

CRAIG ZINN
AUTOMOTIVE GROUP

2026 - 2027 Employee Benefits Guide

NEW!

Mr. Zinn wants to help protect your family: Whole Life Insurance that covers Long Term Care needs.

Remember to check our medical plans!



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MEDICARE PART D

PRESCRIPTION DRUG INFORMATION

If you are enrolled in or will be eligible for Medicare in the next 12 months, Federal law gives you more choices for prescription drug coverage. See notices for more information.



HR Contacts

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Human Resources Office Hours

Monday - Friday 8:00 AM - 5:00 PM

Benefits Website

www.czagbenefits.com Password: 2020

To enroll for benefits please visit the **Self-Service portal on ADP-Workforce Now.**

<https://workforcenow.adp.com>





Your 2026-2027 Benefits Plan

At Craig Zinn Automotive Group, we recognize our ultimate success depends on our talented and dedicated workforce. Together we share in the success of our efforts. We understand that contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefit program, we strive to support the needs of our employees and their dependents by providing a benefits package that is easy to understand, easy to access and affordable for all of our employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

To Your Health,
CZAG Human Resources



Making Changes

Outside of open enrollment, you can only make changes to your benefits if you experience a qualifying life event. These changes include, but are not limited to:

- Marriage, divorce or legal separation
- Death of a spouse or other dependent
- Birth, adoption or change in custody of a child
- A dependent's eligibility status changes due to age, student status, marital status, or employment
- Employment termination (for reasons other than gross misconduct) or a reduction in hours worked resulting in loss of eligibility
- Relocation into or out of a managed care network area
- Coverage under your spouse's medical plan begins or ends
- Employer contributions towards your spouse's medical plan stop
- COBRA medical coverage ends for you or your eligible dependents
- Eligibility for Medicare
- Eligibility for Medicaid or Children's Health Insurance Program Coverage (60 day special enrollment)
- Loss of Medicaid or Children's Health Insurance Program Coverage (60-day special enrollment)

If one of these qualifying events occurs in your life outside of the open enrollment period, you may make changes to your benefit elections, but you **MUST** notify Human Resources within 30 days of the event.

Eligible Employees:

If you are actively employed as a regular, full-time employee working 30 hours or more per week, you and your family are eligible for the benefits offered on the first day of the month following 60 days of full-time employment.

Benefit	Who Pays the Cost?
Medical	Employer and Employee
Dental	Employee
Vision	Employee
Basic Life and AD&D	Employer
Long Term Disability	Employer
Voluntary STD	Employee
Voluntary Life and AD&D	Employee
Voluntary Accident	Employee
Voluntary Critical Illness	Employee
Voluntary Hospital	Employee
Group Whole Life with LTC	Employee
401(k)	Employee



Eligible Dependents:

- Your spouse, unless you are legally separated or divorced
- Your natural children, step-children, legally adopted children, and any children whom you have legal or court-ordered responsibility, who are under 26 years of age (for medical, dental and vision).
- In the state of Florida for MEDICAL coverage ONLY - extended coverage may be offered for dependent children up to the end of the calendar year in which your dependents reach 30 years of age, if they meet the following requirements:
 - Unmarried and do not have dependents of their own,
 - Are residents of Florida or a Student, AND
 - Do not have coverage as a named subscriber, enrollee or covered person under any other group insurance policy or individual health plan or entitled to Medicare benefits.
- Children who are physically or mentally disabled will continue to be covered after age 26, subject to approval and medical documentation supporting the disability.

When Coverage Begins:

Annual open enrollment provides eligible employees the ability to make changes to their current benefit plan choices. You can add or delete dependents and transfer from one plan to another. Changes you make during this open enrollment will be effective June 1, 2026. Outside of open enrollment, you may only make changes to your benefit choices when you have a qualifying life event, such as a marriage, birth, divorce or other loss of coverage. The next open enrollment period will be held prior to our next plan renewal, which is June 1, 2027.

When Coverage Ends:

- Medical, Dental and Vision coverage will stop on the last day of the month in which your employment with the company ends.
- Supplemental coverage will stop on the last day worked.

Pre-Tax vs. Post-Tax Dollars:

There is a definite advantage to paying for some benefits with pre-tax money. Some benefit premiums are paid with pre-tax payroll deductions and some are paid with post-tax payroll deductions. The reduction in taxable salary for pre-tax premiums will not impact any other company benefits that are based on your pay. All other benefits will continue to be based on your salary before any pre-tax premiums are deducted. Pre-tax premiums will be deducted from your paycheck before withholding taxes are calculated.

Choosing your Benefits

You must actively choose any benefit that you pay for or share in the cost with Craig Zinn Automotive Group. Your part of the cost is automatically taken out of your paycheck. There are two ways that the money can be taken out:

- Before your taxes are calculated - medical, dental and vision
- After your taxes are calculated - voluntary life and accidental death & dismemberment, short-term disability, long-term disability, accidental, critical illness, group whole life, medical gap and preferred legal plan

Why do I pay for benefits with before-tax money?

There is a definite advantage to paying for some benefits with before-tax money:

Taking the money out before your taxes are calculated lowers the amount of your pay that is taxable. Therefore, you pay less in taxes.

Pre-Existing Conditions Limitations Notice:

Effective 01/01/2014, in accordance with The Patient Protection and Affordable Care Act, there is no longer any pre-existing conditions limitations for newly covered employees or dependents, or current employees or dependents covered by the medical plans.

Key Benefit Terms:

COBRA - A Federal law that allows workers and dependents who lose their medical, dental or vision coverage to continue any of these coverages for a specified length of time by electing and paying for continuous benefits.

Coinsurance - The percentage of the medical or dental charge that you pay after the deductible has been met.

Copayment - A flat fee that you pay for medical, dental and vision services regardless of the actual amount charged by your doctor or another provider. This generally applies to physicians' office visits and prescription drugs.

Deductible - The amount you pay toward medical and dental expenses each calendar year before the plan begins paying benefits.

Out of Pocket Maximum - The maximum amount you will pay in coinsurance during the calendar year.



Health Insurance



	Emerald		Ruby		Diamond	
Network Access	In-Network Only		In-Network *		In-Network *	
Annual Deductible (Individual/Family)	\$3,500 / \$7,000		\$2,500 / \$5,000		\$1,000 / \$2,000	
Out-of-Pocket Maximum (Includes Deductible)	\$6,000 / \$12,000		\$4,000 / \$8,000		\$3,000 / \$6,000	
Preventive Care	100% Covered		100% Covered		100% Covered	
Primary Care Provider Office Visit	\$25 Copay		\$20 Copay		\$15 Copay	
Specialist Office Visit	\$60 Copay		\$50 Copay		\$50 Copay	
Independent Clinical Lab	100% Covered		100% Covered		100% Covered	
Inpatient Hospital Services	30% After Deductible		20% After Deductible		0% After Deductible	
Telehealth Visits	\$25 Copay		\$20 Copay		\$15 Copay	
Urgent Care	\$25 Copay		\$25 Copay		\$25 Copay	
Emergency Room	\$500 Copay		\$500 Copay		\$200 Copay	
Retail Pharmacy						
Tier - 1	\$25 Copay		\$15 Copay		\$10 Copay	
Tier - 2	\$50 Copay		\$30 Copay		\$20 Copay	
Tier - 3	\$75 Copay		\$50 Copay		\$40 Copay	
Tier - 4	\$150 Copay		\$100 Copay		\$80 Copay	
Payroll Deductions	WEEKLY	SEMI-MONTHLY	WEEKLY	SEMI-MONTHLY	WEEKLY	SEMI-MONTHLY
Employee Only	\$34.70	\$75.18	\$57.34	\$124.24	\$116.16	\$251.68
Employee / Spouse	\$176.70	\$382.84	\$225.46	\$488.50	\$353.15	\$765.15
Employee / Child(ren)	\$142.71	\$309.21	\$184.96	\$400.74	\$296.34	\$642.07
Employee / Family	\$291.40	\$631.36	\$361.67	\$783.61	\$545.11	\$1,181.07

*This benefit summary reflects in-network benefits only for comparison purposes. You can find the out-of-network benefits for the Ruby and Diamond plans in the Cigna Benefits Summary.



Choose a plan with confidence.

Cigna One Guide service can help.

We understand how confusing and overwhelming it can be to review your health plan options. And we want to help by providing the resources you need to make a decision with confidence. That's why **Cigna One Guide® service is available to you now.**

Call a One Guide® representative during preenrollment to get personalized, useful guidance.

Your personal guide will help you:

- Easily understand the basics of health coverage
- Identify the types of health plans available to you
- Check if your doctors are in-network to help you avoid unnecessary costs
- Get answers to any other questions you may have about the plans or provider networks available to you

The best part is, during the enrollment period, your personal guide is just a call away.

Don't wait until the last minute to enroll.

Call **800.325.8958** to speak with a Cigna One Guide representative today.

Access Cigna One Guide – after enrollment – in the way that's most convenient for you:



myCigna.com® or the **myCigna® App**



Live chat



Phone

After enrollment, the support continues for Cigna Healthcare customers.

One Guide service will be there to guide you through the complexities of the health care system, and help you avoid costly missteps. Our goal is a simpler health care journey for you and your family.

One Guide service provides personalized assistance to help you:

- Resolve health care issues
- Save time and money
- Get the most out of your plan
- Find hospitals and health care providers in your plan's network
- Get cost estimates and avoid surprise expenses
- Understand your bills

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and complete details of coverage, see your plan documents.





Know before you go.

Get the right care, at the right time, in the right place.

Lower Cost and time Greater

	Virtual urgent care	Local provider	Urgent care center	Emergency room
	Available on-demand 24/7, via E-Treatment, or schedule a time that works for you to receive care for minor medical illnesses and injuries. Access virtual care on the myCigna® App or myCigna.com® .	Schedule an in-person appointment with a local health care provider to treat common ailments and manage care for all health conditions. Find an in-network provider on the myCigna App or myCigna.com .	For medical conditions that aren't life threatening. Find an in-network urgent care center on the myCigna App or myCigna.com .	For immediate treatment of critical injuries or illness. Open 24/7. If a situation seems life threatening, call 911 or go to the nearest ER.
Ages	All ages. Parent/guardian must accompany minors.	All ages. May vary by provider/service.	All ages. May vary by location. Confirm restrictions for infants as many have age limits.	All ages.
Conditions treated	<ul style="list-style-type: none"> • Colds and flu • Rashes • Sore throats • Pink eye • Ear pain • Fever • Allergies • Acne • Urinary tract infections (UTIs) and more 	<ul style="list-style-type: none"> • General health issues • Preventive care • Routine checkup • Vaccines and screenings • Acute sickness • Questions regarding health 	<ul style="list-style-type: none"> • Fever and flu symptoms • Joint pain, sprains and cuts • Minor respiratory symptoms • Stomach pains • STDs • UTIs 	<ul style="list-style-type: none"> • Sudden numbness, weakness • Uncontrolled bleeding • Seizure or loss of consciousness • Shortness of breath • Chest pain • Head injury/major trauma • Blurry or loss of vision • Severe cuts or burns • Overdose
Cost and time	<ul style="list-style-type: none"> • More affordable than in-person and urgent care or ER visit • Connect with a doctor in minutes • No need to leave work or home with visits available by phone, video or through E-Treatment 	<ul style="list-style-type: none"> • May charge copay/coinsurance and/or deductible • Usually need appointment • Short wait times 	<ul style="list-style-type: none"> • Lower cost than emergency room (ER) • No appointment needed • Waiting times vary • Available most days of the week • Often have extended hours • In-person treatment 	<ul style="list-style-type: none"> • Most expensive • Available 24/7/365 • No appointment needed • Waiting times vary • In-person treatment

Health care that's there for you when and where you need it.

Head-to-toe virtual care from MDLIVE.



Virtual care is making access to high-quality healthcare more convenient and affordable – for you and every covered member of your family. That's why Cigna Healthcare® has partnered with MDLIVE® to offer a broad suite of convenient virtual care options – available by phone or video, and in English or Spanish.



Primary Care

Easy, fast appointments, referrals, prescriptions, lab work and diagnostic tests

- Preventive care and wellness screenings available at no additional cost to identify conditions early
- Manage chronic conditions and establish a relationship with the same primary care provider (PCP) through routine care
- Receive orders for imaging scans, biometrics, and blood work at local facilities



Urgent Care

Available via E-Treatment, phone or video.

- Convenient, affordable alternative to urgent care centers and the emergency room
- Care for many minor illnesses and injuries, such as infections, cold & flu, and sinus problems
- Includes pediatric care, allowing your child to be seen quickly and from the comfort of their home



Dermatology

Fast, customized care for skin, hair, and nail conditions – no appointment required

- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Upload photos and describe symptoms for board-certified dermatologists to review
- Diagnosis and customized treatment plan, usually within 24 hours



Behavioral Care

Talk therapy and psychiatry from the privacy of home, with no waiting rooms

- Access to licensed therapists and board-certified psychiatrists
- Schedule an appointment that works for you and have recurring sessions with the same provider
- Care for topics such as anxiety, stress, life changes, grief and depression



Prescriptions available through home delivery or at local pharmacies, if appropriate.

Finding mental health support can sometimes feel difficult.

With Cigna Total Behavioral Health, you have easy-to-navigate access to support.



A listening ear. A guiding hand.

When you're feeling stressed, anxious, depressed or even a little bit overwhelmed, it's important to know you have someone you can turn to. We can provide the support you need when you need it most.

Our Care Navigators are prepared to give help and guidance in real time.

- Convenient – You can reach a Care Navigator via telephone 24/7/365 or by live online chat Monday-Friday, 9 am-8 pm, ET.
- Personalized – You'll get tailored support to help you find the right solution to fit your needs.
- Included – You can use this confidential service at no additional cost.

Our Care Navigators can:

- Match you with a licensed therapist who's right for you.
- Find you a licensed therapist who has an open appointment.
- Offer you immediate support, with 60-minute telephone sessions with an available licensed clinician **at no additional cost to you.**
- Provide you with immediate help during a crisis situation.
- Help explain your benefits and coverage as well as connect you to community-based resources.

100% follow-up

After your initial call, we'll check in with you to see if you're happy with your therapist or to provide additional support if needed.

Medical members will get up to three visits with a licensed clinician through the Cigna employee assistance program network **at no cost to you!**

 Get started at myCigna.com[®], or call the number on your ID card.



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New Benefit!!!

PAY \$0 FOR SELECT SPECIALTY MEDICATIONS

Filled through Accredo®, a Cigna specialty pharmacy

Specialty medications can cost a lot of money. That's why your plan offers you access to a service called SaveOnSP.¹ **With SaveOnSP, you'll pay \$0 out-of-pocket for your medication.** There's no extra cost to participate – it's available through your pharmacy benefit.²

Pay \$0 with SaveOnSP

If you're filling a medication through Accredo that's available at \$0 with SaveOnSP,³ you should consider using this service.

- ▶ **With SaveOnSP, you'll pay \$0 out-of-pocket for your medication.** The medication's full cost will be paid through a manufacturer copay assistance program.
- ▶ **Without SaveOnSP, you'll pay 30% coinsurance to fill your medication.** You can use the Price a Medication tool on the **myCigna®** App⁴ or **myCigna.com®** to see how much your medication will cost.



Here's an example of how it works.⁵

John's taking an eligible specialty medication. His copay is currently \$70. He has a choice to make.

- ▶ **With SaveOnSP, he won't pay anything (\$0) out-of-pocket.** However, the cost won't count toward his deductible (if he has one) and/or out-of-pocket maximum.
- ▶ **Without SaveOnSP, he'll pay his full 30% coinsurance (which is \$1,000) out-of-pocket.** Also, the cost won't count toward his deductible (if he has one) and/or out-of-pocket maximum.

SaveOnSP proactively contacts members who take an eligible specialty SaveOnSP medication. Members receive mailed letters and phone calls starting about 60 days before the program effective date to explain the program and help them enroll. The member must enroll in the SaveOnSP program. SaveOnSP assists with enrollment by phone. Once enrolled, the member pays \$0 out-of-pocket for eligible specialty medication(s). Enrollment is completed annually as long as the member is taking an eligible drug. If a member tries to fill an eligible medication before enrolling, the pharmacy will receive a message directing the member to contact SaveOnSP. Once the member is enrolled, SaveOnSP coordinates with the pharmacy so the claim processes correctly.

Para obtener ayuda o información en español, llamar al numero 866-494-2111.

1. SaveOnSP is a service of Express Scripts, and Express Scripts is a Cigna company. SaveOnSP is included in your pharmacy benefit at no extra cost to you. SaveOnSP, Express Scripts and Cigna are working together to better serve you and all of your pharmacy, health and wellness needs.
2. SaveOnSP is only available to non-Health Savings Account (HSA) plans. If your plan offers multiple plan options and you'd like to use SaveOnSP, you'll need to select a non-HSA plan during open enrollment. If you move to a different plan during open enrollment, you may no longer be eligible for SaveOnSP.
3. Eligible specialty medications are not considered "essential health benefits" (minimum coverage requirements under the Affordable Care Act). SaveOnSP medications and their coinsurance are subject to change.
4. App/online store terms and mobile phone carrier/data charges apply.
5. For illustrative purposes only. It's not an actual Cigna customer experience. Plans may vary.

All Cigna products and services are provided exclusively by or through operating subsidiaries of Cigna Corporation, including Cigna Health and Life Insurance Company, Connecticut General Life Insurance Company, Accredo Health Group, Inc., Express Scripts, Inc., and HMO or service company subsidiaries of Cigna Health Corporation. "Accredo" refers to Accredo Health Group, Inc. The Cigna name, logo, and other Cigna marks are owned by Cigna Intellectual Property, Inc. "Accredo" is a trademark of Express Scripts Strategic Development, Inc.

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Dental Insurance



Go to www.mycigna.com to locate an in-network provider. Please note that your out-of-pocket costs may be more if you choose to go to an out-of-network provider.

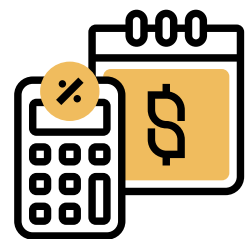
*Child-dependent is covered until age 26. Coverage terminates at the end of the calendar year when the dependent turns 26.

DHMO Network: Cigna Dental Care Plus

DPPO Network: Cigna DPPO Advantage



	DHMO K1109		DPPO	
Network Access	In-Network Only		In-Network	Out-of-Network
Deductible	No Ded \$0 Office Visits		\$50 / \$150	\$100 / \$300
Deductible waived for preventive	None		Yes	Yes
Preventive	Some procedures Covered 100%		100% Covered	80%
Basic	Copays Apply		80%	50%
Major	Copays Apply		60%	40%
Periodontics / Endodontics	Copays Apply		Basic	
Annual Maximum Benefit	None		\$5,000	\$2,500
Out of Network Reimbursement Level	In-Network Only		Fee	UCR
Orthodontic	Copays Apply		50%	
Orthodontic Eligibility	Adult & Children		Children up to age 19	
Orthodontic Maximum	None		\$1,500	
Payroll Deductions	WEEKLY	SEMI-MONTHLY	WEEKLY	SEMI-MONTHLY
Employee Only	\$3.32	\$7.20	\$11.57	\$25.07
Employee / Spouse	\$5.82	\$12.60	\$27.14	\$58.81
Employee / Child(ren)	\$7.20	\$15.60	\$24.65	\$53.42
Employee / Family	\$9.14	\$19.80	\$40.24	\$87.18



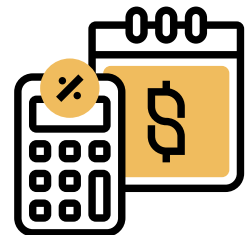
We will continue to partner with UNUM to offer you vision insurance.

With this vision plan, you can obtain new frames every 12 months rather than every 24 months.

Members have the freedom to choose any provider from EyeMed's Insight Network. Our network offers the right mix of independent, national retail and regional retail providers like Lens Crafters, Pearle Vision, Target Optical and many more. Members can also purchase glasses and contact lenses online at Glasses.com and ContractDirect.com.



Voluntary Vision Insurance		
Network Access	In-Network Allowance	Out-Of-Network Reimbursement
Eye Exam	\$10	Up to \$40
Frequency	12 months	
Retinal Imaging	Up to \$39	Not covered
Single	\$10 Copay	Up to \$30
Bifocal	\$10 Copay	Up to \$50
Trifocal	\$10 Copay	Up to \$70
Lenticular	\$10 Copay	Up to \$70
Standard Progressive	\$75 Copay	Up to \$50
Frequency	12 months	
Frames	Up to \$150 Allowance	Up to \$105
Frequency	12 months	
Elective Contact Lenses*	Up to \$150 Allowance	Up to \$150 Allowance
Fitting & Evaluation	Up to \$40	Not Covered
Medically Necessary	Covered	Up to \$210
Payroll Deductions	WEEKLY	SEMI-MONTHLY
Employee Only	\$1.08	\$2.34
Employee / Spouse	\$2.16	\$4.68
Employee / Child(ren)	\$2.28	\$4.94
Employee / Family	\$3.30	\$7.15



*Contact lenses are available once per 12 months in lieu of eyeglass lenses

Life and AD&D Insurance

Life insurance can help provide for you and your loved ones if something were to happen to you. If you have people who depend on you for financial support, it's important to make an educated decision about life insurance options.



Employer Paid Basic Life and AD&D	Benefit Reduction:	Other Benefits Include:
Craig Zinn Automotive Group provides employer paid life insurance and AD&D to all Full-Time Employees eligible for benefits in the amount of: \$25,000	<ul style="list-style-type: none"> • By 35% at age 65 • By an additional 25% at age 70 • By an additional 15% at age 75 • Benefits terminate at retirement 	<ul style="list-style-type: none"> • A "Living Benefit" • Portability

Voluntary Life and AD&D

Employee Benefit	Spouse Benefit	Dependent Children Benefit
<p>Benefit Amount:</p> <ul style="list-style-type: none"> • Choice of \$10,000 Increments • Not to exceed 7 times your annual salary • Maximum Amount: \$300,000 <p>Guarantee Issue:</p> <ul style="list-style-type: none"> • Up to \$200,000, at initial enrollment <p>Other Benefits Included:</p> <ul style="list-style-type: none"> • Living Care / Accelerated Death Benefit • Waiver of Premium • Portability <p>Benefit Reduction</p> <ul style="list-style-type: none"> • By 35% at age 70 • By an additional 15% at age 75 	<p>Benefit Amount:</p> <ul style="list-style-type: none"> • Choice of \$5,000 increments • Maximum Amount: \$150,000 • Not to exceed 100% of employee's selected amount • Employee must elect coverage in order to enroll spouse <p>Guarantee Issue:</p> <ul style="list-style-type: none"> • Up to \$35,000, at initial enrollment <p>Accidental Death and Dismemberment (AD&D)</p> <ul style="list-style-type: none"> • Accidental Death and Dismemberment (AD&D) insurance provides financial protection against unforeseen accidents that result in death or dismemberment. 	<p>Benefit Amount:</p> <ul style="list-style-type: none"> • Choice of \$5,000 increments • Maximum Amount: \$10,000 <p>All children are covered until their 26th birthday.</p>

See the benefit website for the age-banded rates.

Disability insurance can help provide financial support for you and your loved ones if an illness or injury prevents you from working. It is important to make an informed decision about disability insurance options.

Voluntary Short-Term Disability	Company Paid Long-Term Disability
<p>Maximum Weekly Benefit</p> <ul style="list-style-type: none"> • 60% of your salary up to \$1,500 <ul style="list-style-type: none"> ◦ This is the amount of benefit you will receive when you are disabled. <p>Elimination Period</p> <ul style="list-style-type: none"> • Benefit will begin on the 1st Day for an Accident and 8th Day for an Illness. <ul style="list-style-type: none"> ◦ This is the number of days you must be disabled before benefit payments start. <p>Benefit Duration</p> <ul style="list-style-type: none"> • 13 Weeks <ul style="list-style-type: none"> ◦ This is the period of time that benefits will continue to be paid to you during a period of disability. <p>Pre-existing Period</p> <ul style="list-style-type: none"> • 3 months prior / 6 months after <ul style="list-style-type: none"> ◦ This is the period of time you must wait to receive benefits due to a condition that you had prior to coverage. 	<p>Maximum Monthly Benefit</p> <ul style="list-style-type: none"> • 60% of your salary up to \$6,000 <ul style="list-style-type: none"> ◦ This is the amount of benefit you will receive when you are disabled. <p>Elimination Period</p> <ul style="list-style-type: none"> • 90 Days <ul style="list-style-type: none"> ◦ This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits. <p>Benefit Duration</p> <ul style="list-style-type: none"> • This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the SS normal retirement age. <p>Own Occupation</p> <ul style="list-style-type: none"> • 24 Months <ul style="list-style-type: none"> ◦ This is the period of time that the employee need only be disabled from his/her own occupation. <p>Pre-existing Period</p> <ul style="list-style-type: none"> • 3 months prior / 12 months after <ul style="list-style-type: none"> ◦ This is the period of time you must wait to receive benefits due to a condition that you had prior to coverage.



Group Whole Life with Long Term Care

New Benefit!!!

Group Whole Life Insurance can pay money to your family if you die.

It can help them with basic living expenses, tuition and later, final expenses.

How does it work?

You can keep Group Whole Life Insurance as long as you want. Once you've bought coverage, your cost won't increase as you age. Coverage is guaranteed as long as you pay premiums. That means you get protection during your working years and into retirement.

Group Whole Life Insurance also builds cash value at a guaranteed interest rate*. Your plan has a 10-year period during which cash value accumulates, but is not accessible.

Why should I buy coverage now?

- Once you purchase coverage, your premium remains the same as long as premiums are paid.
- When you purchase coverage when first eligible, you qualify for coverage without medical underwriting.
- The cost is conveniently deducted from your paycheck.
- Group Whole Life insurance gives you valuable protection in addition to any term life insurance you might have.
- Your coverage, as well as coverage for your spouse and child (if applicable), is portable, meaning you can take it with you if you leave your company. Your premiums would remain the same but you would be billed directly.



See the benefit website for the age-banded rates.

**Children can be covered past age 26 if they are incapable of self-sustaining employment due to permanent intellectual or physical incapacity prior to reaching age 26. Grandchildren are not eligible for coverage under the Children's Term Rider. The term life coverage provided under this rider ends when a child turns age 26.

Who can get coverage?

Employee (issue ages 15-75)

You can purchase between \$10,000 and \$100,000 in increments of \$10,000 during this enrollment. You can purchase up to \$100,000 without medical underwriting to qualify for coverage.

Spouse (issue ages 15-75):

You can purchase between \$10,000 and \$30,000 in increments of \$10,000 for your spouse during this enrollment. You can purchase up to \$30,000 without medical underwriting to qualify for coverage. You have to purchase coverage for yourself before purchasing coverage for your spouse.

Children's Term Rider

The rider covers all eligible children, as well as future children (newborns, adopted children) for one fixed premium amount. Eligible children must be between live birth and 26 years old, your or your spouse's child, your lawfully adopted child, foster child or any other child residing with you that is dependent on you for primary financial support.**

You can purchase \$20,000 for your children during this enrollment. There will be no option to purchase additional coverage after this enrollment period. You must purchase coverage for yourself to purchase coverage for your children. The amount of Group Whole Life Insurance for a spouse and the amount of coverage under Children's Term Rider will not be more than 100% of the employee Group Whole Life amount.

What's included?

Accelerated Death Benefit for Terminal Illness

You can request an advance payout of your death benefit if you're diagnosed with a terminal illness and expected to live 12 months or less. You can receive up to 100% of the death benefit to a maximum of \$150,000 and it can help cover your costs while you're still alive. Benefits received under this provision are taxable and any payout would reduce the benefit that's paid when you die. When benefits are accelerated under this rider, premiums will be waived for up to 12 months. As with all tax matters, individuals should consult a tax advisor to assess the impact of this benefit.

Accelerated Death Benefit for Long Term Care Rider

Your employer has chosen to include this benefit. Refer to the next page for more information.

Waiver of Premium Rider If you're totally disabled for at least six months before age 65 and you remain totally disabled, you won't have to pay premiums until you recover and return to work. During the six-month elimination period, premiums must continue to be paid. During the period of total disability the cash value does not increase.

New Benefit!!!

Group Whole Life with Long Term Care (continued)

Group Whole Life Insurance

Unum's Accelerated Death Benefit for Long Term Care with Restoration of Benefits Rider can help you preserve your savings.

Protecting long-term plans

Jan's savings are modest, but she's worked hard for every penny. She wants to travel to Italy, pay for her daughter's wedding, and leave something behind for those she loves. But she's seen how quickly the cost of long-term care can deplete a lifetime of savings. She wants to make sure an accident or illness won't threaten her nest egg.

Benefits for the long haul

Thanks to modern medicine, people are now living longer and surviving very serious health problems. But that can mean long-term treatment in a nursing home or assisted living facility. And the same care that saves your life can impact your savings.

By purchasing Group Whole Life insurance with an Accelerated Death Benefit for Long Term Care with Restoration of Benefits Rider, you can help preserve your savings. Most importantly, this coverage allows you to use the benefit whether you receive care at home, or in a long-term care facility, an assisted living facility, an adult day care.

Get the coverage you need

Here are the advantages of our Accelerated Death Benefit for Long Term Care Rider

- Available at initial offering to employees and spouses.
- For long-term care facility, assisted living facility, home health care or adult day care, provides a monthly benefit of 4% of the death benefit,** less any policy debt.
- Benefits are payable once you have been receiving long-term care for 90 days, subject to the conditions of the rider.
- If you are receiving benefits, you don't have to pay the certificate's monthly premiums.
- The benefit period maximum is 100% of the death benefit,** less any policy debt.
- The cost is based on your age at issue.

See your certificate for additional details. This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to the Accelerated Death Benefit for Long Term Care rider and to policy and certificate forms PLA-GWLP22-1, PLA-GWLC22-1 and PLA-GWLADBLTC22-1 or contact your representative.

* Assumes there are no outstanding policy loans.

** Death benefit is the death benefit at the end of the elimination period.

*** Under current tax laws.

How the Accelerated Death Benefit for Long Term Care with Restoration of Benefits works?

Here is an example of how this rider can help you finance a period of long-term care. This illustration is based on an insured individual who has a \$50,000 Life Insurance coverage amount.*

Highlights	
Accelerated Death Benefit for Long Term Care with Restoration of Benefits Rider	
This benefit pays a 4% monthly benefit for LTC facility, assisted living facility, adult day care or home health care benefit. Payments reduce the death benefit** until exhausted (up to 25 months).	\$2,000 per month
Restoration Benefits	
This benefit restores 100% of the certificate's coverage amount, death benefit** and cash value.	\$50,000 death benefit

This is only an example. Eligibility for, entitlement to, and amount of actual benefits will be determined according to the terms of your certificate.

Restoration of Benefits

- Restores 100% of the certificate's coverage amount, death benefit** and cash value.
- Certificate values reduced under the Accelerated Death Benefit for Long Term Care Rider will be restored one time.



Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.



EMPLOYEE ASSISTANCE PROGRAM (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- And more



WORK/LIFE BALANCE

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Child care
- Elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions
- Even reducing your medical/dental bills!
- And more

Who is covered?

Unum's EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver™ — helps you save on medical bills

Help is easy to access:

Phone support: 1-800-854-1446

Online support: unum.com/lifebalance

In-person: You can get up to three visits, available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.



Don't forget this travel essential!

Pack your worldwide emergency travel assistance phone number and leave travel worries at home.



IF YOU EXPERIENCED A MEDICAL EMERGENCY WHILE TRAVELING, WOULD YOU KNOW WHOM TO CALL?

Whenever you travel 100 miles or more from home — to another country or just another city — be sure to pack your worldwide emergency travel assistance phone number. Travel assistance speaks your language, helping you locate hospitals, embassies and other “unexpected” travel destinations. Add the number to your cell phone contacts, so it's always close at hand. Just one phone call connects you and your family to medical and other important services 24 hours a day.

USE YOUR TRAVEL ASSISTANCE PHONE NUMBER TO ACCESS:

- Hospital admission assistance*
- Emergency medical evacuation
- Prescription replacement assistance
- Transportation for a friend or family member to join a hospitalized patient
- Care and transport of unattended minor children
- Assistance with the return of a vehicle
- Emergency message services
- Critical care monitoring
- Emergency trauma counseling
- Referrals to Western-trained, English-speaking medical providers
- Legal and interpreter referrals
- Passport replacement assistance

WHETHER TRAVELING FOR BUSINESS OR PLEASURE, ONE PHONE CALL CONNECTS YOU TO:

- Multi-lingual, medically certified crisis management professionals.
- A state-of-the-art global response operations center.
- Qualified medical providers around the world.

With the Assist America Mobile App, you can:

- Call Assist America's Operation Center from anywhere in the world with the touch of a button.
- Access pre-trip information and country guides.
- Search for local pharmacies (U.S. only).
- Download a membership card.
- View a list of services.
- Search for the nearest U.S. embassy.
- Read Assist Alerts.



Download and activate the app today from the Apple App Store or Google Play.

Reference Number: 01-AA-UN-762490



CRAIG ZINN AUTOMOTIVE GROUP

Hospital Insurance



How does it work?

Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is paid directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get affordable rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire, without having to answer new health questions. You'll be billed directly.

Be Well Benefit

Every year, each family member who has Hospital coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, wellchild visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

Who can get coverage?

You:	If you're actively at work.
------	-----------------------------

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

How much does it cost?

Your weekly premium	
You	\$3.39
You and your spouse	\$7.23
You and your children	\$5.74
Family	\$9.58
Your semi-monthly premium	
You	\$7.35
You and your spouse	\$15.67
You and your children	\$12.44
Family	\$20.75



Accident Insurance



Accident insurance pays a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur on and off the job. And it includes a range of incidents, from common injuries to more serious events.

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly.

What's Included?

Be Well Benefit

Every year, each family member who has Accident coverage can also receive \$50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-Ray, mammography
- Immunization including HPV, MMR, tetanus, influenza

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 10% increase in payable benefits within the injury and Treatment schedule of benefit categories.

ACCIDENT INSURANCE - PLAN Payroll Deductions		
UNUM	WEEKLY	SEMI-MONTHLY
Employee Only	\$3.35	\$7.26
Employee / Spouse	\$6.20	\$13.44
Employee / Child(ren)	\$5.68	\$12.31
Employee / Family	\$8.53	\$18.49

Critical Illness Insurance



If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

The money can help you pay out-of-pocket medical expenses, like co-pays and deductibles.

You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

How much is enough?

The amount of Critical Illness insurance you need depends on your current situation and the expenses you may incur if diagnosed with a serious illness. Consider the following:

Anticipated Out-Of-Pocket Expenses

Home health care needs	\$ _____
Out-of-pocket medical expenses	\$ _____
Travel to treatment centers	\$ _____
Family travel	\$ _____
Child or adult care	\$ _____

Modifications to Accommodate Lifestyle

Home alteration	\$ _____
Car modification	\$ _____
Other	\$ _____

Income

Your lost income (due to time off work)	\$ _____
Lost income of a spouse or caregiver	\$ _____

Total Critical Illness Insurance Needed

Out-of-Pocket Expenses + Modifications + Lost Income = \$ _____

Total Need for Critical Illness Insurance

\$ _____

CRITICAL ILLNESS - PLAN PAYROLL DEDUCTION		
Mutual of Omaha	WEEKLY	SEMI-MONTHLY
Employee Only	Age Banded	Age Banded
Employee / Spouse	Age Banded	Age Banded
Employee / Child(ren)	Age Banded	Age Banded
Employee / Family	Age Banded	Age Banded

Who can get coverage?

You:	Choose \$10,000, \$20,000 or \$30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.



The Preferred Legal Plan incorporates all of the tremendous benefits obtainable with legal expense insurance. Legal Expense Insurance is a comprehensive legal protection program designed to help individuals and their families as well as small business owners deal with various personal and business-related legal issues in a dignified, affordable manner.

A New Wave of Legal Representation

Have Your Own Attorney on Retainer for Less than the Cost of a Cup of Coffee a Day!

The Preferred Legal Plan (PLP) is a licensed legal expense organization providing its members with full service and representation on all types of legal services, including divorce, traffic tickets, buying or selling a home, bankruptcy, wills, probate, DUI, immigration, credit report issues, child support, custody and visitation, garnishments, loan modifications, foreclosures, criminal defenses, litigation, small claims court, personal injury, landlord-tenant disputes, domestic violence and more.

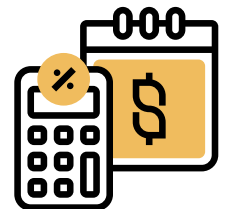
- Free unlimited legal advice via phone consultation
- Free face-to-face consultations with attorneys
- Free review of legal documents (real estate contracts, lease agreements, etc.)
- Free letters and phone calls to third parties on your behalf
- Free credit report analysis and repair and settling accounts in collection
- Free Identify Theft information and restoration
- Free simple Wills for member and spouse (or domestic partner)
- Free legal forms available through PLP Form Library
- Free notary services
- Up to 70% reduced legal fees for attorney representation on all types of legal services
- 24 hours a day, 7 days a week access
- Access to PLP statewide panel of quality attorneys located throughout Florida
- Spouse, dependent children and entire household are covered for one low price
- All communications are strictly confidential
- Tri-lingual attorneys. Se habla espanol. Nou pale Creol.
- Unlimited, immediate use of membership. All pre-existing issues covered.
- No long-term contracts. Employee can cancel during Open Enrollment or if they have a Qualifying Event that is reported within 30 days. Membership is portable.

Questions? Contact PLP toll-free at 888-577-3476

Preferredlegal.com

Legal Insurance

Payroll Deductions		
Preferred Legal	WEEKLY	SEMI-MONTHLY
Employee Only	\$3.22	\$6.98



Important Information about my Plan Highlight

This Plan Highlight is provided as a quick reference to certain key provisions of your retirement plan. Since the plan is based on a complex legal document, the Plan Highlight does not attempt to describe every aspect of the plan or to detail all of its terms. For more complete descriptions of plan provisions, refer to the Summary Plan Description (SPD). If there is a conflict between this Plan Highlight and the SPD, the SPD will prevail.

Can I participate?

Unless you are part of an excluded class of employees, you are eligible for the plan when you have attained age 18. You must also complete twelve month(s) of service with a minimum of 1,000 hours of service.

Please review your Summary Plan Description to determine if you are a member of an excluded class of employees.

When can I start contributing?

Once you are eligible for this program, you may begin participating on the Plan's "Entry Date." The entry date(s) will be monthly. Your Entry Date will be the first day of the month on or following the date the eligibility requirements are satisfied.

How much can I contribute?

You may defer as much as 100% of your eligible wages up to the indexed IRS dollar limitation which is \$24,500 in 2026. If you are age 50 or older by the end of the plan year, you are also eligible to make additional 'catch - up' contributions up to the IRS limitation of \$8,000 this year. All contributions are made on a pre-tax basis for federal income tax purposes and may be made on a pre-tax basis for state income tax purposes if applicable in your state. Contributions are not made before federal payroll tax (FICA).

Can I rollover existing retirement accounts into my account?

Yes, if you have an existing pre-tax individual retirement account (IRA), or qualified retirement plan with a prior employer, you may rollover that account into the Plan.

How does Craig Zinn Automotive Group contribute to my account?

Your Employer may make a Profit Sharing contribution. The amount of this contribution, if any, will be determined by your Employer. You will be eligible for your company's Profit Sharing contribution when you meet the initial entry requirements for the plan. To receive a contribution in subsequent years, you must continue to work 1,000 hours. You must also be employed on the last day of the Plan Year. Your Employer may make a Match contribution. The amount of this contribution, if any, will be determined by your Employer. You will be eligible for your company's match contribution when you meet the initial entry requirements for the plan. To receive a contribution in subsequent years, you must continue to work 1,000 hours. You must also be employed on the last day of the Plan Year.

How do I become vested?

Vesting is your ownership in your retirement account balance. You are always 100% vested in your Employee Deferrals, Rollover Contributions, and Employer Safe Harbor Contributions (if made in the plan) and in the associated investment gains. However, money contributed by the Company may be subject to a vesting schedule. Service for vesting purposes starts from your original date of hire. For each year that you complete 1,000 hours of service, you will be credited with one Year of Service for vesting purposes. Should you leave the company prior to the required service to be fully vested in your entire account balance, you will be entitled to receive an applicable percentage of employer's contribution as show below, plus the entire balance of your deferral contributions. Rollover Account(s) and any Employer Contributions made to a full vested account (examples include Safe Harbor Contributions). Please refer to your summary plan description as this information may change at any time.

Source	Vesting Schedule
Profit Sharing	2/20
Match	2/20

When can money be withdrawn from my account?

You may receive a distribution from the Plan upon separation of service.

Your plan also allows in-service distributions. You may be permitted to take a distribution of all or a portion of your vested account while still an active employee. Please review your SPD to determine if you are eligible for this type of distribution.

May I withdraw funds in the case of a financial hardship?

You may take a distribution from your account if a heavy financial burden can be demonstrated to the Plan Administrator. You must demonstrate that you are unable to obtain funds from any other source. The IRS has provided guidance to assist Plan Administrators in identifying a qualified hardship. A hardship may be distributed only from eligible accounts for the following reasons.

- Buying a principal residence
- Paying for your or a dependent's college education
- Paying certain medical expenses
- Preventing eviction from or foreclosure on your principal residence
- Paying for funeral expenses, or
- Paying for qualifying repairs to your principal residence, within tax law limits

401(k) Advisor

Manuel "Manny" Alonso, Advisor
manny.alonso@raymondjames.com
Office: (305) 662-9394
Cell: (305) 586-7889



Craig Zinn Automotive Group
Employees Get
Up To 20% Off

[Click Anywhere](#)
or Scan Below to
Get Your Discount



Top-Rated Pet Insurance Starting as Low as \$9/Month

Every pet is welcome, any breed, any age, even pets with pre-existing conditions. If a condition remains symptom-free for some time, it may also qualify for future coverage!

Customizable Vet Bill Coverage for Every Pet



Accident Plans

for when they get hurt



Illness Plans

for when they get sick



Wellness Plans

to keep them healthy

How does pet insurance work?

1

Visit Any Vet in the
U.S or Canada

2

Submit Your Claim
Online or our App

3

Get Cash Back for
Covered Vet Bills



Did you know?

Every 6 seconds, a pet owner faces an unexpected vet bill of \$1,000 or more.

Get Your [Special Offer](#) Today: spotpet.link/czgroup



Gallagher

Insurance | Risk Management | Consulting



Annual Enrollment Notices & Disclosures

Craig Zinn Automotive Group June 01, 2026

Arthur J. Gallagher & Co.
www.ajg.com

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 11 - 13 where Notice of Creditable Coverage begin for more details.

PATIENT PROTECTIONS DISCLOSURE

The Craig Zinn Automotive Group Health Plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, Cigna designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Cigna at 866.494.2111 or www.MyCigna.com.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Cigna or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Cigna at 866.494.2111 or www.MyCigna.com.

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: Emerald (Individual: 30% coinsurance and \$3,500 deductible; Family: 30% coinsurance and \$7,000 deductible)

Plan 2: Ruby (Individual: 20% coinsurance and \$2,500 deductible; Family: 20% coinsurance and \$5,000 deductible)

Plan 3: Diamond (Individual: 0% coinsurance and \$1,000 deductible; Family: 0% coinsurance and \$2,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 954.893.8026 or benefits@czag.net.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2026. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidprecovery.com/flmedicaidprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
<p>GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2</p>	<p>Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584</p>
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
<p>Medicaid Website: iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562</p>	<p>Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660</p>
KENTUCKY – Medicaid	LOUISIANA – Medicaid
<p>Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms</p>	<p>Louisiana Medicaid Website: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084</p>
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
<p>Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711</p>	<p>Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspreassistance@accenture.com</p>
MINNESOTA – Medicaid	MISSOURI – Medicaid
<p>Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672</p>	<p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p>

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcnp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah’s Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since January 31, 2026, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
 Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
 1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
 Centers for Medicare & Medicaid Services
www.cms.hhs.gov
 1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Craig Zinn Automotive Group is committed to the privacy of your health information. The administrators of the Craig Zinn Automotive Group Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Human Resources at 954.893.8026 or benefits@czag.net.

HIPAA SPECIAL ENROLLMENT RIGHTS

Craig Zinn Automotive Group Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Craig Zinn Automotive Group Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children’s Health Insurance Program – If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents’ determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan’s special enrollment provisions, contact Human Resources at 954.893.8026 or benefits@czag.net.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children’s health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan’s annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children’s health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

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

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

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

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, your current Craig Zinn Automotive Group coverage will not be affected.

In accordance with the Social Security Act of 1964, this plan will pay as the Secondary plan to Medicare Part A and B as follows:

- a) former Employee such as a retiree, a former Disabled Employee, a former Employee's Dependent, or an Employee's Domestic Partner who is also eligible for Medicare and whose insurance is continued for any reason as provided in this plan (including COBRA continuation);
- b) an Employee, a former Employee, an Employee's Dependent, or a former Employee's Dependent, who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months.

When a person is eligible for Medicare A and B as described above, this plan will pay as the Secondary Plan to Medicare Part A and B regardless if the person is actually enrolled in Medicare Part A and/or Part B and regardless if the person seeks care at a Medicare Provider or not for Medicare covered services,

If you do decide to join a Medicare drug plan and drop your current Craig Zinn Automotive Group coverage, be aware that you and your dependents will not be able to get this coverage back.

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

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

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Craig Zinn Automotive Group changes. You also may request a copy of this notice at any time.

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, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: June 01, 2026
Name of Entity/Sender: Craig Zinn Automotive Group
Contact—Position/Office: Human Resources
Office Address: 1841 N State Road 7
Hollywood, Florida 33021-4510
United States
Phone Number: 954.893.8026

COBRA GENERAL NOTICE

Model General Notice of COBRA Continuation Coverage Rights (For use by single-employer group health plans)

** Continuation Coverage Rights Under COBRA**

Introduction

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); or
- You 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; or
- 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 to: Human Resources.

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.

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 period¹ 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.

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>

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

Craig Zinn Automotive Group

Human Resources

1841 N State Road 7

Hollywood, Florida 33021-4510

United States

954.893.8026

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the credit that lowers your monthly premium, or a reduction in certain cost-sharing, if your employer does not offer coverage to you at all or does not offer coverage that is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%¹ of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.^{1 2}

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

¹ Indexed annually; see <https://www.irs.gov/pub/irs-drop/rp-22-34.pdf> for 2023.

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by [HealthCare.gov](https://www.healthcare.gov) and either- submit a new application or update an existing application on [HealthCare.gov](https://www.healthcare.gov) between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit [HealthCare.gov](https://www.healthcare.gov) or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit <https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/> for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit [HealthCare.gov](https://www.healthcare.gov) for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name Craig Zinn Automotive Group		4. Employer Identification Number (EIN) 59-2359573	
5. Employer address 1841 N State Road 7		6. Employer phone number 954.893.8026	
7. City Hollywood	8. State Florida	9. ZIP code 33021-4510	
10. Who can we contact about employee health coverage at this job? Yohana Rodriguez			
11. Phone number (if different from above)		12. Email address benefits@czag.net	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
 - All employees. Eligible employees are: Actively employed as a regular, full-time employee working 30 hours or more per week.
 - Some employees. Eligible employees are:
- With respect to dependents:
 - We do offer coverage. Eligible dependents are: Your spouse, unless you are legally separated or divorced. Your unmarried natural children, step-children living with you, legally adopted children, and any children whom you have legal or court-ordered responsibility, who are under 26 years of age (for medical, dental and vision). In the state of Florida for medical coverage only, extended coverage may be offered for dependent children up to the end of the calendar year in which your dependents reach 30 years of age, if they meet the following requirements:
 - unmarried and do not have dependents of their own
 - Are residents of Florida or a Student, AND
 - Do not have coverage as a named subscriber, enrollee or covered person under any other group insurance policy or individual health plan or entitled to Medicare benefits.
 Children who are physically or mentally disabled will continue to be covered after age 26, subject to approval and medical documentation supporting the disability.
 - We do not offer coverage.
- If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
 - ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process. Here's the employer information you'll enter when you visit [HealthCare.gov](https://www.healthcare.gov) to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?

Yes (Continue)

13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?

First day of the month following 60 days of full-time employment.

No (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?

Yes (Go to question 15) No (STOP and return form to employee)

15. For the lowest cost plan that meets the minimum value standard* offered only to the employee (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.

a. How much would the employee have to pay in premiums for this plan? \$136.30 – Please note premiums will be adjusted based on your payroll cycle

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?

Employer won't offer health coverage

Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)

a. How much would the employee have to pay in premiums for this plan?

b. How often? Weekly Every 2 weeks Twice a month Monthly Quarterly Yearly Please note premiums will be adjusted based on your payroll cycle

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



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