



Employee Benefit Guide

***Plan Year October 1, 2026
Through September 30, 2027***

presented by:



Introduction

Mercedes-Benz of South Orlando is committed to employee health and welfare. This commitment involves offering a comprehensive benefits program to help prepare you and your family for planned as well as unplanned life events. This guide provides a summary of benefit options available to you.

New beginning October 1, 2026, Mercedes-Benz of South Orlando will be moving Dental, Vision, and Voluntary Life to Principal. Mutual of Omaha will offer Short-Term & Long-Term Disability, Accident, Critical Illness, and Hospital coverage. The Standard will provide Group Whole Life and Cancer coverage.

Note: Dental, Vision, Voluntary Life, and Short-Term Disability benefits have all been enhanced / increased.

Eligibility and Enrollment

All full-time employees working at least 30 hours per week are eligible for benefits. Coverage may also be elected for dependents, including legal spouses and dependent children to age 26 (age 30 in certain circumstances). Beginning on and after January 1, 2024, new hires will now be eligible for benefits on the first of the month following 60 days of full-time employment.

If you choose not to enroll when first eligible, you will have the opportunity to do so during the next annual enrollment. All plan elections are “locked in” for the plan year. Should you or a family member experience an IRS-approved qualifying event, and you notify HR of the qualifying event within 30 days, you will receive special enrollment rights.

Examples of an IRS-approved qualifying event include but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption (or placement for adoption) of a child
- Involuntary loss of other group health insurance
- Death of a dependent
- A dependent becomes covered under another policy
- Change in employment status – moving from part-time to full-time

In the event of a qualifying change in status, you must provide written notification, which includes date of qualifying event and benefits affected, to Human Resources within 30 days of event. You are required to inform Human Resources if you were covering a spouse at the time of your divorce and anytime your covered dependent loses eligibility. The election changes you make must be consistent with the event. For example, if you have a new child, you may add your child but you may not drop your spouse from coverage. If you do not report your qualifying change in status within 30 days, no benefit changes will be allowed until the next open enrollment period.

Payroll Deduction Summary

Benefit	24 Pay Periods (Semi-Monthly Deduction)	26 Pay Periods (Bi-Weekly Deduction)
Florida Blue Medical Base Plan (5781)		
Employee Only	\$0.00	\$0.00
Employee + Spouse	\$517.20	\$477.41
Employee + Child(ren)	\$404.06	\$372.98
Family	\$921.25	\$850.38
Florida Blue Medical Buy-Up Plan (3559)		
Employee Only	\$28.12	\$25.96
Employee + Spouse	\$581.30	\$536.58
Employee + Child(ren)	\$460.29	\$424.88
Family	\$1,013.46	\$935.50
Principal Dental Plan		
Employee Only	\$0.00	\$0.00
Employee + Spouse	\$18.55	\$17.12
Employee + Child(ren)	\$20.38	\$18.81
Family	\$44.01	\$40.62
Principal (VSP) Vision Plan		
Employee Only	\$0.00	\$0.00
Employee + Spouse	\$2.88	\$2.66
Employee + Child(ren)	\$3.45	\$3.18
Family	\$6.32	\$5.83

Important Information Regarding Florida Blue

Remember to register at www.floridablue.com to set up your personalized member account. You can see your benefits, claims, doctors, ID card, and cost-saving tools – all at your fingertips! You will have 24/7 access to your healthcare.

To register:
Go to www.floridablue.com
Click on “Log In”
Then “New Member Registration”

You can also download the Florida Blue app from Apple App or Google Play and register using your FL Blue member account user ID and password. You will have mobile access to your personalized member account and you can even download your member ID card.



Group Medical Plan

Group Medical Plan Choices	Florida Blue Policy J1055	
Plan Descriptions	Base Plan Blue Options (5781)	Buy-Up Plan Blue Options (3559)
Deductible-in Network (Ind./Fam.)	\$1,500/\$4,500	\$500/\$1,500
Ded. Out of Network (Ind./Fam.)	\$4,500/\$13,500	\$750/\$2,250
Coinsurance % (In/Out)	70%/50%	80%/60%
Max. Out of Pocket (Ind./Fam.) In	\$5,500/\$11,000	\$2,500/\$5,000
Max. Out of Pocket (Ind./Fam.) Out	\$11,000/\$22,000	\$5,000/\$10,000
Lifetime Benefit Max	Unlimited	Unlimited
Additional <i>In-Network</i> Benefits:		
PCP Office Visit	\$30	\$20
Specialist Office Visit	\$55	\$40
Diagnostic Lab	\$0	\$0
X-Ray	\$50	\$0 or \$50
Complex Imaging (MRI, MRA, CT)	\$250	\$150
In Hospital Admission	Ded + 30%	\$600 or \$1000 Copay + Phys Ded+20%
Outpatient Procedure/Surgery	ASC: \$200 + Phys \$55/visit; Hosp: Ded + 30%	ASC: \$100 + Phys \$100/visit Hosp: \$200 or \$300 Copay + Phys Ded+20%
Urgent Care	\$60	\$45
Emergency Room	FAC \$500 + Phys Ded+30%	FAC \$350 + Phys Ded+20%
Prescription Drug - Generic	\$10	\$10
Prescription Drug – Name Preferred	\$50	\$50
Prescription Drug – Name Brand	\$80	\$80
Mail Order Prescription	2.5x Copay for 90-day supply	2.5x Copay for 90-day supply

Ded=Deductible; ASC=Ambulatory Surgical Center; Phys=Physician Services; FAC=Facility; Hosp=Hospital

As an employee of Mercedes-Benz of South Orlando, you will have the choice of medical plans offered by Florida Blue. You will be able to select a new plan every year at open enrollment or with a family status change. You must apply for family status changes within 30 days of the event.

Additional information can be found at
www.FloridaBlue.com

Note: The financial analysis is provided by ISCF in an effort to offer clarity in the review of multiple programs. The summary is a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.

Cost Saving Tips

Stay In-Network

- Confirm you are utilizing an in-network provider – BLUE OPTIONS
- Make sure you are working with an in-network laboratory. Florida Blue is QUEST DIAGNOSTICS
- Utilize Value Choice Primary Care, Specialists and Urgent Care to save on copays
- Prescriptions can be filled at any major pharmacy chain except CVS, Target, & Navarro. CVS, Target, & Navarro are not FL Blue contracted in-network pharmacies.

Value Choice Primary Care - \$0 Copay per PCP Visit

As a FL Blue member, you may save time and money when you see a primary care doctor at any Sanitas Medical Centers. Locations are as follows:

Sanitas Medical Centers - Central Florida

- Ocoee – 8995 W Colonial Dr, Ocoee, FL 34761
- Orlando South Central – 5160 S John Young Pkwy, Ste 5190, Orlando, FL 32839
- Orlando East – 11750 E Colonial Dr, Orlando, FL 32817
- Orlando East Central – 258 S Chickasaw Trl, Ste 310, Orlando, FL 32825
- Kissimmee – 1307 E Osceola Pkwy, Kissimmee, FL 34744
- Kissimmee – 833 E Oak St, Kissimmee, FL 34744
- Poinciana – 353 Cypress Pkwy, Kissimmee, FL 34759

Sanitas Medical Centers - West Florida

- Temple Terrace – 8793 N 56th Street, Tampa, FL 33617
- Tampa Lake Magdalene – 14823 N Florida Ave, Tampa, FL 33613
- Tampa Citrus Park – 12879 Citrus Park Dr, Tampa, FL 33625
- Riverview – 3140 S Falkenburg Rd, Riverview, FL 33578
- Tampa – 3617 W Hillsborough Ave, Tampa, FL 33614
- Grove Park – 4546 Grand Blvd, New Port Richey, FL 34652

Value Choice Urgent Care - \$0 Copay on First 2 Visits to Urgent Care

When you need care, you have lots of choices. Choosing an urgent care center can save you money and often has shorter waiting times. As a FL Blue member, you can save even more. For as little as \$0 for the first two (2) visits, you can get quality care from GuideWell Emergency Doctors. Locations are as follows:

GuideWell Emergency Doctors

- Ocoee – 9580 W Colonial, Ocoee, FL 34761
- Orlando – 1706 N Semoran Blvd, Ste 100, Orlando, FL 32807
- Winter Park – 113 N Orlando Ave, Winter Park, FL 32789
- Stadium – 4748 N Dale Mabry Hwy, Tampa, FL 33614
- University – 2330 E Fletcher Ave, Tampa, FL 33612
- Northdale – 16318 N Dale Mabry Hwy, Tampa, FL 33618
- Largo – 1603 Missouri Ave N, Largo, FL 33770
- Palm Harbor– 2375 Curlew Rd, Palm Harbor, FL 34698
- St Petersburg – 1425 4th St N, Ste Petersburg, FL 33704

Ask Your Physician Questions

- Is there a generic alternative for this prescription?
- Can this test be performed in your office?
- Is the lab or advanced imaging facility that you are recommending In-Network?
- Are you applying a preventative code, rather than a diagnostic code, to my routine wellness visit?

Emergency Room vs. Urgent Care Facility

If you have a life-threatening emergency, please go straight to the emergency room. **However, if you have a minor injury or have the flu, go to an urgent care facility.** The Urgent Care Facility will save you time and money at the time of service. Good decisions will also positively impact your medical insurance renewal next year.

Mail Order Savings

If you are taking a maintenance medication for things like allergies, high blood pressure, high cholesterol, birth control, etc. consider using Florida Blue's mail order drug program. The Mail Order program will mean your prescription is delivered to your house – saving you money and time! Please reference the Mail Order savings and convenience within your plan documents for more detailed information.

Urgent Care vs Emergency Room

 URGENT CARE CENTER	 EMERGENCY ROOM
Cold, flu, or fever	Chest pain
Strains, sprains, or breaks	Abdominal pain
Infections	Stroke
Mild burns	Severe head injury
Allergies	Major trauma
Diagnostic services (X-rays, lab tests)	Compound fractures
Minor broken bones (e.g., toes, fingers)	Deep knife or gunshot wounds
Severe sore throat or cough	Moderate or severe burns
Skin rashes and infections	Poisoning or suspected poisoning
Urinary tract infections	Seizures or loss of consciousness
Vomiting, diarrhea or dehydration	Serious head, neck or back injuries
Controlled bleeding, cuts that require stitches	Uncontrollable bleeding

71% of emergency department visits are unnecessary or could have been avoided.



LOWER
cost



You will usually
be seen in under
20 minutes



EXTENDED HOURS
OPEN
WEEKENDS



HIGHER
cost



Average length of
time spent in the
ER nationwide
2 hours
15 minutes



Open
24/7

If you have a life-threatening illness or injury, go to the ER or call 911 right away.



Group Dental Plan

Group Dental Plan	Principal
Benefits	PPO
	Dental PPO
Deductible (Ind./Fam.)	\$50 / \$150
Out of Network Ded (Ind./Fam.)	\$50 / \$150
Per Year Max (per insured) In/Out	\$2,500 / \$2,500
Orthodontia Lifetime Benefit	\$2,000
Preventive (In/Out of Network)	100% / 100%
Basic (In/Out of Network)	80% / 80%
Major (In/Out of Network)	50% / 50%
Orthodontia	50% / 50%
Wait for Major Services	None
Rollover Benefit	Yes
Reimbursement Rate	90 th Percentile

Enhanced/Increased benefits in bold

Preventive: Exam and Cleaning 2x Per Year, Bitewing X-Rays (1 series per calendar year), lab and diagnostic tests. For children 14 and younger this also includes Fluoride treatments 2 times per year, Sealants, Space maintainers, and Harmful habit appliance.

Basic: Full Mouth X-Rays, Fillings, Emergency Exams, Simple & Complex Oral Surgery, Anesthesia/IV Sedation, Periodontics and Endodontics.

Major: Inlays, Onlays, Crowns, Dentures, Implants, Removable Prosthetics and Fixed Partial Dentures.

Orthodontic: X-Rays, Fixed and Removable appliances

As an employee of Mercedes-Benz of South Orlando, you will have the choice of adding yourself, your spouse and/or any dependents to your dental plan at your cost via payroll deduction. You will be able to select a new option every year at open enrollment or with a family status change. You must apply for family status changes within 30 days of the event.

Network Info: www.principal.com/dentist or call: (800) 247-4695

Note: The financial analysis is provided by ISCF in an effort to offer clarity in the review of multiple carriers and programs. The summary is a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Group Vision Plan

Group Vision Plan		Principal (VSP Network)	
Benefits		In Network	Out of Network
Exam Copay Material Copay (Frames/Lenses/Contacts) Frequencies: Exam, Lenses, and Contacts Frames Frame Allowance Frame Allowance at Costco & Walmart Lenses for Eyewear: Single lined lenses Bifocal lined lenses Trifocal lenses Lenticular lenses Elective Contact Lenses Necessary Contact Lenses		\$10 copay	Up to \$45
		\$25 copay	scheduled below
		1x every 12 months	
		1x every 12 months	
		Up to \$200 plus 20% discount on overage	Up to \$70
		\$110 allowance at Costco and Walmart	
		\$25 copay	Up to \$30
		\$25 copay	Up to \$50
		\$25 copay	Up to \$60
		\$25 copay	Up to \$100
		Up to \$200; Up to \$60 for fitting	Up to \$105
		\$25 copay	Up to \$210
Lens options such as progressive lenses, tints, UV, and anti-reflective coating may be available at an additional copay or discount depending on the participating provider.			

As an employee of Mercedes-Benz of South Orlando, you will have the choice of adding yourself, your spouse and/or any dependents to your vision plan at your cost via payroll deduction. You will be able to select a new option every year at open enrollment or with a family status change. You must apply for family status changes within 30 days of the event.

Network Info: www.vsp.com

Note: The financial analysis is provided by ISCF in an effort to offer clarity in the review of multiple carriers and programs. The summary is a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Group Voluntary Term Life/AD&D Principal

Elect an amount as follows:

Employee Life/AD&D Insurance: Increments of \$10,000 up to \$500,000

Spouse Life/AD&D Insurance: Increments of \$5,000 up to \$250,000
Spouse: Minimum Coverage is \$5,000

Note: Employee must purchase Voluntary Life to have Dependent Life eligible; Spouse Life is limited up to 100% of Employee amount.

Child Life Insurance: Choice of \$5,000 or \$10,000

Note: Child is unmarried dependent child(ren) age 6 months up to age 26. Children under 14 days old receive a \$1,000 benefit.

Guarantee Issue Amounts:

Employee - **\$200,000 Under Age 70**; \$10,000 Over Age 70
Spouse - \$30,000 Under Age 70; \$10,000 Over Age 70
Child(ren) - \$10,000

Note: Guarantee Issue during your initial eligibility enrollment period only. Late entrants must provide Evidence of Insurability to Principal.

May I increase my benefit later?

You may be able to enroll for or increase your benefit and your dependents benefit two (2) increments per year during your open enrollment period up to the guarantee issue limit without providing health information.

Coverage is subject to a 35% reduction of benefits at age 65 and an additional 15% reduction at age 70.

See Benefits Counselor for rates.

Note: The financial analysis is provided by ISCF in an effort to offer clarity in the review of multiple carriers and programs. The carrier is the sole source in confirming actual rates. The summary is a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Group Voluntary Whole Life The Standard

Group Whole Life is a permanent life insurance product that is totally portable if you leave employment or retire from Boyland Auto Orlando. Coverage includes two living benefits called (1) Accelerated Death Benefit for Terminal Illness or Condition, and (2) Accelerated Death Benefit for Long Term Care with Restoration of Benefits and Extension of Benefits riders. The second rider acts like a Long Term Care benefit that can be used for home health care or care in a living community setting to name a couple of examples.

With Americans living longer than ever, most of us will need some extra help with everyday activities as we age.¹ The benefits of long-term care insurance go beyond what your health insurance may cover by reimbursing you for services needed to help you maintain your lifestyle if age, injury, illness, or a cognitive impairment makes it challenging for you to take care of yourself.

¹ 2020 US Department of Health and Human Services (www.longtermcare.gov)

Accelerated Death Benefit for Terminal Illness or Condition Rider – How it Works: This living benefit pays a lump-sum advance of 75% of the death benefit when certified terminally ill by a physician.

Accelerated Death Benefit for Long Term Care with Restoration of Benefits and Extension of Benefits Rider – How it Works: This living benefit allows access to the whole life benefits during the insured's lifetime in form of a monthly advance of 6% of the death benefit for up to 17 months while receiving qualified long-term care services after a 90-day elimination period when certified chronically ill by a licensed health care practitioner. The restoration benefit restores the death benefit and cash value on a monthly basis to the pre-acceleration amounts. After 100% of the death benefit has been used as a monthly advance, the extension of benefit extends the monthly advance for up to an additional 17 months, providing a total of up to 34 months of benefits.

Portability – Coverage may be continued if the employee ceases to be a member of an eligible class for any reason. The rates do not change when the employee leaves the Group. To continue coverage, premiums must be paid directly to the company.

Who can Elect Coverage:

- Employee ages 18 – 70
- Working Spouse ages 18 - 70
- Non-Working Spouse ages 18 - 70
- Child ages 0 – 25

Elect an amount as follows:

- Employee Life Insurance: Increments of \$5,000 up to \$75,000
- Spouse Life Insurance: Increments of \$5,000 up to \$30,000
- Child Term Life Insurance: Increments of \$5,000 up to \$20,000

Note: Employee must purchase Voluntary Life to have Dependent Life eligible; Spouse & Child Life is limited up to 100% of Employee amount.

Guarantee Issue Amounts:

- Employee - \$75,000
- Working Spouse - \$30,000
- Non-Working Spouse - \$10,000
- Spouse Work Status Not Available - \$10,000 *(default if working/non-working is not noted)*
- Child(ren) - \$20,000

Note: Guarantee Issue during your initial eligibility enrollment period only. Late entrants must provide Evidence of Insurability to The Standard.

Rates are based upon each covered person's age at the effective date of coverage. Rates do not change as you age. Policy has no reduction in benefits.

Pre-Existing Condition Limitation – Benefits are not paid for a period of chronic illness care resulting from a pre-existing condition that begins within 6 months after the effective date of coverage. This does not apply to a period of care beginning 6 months after the effective date. A pre-existing condition is a condition, whether diagnosed or not, for which symptoms existed within the 6-month period prior to the effective date, or medical advice or treatment was recommended or received from a health care provider within 6 months before the effective date.

See Benefits Counselor for rates.

Note: The financial analysis is provided by ISCF in an effort to offer clarity in the review of multiple carriers and programs. The carrier is the sole source in confirming actual rates. The summary is a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Group Disability Benefits Mutual of Omaha

Disability Insurance is in essence paycheck insurance. This coverage will provide a benefit directly to you in the event you are unable to work due to injury or illness. An injury or sickness may slow you down, but it won't slow down your monthly bills. Expenses like mortgage, rent, car payments, or even daily expenses like groceries and gas, still need to be paid. Disability insurance can help replace your lost income and ensure your finances are not depleted. Please review below for coverage descriptions

Why should you consider disability insurance?

More than half of the American workforce have no disability insurance and are therefore vulnerable to losing their income due to an illness or injury. *

* http://www.disabilitycanhappen.org/diam/2017/diam2017_factsheet_general.pdf.

Short Term Disability is paid 100% by the employee.

Short Term Disability Benefits: Coverage for disability begins on the 15th day of a disability and will continue for up to 24 weeks as long as the employee has the inability to perform the material and substantial duties of their regular occupation. Benefit payments will be paid weekly at 60% of the pre-disability income up to **\$1,500 of weekly benefit**. Benefits received are tax-free.

Note: For new hires and those electing STD for the first time, the plan includes a 3/6 pre-existing condition limitation.

What if I have a pre-existing condition?

A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to effective date of coverage. The pre-existing condition under this plan is 3/6 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 6 months of coverage, would not be covered.

See Benefit Counselor for your payroll deduction.



Long Term Disability is paid 100% by the employee.

Long Term Disability Benefits: Coverage for disability begins after 180 days of disability. This is when the employee has the inability to perform the material and substantial duties of their regular occupation. This coverage lasts for 24 months when the claim is reviewed to see if the employee is not able to meet any occupation definition. Depending on evaluation the employee may be eligible for coverage to up to Normal Social Security Retirement Age. This coverage will pay 60% of the pre-disability income up to \$7,500 of monthly benefit. Benefits received are tax-free. Coverage includes:

- *Waiver of Premium*
- *An employee must be actively at work to be eligible*
- *Total and Partial Disability are covered*
- *Rehabilitation Benefits*
- *Disability Offset Freeze*
- *Survivor Benefits*
- *Pre-existing condition limitation of 3/12 applies to first time enrollees and/or new hires*
- *Mental/Nervous benefits limited to 24 months*
- *Drug/Alcohol benefits limited to 24 months*
- *Reasonable Accommodation Benefit*

This year LTD is offered on a guaranteed issue basis.

Note: Guarantee Issue during your initial or new hire eligibility enrollment period only. Late entrants must provide Evidence of Insurability to Mutual of Omaha.

What if I have a pre-existing condition?

A pre-existing condition is one for which you have received medical treatment, consultation, care or services including diagnostic measures, or if you were prescribed or took prescription medications in the predetermined time frame prior to effective date of coverage. The pre-existing condition under this plan is 3/12 which means any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a disability during the first 12 months of coverage, would not be covered.

See Benefit Counselor for your payroll deduction.

Mutual of Omaha provides prior coverage credit toward pre-existing conditions for those enrolled in current Sun Life STD and LTD.

Note: The financial analysis is provided by ISCF in an effort to offer clarity in the review of the multiple carriers and programs. The carrier is the sole source in confirming the actual rates. The summary is a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Flexible Spending Accounts WEX

Keep more of what you earn. The **Health Care FSA** and **Dependent Care FSA**, allow you to pay for certain eligible health and/or dependent care expenses utilizing pretax dollars. This means that you will pay less in taxes and have more money to spend and save.

When you enroll in a flexible spending account (FSA) during open enrollment, you specify the dollar amount you'd like to direct into your account from each paycheck, up to the annual maximum. You make deposits to your account through tax-free payroll deductions. You use the money in the account to pay off your eligible health or dependent care expenses. WEX administers the flexible spending account program.

Be sure to carefully estimate your FSA contribution amount. Any unused dollars in your account(s) at the end of plan year will be forfeited.

2026 Annual FSA Contribution Amounts

Health Care FSA	\$3,400 maximum – Individual & Family Limit
Dependent Care FSA	\$7,500 maximum – Individual & Family Limit

Health Care Flexible Spending Account

Health Care FSA reimburses you for eligible medical, dental, or vision expenses for you, your spouse, or your eligible dependents. You can use it to pay for certain medical expenses not covered by another insurance plan for anyone you claim as a dependent on your tax return – like copays, deductible, out-of-pocket expenses.

When you enroll in a Health Care FSA, your account is funded up to the amount you elect to contribute for the entire year. So even if you incur eligible expenses before the account is fully-loaded, you can “spend” up to your total plan-year election before funds are deducted from your paycheck and deposited into your account. Your Health Care FSA contributions will continue to be deducted from your paycheck throughout the year.

Accessing the Money in Your Health Care FSA

You will receive a WEX debit card when you enroll in the Health Care FSA. You can use your debit card to pay for eligible goods and services at the point of purchase. Funds will be automatically deducted from your Health Care FSA, reducing your account balance.

The debit card eliminates your need to submit reimbursement requests. Use your FSA debit card at all providers – including physicians, dentists, vision providers, hospitals, urgent care centers, and pharmacies.

When estimating how much to contribute, consider **recurring or planned** expenses – like monthly prescriptions, regular doctor/lab expenses, upcoming planned surgeries, orthodontia (braces) for children, or need to update glasses/contacts.

Examples of eligible Health Care expenses include but are not limited to:

COVID-19

Disposable Face Masks
Antibacterial Hand Sanitizer
Sanitizing Wipes to Prevent
COVID 19

Medicine

Acne Medicine
Allergy Medicine
Ibuprofen

General

Prescriptions
Doctor Fees
Crutches
Flu Shot
Hearing Aids
Motorized Wheelchair
Surgery
X-rays

Dental & Vision

Braces
Dental Cleanings
Orthodontic
Eyeglasses
Contact Lenses
Eye Exam
Eye Surgery

Dependent Care Flexible Spending Accounts

When you enroll in a Dependent Care FSA, you can set aside money to pay for eligible non-medical dependent day care expenses for your children and/or elderly parents so you and your spouse can go to work. Examples of eligible expenses include a childcare or adult day care center, after school or extended day care, a nursery school, summer/holiday day camp, or a caregiver for an elderly or incapacitated dependent.

Note: Under IRS rules, dependent care must be provided by a person with a Social Security Number or a dependent care facility with a Taxpayer Identification Number.

How it Works

When you enroll in the Dependent Care FSA, you will need to submit reimbursement claims to WEX. Unlike Health Care FSA, your Dependent Care FSA is not prefunded. This means that you will be reimbursed only up to the balance in your account at the time you submit a claim. If your claim amounts to more than your account balance, the unreimbursed portion of your claim will be tracked by WEX.

Reimbursements

To obtain reimbursement from your dependent care FSA, complete claim form and attach itemized receipts. Submit your claim form and all documentation via mail, the WEX website, and/or mobile app. *Note: Accounts must be activated via WEX website in order to use the mobile app.*



Voluntary Supplemental - Accident Mutual of Omaha

Mutual of Omaha supplemental policies are offered on a voluntary basis so you have ability to elect benefits that meet you and your families specific needs. Children are eligible for coverage up to age 26.

Accident Insurance – Covers accident both on and off the job. Plan that provides you and your family with hospital, emergency room, doctor, treatment of injuries including specified surgeries, medical services, accidental death and catastrophic accident benefits in the event of a covered accident. Benefits help cover health insurance copays, deductibles, and coinsurance. *Note: Benefits have been enhanced / strengthened in moving to Mutual of Omaha.* Some benefits include but are not limited to:

Accident / Injury	Benefit	Accident / Injury	Benefit
Accidental Death	\$50,000 Employee; \$25,000 Spouse; \$10,000 Child	Ambulance	\$900 Ground / \$2,500 Air
Hospital Admission	\$2,500	Emergency Room Admission	\$400
Hospital Confinement / Per day	\$700/day; Up to 365 days	Urgent Care Center Admission	\$325
ICU Confinement / Per day	\$1,400/day; Up to 30 days	Surgical	Up to \$5,000
Fractures / Dislocations	Up to \$12,000 (surgical); Up to \$6,000 (non-surgical)	Annual Wellness Screening Benefit	\$50

Accident Cost	24 Pay Periods (Semi-Monthly Deduction)	26 Pay Periods (Bi-Weekly Deduction)
Employee Only	\$5.50	\$5.08
Employee + Spouse	\$8.50	\$7.85
Employee + Child(ren)	\$11.50	\$10.62
Family	\$15.00	\$13.85

Note: The summary is provided by ISCF as a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Voluntary Supplemental - Critical Illness Mutual of Omaha

Critical Illness Insurance - Pays a lump sum benefit if you are diagnosed with a covered specified critical illness such as heart attack, stroke, cancer, or specified disease plus some chronic and childhood conditions. Some benefits are subject to pay a recurrence benefit. *Note: Benefits have been enhanced / strengthened in moving to Mutual of Omaha.* Some benefits include but are not limited to:

Elect an amount as follows:

Employee: Increments of \$5,000 up to \$50,000

Spouse: Increments of \$5,000 up to \$30,000

Note: Employee must purchase Voluntary Critical Illness to have Dependent coverage eligible; Spouse Life is limited up to 100% of Employee amount.

Children are included at 50% of Employee amount at no cost.

Guarantee Issue Amounts:

Employee - \$50,000

Spouse - \$30,000

Child – All amounts are Guarantee Issue

Critical Illness Benefits	Initial Diagnosis	Recurrence
Heart Attack	100%	100%
Stroke	100%	100%
Major Organ Failure	100%	100%
Invasive Cancer	100%	100%
Non-Invasive Cancer (In Situ)	25%	25%
Annual Wellness Screening Benefit	\$50	

See Benefit Counselor for your payroll deduction.

Note: The summary is provided by ISCF as a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Voluntary Supplemental - Hospital Indemnity Mutual of Omaha

Hospital Indemnity – Choice of High or Low plan provides you and your family with cash payments to cover copays, deductible, and out-of-pocket expenses in the event of a hospital admission. *Note: Benefits have been enhanced / strengthened in moving to Mutual of Omaha.* Some benefits include but are not limited to:

Hospital Indemnity Benefits	Low Plan	High Plan
First Day Benefits		
Hospital	\$1,000/day; 1 admit yr	\$2,000/day; 1 admit yr
ICU	\$1,000/day; 1 admit yr	\$2,000/day; 1 admit yr
Confinement Benefits		
Hospital	\$100/day; 10 days	\$100/day; 10 days
ICU	\$100/day; 10 days	\$100/day; 10 days
Pregnancy (Normal & Complications)	Included	
Pre-Ex	None	

Hospital Indemnity Cost	24 Pay Periods (Semi-Monthly Deduction)	26 Pay Periods (Bi-Weekly Deduction)
Principal – Low Plan		
Employee Only	\$4.73	\$4.36
Employee + Spouse	\$9.98	\$9.21
Employee + Child(ren)	\$7.35	\$6.78
Family	\$13.13	\$12.12
Principal – High Plan		
Employee Only	\$7.35	\$6.78
Employee + Spouse	\$15.75	\$14.54
Employee + Child(ren)	\$13.13	\$12.12
Family	\$23.63	\$21.81

Note: The summary is provided by ISCF as a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.



Voluntary Supplemental Benefits The Standard

The Standard supplemental policy is offered on a voluntary basis so you have ability to elect benefits that meet you and your families specific needs. Children are eligible for coverage up to age 26.

Cancer Insurance - Policy helps pay some of the direct and indirect costs related to a cancer diagnosis and treatment. Plans include benefits for initial diagnosis, hospital confinement, surgical, radiation / chemotherapy, transportation and lodging, and cancer screening. You have two plans to choose from – Level 1 or Level 2. *Note: Benefits have been enhanced / strengthened in moving to The Standard.* Some benefits include but are not limited to:

Cancer Benefits	Level 1	Level 2
First Occurrence / Diagnosis	\$2,000	\$5,000
Surgery	Up to \$2,250	Up to \$4,500
Hospital Confinement	\$200/day; Up to 70 days	\$200/day; Up to 70 days
ICU	\$300/day; Up to 45 days	\$300/day; Up to 45 days
Radiation / Chemotherapy	Up to \$10,000/yr	Up to \$10,000/yr
Annual Cancer Screening Benefit	\$50	\$50

Cancer Cost	24 Pay Periods (Semi-Monthly Deduction)	26 Pay Periods (Bi-Weekly Deduction)
The Standard – Level 1		
Employee Only	\$10.16	\$9.38
Employee + Spouse	\$17.31	\$15.98
Employee + Child(ren)	\$17.31	\$15.98
Family	\$17.31	\$15.98
The Standard – Level 2		
Employee Only	\$12.57	\$11.60
Employee + Spouse	\$21.54	\$19.88
Employee + Child(ren)	\$21.54	\$19.88
Family	\$21.54	\$19.88

Note: The summary is provided by ISCF as a broad overview of the plan design. Please refer to the actual plan design description offered by the carrier.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

Important Notice from Mercedes-Benz of South Orlando 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 Mercedes-Benz of South Orlando 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. Mercedes-Benz of South Orlando has determined that the prescription drug coverage offered by the Mercedes-Benz of South Orlando 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 while enrolled in Mercedes-Benz of South Orlando coverage as an active employee, please note that your Mercedes-Benz of South Orlando P coverage will be the primary payer for your prescription drug benefits and Medicare will pay secondary. As a result, the value of your Medicare prescription drug benefits will be significantly reduced. Medicare will usually pay primary for your prescription drug benefits if you participate in Mercedes-Benz of South Orlando coverage as a former employee.

You may also choose to drop your Mercedes-Benz of South Orlando coverage. If you do decide to join a Medicare drug plan and drop your current Mercedes-Benz of South Orlando coverage, be aware that you and your dependents may 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 Mercedes-Benz of South Orlando 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 Mercedes-Benz of South Orlando 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:

- x Visit www.medicare.gov
- x 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
- x 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: October 1, 2026

Name of Entity/Sender: Mercedes-Benz of South Orlando
Contact--Position/Office: Sharon Wilson, Controller
Address: 4301 Millenia Blvd, Orlando, FL 32839
Phone Number: 407-367-2706

HIPAA SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment in Mercedes-Benz of South Orlando group health coverage for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, 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).

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

Finally, you and/or your dependents may have special enrollment rights if coverage is lost under Medicaid or a State health insurance ("CHIP") program, or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify the company and enroll in the plan.

To request special enrollment or obtain more information, contact Sharon Wilson, Controller, 407-367-2706.

HIPAA NOTICE OF PRIVACY PRACTICES

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

Mercedes-Benz of South Orlando sponsors certain group health plan(s) (collectively, the "Plan" or "We") to provide benefits to our employees, their dependents and other participants. We provide this coverage through various relationships with third parties that establish networks of providers, coordinate your care, and process claims for reimbursement for the services that you receive. This Notice of Privacy Practices (the "Notice") describes the legal obligations of Mercedes-Benz of South Orlando, the Plan and your legal rights regarding your protected health information held by the Plan under HIPAA. Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice to you pursuant to HIPAA. The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

Note: If you are covered by one or more fully-insured group health plans offered by Mercedes-Benz of South Orlando, you will receive a separate notice regarding the availability of a notice of privacy practices applicable to that coverage and how to obtain a copy of the notice directly from the insurance carrier.

Contact Information

If you have any questions about this Notice or about our privacy practices, please contact Sharon Wilson, Controller, swilson@mbso.com

Mercedes-Benz of South Orlando
Sharon Wilson, Controller
PO 4301 Millenia Blvd, Orlando, FL 32839
407-367-2706
swilson@mbso.com

Effective Date

This Notice as revised is effective October 1, 2026.

Our Responsibilities

We are required by law to:

- x maintain the privacy of your protected health information;
- x provide you with certain rights with respect to your protected health information;
- x provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- x follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and to make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any material change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices. You may also obtain a copy of the latest revised Notice by contacting our Privacy Officer at the contact information provided above. Except as provided within this Notice, we may not disclose your protected health information without your prior authorization.

How We May Use and Disclose Your Protected Health Information

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose protected health information will fall within one of the categories.

For Treatment

We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel

who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is inappropriate or dangerous for you to use.

For Payment

We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

For Health Care Operations

We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. The Plan is prohibited from using or disclosing protected health information that is genetic information about an individual for underwriting purposes.

To Business Associates

We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with us.

As Required by Law

We will disclose your protected health information when required to do so by federal, state or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety

We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors

For the purpose of administering the Plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation

If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose your protected health information for public health actions. These actions generally include the following:

- x to prevent or control disease, injury, or disability;
- x to report births and deaths;
- x to report child abuse or neglect;
- x to report reactions to medications or problems with products;
- x to notify people of recalls of products they may be using;
- x to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- x to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities

We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the

government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may disclose your protected health information if asked to do so by a law enforcement official—

- x in response to a court order, subpoena, warrant, summons or similar process;
- x to identify or locate a suspect, fugitive, material witness, or missing person;
- x about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- x about a death that we believe may be the result of criminal conduct;
- x about criminal conduct; and
- x in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities

We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates

If you are an inmate of a correctional institution or are in the custody of a law enforcement official, we may disclose your protected health information to the correctional institution or law enforcement official, if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research

We may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has
 - (a) reviewed the research proposal; and
 - (b) established protocols to ensure the privacy of the requested information and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information we are required to make.

Government Audits

We are required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

Disclosures to You

When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We are also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Notification of a Breach.

We are required to notify you in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information, as defined by HIPAA.

Other Disclosures

Personal Representatives

We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person;
- (2) treating such person as your personal representative could endanger you; or
- (3) in the exercise or professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members

With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations

Other uses or disclosures of your protected health information not described above, including the use and disclosure of psychotherapy notes and the use or disclosure of

protected health information for fundraising or marketing purposes, will not be made without your written authorization. You may revoke written authorization at any time, so long as your revocation is in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation. You may elect to opt out of receiving fundraising communications from us at any time.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy

You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, submit your request in writing to the Privacy Officer at the address provided above under Contact Information. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may have a right to request that the denial be reviewed and you will be provided with details on how to do so.

Right to Amend

If you feel that the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at the address provided above under Contact Information. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- x is not part of the medical information kept by or for the Plan;
- x was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- x is not part of the information that you would be permitted to inspect and copy; or
- x is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures

You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures. To request this list or accounting of disclosures, you must submit your request in writing

to the Privacy Officer at the address provided above under Contact Information. Your request must state a time period of no longer than six years and may not include dates prior to your request. Your request should indicate in what form you want the list (for example, paper or electronic). We will attempt to provide the accounting in the format you requested or in another mutually agreeable format if the requested format is not reasonably feasible. The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. We are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you. To request restrictions, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Privacy Officer at the address provided above under Contact Information. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, telephone or write the Privacy Officer as provided above under Contact Information.

For more information, please see [Your Rights Under HIPAA](#).

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

To file a complaint with the Plan, telephone write the Privacy Officer as provided above under Contact Information. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Rights or with us. You should keep a copy of any notices you send to the Plan Administrator or the Privacy Officer for your records.

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

If you or your child(ren) 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 child(ren) 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](tel: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 \(3272\)](tel:1-866-444-EBSA).

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, 2024. Contact your State for more information on eligibility –

FLORIDA – Medicaid

Website: <http://flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html>
Phone: 1-877-357-3268

To see if any other states have added a premium assistance program since January 31, 2024, 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)

Department of Health and Human Services Centers for Medicare &
Medicaid Services

www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

WOMEN'S HEALTH CANCER RIGHTS ACT (WHCRA) NOTICE

Do you know that your Plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 407-367-2706 for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT (NMHPA) NOTICE

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 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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

MODEL GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS

**** 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:

- x Your hours of employment are reduced, or
- x 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:

- x Your spouse dies;
- x Your spouse's hours of employment are reduced;
- x Your spouse's employment ends for any reason other than his or her gross misconduct;
- x Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- x 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:

- x The parent-employee dies;
- x The parent-employee's hours of employment are reduced;
- x The parent-employee's employment ends for any reason other than his or her gross misconduct;
- x The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- x The parents become divorced or legally separated; or
- x 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:

- x The end of employment or reduction of hours of employment;
- x Death of the employee; or
- x 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: Sharon Wilson - Controller.

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, Medicaid, 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.

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

Mercedes-Benz of South Orlando
Sharon Wilson, Controller
4301 Millenia Blvd, Orlando, FL 32839
407-367-2706
swilson@mbso.com



Important Contact Information

Medical	Dental
Florida Blue – Policy #J1055 www.FloridaBlue.com (888) 476-2227	Principal www.principal.com (800) 247-4695
Vision	Voluntary Term Life
VSP (Vision Service Plan) www.vsp.com (800) 877-7195	Principal www.principal.com (800) 245-1522
Group Whole Life & Cancer	Short Term & Long Term Disability
The Standard (800) 521-3535	Mutual of Omaha www.MutualofOmaha.com/Dental (800) 927-9197
Accident, Critical Illness, & Hospital	Flexible Spending Accounts
Mutual of Omaha www.MutualofOmaha.com/Dental (800) 927-9197	WEX www.customerservice@wexhealth.com (866) 451-3399 <i>Note: Accounts must be activated via WEX website in order to use the mobile app</i>

This booklet is intended for illustrative purposes only. The brief summaries of benefits are intended to highlight key features of the plans and do not include all benefits, limitations, and/or contract exclusions. Please refer to the carriers' Certificate of Coverage, Summary Plan Description, or other Policy Document for complete plan terms. If any information in this booklet is conflicting, the Certificate of Coverage, Summary Plan Description, or other Carrier Policy Document will prevail.

