wellbeing365

Benefits
Owner's Manual

Benefits Effective Jan. 1–Dec. 31, 2025

IMPORTANT NOTICE

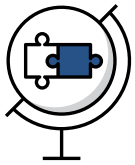
This Benefits Guide includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From DriveTime About Your Prescription Drug Coverage and Medicare."

Benefits Built for You

At the DriveTime family of companies, we care about you. That's why we offer benefits that support your total wellbeing.

Understanding your benefits and knowing how to use them is just as important as having access to them. Review this owner's manual to learn about the benefits available to you for the 2025 plan year (January 1, 2025, through December 31, 2025). Then, choose the options that are best for you and your family.

wellbeing365


Engage


Physical


Mental


Financial

Who is eligible

You are eligible to elect benefits on your first day of employment. Your benefits coverage will begin on day 31 of employment.

Many of the plans allow you to cover your eligible dependents, which include:

- Your legal spouse or common law spouse*
- Your children to age 26, regardless of student, marital, or tax-dependent status (including a stepchild, legally-adopted child, a child placed with you for adoption, or a child for whom you are the legal guardian)
- Your dependent children of any age who are physically or mentally unable to care for themselves

*Common law spouses are only eligible in Texas.

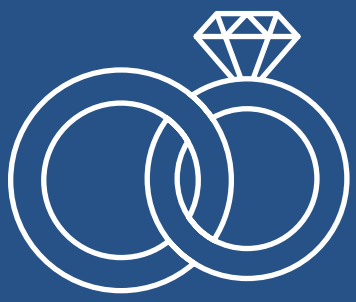
You may need to provide proof of your dependent's eligibility, such as a marriage license, birth certificate, or court document.

Who pays

DriveTime pays 100% of some benefits; others require your contribution.

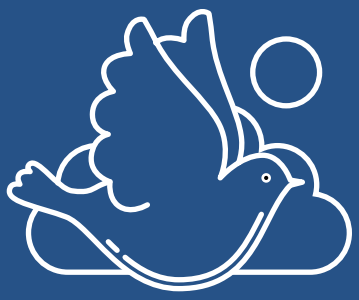
Benefit	You Pay	DriveTime Pays
Medical Insurance	X	X
Teladoc		X
Lantern (formerly SurgeryPlus)		X
Personify Health (formerly Virgin Pulse)		X
Dental Insurance	X	X
Vision Insurance	X	
Health Savings Account	X	X
Flexible Spending Accounts	X	
Short-Term Disability Insurance		X
Voluntary Long-Term Disability Insurance	X	
Basic Life and AD&D Insurance		X
Supplemental Life and AD&D Insurance	X	
Accident, Critical Illness, and Hospital Indemnity Insurance	X	
401(k) Retirement Savings Plan	X	X
Maternity and Paternity Leave		X
Employee Assistance Program		X
LifeGuides		X
Pet Insurance	X	X

Changing your benefits



MARRIAGE

BIRTH OR ADOPTION



DEATH

Due to IRS regulations, once you have made your elections for 2025, you cannot change your benefits until the next annual open enrollment period.

The only exception is if you experience a qualifying life event. **Election changes must be consistent with your life event.**

Qualifying life events include, but are not limited to:

- Marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your child's eligibility for benefits
- Qualified Medical Child Support Order
- Change in your spouse's work status that affects his or her benefits

HOW TO REQUEST A BENEFITS CHANGE

Log into Workday within 31 days of the qualifying life event and follow these steps:

1. Select View All Apps from the Homepage.
2. Select the Benefits app.
3. Select the Benefits box.
4. Select the Change Reason you need and Enter Date. Documents will be required as proof of the qualifying life event you are choosing. Examples include a marriage license or birth certificate.
5. Select Submit.
6. Select Inbox icon.
7. Select the Change Benefit Elections.
8. Select Let's Get Started.
9. Answer the question and select Continue.
10. Select the Enroll tab on each Account you want to change/enroll in. Answer all the required information needed in each account. These could include names, birth dates, and Social Security numbers.
11. Select either Review and Sign to complete or Save for Later if you need to review your choices.

Change requests submitted after 31 days cannot be accepted.

Pick your best benefits

Want to save time and find the right plans for your needs? Talk with ALEX at **start.myalex.com/drivetime**.

Look for this icon placed next to items that ALEX can explain in more detail.

WHO IS ALEX?

ALEX is your personal DriveTime benefits expert. He's funny, speaks in plain English—not insurance-talk—and is available to help you figure out which benefits plans will best serve your needs (anonymously, of course).

WHAT INFORMATION DOES ALEX NEED FROM ME?

Rest assured, ALEX respects your privacy and will never ask for personally identifiable information. Here's the information he needs to match you with the right health plan:

- Age and gender for you and your family.
- Household income.
- Health care utilization over the last 12 months.
- Regularly taken prescription drugs.
- Willingness to take a risk—understanding the trade off between risk protection and cost savings.
- Ability to pay for unexpected medical care (e.g. having an emergency fund).

HOW LONG DOES IT TAKE TO GET A RECOMMENDATION?

It takes less than 10 minutes to receive a recommendation. In fact, most users complete the entire process in about 6 minutes, allowing you to easily and quickly make your benefits decisions.

DOES ALEX FAVOR CERTAIN PLANS OVER OTHERS?

No, ALEX is 100% objective and solely focused on finding the ideal health plan for you—not your employer and not your insurance company.

Choosing benefits is hard. ALEX makes it easy.

Medical insurance

TALK WITH ALEX

DriveTime offers three medical plan options through UnitedHealthcare—the PPO plan, the Surest Defined Copay Plan, and the high-deductible health plan (HDHP).

All plans utilize the same UnitedHealthcare network of providers and facilities.

COMPARE YOUR OPTIONS

PPO
- Higher cost per paycheck
- Lower embedded deductible
- You can fund a health care flexible spending account (FSA)

Surest Defined Copay Plan
- Mid cost per paycheck
- No deductible
- Set copays for all services and providers including bundled services
- You can fund a health care flexible spending account (FSA)

HDHP
- Lower cost per paycheck
- Higher embedded deductible
- You can fund a health savings account (HSA)

THREE THINGS TO CONSIDER

1. What **PLANNED** medical services do you expect to need in the upcoming year?

2. Do you prefer to pay **MORE** for your medical insurance premium or do you prefer to pay a **LOWER** premium and invest your savings in a health savings account (HSA)?

3. Do you or any of your covered family members take any prescription **MEDICATIONS** on a regular basis? HDHP members must meet their deductible before the copay amount applies. PPO and Surest Defined Copay Plan members are only required to pay the copay amount.

DEDUCTIBLE

The amount you must pay for services before the plan will begin to pay. After one member—whether it be employee, spouse, or child—meets their own deductible, the plan will begin to pay.

PPO In-Network Deductible: Individual: $1,500; Family: $3,000

Surest Defined Copay Plan In-Network Deductible: Individual/Family: $0

HDHP In-Network Deductible: Individual: $3,500; Family: $7,000

OUT-OF-POCKET (OOP) MAX

The maximum amount of money you will pay for medical services during the plan year. The OOP max is the sum of your deductible (if applicable), copays, and coinsurance payments.

PPO In-Network OOP Max: Individual: $3,500; Family: $7,000

Surest Defined Copay Plan In-Network OOP Max: Individual: $4,000; Family: $8,000

HDHP In-Network OOP Max: Individual: $5,000; Family: $10,000

COINSURANCE

A form of cost-sharing where you and the insurance plan share expenses in a specified ratio after you meet the deductible (until you reach the OOP max).

PPO In-Network Coinsurance: 20%

Surest Defined Copay Plan In-Network Coinsurance: Not Applicable

HDHP In-Network Coinsurance: 20%

Medical insurance

TALK WITH ALEX

The three plans offer in- and out-of-network benefits, providing you the freedom to choose any provider. However, you will pay less out of your pocket when you choose a UnitedHealthcare provider. Locate a UnitedHealthcare network provider at **myuhc.com**.

The table below summarizes the benefits of each medical plan. The coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	PPO		Surest Defined Copay Plan		HDHP	
	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network
Plan Year Deductible Individual/Family	Embedded $1,500/$3,000	Embedded $3,000/$6,000	$0/$0		Embedded $3,500/$7,000	Embedded $5,600/$11,200
The amount that DriveTime contributes to your health savings account (HSA)	N/A		N/A		Up to a $400 match for employee-only coverage; Up to a $700 match for all other coverage levels	
Out-of-Pocket Maximum (Includes deductible, copays, and coinsurance) Individual/Family	Embedded $3,500/$7,000	Embedded $7,000/$14,000	Embedded $4,000/$8,000	Embedded $8,000/$16,000	Embedded $5,000/$10,000	Embedded $10,000/$20,000
Preventive Care	Plan pays 100%	40% after ded.	Plan pays 100%	$100 copay	Plan pays 100%	40% after ded.
Physician Services						
Premium Primary Care Physician	$20 copay	40% after ded.	Check the Surest app for lowest-cost providers		10% after ded.	40% after ded.
Primary Care Physician	$30 copay	40% after ded.	$10-$65 copay	$195 copay	20% after ded.	40% after ded.
Premium Specialist	$40 copay	40% after ded.	Check the Surest app for lowest-cost providers		10% after ded.	40% after ded.
Specialist	$50 copay	40% after ded.	$10-$65 copay	$195 copay	20% after ded.	40% after ded.
Virtual Care	$0 fee	Not covered	$0-$65 copay	Not covered	0% after ded.	Not covered
Urgent Care	$75 copay	40% after ded.	$35 copay	$105 copay	20% after ded.	40% after ded.
Lab/X-Ray						
Diagnostic Lab/X-Ray	20%	40% after ded.	Plan pays 100%[1]		20% after ded.	40% after ded.
High-Tech Services	20% after ded.	40% after ded.	$60-$450 copay	Up to $1,350 copay	20% after ded.	40% after ded.
Hospital Services						
Inpatient	$200 copay, then 20% after ded.	40% after ded.	$75 to $2,500 copay	Up to $7,000 copay	20% after ded.	40% after ded.
Outpatient	20% after ded.	40% after ded.			20% after ded.	40% after ded.
Emergency Room (ER)	1–2 visits: $250 + 20% after ded. 3–5 visits: $350 + 20% after ded. 6+ visits: $500 + 20% after ded.		$350 copay		20% after ded.	
Prescription Drugs					**After ded.:**	
Tier 1	$10 copay	Not covered	$10 copay	Not covered	$10 copay	Not covered
Tier 2	$35 copay		$35 copay		$35 copay	
Tier 3	$60 copay		$60 copay		$60 copay	
Tier 4	20% up to $250		20% up to $250		20% up to $250	
Mail Order (90-day supply)	2x retail copay		2x retail copay		2x retail copay	

Note: The Premium Provider program is not available in St. Louis. (1) Cost included in bundled services copay.

ARE YOU COVERING YOUR SPOUSE AND/OR CHILDREN?

The deductibles on the PPO and HDHP are embedded. That means after one member—whether it be employee, spouse, or child—meets their own deductible, the plan will begin to pay.

Medical insurance

TALK WITH ALEX

UNDERSTANDING THE SUREST DEFINED COPAY PLAN

There is no deductible or coinsurance under the Surest Defined Copay Plan. When you need care, other than preventive care, you pay a designated copay for all services. The Surest Defined Copay Plan is easy to use, offers up-front pricing and is designed to help you find opportunities to save money. This plan utilizes the same UnitedHealthcare network, providers, and facilities as the PPO and HDHP.

Health services are assigned a designated copay based on the provider and location. For preventive care, the copay is $0 if you visit an in-network provider. A surgery copay includes surgeon, anesthesiologist, and hospital fees. Maternity care includes routine prenatal visits, routine ultrasounds, labs, and tests covered at a $0 copay. The maternity delivery copay includes these in-network services: routine labor and delivery—vaginal or C-section; episiotomy, epidurals, medications, and supplies; provider fees, including OB-GYN, midwife, and anesthesiologist; routine hospital or birthing center stay; routine labs and tests; and routine newborn care in the hospital.

Just like the other medical plans available to you, the out-of-pocket maximum is the most you'll pay in a calendar year for services covered by the plan. Once this limit is reached, the plan pays 100% for covered services for the rest of the calendar year.

Before making an appointment, check and compare costs—then choose the option that works best for your budget and lifestyle. Receive one bill for a single trip to the doctor or hospital.

To view prices or check if your doctor is in the network, visit britehr.app/DriveTime-2025.

MEDICAL COSTS

Listed below are the per pay period costs for medical insurance. The amount you pay for coverage is based on your completion of the wellness program requirements. The rates are deducted from your paycheck on a pre-tax basis, which means you don't pay taxes on the amount you pay for coverage.

Wellness rates:

Coverage Level	PPO		Surest Defined Copay Plan		HDHP	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Employee Only	$63.00	$254.78	$41.00	$168.22	$0.00	$156.60
Employee + Spouse	$225.00	$523.63	$147.00	$334.95	$54.00	$313.20
Employee + Child(ren)	$173.00	$430.73	$113.00	$278.52	$32.00	$259.20
Employee + Family	$291.00	$743.21	$190.00	$475.87	$86.00	$442.80

Standard rates:

Coverage Level	PPO		Surest Defined Copay Plan		HDHP	
	Full-Time	Part-Time	Full-Time	Part-Time	Full-Time	Part-Time
Employee Only	$151.00	$316.66	$104.00	$214.63	$43.00	$199.80
Employee + Spouse	$398.00	$631.86	$274.00	$433.12	$162.00	$405.00
Employee + Child(ren)	$260.00	$518.40	$179.00	$348.14	$103.00	$324.00
Employee + Family	$463.00	$897.38	$319.00	$615.15	$189.00	$572.40

Medical insurance

MAVEN

Maven, our maternity benefit, is available to medical plan members for maternity and high-risk pregnancy support.

With Maven's 24/7 virtual platform, you and your partner can access support during pregnancy and 3 months postpartum for:

- Pregnancy and birth planning
- Postpartum and what to expect
- Breastfeeding and bottle feeding
- Infant sleep coaching
- Prenatal and postpartum mental health
- Career coaching and returning to work after parental leave
- Pregnancy loss and miscarriage

Maven is a product of Maven Clinic Co. Maven is an independent company contracted to provide family-building support including care advocacy, virtual coaching, and education. Maven does not provide medical care and is not intended to replace your in-person health care providers. Use of the services is subject to terms of service and privacy policy. Maven® is a registered trademark of Maven Clinic Co. All rights reserved.

Join Maven today for free. Scan the QR code or **click here** to join today.

VIRTUAL CARE

Virtual care allows you to connect with a physician for your on-going care needs and get the guidance to in-person care when needed.

Help with ongoing health concerns and conditions:

- **Wellness screenings:** Cancer screenings, cholesterol, blood sugar tests, adult vaccines, and risk assessments.
- **Diabetes:** A1c, kidney, neuropathy screenings, medication.
- **Back pain and arthritis:** Evaluation, care, lifestyle tips, medication.
- **Skin conditions:** Infections, rashes, burns, acne, eczema.
- **Men's and women's health:** Sexual health, hormone testing, exercise, diet.
- **Heart health:** Blood pressure, cholesterol screenings, care plans, medication.
- **Sleep problems and asthma:** Care plans, screening, medication.

Data rates may apply.

Virtual care is applied to physician services benefits — it is not applied to 24/7 Virtual Visits benefit. Due to physician licensing restrictions, virtual care is only available within the member's state of residence.

GET STARTED TODAY

Access your UnitedHealthcare or Surest member portal to find virtual services available to address your needs.

Schedule same-day or next-day appointments.

Engage with your virtual provider as needed.

Medical insurance

TALK WITH ALEX

Access your plan information 24/7.

PPO AND HDHP MEMBERS

Download the UnitedHealthcare app and activate your account to:

- Find doctors and medical services.
- Manage and track claims.
- See cost estimates for medical procedures.
- Compare quality of care ratings for doctors and hospitals.
- Manage your health and medical costs.

Scan the QR to download the app or register online at **myuhc.com** to get started.

The UnitedHealthcare® app is available for download for iPhone® or Android®. Android is a registered trademark of Google LLC.

SUREST DEFINED COPAY PLAN MEMBERS

Download the Surest app and activate your account to:

- Understand variable copay options for services.
- Compare care options.
- Choose the care that works best for your family, lifestyle, and budget.

Scan the QR to download the app or register online at **benefits.surest.com** to get started.

SAVE MONEY ON YOUR HEALTH CARE

Choose an in-network provider.

Choose an in-network provider and you'll pay less out of your pocket. In-network doctors and facilities contract with the insurance company and agree to charge a lower price for services.

- **PPO or HDHP:** Save even more by choosing a Premium Provider (look for the icons to the left).
- **Surest Defined Copay Plan:** Compare the cost of providers and services on the Surest app. Lower prices are assigned to higher-value care options.

Note: The Premium Provider program is not available in St. Louis.

Know your medication options.

Talk with your doctor about lowering your out-of-pocket costs by switching from a brand-name medication to a generic. Then sign up for home delivery through UnitedHealthcare's mail-order pharmacy. Home delivery will save you money—and time, too.

Try Teladoc.

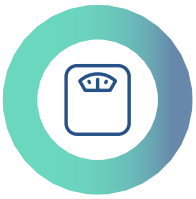
Teladoc providers can treat you right from your phone, tablet, or computer. It's more convenient and less expensive than urgent care. Visit **teladoc.com** to get started.

Medical insurance

DriveTime medical plan members have access to the following programs at no additional cost.

QUIT FOR LIFE

We recognize that quitting tobacco is difficult, and we encourage you to take advantage of the Quit For Life tobacco cessation program available to employees **AT NO ADDITIONAL COST**. **Quit For Life treats every tobacco user as a unique individual and tailors a quitting plan based on your needs.** Log into **myuhc.com** to sign up.



REAL APPEAL

Real Appeal is an online platform that can help you meet your weight loss and health goals **AT NO ADDITIONAL COST**. Get access to online coaching, tools to help track your food, activity, and weight loss progress, and a success kit shipped right to your door with food and weight scales, recipes, and more. Log into **newstart.realappeal.com** to become a member.

SELF-CARE BY ABLETO

Self-Care by AbleTo offers clinical techniques to help dial down the symptoms of stress, anxiety, and depression—anytime.

DriveTime medical plan participants can upgrade to premium **AT NO ADDITIONAL COST**. Visit **ableto.com/begin** to learn more.

TELADOC

DriveTime provides 24/7/365 access to licensed physicians through Teladoc **AT NO EXTRA COST**. Use Teladoc when your primary physician is unavailable or you are traveling and need medical advice. Visit **teladoc.com** to get started.

LANTERN

Lantern (formerly known as SurgeryPlus) helps medical plan members find a board-certified surgeon for many different surgeries. **SAVE MONEY** with negotiated costs that, in many cases, cover your out-of-pocket deductible and coinsurance costs. When you need to plan a surgery or want to learn more, call Lantern at 855-810-4946 or visit **my.lanterncare.com**.

HINGE HEALTH

DriveTime partners with Hinge Health to help you conquer back and joint pain, recover from injuries, prepare for surgery, or stay healthy and pain free **AT NO ADDITIONAL COST**. Sign up at **hingehealth.com/drivetimeOE**.

Medical insurance

In-network preventive care is $0 out-of-pocket for medical plan members.

The DriveTime medical plans pay 100% of the cost of preventive care when received from a network provider. This means you won't have to pay anything out of your pocket.

Some services are generally not considered preventive if you get them as part of a visit to diagnose, monitor, or treat an illness or injury. Please be aware that you will be responsible for the cost of any non-preventive care services you receive at your preventive care exam based on your plan design.

Learn more about preventive care at **myuhc.com** or **benefits.surest.com**.

WHAT IS PREVENTIVE CARE?

The focus of preventive health care is to **PREVENT** illnesses, disease, and other health problems, and to **DETECT** issues at an early stage when treatment is likely to work best.

WHY IS PREVENTIVE CARE IMPORTANT?

It is important that you have a preventive exam each year—even if you feel healthy and are symptom free—in order to **IDENTIFY FUTURE HEALTH RISKS**.

WHAT'S COVERED?

Covered preventive services **VARY BY AGE AND GENDER**. Talk with your provider to determine which screenings, tests, and vaccines will be covered, when you should get them, and how often.

The Quit For Life Program provides information regarding tobacco cessation methods and related well-being support. Any health information provided by you is kept confidential in accordance with the law. The Quit For Life Program does not provide clinical treatment or medical services and should not be considered a substitute for your doctor's care. Please discuss with your doctor how the information provided is right for you. Participation in this program is voluntary. If you have specific health care needs or questions, consult an appropriate health care professional. This service should not be used for emergency or urgent care needs. In an emergency, call 911 or go to the nearest emergency room.

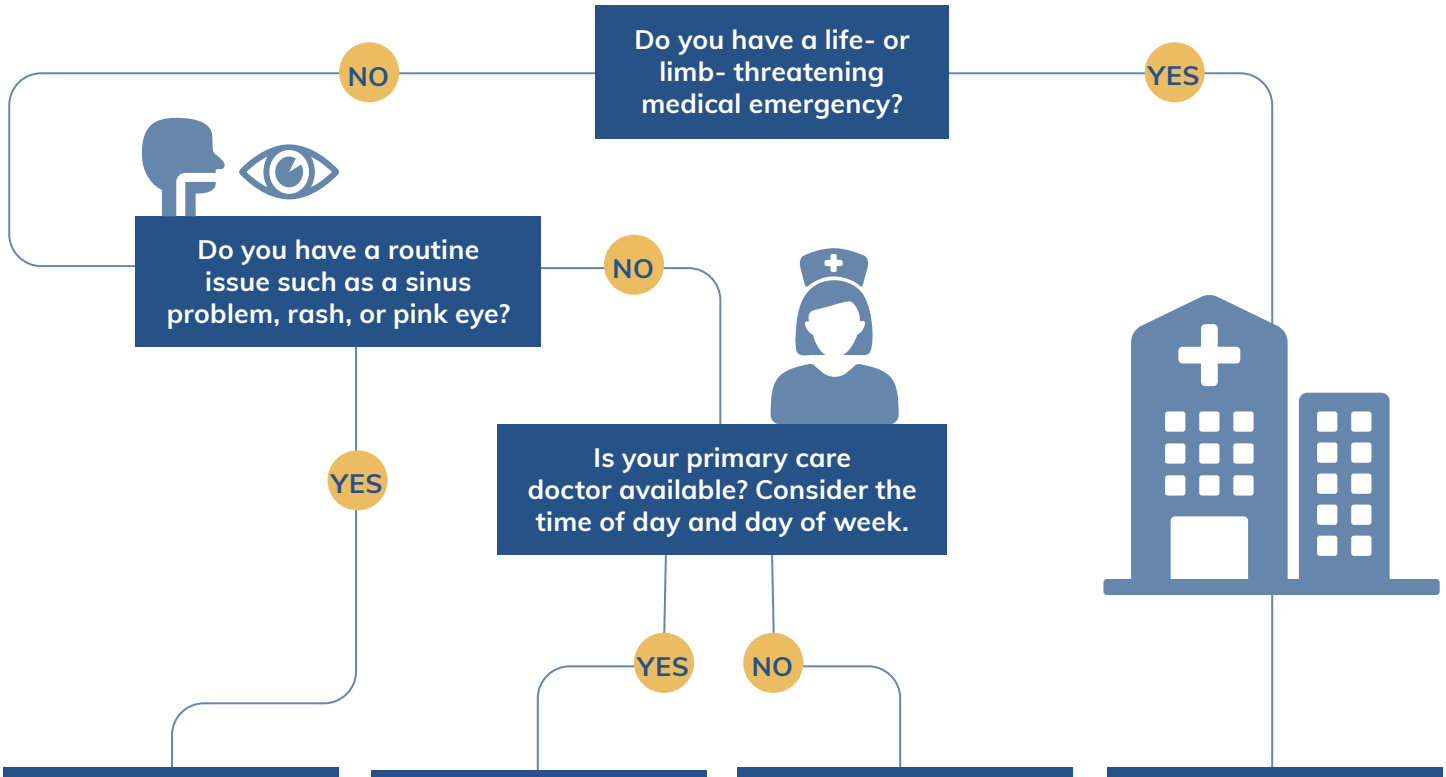
Real Appeal is a voluntary weight management program that is offered to eligible members at no additional cost as part of their benefit plan. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical and/or nutritional advice. Participants should consult an appropriate health care professional to determine what may be right for them. Results, if any, may vary. Any items/tools that are provided may be taxable and participants should consult an appropriate tax professional to determine any tax obligations they may have from receiving items/tools under the program.

The information provided through the Hinge Health app are for informational purposes only. Hinge Health staff cannot diagnose problems or suggest treatment. The program and app are not a substitute for your doctor's care. Members are encouraged to discuss with their doctor how the information provided may be right for them. Your health information is kept confidential in accordance with the law. Hinge Health app is not an insurance program and may be discontinued at any time. This program and its components may not be available in all states or for all group sizes and is subject to change. Coverage exclusions and limitations may apply.

Medical insurance

Know where to go for your health care.

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. Use the chart below to help you choose where to go for care.



Use Teladoc

Get care without leaving your house. An appointment with a physician is available from your phone or computer.

Log into **teladoc.com** to make an appointment.

In-network, you pay:

- **PPO: $0 fee**
- **Surest Defined Copay Plan: $0 fee**
- **HDHP: $0 fee**

Go to a Primary Care Doctor

For care during normal office hours, go to your primary care doctor. They can provide follow-up care and refer you to a specialist, if needed. PPO and HDHP members can save money by seeing a Premium Provider.

In-network, you pay:

- **PPO: $30 copay**
- **Surest Defined Copay Plan: $10-65 copay**
- **HDHP: 10% after ded.**

Go to an Urgent Care Center

Urgent care centers typically don't require an appointment and are often open in the evenings and on weekends. Plus, in-network urgent care centers are faster and much less expensive than the ER.

In-network, you pay:

- **PPO: $75 copay**
- **Surest Defined Copay Plan: $35 copay**
- **HDHP: 20% after ded.**

Go to the Emergency Room (ER)[1]

In the case of a true medical emergency, go to the ER. At the ER, true emergencies are treated first, and other cases must wait—sometimes for hours. And, it will cost you a lot more to get care at the ER.

In-network, you pay:

- **PPO: $250 + 20% after ded.[2]**
- **Surest Defined Copay Plan: $350 copay**
- **HDHP: 20% after ded.**

(1) All plans ensure that all hospitals are treated as in-network when you experience an emergency. (2) For first and second visits. Additional visits will cost more.

Personify Health (formerly Virgin Pulse)

DriveTime believes in supporting employees on their health journey.

That's why we partner with Personify Health (formerly known as Virgin Pulse) to offer a comprehensive wellness portal. Personify Health is available to all DriveTime employees. Participation is optional, however, employees on the medical benefits plan are required to complete certain activities in order to earn the lower Wellness Rate.

See below for a sample of what Personify Health has to offer:

- Step tracking and walking competitions against coworkers
- Guided wellness journeys and healthy habit challenges
- Monthly wellness webinars
- Nutrition and exercise tracking
- Annual health check survey
- And much, much more!

Best of all, many of these activities are rewarded with Pulse Cash. Redeem your cash for fitness equipment, gift cards, and more!

HOW TO ENROLL

Mobile app:

1. Download the Personify Health mobile app for iOS or Android.
2. Search for "DriveTime."
3. Enter first name, last name, and date of birth to match DriveTime's eligibility file.

Web page:

1. Visit **join.virginpulse.com/drivetime** to activate your account.
2. Enter first name, last name, and date of birth to match DriveTime's eligibility file.

Troubleshooting

Create a case in Workday for assistance, or call Personify Health at 888-671-9395.

DriveTime has two premium rate structures for medical benefits: the Standard Rate and the Wellness Rate.

The Wellness Rate is substantially lower than the Standard Rate. Each year employees have the opportunity to earn the Wellness Rate for the following year.

1 JOIN PERSONIFY HEALTH

2 COMPLETE THE HEALTH CHECK SURVEY

3 GET A BIOMETRIC SCREENING

Dental insurance

DriveTime offers two dental insurance plan options through Delta Dental.

The dental plans offer in- and out-of-network benefits, providing you the freedom to choose any provider. However, you will pay less out of your pocket when you choose a Delta Dental provider. That's because expenses from out-of-network providers are reimbursed based on reasonable and customary charges (R&C) charges. Any charges over the R&C amount will be your responsibility. Locate a Delta Dental network provider at **deltadental.com**.

The table below summarizes the key features of the dental plans. The coinsurance amounts listed reflect the amount you pay. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	Base Dental Plan	Premier Dental Plan
Plan Year Deductible Individual/Family	$50/$150	$50/$150
Plan Year Benefit Maximum	$1,500	$5,000
Preventive Care (Oral exams, cleanings, x-rays)	Plan pays 100% (Two cleanings per calendar year)	Plan pays 100% (Four cleanings per calendar year)
Basic Services (Periodontal services, endodontic services, oral surgery, fillings)	20% after deductible	10% after deductible
Major Services (Bridges, crowns [inlays/onlays], dentures [full/partial])	50% after deductible	50% after deductible
Orthodontia Services	50% (Coverage for children up to age 26)	50% (Coverage for adults and children up to age 26)
Orthodontia Lifetime Maximum	$1,500	$2,000

Maximize your health, wherever you are! Search for a dentist near you, view ID cards and more, right on your mobile device. Scan the QR code to download the app.

BrightNow! Dental offers exclusive dental discounts for DriveTime employees and their families. Visit **brightnow.com** for a list of offices in your area. Call the office closest to you to ask about services or schedule an appointment. Be sure to mention you are a DriveTime Auto employee.

DENTAL COSTS

Listed below are the per pay period costs for dental insurance. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis.

Coverage Level	Base Dental Plan		Premier Dental Plan	
	Full-Time	Part-Time	Full-Time	Part-Time
Employee Only	$4.19	$8.42	$8.42	$11.85
Employee + Spouse	$11.55	$19.07	$19.07	$30.89
Employee + Child(ren)	$12.73	$21.55	$21.63	$34.83
Employee + Family	$21.33	$34.88	$35.08	$56.49

Vision insurance

DriveTime offers two vision insurance plan options through EyeMed (powered by Delta).

You have the freedom to choose any vision provider. However, you will maximize the plan benefits when you choose a network provider. Locate a network provider at **eyemed.com**.

The table below summarizes the key features of the vision plans. Please refer to the official plan documents for additional information on coverage and exclusions.

Summary of Covered Benefits	Standard Vision Plan	Premier Vision Plan	Out of Network
Eye Exam	$15 copay (Every 12 months)	$15 copay (Every 12 months)	Up to $45
Single Corrective Lenses	$15 copay (Every 12 months)	$15 copay (Every 12 months)	Up to $100
Frames	$150 allowance + 20% off balance (Every 24 months)	$200 allowance + 20% off balance (Every 12 months)	Up to $70
	OR	AND	
Contact Lenses	$150 allowance (Every 12 months)	$150 allowance (Every 12 months)	Up to $105
Laser Vision Correction	15% off retail or 5% off promo	15% off retail or 5% off promo	N/A

MOBILE APP

You have access to tools and resources that make accessing and using your vision benefit easy—no matter where you are. **Download the EyeMed Member App from the App Store or Google Play today!**

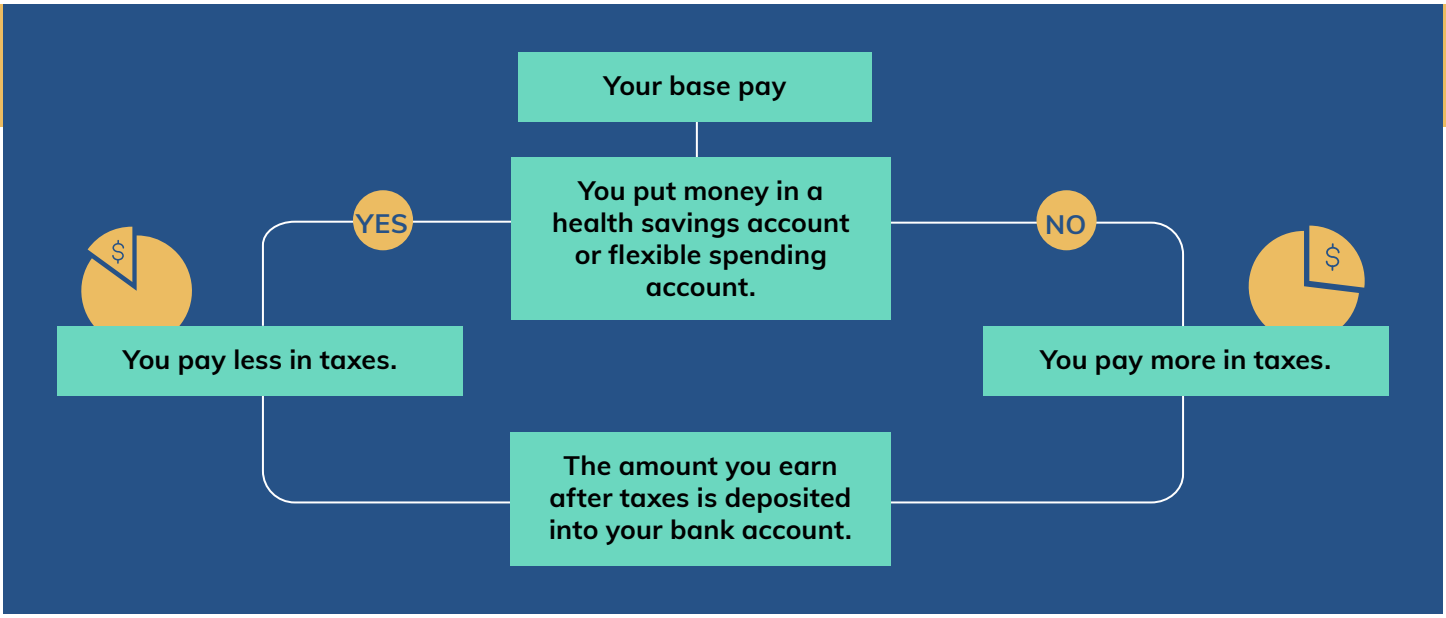
- Find nearby network providers
- On-the-fly appointment scheduling
- Direct line to EyeMed support
- Eye exam and contact lens reminders
- Electronic ID card for office visits
- Access benefits plan details

VISION COSTS

Listed below are the per pay period costs for vision insurance. The amount you pay for coverage is deducted from your paycheck on a pre-tax basis. The costs for full-time and part-time employees are the same.

Coverage Level	Standard Vision Plan	Premier Vision Plan
Employee Only	$3.60	$6.02
Employee + Spouse	$7.01	$11.74
Employee + Child(ren)	$7.54	$17.44
Employee + Family	$8.01	$18.53

Budgeting for your care



You can save about 12%* on your care by putting money in a health savings account or flexible spending account. That is because you don't pay taxes on your contributions.

COMPARE YOUR OPTIONS

	Health Savings Account (HSA) More Information on Page 19	**Health Care Flexible Spending Account (FSA)** More Information on Page 20	**Dependent Care Flexible Spending Account (FSA)** More Information on Page 20
Eligible medical plans	HDHP only	PPO and Surest Defined Copay Plan	N/A
Eligible expenses	Medical, dental, and vision	Medical, dental, and vision	Child and elder day care only
DriveTime contribution available in full within your first week of benefits coverage	DriveTime will match your contribution dollar-for-dollar up to $400 for an individual and $700 for family.	N/A	N/A
Your full election is available within your first week of benefits coverage	Your annual contribution is funded per pay period. You can deposit additional amounts separately.	Yes	Yes
You can change your election throughout the year	Yes	No, the only exception is if you experience a qualifying life event (see page 4).	No, the only exception is if you experience a qualifying life event (see page 4).
Funds roll over from one year to the next	Yes	Up to $640	No
You can invest your funds	Yes	No	No

*Percentage varies based on your tax bracket.

Budgeting for your care

Decide which account is right for you.

The table below summarizes the key features of an HSA versus an FSA.

HSA	FSA
HEALTH PLAN ELIGIBILITY Must be enrolled in the HDHP	**HEALTH PLAN ELIGIBILITY** Must be enrolled in the PPO or Surest Defined Copay Plan
CONTROL Owned by the employee	**CONTROL** Owned by the employer
FUNDING Employer and/or employee funded	**FUNDING** Employee funded only (no employer funding)
2025 CONTRIBUTION LIMITS $4,300 single; $8,550 family $1,000 more if age 55+	**2025 CONTRIBUTION LIMITS** Health Care FSA: $3,200; Dependent Care FSA: $5,000 Note: Limits are subject to change for 2025
ROLLOVER AVAILABLE Yes, unlimited	**ROLLOVER AVAILABLE** Up to $640 (which must be used by 12/31/25)
CAN PARTICIPANTS INVEST FUNDS? Yes, when balance is at least $1,000	**CAN PARTICIPANTS INVEST FUNDS?** No

Health Savings Account (HSA)

TALK WITH ALEX

If you enroll in the HDHP, you are eligible to fund a health savings account (HSA) through our partner bank, WEX.

An HSA is a savings account that you can use to pay out-of-pocket health care expenses with pre-tax dollars.

DRIVETIME CONTRIBUTION

DriveTime will match your contributions dollar-for-dollar up to the following amounts:

- **Employee-only:** $400
- **All other levels:** $700

Note: You must re-elect your HSA contribution during open enrollment each year.

2025 IRS HSA CONTRIBUTION MAXIMUMS

Contributions cannot exceed the IRS allowed annual maximums.

- **Individuals:** $4,300
- **All other levels:** $8,550

If you are age 55+ by December 31, 2025, you may contribute an additional $1,000.

HSA ELIGIBILITY

You are eligible to fund an HSA if you are enrolled in the HDHP. Refer to **wexinc.com/discovery-benefits** for eligibility information.

PARTICIPANT SERVICES

Questions about your HSA? Contact WEX's participant services department at **customerservice@wexhealth.com**.

The UnitedHealthcare plan with Health Savings Account (HSA) is a qualifying high deductible health plan (HDHP) that is designed to comply with IRS requirements so eligible enrollees may open a Health Savings Account (HSA). The HSA refers only and specifically to the Health Savings Account that is provided in conjunction with a particular bank and not to the associated HDHP.

MAXIMIZE YOUR TAX SAVINGS WITH AN HSA

USE

Use your HSA dollars today to pay for eligible health care expenses such as: deductibles, doctor's office visits, dental expenses, eye exams, and prescriptions.

SAVE

Use your HSA to prepare for the unexpected. An HSA allows you to save and roll over money from year to year. The money in the account is always yours, even if you change health plans or jobs.

INVEST

The money in your HSA can be invested and grows tax-free—including interest and investment earnings. After you reach age 65, your HSA dollars can be spent without penalty on any expense.

Flexible Spending Accounts (FSA)

DriveTime offers two flexible spending account (FSA) options, which are administered by WEX.

Log into your account at **wexinc.com** to: view your account balance(s), calculate tax savings, view eligible expenses, download forms, view transaction history, and more. Questions about your FSA? Contact WEX's participant services department at **customerservice@wexhealth.com**.

You must re-elect your FSA contributions during open enrollment each year.

HEALTH CARE FSA (FOR PPO OR SUREST DEFINED COPAY PLAN MEMBERS)

Pay for eligible out-of-pocket medical, dental, and vision expenses with pre-tax dollars. **You may contribute up to $3,200 or up to the IRS allowed annual maximum for 2025.**

DEPENDENT CARE FSA (FOR ALL ELIGIBLE EMPLOYEES)

The dependent care FSA allows you to pay for eligible dependent day care expenses with pre-tax dollars. Eligible dependents are children under 13 years of age, or a child over 13, spouse, or elderly parent residing in your house who is physically or mentally unable to care for himself or herself.

You may contribute up to $5,000 or up to the IRS allowed annual maximum for 2025 if you are married and file a joint return or if you file a single or head of household return. If you are married and file separate returns, you can each elect $2,500 or up to the IRS allowed annual maximum for 2025.

When you fund a dependent care FSA to the maximum amount ($5,000), you may save $600 per year on average.* That is because you don't pay taxes on your FSA contributions.

*Amount varies based on your tax bracket.

Flexible spending accounts (FSAs) are subject to eligibility and restrictions. A flexible spending account is not insurance. It may also be referred to as a flexible spending arrangement. This communication is not intended as legal or tax advice. Please contact a competent legal or tax professional for personal advice on eligibility, tax treatment, and restrictions. Federal and state laws and regulations are subject to change.

FSA QUICK TIPS

- **Keep all receipts in case WEX requires you to verify the eligibility of a purchase**
- **For the health care FSA, at the end of the plan year, you can roll over $640 from your health care FSA to use in future years. Any amount in excess of $640 will be forfeited**
- Dependent care FSA dollars are use it or lose it (no roll over allowed)
- You cannot take income tax deductions for expenses you pay with your FSA(s)
- You cannot stop or change your FSA contribution(s) during the plan year unless you experience a qualifying life event

Disability insurance

DriveTime offers disability insurance through Unum.

Disability insurance is designed to help you meet your financial needs if you become unable to work due to an illness or injury.

WAITING PERIOD

14 days

COMPANY PAID

SHORT-TERM DISABILITY INSURANCE

DriveTime automatically provides short-term disability (STD) insurance through Unum to all benefits-eligible employees **AT NO COST**. Benefits will be reduced by other income, including state-mandated STD plans.

- **Benefit:** 60% of eligible earnings up to $1,385 per week
- **Elimination period:** 14 days
- **Benefit duration:** Up to 13 weeks

VOLUNTARY LONG-TERM DISABILITY INSURANCE

DriveTime provides you the option to purchase voluntary long-term disability (LTD) insurance through Unum. **You can buy up in order to extend the benefit duration.**

- **Benefit:** 60% of eligible earnings up to $6,000 per month, benefit is tax exempt
- **Elimination period:** 90 days
- **Benefit duration:** Basic: Lesser of reducing benefit duration or 5 years; Buy-Up: Reducing benefit duration with Social Security normal retirement age.

Note: Your eligible earnings combines your current year annualized base salary + your prior year bonuses and commissions up to $120,000.

VOLUNTARY LONG-TERM DISABILITY COSTS

Listed below are the monthly and per pay period costs for voluntary LTD insurance. The rates are deducted from your paycheck on a post-tax basis.

	Base LTD Plan		Buy-Up LTD Plan	
	Monthly	Per Pay Period	Monthly	Per Pay Period
Rate Per $100 of Covered Payroll	$0.390	$0.180	$0.600	$0.280

ELECT COVERAGE NOW! If you do not enroll in voluntary LTD insurance when first eligible or want to switch from the base plan to the buy-up plan, you will need to complete an Evidence of Insurability form and submit to Unum for approval.

Life and AD&D insurance

DriveTime provides basic life and AD&D insurance through Unum to all benefits-eligible employees at no cost. You have the option to purchase supplemental life and AD&D insurance.

BASIC LIFE AND AD&D INSURANCE

DriveTime automatically provides basic life and AD&D insurance through Unum to all benefits-eligible employees **AT NO COST**. If you die as a result of an accident, your beneficiary would receive both the life benefit and the AD&D benefit. **Please be sure to keep your beneficiary designations up to date.**

- **Employee life benefit:** 1x base salary up to $50,000
- **Employee AD&D benefit:** 1x base salary up to $50,000

COMPANY PAID

Depending on your personal situation, basic life and AD&D insurance might not be enough coverage for your needs. To protect those who depend on you for financial security, you may want to purchase supplemental coverage.

Click here to learn more about the importance of life and AD&D insurance.

SUPPLEMENTAL LIFE AND AD&D INSURANCE

DriveTime provides you the option to purchase supplemental life and AD&D insurance for yourself, your spouse, and your dependent children through Unum.

You must purchase supplemental coverage for yourself in order to purchase coverage for your spouse and/or dependents. Supplemental life rates are age-banded.

- **Employee:** $10,000 increments up to $500,000 or 5x base salary, whichever is less; guarantee issue: $300,000
- **Spouse:** $5,000 increments up to $100,000 or 50% of the employee's election, whichever is less; guarantee issue: $30,000
- **Dependent child(ren):** 15 days to 6 months: $1,000; 6 months to age 26: $10,000; guarantee issue: $10,000

The supplemental life and AD&D plan is portable, meaning you can take the coverage with you if you change jobs.

ELECT COVERAGE NOW! If you elect supplemental coverage when you're first eligible to enroll, you may purchase up to the guarantee issue amount(s) without completing a statement of health (evidence of insurability). If you do not enroll when first eligible, and choose to enroll during a subsequent annual open enrollment period, you will be required to submit evidence of insurability for any amount of coverage. Coverage will not take effect until approved by Unum.

Accident insurance

DriveTime provides you the option to purchase accident insurance through UnitedHealthcare.

Accident insurance helps protect against the financial burden that accident-related costs can create. This means that you will have added financial resources to help with expenses incurred due to an injury, to help with ongoing living expenses, or to help with any purpose you choose.

This plan will provide an annual benefit of $50 when you complete an eligible health screening such as a stress test, glucose test, breast ultrasound, pap smear, etc. Please see your official plan documents for a full list of wellness exams.

Unlike accidental death and dismemberment (AD&D) insurance, accident insurance covers both short- and long-term injuries. Claims payments are made in flat amounts based on services incurred during an accident.

ACCIDENT COSTS

Listed below are the per pay period costs for accident insurance. The rates are deducted on a post-tax basis.

Coverage Level	Accident Plan
Employee Only	$3.66
Employee + Spouse	$5.72
Employee + Child(ren)	$6.82
Employee + Family	$10.50

This policy does not meet the definition of minimum essential coverage and therefore should not be used as a substitute for major health insurance.

ACCIDENT INSURANCE INCLUDES BENEFITS FOR:

- **Injuries:** Fractures, dislocations, concussions, lacerations, eye injuries, torn knee cartilage, ruptured discs, second and third degree burns
- **Medical services and treatments:** Ambulance, emergency care, therapy services, medical testing (including x-rays, MRIs, CT scans), medical appliances, and certain types of surgeries
- **Hospitalization:** Hospital admission, confinement, and inpatient rehab after an accident
- **Additional benefits:** Accidental death, dismemberment, loss and paralysis

For complete plan details, refer to the official plan documents.

Hospital indemnity insurance

DriveTime provides you the option to purchase hospital indemnity insurance through UnitedHealthcare.

Hospital indemnity insurance can complement your medical coverage by helping to ease the financial impact of a hospitalization. It provides a lump-sum payment that can be used for hospital admission, accident-related inpatient rehabilitation, hospital stays, or any other covered expenses that you incur.

This plan will provide an annual benefit of $50 when you complete an eligible health screening such as a stress test, glucose test, breast ultrasound, pap smear, etc. Please see your official plan documents for a full list of wellness exams.

HOSPITAL INDEMNITY COSTS

Listed below are the per pay period costs for hospital indemnity insurance. The rates are deducted from your paycheck on a post-tax basis.

Coverage Level	Hospital Indemnity Plan
Employee Only	$5.46
Employee + Spouse	$13.28
Employee + Child(ren)	$8.80
Employee + Family	$16.82

Critical illness insurance

DriveTime provides you the option to purchase critical illness insurance through UnitedHealthcare.

While the DriveTime medical plans provide coverage for hospital and medical expenses, they don't cover costs like daily living expenses, child care, or copays. A critical illness insurance policy can help you with these and other unexpected expenses.

Critical illness insurance provides a financial, lump-sum benefit upon diagnosis of a covered illness. These covered illnesses are typically very severe and likely to render the affected person incapable of working.

- **Employee:** $5,000 increments up to $30,000; guarantee issue: $30,000
- **Spouse and dependent child(ren):** Up to 50% of employee election

This plan will provide an annual benefit of $50 when you complete an eligible health screening such as a stress test, glucose test, breast ultrasound, pap smear, etc. Please see your official plan documents for a full list of wellness exams.

These policies do not meet the definition of minimum essential coverage and therefore should not be used as a substitute for major health insurance.

401(k) plan

DriveTime offers a safe harbor 401(k) retirement savings plan, which is administered by Fidelity Investments.

DRIVETIME MATCHES!

After 90 days of employment, DriveTime will match 100% of the first 3% and 50% up to 5%.

UPDATE ANYTIME

You may increase, decrease, or stop your contributions anytime through Fidelity's website: **401k.com**.

IT'S YOUR INVESTMENT

You have complete ownership of your contribution and earnings. If you leave DriveTime, it all goes with you.

VESTING

All safe harbor matching contributions are 100% vested immediately.

Enrollment is now easier than ever! **In just 60 seconds, enroll in your 401(k) using one of three simple methods: Go to 401k.com/Easy, text "ENROLL" to 343-898, or download the NetBenefits mobile app.**

DON'T FORGET TO KEEP YOUR BENEFICIARIES UP TO DATE!

Designate your beneficiaries so that your intentions are made clear for your loved ones.

You can set up beneficiaries as part of your enrollment by visiting **401k.com** or downloading the NetBenefits mobile app at any time.

401(k) plan

HELP IS HERE

Did you know that as a participant in a Fidelity workplace retirement savings plan, you have access to free financial help? From workshops to online tools to Fidelity's registered phone representatives, you have resources at your fingertips that can help you put a plan in place—for whatever financial goals you may have.

Watch this quick three-minute video to see all the help you can take advantage of and take your next steps towards financial wellness today!

FIVE STEPS TO JUMP-START YOUR FINANCIAL WELLNESS

Want to get a handle on your finances, but aren't sure how to start? Here's an easy path to improvement: **Download this checklist** for steps you can take to get moving along your path to financial wellness. Sometimes one small step is all it takes.

To learn about all the ways Fidelity is helping employees like you get the financial help they need, **watch this three-minute video**.

GET HELP WITH YOUR MONEY GOALS

Your financial wellness is an important part of your overall well-being. It helps you navigate through all of life's moments with more confidence—tackling your short-term financial goals while showing some love to those long-term ones, too.

Fidelity's **financial wellness checkup** can help you understand what's going well and what else you can do to work toward your money goals. Take a few minutes to answer some questions (think: saving and spending, debt management, and more). From there, you'll get a look into how you're doing and find tips that can help you move forward.

NetBenefits.com/financialwellness

935170.2.0

Paid time off

DriveTime recognizes that employees need time away from work to relax, recover, or re-energize without the added stress of unpaid leave.

As such, we provide a competitive PTO program, designed with your wellbeing in mind. PTO can be used for vacation, illness, injury, and/or personal business. You will begin to accrue PTO upon your date of hire. PTO may be taken as soon as it is accrued, subject to approval of your supervisor.

When taking time off, you must use available PTO time before taking time off without pay. The PTO accrual rate for an employee is based on the length of employment, with the rates being adjusted on the anniversary of the employee's date of hire.

All employees are eligible to roll over up to 80 hours of PTO to the next year. That means the remaining balances at the end of 2024 (up to 80 hours) will be available for use at the beginning of 2025.

FULL-TIME PTO ACCRUAL

Length of Service	Classification	Paid Hours Accrued Per Year
Less Than One Year	Hourly/Retail Sales	120 hours
Less Than One Year	Salaried	128 hours
Between One and Three Years	All employees	136 hours
Between Three and Five Years	All employees	160 hours
Five or More Years	All employees	192 hours

PART-TIME PTO ACCRUAL

Part-time employees are eligible to earn PTO based on the number of hours they work.

Length of Service	Classification	Paid Hours Accrued Per Year
Less Than One Year	Hourly	53 hours
Less Than One Year	Salaried	77 hours
Between One and Three Years	Hourly	82 hours
Between Three and Five Years	Hourly	96 hours
Five or More Years	Hourly	115 hours

Please refer to policy number 4.03 in your Employee Handbook for more information.

Paid time off

CALIFORNIA EMPLOYEES PTO ACCRUAL

Length of Service	Classification	Sick Hours	Paid Hours Accrued Per Year*
Less Than One Year	Hourly	1 hour earned for every 30 hours worked; capped at 48 hours (72 hours for employees in the City of Los Angeles)	44 hours
Less Than One Year	Salaried		84 hours
Between One and Three Years	All employees		92 hours
Between Three and Five Years	All employees		116 hours
Five or More Years	All employees		148 hours

*Vacation balances cap at annual accrual amount.

Leave of absence program

DriveTime provides a comprehensive leave of absence program.

There are three different types of Family Medical Leave (FMLA): continuous, intermittent, and military. Generally, FMLA is 12 weeks or 480 hours of job protection with no pay.* If you have short-term disability (STD), it may cover 60% of pay after 14 days of your leave of absence.

*FMLA, PLOA, Company Medical Leave, and Military Leaves are unpaid. Employees will be required to use up to 40 hours of accrued PTO if available, which will run concurrent with their leave time. Employees may not borrow PTO when on a leave.

ARE YOU ELIGIBLE FOR LEAVE?

Types of Leave	Eligibility	Definition	Example
Continuous FMLA	Employed for at least 12 months or 1,250 hours	Employee may take up to 12 weeks per rolling 12 months.	Birth of a child
Intermittent FMLA	Employed for at least 12 months or 1,250 hours	Employee may take up to 480 hours of unpaid FMLA in separate blocks of time for a single qualifying reason.	Family emergency
Company Medical Leave of Absence	Employed full-time or part-time and have not completed at least one year (12 months) of employment with the company	Can take up to 6 weeks of leave continuously from regional leadership level in partnership with the Leave Department.	Medical
Americans with Disabilities Act (ADA)	All employees are eligible as of date of hire	Substantially limits normal life functions (walking, talking).	Physical therapy
Military Leave	All employees are eligible as of date of hire	Employees may take leave for the duration of military training. Spouses and family of service members are eligible for leave under FMLA as well.	Military training

Bonding and recovery leave

DriveTime knows how important it is for parents to bond with their new baby.

For this reason, we offer the following paid leave to employees with at least one year of employment as of the date that their leave begins.

MATERNITY LEAVE

Payor	Less Than One Year of Service	Between One and Three Years of Service	Three or More Years of Service
Unum Short-Term Disability (STD) Insurance	60% of eligible earnings as approved by the STD plan	60% of eligible earnings as approved by the STD plan	60% of eligible earnings as approved by the STD plan
DriveTime	N/A	40% of eligible earnings while you are receiving STD benefits	40% of eligible earnings while you are receiving STD benefits
		DriveTime will pay 100% of eligible earnings from end of STD to 8 weeks after delivery	DriveTime will pay 100% of eligible earnings from end of STD to 12 weeks after delivery

Note: You can add your newborn onto your insurance plan(s) within 31 days of the newborn's date of birth. Refer to page 4 for details.

MATERNITY LEAVE EXAMPLE

- Juanita **delivers her baby on January 7, 2025**.
- Juanita has **four years of service** with DriveTime on the day she delivers her baby.
- Her annual base rate of pay is **$40,000 on January 7. In 2025 she earned $500 in bonus.**
- **STD is approved for six weeks** beginning on January 7.
- Her eligible earnings are $778.85 ($40,000 + $500 = $40,500/52 weeks = $778.85).

First two weeks: January 7–January 21 is the 14-day waiting period for benefits to begin. Juanita can use her PTO during these two weeks to be paid.

Next four weeks: January 22–February 18, Juanita is paid $467.31 ($778.85 x 60%) weekly for the next four weeks by Unum and $311.54 (the balance of the $778.85 - $457.31) weekly for the next four weeks by DriveTime

Next six weeks: February 25–March 31, Juanita will be paid $778.31 by DriveTime

Total leave: **12 weeks**

Total paid: Unum: $1,869.24

DriveTime: $5,916.02

BONDING LEAVE

Employees will receive two weeks at 100% pay. In order to qualify the birth event must take place after you have hit 1 year tenure service requirement and is subject but not limited to FMLA eligibility rules and entitlement.

Employee assistance program

Employee assistance program (EAP) services are provided at no cost through GuidanceResources.

COMPANY PAID

CONFIDENTIAL EMOTIONAL SUPPORT

Access to five face-to-face visits with highly-trained clinicians who can help you or your family members with:

- Anxiety, depression, and stress
- Grief, loss, and life adjustments
- Relationship/marital conflicts

WORK-LIFE SOLUTIONS

Specialists provide qualified referrals and resources for just about anything on your to-do list, such as:

- Finding child and elder care
- Hiring movers or home repair contractors
- Planning events, locating pet care

LEGAL GUIDANCE

Talk to attorneys for practical assistance with your most pressing legal issues, including:

- Divorce, adoption, family law, wills, trusts, and more

Get a free 30-minute consultation and a 25% reduction in fees.

FINANCIAL RESOURCES

Financial experts can assist with a wide range of issues like:

- Retirement planning and taxes
- Relocation, mortgages, and insurance
- Budgeting, debt, bankruptcy, and more

ONLINE SUPPORT

GuidanceResources Online is your 24/7 link to vital information, tools, and support. Log in for:

- Articles, podcasts, videos, and slideshows
- On-demand trainings
- “Ask the Expert” personal responses to your questions

Your ComPsych GuidanceResources program offers someone to talk to and resources to consult whenever and wherever you need them.

Services are available to you and members of your household ages 18 and older.

Call: 855-399-2524

Your toll-free number gives you direct, 24/7 access to a GuidanceConsultant, who will answer your questions and, if needed, refer you to a counselor or other resources.

Log in today to connect directly with a GuidanceConsultant about your issue or to consult articles, podcasts, videos, and other helpful tools.

Online: guidanceresources.com
App: GuidanceResources® Now
Web ID: DTEAP

LifeGuides

LifeGuides is free, 100% confidential, and different from the EAP. Enjoy unlimited sessions for you and your adult household members (18+).

GROW AND THRIVE IN THREE EASY STEPS

1. Choose from 400+ topics in personal growth, professional development, lifelong learning, and life challenges.

Emotional Wellbeing & Stress

Growth, Purpose & Fulfillment

Healthy Body

Building Prosperity

Work Life & Leadership

Home Life & Relationships

Coping with Illness

Identity, Belonging & Community

Military Service & Veterans

Disability & Living Fully

2. Browse profiles and select a Guide who matches with your personal need. You can choose multiple guides if you have multiple life challenges or needs to discuss.
3. Schedule your Guide session—connect by video, text, chat, or phone.

Visit **app.lifeguides.com/drivetime** to get started.

Questions? Contact Our Concierge by calling 877-532-3472 (Available Monday–Friday 9 a.m.–9 p.m. ET, Saturday 9 a.m.–1 p.m. ET, and Sunday 1 p.m.–6 p.m. ET.)

Work perks

EMPLOYEE DISCOUNTS

As a DriveTime employee, you have access to discounts from the following companies:

- **Tickets at Work:** Visit **ticketsatwork.com** (discount code: drive) to access discounted Apple products, childcare discounts, and tickets for movies, concerts, cruise lines, amusement parks, etc.
- **Advance Auto Parts and Carquest:** Exclusive discount for employees. Present the following information at time of checkout: AIS TEAMMATES ACCOUNT, EXPLORIS Acct: DT2000, APEX Acct: 1870822138, PO Required: Your Employee ID #.
- **Take 5:** Get a 25% discount on your oil change. Enter company name: F&F SilverRock and account number: 11010.
- **Simple Tire:** Buy tires at an additional 7% discount. Visit **simpletire.com/partner-program?uid=1BzkhHugodU6zmty7vQYa9**.
- **AT&T**
- **Verizon**
- **Staples**

Identity protection

DriveTime provides you the option to purchase identity protection through LifeLock.

LifeLock helps to proactively safeguard your personal information and alerts you of potential threats. The cost for coverage is $9.99 per month for employee-only coverage or $18.98 per month for family coverage. Learn more by calling 800-607-9174.

Pet insurance

DriveTime provides you the option to purchase pet insurance through Figo.

Figo offers customizable plans that can cover your pet's unexpected accidents and illnesses. If your pet becomes sick or injured, seek treatment from any licensed veterinarian in the US, Puerto Rico, or Canada. **Figo members also have access to 24/7 virtual vet visits.**

Enrollment is available anytime during the year. For more information and a complete list of coverages, visit **figopetinsurance.com**.

Education/Tuition Assistance

DriveTime encourages you to improve your performance and professional development.

All regular full and part-time employees who have completed 90 days of continuous service are eligible for assistance with tuition costs. The maximum reimbursement of tuition and registration fees will be up to $5,250 per calendar year for a full-time employee and $3,150 for a part-time employee.

- A or B grades are 100% reimbursement regardless of university or community college.
- C grades are 80% reimbursement.

Complete these three steps to apply for education assistance:

1. Take the Education/Tuition Assistance Program Overview course in Workday Learning.
2. Submit your application 30 days prior to the start of the program through Workday.
3. Email your Education/Tuition Assistance Paperwork no more than 30 days after the completion of the course to **RM-TuitionReimbursement@drivetime.com**.

Your completed paperwork should include the following documents:

- Itemized tuition statement and receipts—must indicate tuition costs and fees.
- Unofficial/official transcript of grades or completion certificate.
- Award List or Award Letter, if you receive scholarships/grants.

Please note, you must be in good academic standing at the time of your request to be eligible for education/tuition assistance.

Note: Education partners are subject to change. Any DriveTime employee is eligible for the above discounts, even on unapproved courses. However, any unapproved courses will not be reimbursed by DriveTime.

wellbeing365

Your Benefits
Contact Information

Visit Workday or call 866-469-3847 to enroll, view your benefits, or submit questions.

Provider/Plan	Contact Number	Website
Medical—UnitedHealthcare **Surest**	844-298-8934 866-683-6440	myuhc.com join.surest.com/DriveTime (access code: DriveTime2025)
Telemedicine—Teladoc	800-835-2362	teladoc.com
Lantern	855-810-4946	my.lanterncare.com
Dental—Delta Dental	800-352-6132	deltadental.com
Vision—DeltaVision	866-800-5457	eyemed.com
Health Savings Account—WEX	866-451-3399	wexinc.com
Flexible Spending Accounts—WEX	866-451-3399	wexinc.com
Life and Disability Insurance—Unum	Contact Center: 866-679-3054 File a Claim: 800-858-6843	Contact Center: unum.com/employees/contact-us File a Claim: unum.com/employees/file-a-claim
Accident, Critical Illness, and Hospital Indemnity Insurance—UnitedHealthcare	Benefit Questions: 800-444-5854 Claims: 888-299-2070	Benefit Questions: uhc.com/employer/health-plans/supplemental Claims: myuhcfp.com
401(k) Retirement Savings Plan—Fidelity	800-890-4015	401k.com
Employee Assistance Program—GuidanceResources	855-399-2524	guidanceresources.com (web ID: DTEAP)

This summary of benefits is not intended to be a complete description of the terms and DriveTime insurance benefit plans. Please refer to the plan document(s) for a complete description. Each plan is governed in all respects by the terms of its legal plan document, rather than by this or any other summary of the insurance benefits provided by the plan. In the event of any conflict between a summary of the plan and the official document, the official document will prevail. Although DriveTime maintains its benefit plans on an ongoing basis, DriveTime reserves the right to terminate or amend each plan, in its entirety or in any part at any time.

The AbleTo mobile application should not be used for urgent care needs. If you are experiencing a crisis or need emergency care, call 911 or go to the nearest emergency room. The Self Care information contained in the AbleTo mobile application is for educational purposes only; it is not intended to diagnose problems or provide treatment and should not be used on its own as a substitute for care from a provider. AbleTo Self Care is available to members ages 13+ at no additional cost as part of your benefit plan. Self Care is not available for all groups in District of Columbia, Maryland, New York, Pennsylvania, Virginia, or West Virginia and is subject to change. Refer to your plan documents for specific benefit coverage and limitations or call the toll-free member phone number on your health plan ID card. Participation in the program is voluntary and subject to the terms of use contained in the mobile application.

(ES24-3582150)

Notices

DriveTime

HEALTH PLAN NOTICES

TABLE OF CONTENTS

IMPORTANT NOTICE
This packet of notices related to our health care plan includes a notice regarding how the plan's prescription drug coverage compares to Medicare Part D. If you or a covered family member is also enrolled in Medicare Parts A or B, but not Part D, you should read the Medicare Part D notice carefully. It is titled, "Important Notice From DriveTime About Your Prescription Drug Coverage and Medicare."

Notices

MEDICARE PART D CREDITABLE COVERAGE NOTICE
IMPORTANT NOTICE FROM DRIVETIME 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 DriveTime and about your options under Medicare's prescription drug coverage. This information can help you decide whether you want to join a Medicare drug plan. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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

2. DriveTime has determined that the prescription drug coverage offered by the DriveTime Employee Health Care Plan ("Plan") is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is considered "creditable" prescription drug coverage. This is important for the reasons described below.

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

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

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

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

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

Notices

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

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

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

Coordinating Other Coverage With Medicare Part D
Generally speaking, if you decide to join a Medicare drug plan while covered under the DriveTime Plan due to your employment (or someone else's employment, such as a spouse or parent), your coverage under the DriveTime Plan will not be affected. For most persons covered under the Plan, the Plan will pay prescription drug benefits first, and Medicare will determine its payments second. For more information about this issue of what program pays first and what program pays second, see the Plan's summary plan description or contact Medicare at the telephone number or web address listed below.

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

For More Information About This Notice or Your Current Prescription Drug Coverage…
Contact the person listed below for further information, or call 602-852-6600. **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 DriveTime changes. You also may request a copy.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

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

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

Notices

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

Date:	January 1, 2025
Name of Entity/Sender:	Meagan Roberts
Contact—Position/Office:	Director, Total Rewards
Address:	1720 E Rio Salado Pkwy Tempe, AZ 85281
Phone Number:	602-852-6600

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

Notices

HIPAA COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

DRIVETIME
IMPORTANT NOTICE
COMPREHENSIVE NOTICE OF PRIVACY POLICY AND PROCEDURES

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

This notice is provided to you on behalf of:

Welfare Benefit Plan*

* This notice pertains only to healthcare coverage provided under the plan.

For the remainder of this notice, DriveTime is referred to as Company.

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

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

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

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

- An example of a "treatment" activity includes consultation between the plan and your health care provider regarding your coverage under the plan.
- Examples of "payment" activities include billing, claims management, and medical necessity reviews.
- Examples of "health care operations" include disease management and case management activities.

The group health plan may also disclose protected health information to a designated group of employees of the Company, known as the HIPAA privacy team, for the purpose of carrying out plan administrative functions, including treatment, payment and health care operations.

Notices

If protected health information is properly disclosed under the HIPAA Privacy Practices, such information may be subject to redisclosure by the recipient and no longer protected under the HIPAA Privacy Practices.

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

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

7. Special Rule for Mental Health Information: Your written authorization generally will be obtained before a group health plan will use or disclose psychotherapy notes (if any) about you.

8. Uses and Disclosures for which Authorization or Opportunity to Object is not Required: A group health plan may use and disclose your protected health information without your authorization under the following circumstances:

- When required by law;
- When permitted for purposes of public health activities;
- When authorized by law to report information about abuse, neglect or domestic violence to public authorities;
- When authorized by law to a public health oversight agency for oversight activities (subject to certain limitation described in paragraph 20 below);
- When required for judicial or administrative proceedings (subject to certain limitation described in paragraph 20 below);
- When required for law enforcement purposes (subject to certain limitation described in paragraph 20 below);
- When required to be given to a coroner or medical examiner or funeral director (subject to certain limitation described in paragraph 20 below);
- When disclosed to an organ procurement organization;
- When used for research, subject to certain conditions;
- When necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat; and
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Notices

9. Minimum Necessary Standard: When using or disclosing protected health information or when requesting protected health information from another covered entity, a group health plan must make reasonable efforts not to use, disclose or request more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use, disclosure or request. The minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to the individual about his or her own protected health information, as permitted or required by HIPAA; disclosures made to the Department of Health and Human Services; or uses or disclosures that are required by law.

10. Disclosures of Summary Health Information: A group health plan may use or disclose summary health information to the Company for the purpose of obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the participant claims history and other information without identifying information specific to any one individual.

11. Disclosures of Enrollment Information: A group health plan may disclose to the Company information on whether an individual is enrolled in or has disenrolled in the plan.

12. Disclosure to the Department of Health and Human Services: A group health plan may use and disclose your protected health information to the Department of Health and Human Services to investigate or determine the group health plan's compliance with the privacy regulations.

13. Disclosures to Family Members, other Relations and Close Personal Friends: A group health plan may disclose protected health information to your family members, other relatives, close personal friends and anyone else you choose, if: (i) the information is directly relevant to the person's involvement with your care or payment for that care, and (ii) either you have agreed to the disclosure, you have been given an opportunity to object and have not objected, or it is reasonably inferred from the circumstances, based on the plan's common practice, that you would not object to the disclosure.

For example, if you are married, the plan will share your protected health information with your spouse if he or she reasonably demonstrates to the plan and its representatives that he or she is acting on your behalf and with your consent. Your spouse might to do so by providing the plan with your claim number or social security number. Similarly, the plan will normally share protected health information about a dependent child (whether or not emancipated) with the child's parents. The plan might also disclose your protected health information to your family members, other relatives, and close personal friends if you are unable to make health care decisions about yourself due to incapacity or an emergency.

14. Appointment of a Personal Representative: You may exercise your rights through a personal representative upon appropriate proof of authority (including, for example, a notarized power of attorney). The group health plan retains discretion to deny access to your protected health information to a personal representative.

15. Individual Right to Request Restrictions on Use or Disclosure of Protected Health Information: You may request the group health plan to restrict (1) uses and disclosures of your protected health information to carry out treatment, payment or health care operations, or (2) uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the group health plan is not required to and normally will not agree to your request in the absence of special circumstances. A covered entity (other than a group health plan) must agree to the request of an individual to restrict disclosure of protected health information about the individual to the group health plan, if (a) the disclosure is for the purpose of carrying out payment or health care operations and is not otherwise required by law, and (b) the protected health information pertains solely to a health care item or service for which the individual (or person other the health plan on behalf of the individual) has paid the covered entity in full.

16. Individual Right to Request Alternative Communications: The group health plan will accommodate reasonable written requests to receive communications of protected health information by alternative means or at alternative locations (such as an alternative telephone number or mailing address) if you represent that disclosure otherwise could endanger you. The plan will not normally accommodate a request to receive communications of protected

health information by alternative means or at alternative locations for reasons other than your endangerment unless special circumstances warrant an exception.

17. Individual Right to Inspect and Copy Protected Health Information: You have a right to inspect and obtain a copy of your protected health information contained in a "designated record set," for as long as the group health plan maintains the protected health information. A "designated record set" includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the group health to make decisions about individuals.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may contact the Secretary of the U.S. Department of Health and Human Services.

18. Individual Right to Amend Protected Health Information: You have the right to request the group health plan to amend your protected health information for as long as the protected health information is maintained in the designated record set. The group health plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the group health plan is unable to comply with the deadline. If the request is denied in whole or part, the group health plan must provide you with a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your protected health information.

19. Right to Receive an Accounting of Protected Health Information Disclosures: You have the right to request an accounting of all disclosures of your protected health information by the group health plan during the six years prior to the date of your request. However, such accounting need not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own protected health information; (3) prior to the compliance date; or (4) pursuant to an individual's authorization.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the group health plan may charge a reasonable fee for each subsequent accounting.

20. Reproductive Health Care Privacy: Effective December 22, 2024, a group health plan may not disclose protected health information to: (i) conduct a criminal, civil, or administrative investigation into a person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; (ii) impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care; or (iii) identify any person for the purposes described in (i) and (ii).

Reproductive health care means care, services, or supplies related to the reproductive health of the individual.

This prohibition only applies if the reproductive health care is lawful under the law of the state in which the health care was provided and under the circumstances in which it was provided, or if the reproductive health care was protected, required, or authorized by Federal law, including the United States Constitution, regardless of the state in which it is provided. For example, if you receive reproductive health care in a state where such care is lawful even though it is not lawful in the state where you reside, the plan may not disclose this information to conduct an investigation.

A group health plan may not use or disclose protected health information potentially related to reproductive health care for the purposes of uses and disclosures of 1) public health oversight activities, 2) judicial and administrative proceedings, 3) law enforcement purposes, and 4) coroners and medical examiners without obtaining a valid attestation from the person requesting the use or disclosure of such information. A valid attestation under this section must include the following elements:

(i) A description of the information requested that identifies the information in a specific fashion, including one of the following: (A) the name of any individual(s) whose protected health information is sought, if practicable; and (B) if including the name(s) of any individual(s) whose protected health information is sought is not practicable, a description of the class of individuals whose protected health information is sought.

(ii) The name or other specific identification of the person(s), or class of persons, who are requested to make the use or disclosure.

(iii) The name or other specific identification of the person(s), or class of persons, to whom the covered entity is to make the requested use or disclosure.

(iv) A clear statement that the use or disclosure is not for a purpose prohibited by the reproductive health care regulation.

(v) A statement that a person may be subject to criminal penalties if that person knowingly and in violation of HIPAA obtains individually identifiable health information relating to an individual or discloses individually identifiable health information to another person.

(vi) Signature of the person requesting the protected health information, which may be an electronic signature, and date. If the attestation is signed by a representative of the person requesting the information, a description of such representative's authority to act for the person must also be provided.

For example, if you lawfully obtain an abortion and an investigation into the provider is conducted, law enforcement would need to submit an attestation in order to try and obtain the information. The plan would deny the request per HIPAA's prohibition on the disclosure of reproductive health care because such care was lawful.

21. The Right to Receive a Paper Copy of This Notice Upon Request: If you are receiving this Notice in an electronic format, then you have the right to receive a written copy of this Notice free of charge by contacting the Privacy Official (see section 24).

22. Changes in the Privacy Practice. Each group health plan reserves the right to change its privacy practices from time to time by action of the Privacy Official. You will be provided with an advance notice of any material change in the plan's privacy practices.

23. Your Right to File a Complaint with the Group Health Plan or the Department of Health and Human Services: If you believe that your privacy rights have been violated, you may complain to the group health plan in care of the HIPAA Privacy Official (see section 24). You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The group health plan will not retaliate against you for filing a complaint.

24. Person to Contact at the Group Health Plan for More Information: If you have any questions regarding this Notice or the subjects addressed in it, you may contact the Privacy Official.

Privacy Official
The Plan's Privacy Official, the person responsible for ensuring compliance with this notice, is:

Meagan Roberts
Director, Total Rewards
602-852-6600

Effective Date
The effective date of this notice is: January 14, 2025.

Notices

NOTICE OF SPECIAL ENROLLMENT RIGHTS

DRIVETIME EMPLOYEE HEALTH CARE PLAN

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

Loss of eligibility includes but is not limited to:

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

Unless the event giving rise to your special enrollment right is a loss of eligibility under Medicaid or CHIP, you must request enrollment within *31 days* after your or your dependent's(s') other coverage ends (or after the employer that sponsors that coverage stops contributing toward the coverage).

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

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within *31 days* after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact:

Meagan Roberts
Director, Total Rewards
602-852-6600

**** This notice is relevant for healthcare coverages subject to the HIPAA portability rules.***

Notices

GENERAL COBRA NOTICE

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?

Notices

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

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

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.
COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

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

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

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

Notices

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

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

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

For additional information regarding your COBRA continuation coverage rights, please contact the Plan Administrator below:

Meagan Roberts
Director , Total Rewards
1720 E Rio Salado Pkwy
Tempe, AZ 85281
602-852-6600

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Notices

NOTICE OF RIGHT TO DESIGNATE PRIMARY CARE PROVIDER AND OF NO OBLIGATION FOR PRE-AUTHORIZATION FOR OB/GYN CARE

DriveTime Employee Health Care 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. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator at 602-852-6600.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from DriveTime Employee Health Care Plan 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 DriveTime Employee Health Care Plan at:

Meagan Roberts
Director, Total Rewards
602-852-6600

Notices

WOMEN'S HEALTH AND CANCER RIGHTS NOTICE

DriveTime Employee Health Care Plan is required by law to provide you with the following notice:

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

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

The DriveTime Employee Health Care Plan provide(s) medical coverage for mastectomies and the related procedures listed above, subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply:

PPO	In-Network	Out-of-Network
Individual Deductible	$1,500	$3,000
Family Deductible	$3,000	$6,000
Coinsurance	80%	60%
HDHP	In-Network	Out-of-Network
Individual Deductible	$3,500	$5,600
Family Deductible	$7,000	$11,200
Coinsurance	80%	60%
Surest Defined Copay Plan	In-Network	Out-of-Network
Individual Deductible	$0	$0
Family Deductible	$0	$0
Coinsurance	0%	0%

If you would like more information on WHCRA benefits, please refer to your Summary Plan Description or contact your Plan Administrator at:

Meagan Roberts
Director, Total Rewards
602-852-6600

Notices

MICHELLE'S LAW NOTICE

(To Accompany Certification of Dependent Student Status)

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

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

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

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

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

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

If you have any questions regarding the information contained in this notice or your child's right to Michelle's Law's continued coverage, you should contact Meagan Roberts, Director, Total Rewards, 602-852-6600.

Notices

NOTICE FOR EMPLOYER-SPONSORED WELLNESS PROGRAMS

DriveTime Wellness Program is a voluntary wellness program available to Employees and Spouses. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990 (ADA), the Genetic Information Nondiscrimination Act of 2008 (GINA), and the Health Insurance Portability and Accountability Act, as applicable, among others. Details about the wellness program, including criteria and incentives, can be found in the Wellness Program Flyers and Benefits Guide.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Meagan Roberts at 602-852-6600 or Meagan.Roberts@drivetime.com.

The information from the Biometric Screening and the Health Risk Assessment will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program, such as earning points towards your wellness goal to reduce your medical insurance premium. You also are encouraged to share your results or concerns with your own doctor. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

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

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

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact Meagan Roberts at 602-852-6600 or Meagan.Roberts@drivetime.com.

Notices

Indemnity Insurance Notice

IMPORTANT: This is a fixed indemnity policy, NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

· The payment you get isn't based on the size of your medical bill.

· There might be a limit on how much this policy will pay each year.

· This policy isn't a substitute for comprehensive health insurance.

· Since this policy isn't health insurance, it doesn't have to include most federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

· **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.

· To find out if you can get health insurance through your employer, DriveTime, please review eligibility within the Benefits Guide.

Questions about this policy?

· For questions or complaints about this policy, contact your state Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (**naic.org**) under "Insurance Departments."

· If you have this policy through DriveTime, please contact the Benefits Team.

Notices

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 July 31, 2024. 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.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

Notices

GEORGIA – Medicaid	INDIANA – Medicaid
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	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
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
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	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
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	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

Notices

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@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://dhcfp.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

Notices

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 July 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)

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)

Notices

SUMMARY ANNUAL REPORT

For DRIVETIME WELFARE BENEFIT PLAN

This is a summary of the annual report of the DRIVETIME WELFARE BENEFIT PLAN, EIN 86-0721358, Plan No. 501, for period 01/01/2022 through 12/31/2022. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

DRIVETIME AUTOMOTIVE has committed itself to pay certain self-insured Medical claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with UNITEDHEALTHCARE INSURANCE COMAPNY, COMPSYCH, UNUM LIFE INSURANCE COMPANY OF AMERICA, and DELTA DENTAL OF ARIZONA to pay Dental, Vision, Life Insurance, Short-term Disability, Long-term Disability, Accidental Death and Dismemberment, Employee Assistance Program, Critical Illness, Hospital, and Accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2022 were $5,188,097.

Because they are so called "experience-rated" contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending 12/31/2022, the premiums paid under such "experience-rated" contracts were $2,510,981 and the total of all benefit claims paid under these contracts during the plan year was $1,920,423.

Your Rights To Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- insurance information, including sales commissions paid by insurance carriers;

To obtain a copy of the full annual report, or any part thereof, write or call the office of DRIVETIME AUTOMOTIVE at 1720 WEST RIO SALADO PARKWAY, TEMPE, AZ, 85281 or by telephone at 602-852-6600.

You also have the legally protected right to examine the annual report at the main office of the plan (DRIVETIME AUTOMOTIVE, 1720 WEST RIO SALADO PARKWAY, TEMPE, AZ, 85281) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Notices

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 less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 07/31/2023)