date the event occurred. In addition, the Covered Employee is responsible for notifying both the Plan Administrator and his/her employer of a Covered Dependent's loss of eligibility under the terms of the Plan.

The Plan Administrator, through its third party administrator, Business Resource Services will then provide all qualified beneficiaries with the opportunity to elect COBRA continuation coverage.

Election of Coverage

A qualified beneficiary who wishes to elect COBRA continuation coverage must make that election *in writing* no later than 60 days after the date he or she receives notice of his or her continuation coverage rights or the date he or she would otherwise lose coverage because of the qualifying event, whichever is later.

Once the qualified beneficiary has made the written election for COBRA continuation coverage, he or she has 45 days from the date of the election to pay the first premium. The first premium payment must cover the period of coverage from the date of COBRA election retroactive to the date of the loss of coverage due to the qualifying event.

Note that if a Covered Employee is entitled to continue active health plan coverage while absent from work in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), COBRA coverage will begin at the end of the month following 30 days from the date such USERRA leave began.

Length of Coverage

The period of continuation coverage differs depending on the qualifying event. Generally, qualified beneficiaries who would otherwise lose coverage because of a **termination of employment or reduction in hours** may elect to participate in the Plan through COBRA continuation coverage for **18 months** from the date of the termination or reduction in hours.

Covered Dependents who would otherwise lose coverage because of **divorce or legal separation, or loss of dependent status,** may elect to participate in the Plan through COBRA continuation coverage for up to **36 months** from the date of the qualifying event.

If, during the original 18 month period of continuation coverage, a spouse or dependent qualified beneficiary experiences a second qualifying event such as divorce, legal separation, or loss of Dependent status, the spouse or dependent may elect to continue to participate in the Plan for up to 36 months from the original qualifying event. In order to be eligible to make this election, the **spouse or dependent must notify the Plan Administrator within 60 days** of the second qualifying event. In no event will the period of continuation of coverage be longer than 36 months from the original qualifying event.

A qualified beneficiary who elects COBRA continuation coverage because of a Covered Employee's termination or reduction in hours may, under the circumstances outlined here, elect up to 29 months of continuation coverage if a family member who is also a qualified beneficiary is disabled. For purposes of this provision, "disabled" means that the qualified beneficiary has received a determination of disability from the Social Security Administration. The disability must have started before the qualifying event or within 60 days after the date of the qualifying event. In addition, the qualified beneficiary who seeks the additional period of coverage must present the disability determination to the Plan Administrator **within 60 days** after the date of the determination *and* within the original 18-month period of continuation coverage.

Cost of Coverage

The Plan charges 102% of the cost to the Plan for continuation coverage, except that it charges 150% of the cost to the Plan for continuation coverage for any month in which continuation coverage is due solely to disability status. At the time you are eligible to elect continuation coverage, the Plan Administrator will notify you of the specific dollar amount for coverage.

Termination of Coverage

Under certain circumstances, COBRA continuation coverage could end before the end of the 18- or 36-month period, whichever is applicable. COBRA continuation coverage will end before the end of the applicable period upon any of the following occurrences:

a. **Failure to pay premiums:** if any qualified beneficiary fails to pay any premium on a timely basis, COBRA continuation coverage will end retroactively as of the date for which premiums have been paid. Premiums are considered to be timely if they are made within 30 days of the date they are due.

b. **End of Plan:** coverage will end on the date on which the Plan Sponsor ceases to provide any group health plan.

c. **Group health plan coverage or Medicare entitlement:** coverage will end on the date on which a qualified beneficiary first becomes (after the date of the election) covered under any group health plan as an employee or otherwise if that group health plan does not contain any exclusion or limitation with respect to any preexisting condition that applies to that qualified beneficiary or on the date that qualified beneficiary becomes entitled to benefits under Medicare.

d. **Termination of disability:** coverage will end for any qualified beneficiary whose continuation coverage is due to the disability of a qualified beneficiary family member 30 days after the Social Security Administration makes a final determination that the beneficiary is no longer disabled.

Once continuation coverage has ended, you may have the right to convert COBRA continuation coverage to an individual policy, if that right exists in the Plan at the time COBRA continuation coverage ends.

PLEASE NOTE: *timeframes outlined above may change periodically due to temporary federal mandates.*

Vermont State Continuation Coverage ("VIPER"; Participating Employers with less than 20 Employees)

In the event of a loss of coverage due to loss of employment, including reduction of hours that results in the ineligibility for employer-sponsored coverage; death of the covered employee which causes dependents to lose coverage; divorce, civil union dissolution, or legal separation which results in the loss of coverage for a covered employee’s spouse or civil union partner, or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for group health and dental benefits for 18 months.

If elected, group health benefits, which include dental benefits will continue until the earliest of the following to occur:

1. the end of the eighteen-month period following death or termination;

2. the end of the last period for which the Covered Person made the required premium payment;

3. the date on which the Covered Employee is covered under Medicare;

4. the date on which the Covered Employee is covered by any other group insured or uninsured arrangement which provides dental coverage or hospital and medical coverage for individuals in a group and under which the person was not covered immediately prior to such qualifying event, and no preexisting condition exclusion applies; provided, however, that the person shall remain eligible for continuation coverages which are not available under the insured or uninsured arrangement.

5. the date on which the Plan Sponsor terminates the group health benefits.

When a Covered Employee experiences a **reduction in hours or termination of employment, or when a covered employee dies,** or when the Participating Company becomes aware that a Covered Dependent of a Covered Employee has become ineligible to receive coverage under the Plan, the Participating Company must inform the Plan Administrator that this has occurred.

When a Covered Employee and Covered Dependent spouse are **legally separated or divorced, or in the event of a civil union dissolution or that a Covered Dependent no longer qualifies as such under the Plan**, the person losing coverage is responsible for notifying the Plan Administrator that the event has occurred. The beneficiary must inform the Plan Administrator that the particular event occurred **within 60 days** of the date the event occurred. In addition, the Covered Employee is responsible for notifying both the Plan Administrator and his/her employer of a Covered Dependent's loss of eligibility under the terms of the Plan.

The Plan Administrator, through its third party administrator, Business Resource Services, may provide qualified beneficiaries with the opportunity to elect VIPER continuation coverage.

PLEASE NOTE: *timeframes outlined above may change periodically due to temporary federal/state mandates.*

B. SHORT-TERM DISABILITY BENEFIT OPTION

More specific details regarding short-term disability benefits are set out in the VADA's Short-Term Disability Benefits Description, and subject to future revisions.

C. LIFE INSURANCE BENEFIT OPTION

More specific details regarding group life insurance are set out in the UNUM Employee Benefit Booklet and subject to future revisions.

D. IN GENERAL

The following provisions will apply to the extent applicable for any Benefit Options that are available under the Plan:

Special Rights on Childbirth

With respect to Benefit Options that offer such services, note that group health plans and health insurance issuers offering group insurance coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than the above periods. In any case, such plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods.

Michelle's Law

Michelle's Law applies to Benefit Options that are group health plans for plan years beginning on or after October 9, 2009 (for calendar year plans, the law is effective beginning January 1, 2010). Michelle's Law provides continued coverage under group health plans for dependent children who are covered under the Employer's group medical plan, as a student but lose their student status because they take a medically necessary leave of absence from school.

As a result, if your child is no longer a student, as defined in the plan, because he/she is on a medically necessary leave of absence, your child may continue to be covered under the Plan for up to one year from the beginning of the leave of absence. This continued coverage applies if, immediately before the first day of the leave of absence, your child was (1) covered under the plan and (2) enrolled as a student at a post-secondary educational institution (includes colleges and universities).

For purposes of this continued coverage, a "medically necessary leave of absence" means a leave of absence from a post-secondary educational institution, or any change in enrollment of the child at that institution, that:

1. begins while the child is suffering from a serious illness or injury,
2. is medically necessary, and
3. causes the child to lose student status for purposes of coverage under the plan.

This coverage provided to dependent children during any period of continued coverage:

1. is available for up to one year after the first day of the medically necessary leave of absence, but ends earlier if coverage under the

plan would otherwise terminate, and

2. stays the same as if your child had continued to be a covered student and had not taken a medically necessary leave of absence.

If the coverage provided by the plan is changed during this one-year period, the plan must provide the changed coverage for the dependent child for the remainder of the medically necessary leave of absence unless, as a result of the change, the plan no longer provides coverage for dependent children.

If you believe your child is eligible for this continued coverage, the child's treating physician must provide a written certification to the plan stating that your child is suffering from a serious illness or injury and that the leave of absence (or other change in enrollment) is medically necessary.

Mental Health Parity Act

The Mental Health Parity Act (MHPA) of 1996 applies to any Benefit Options that are group health plans. MHPA was originally enacted to provide parity between mental health benefits and medical/surgical benefits. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) added provisions related to substance use disorder benefits and requires parity in financial requirements and treatment limitations, and became effective for plan years beginning after October 3, 2009 (for calendar year plans, on January 1, 2010).

Nothing in the MHPA or MHPAEA requires a Benefit Option to offer mental health benefits or substance use disorder benefits. However, if the particular Benefit Option does elect to provide such coverage, then the parity requirements will apply, in accordance with current regulations.

If you have questions about the MHPA or the MHPAEA, please contact the Plan Sponsor, or look on the DOL website.

Genetic Information Nondiscrimination Act of 2008 (GINA)

In accordance with Title I of the Genetic Information Nondiscrimination Act of 2008, in no event shall the Plan or any of its insurers discriminate against any participant on the basis of genetic information with respect to eligibility, premiums or contributions.

PPACA

Any Benefit Options that are group health plans will comply with the latest guidance and IRS, DOL, and HHS regulations interpreting PPACA.

SECTION V. PLAN AMENDMENT OR TERMINATION

The Plan Sponsor has delegated its authority to amend or terminate the Plan to the Board of Directors, or if the Board of Directors so delegates, to the Plan Administrator. The Plan Administrator has the authority to amend the Plan, modify any of the provisions herein, or discontinue any Benefit Option available under the Plan at any time without the consent of, or prior notice to, any Covered Persons hereunder. The Plan may be amended, modified or terminated for any reason, including as required by Plan utilization costs, market forces, federal legislation, or any other general business concerns of the Plan Administrator.

Nothing in the Plan shall be construed as providing for any continued rights to employment, or any vested right to benefits, including any benefits that may be available to retirees.

SECTION VI. CLAIMS AND APPEALS PROCEDURES

The appeals procedures contained in this General SPD, and supplemented by the claims and appeals procedures described in the carrier-produced benefits summaries, are intended to comply with claims and appeal procedure requirements under ERISA and applicable federal health care reform law and regulations.

The Plan Sponsor is responsible for appeals concerning eligibility for Benefit Options, as opposed to appeals related to substantive benefits available under the various Benefit Options under the Plan, which are the responsibility of the third party administrators or insurers.

A. ELIGIBILITY DETERMINATIONS

At all times and with regard to all Benefit Options, the Plan Administrator has the sole discretionary authority to determine all questions of eligibility for participation in the Plan, and to interpret and apply the terms of the Plan in determining eligibility for participation in the Plan. The Plan Administrator's decisions shall be final and binding on all parties.

Should a question arise as to your eligibility for participation in the Plan, the Plan Administrator will communicate with you regarding applicable deadlines and procedures.

B. SUBSTANTIVE CLAIMS AND APPEALS DETERMINATIONS

Substantive benefit determinations under the Plan are subject to appeals procedures set forth by the insurer or third party administrator. As such, for all claims and appeals concerning issues other than eligibility under the Plan, refer to the following carrier-produced summaries for additional information:

- For the rules governing the Dental Benefit Option claims and appeals procedures, see the Northeast Delta Dental Plan Description and subject to future revisions.

- For the rules governing the Short-Term Disability Benefit Option claims and appeals procedures, see VADA's Short-Term Disability Benefits Description and subject to future revisions.

- For the rules governing the Life Insurance Benefit Option claims and appeals procedures, see the UNUM Employee Benefit Booklet and subject to future revisions.

No legal action related to the Plan and an employer's or individual's participation in the Plan may be commenced before the individual has exhausted the appeal procedures described or referenced above.

SECTION VII. STATEMENT OF ERISA RIGHTS

Federal law and regulations require the Plan Administrator to provide you with this statement:

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

> Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents and copies of any documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports.
>
> Obtain copies of all Plan documents and other Plan information on written requests to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
>
> Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
>
> Receive a copy of the Plan's COBRA procedures and forms.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Plan benefit or exercising your rights under ERISA. If your participation is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the appropriate fiduciary review and reconsider your claim for participation. Under

ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Administrator to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a request for participation that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse a Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees. If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

The law requires that the Plan include the above statement of ERISA rights. Please understand that VADA is required to use the words contained in the regulations. By presenting it, VADA does not want to suggest that to be treated fairly and obtain proper representation; you must take legal action or seek aid from any governmental agency. You, of course, have the right to do so. However, VADA would like you to remember that it would like to help you with any problems you may have concerning the Plan. The Plan Administrator hopes you will come to it first with any problems that might arise.

Addendum to the "Additional Summary Plan Description Information" Included with your certificate of coverage or policy and effective for claims filed on or after April 1, 2018.

The regulations governing ERISA disability claims and appears have been amended. The amended regulations apply to disability claims filed on or after April 1, 2018. To the extent the Additional Summary Plan Description information included with your certificate of coverage or policy conflicts with these new requirements, these new rights and procedures will apply.

These new rights and procedures include:

Any cancellation or discontinuance of your disability coverage that has a retroactive effect will be treated as an adverse benefit determination, except in the case of failure to timely pay required premiums or contributions toward the cost of coverage.

If you live in a county with a significant population of non-English speaking persons, the plan will provide, in the non-English language(s), a statement of how to access oral and written language services in those languages.

For any adverse benefit determination, you will be provided with an explanation of the basis for disagreeing or not following the views of: (1) health care professionals who have treated you or vocational professionals who have evaluated you; (2) the advice of medical or vocational professionals obtained on behalf of the plan; and (2) any disability determination made by the Social Security Administration regarding you and presented to the plan by you.

For any adverse benefit determination, you will be given either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making that decision, or a statement that such rules, etc. do not exist.

Prior to a final decision being made on an appeal, you will have the opportunity to review and respond to any new or additional rationale or evidence considered, relied upon, or generated by the plan in connection with your claim.

If an adverse benefit determination is upheld on appeal, you will be given notice of any applicable contractual limitations period that applies to your right to bring legal proceedings and the calendar date on which that period expires.

Should the plan fail to establish or follow ERISA required disability claims procedures, you may be entitled to pursue legal remedies under section 502(a) of the Act without exhausting your administrative remedies, as more completely set forth in section 503-1(I).

SECTION VIII. HIPAA PRIVACY AND SECURITY

VERMONT VEHICLE & AUTOMOTIVE DISTRIBUTORS ASSOCIATION NOTICE OF PRIVACY PRACTICES

This notice describes how individually identifiable health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

VERMONT VEHICLE & AUTOMOTIVE DISTRIBUTORS ASSOCIATION ["VADA"] LEGAL DUTY

VADA is required by federal law to maintain the privacy of your health information that it uses or receives in administering your group health plan benefits. VADA is also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This Notice is effective as of April 14, 2004, and VADA will follow the privacy practices described in this Notice while they are in effect.

This Notice provides you with the following information:

- How VADA may use and disclose your health information;
- Your privacy rights in your health information; and
- Our obligations concerning the use and disclosure of medical information.

VADA reserves the right to change its privacy practices and the terms of this Notice at any time. Any revision or amendment will be effective for all information held by VADA whether obtained prior to or after the amendment. You may request a copy of the Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

VADA sponsors the Vermont Vehicle & Automotive Distributors Association Benefit Plan. This plan provides health benefits to you and your family, as described in the summary plan descriptions and benefits packages for the plan. We may receive or maintain health information about you for payment and operations purposes. This notice applies to all of the health records we maintain. We also hire business associates (such as Delta Dental) to help the plan provide these benefits to you. Our business associates may use the health information about you for treatment purposes. You may receive separate notices of privacy practices from these business associates about the health information that they receive or maintain about you.

Uses for Payment. We may use and disclose your health information to review and to pay claims under the terms of the plan. We may gather information from other covered entities or business associates for purposes of determining whether services or supplies you have received are covered as benefits under the plan. This includes determinations of eligibility or coverage, adjudication of claims, and subrogation or reimbursement of health care claims from responsible third parties.

For example, if you have a concern regarding how a claim has been paid, you may contact Marilyn Miller, the Executive Director and designated Privacy Officer. She may gather information that identifies you, your diagnosis, and treatment or supplies provided in the course of treatment to determine the appropriate determination of your claim for benefits.

Uses for Healthcare Operations. We may use and disclose health information about you for operational purposes. For example, your health information may be disclosed to appropriate employees of VADA to:

- Evaluate the performance of our business associates;
- Assess the quality of care or services provided by our business associates or other third parties;
- Determine plan design and to make underwriting decisions regarding covered benefits;
- Conduct retrospective reviews of services or supplies covered as benefits under the plan to make appropriate recovery attempts;
- Solicit bids from third parties for claims administration or other services to be provided to the plan, including annual contract renewals with existing claims administrator or other business associates.

Disclosures to the Plan Sponsor. The plan may disclose health information to VADA, the sponsor of the plan. For example, VADA employees may share enrollment information with payroll, other human resources personnel, or other departments with a need to know such information.

To You or Your Authorized Representative. VADA must provide your health information to you upon request, as more fully described in the "Your Rights to Health Information" section of this Notice. We will disclose your health information to your authorized representative, which could be a friend or family member, only if you agree to allow us to do so, or if in our professional judgment it is necessary for us to conduct our operations.

Required by Law. We may use or disclose your health information where required by law. For example, we may disclose information for the following purposes:

- Judicial and administrative proceedings;
- Reporting information related to victims of abuse, neglect, or domestic violence;
- Assisting law enforcement officials in performance of their duties;
- Assisting public health officials to avert a serious threat to your health or safety, or the public health and safety;
- National security and intelligence activities.

Your Authorization. In addition to use of your health information for the purposes described above, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except as described in this Notice.

YOUR RIGHTS TO YOUR HEALTH INFORMATION

VADA may maintain records containing your health information. In most cases, our business associates, such as Delta Dental, will possess the information that is responsive to any of the individualized requests detailed in this section. These business associates maintain certain designated record sets and you may contact the business associate to review that information. The business associate is obligated to provide you with the same rights as those described in this Notice. You have the following rights regarding health information that we maintain about you:

- Access. You have the right to review or obtain copies of your health information.

- Disclosure Accounting. You have the right to receive a list of instances in which we, or our business associates, have disclosed your health information for purposes other than payment, healthcare operations, or where you have provided us with an authorization for disclosure. You may request this list for any disclosures made in the previous 6 years, provided we are not required to give you an accounting of disclosures made prior to April 14, 2004.

- Request Restrictions. You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions and may not do so in instances where, in our judgment, the restrictions would materially impair our ability to perform necessary functions of administering the plan.

- Alternative Communications. You have the right to request in writing that we communicate with you about your health information by alternative means or an alternative location. Your request must specify the alternative location.

- Amendments. You have the right to request that we amend your health information contained in our records. Your written request must explain why the information should be amended. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact the Executive Director at 802-461-2655. Marilyn Miller, the Executive Director, is also the Privacy Officer responsible for handling any grievances associated with our uses and disclosures of your health information. If you are concerned that we may have violated your privacy rights, or you disagree with a decision made about access to your health information, or in response to a request you made related to the "Your Rights to Health Information" section of this Notice, you should contact Marilyn Miller by telephone at the number listed above, or in writing to the following address: Vermont Vehicle & Automotive Distributors Association Attention: Marilyn Miller, 1284 US Route 302-Berlin, Suite 2, Barre, VT 05641. You may also submit a written complaint to the U.S. Department of Health and Human Services, at the Hubert H. Humphrey Building, 200 Independence Ave. S.W., Washington, D.C., 20201.

VADA supports your right to the privacy of your health information. We will not retaliate in any way if you file a complaint with us or with the U.S. Department of Health and Human Services.