Southeast Texas Classic Automotive, Inc.

2025 Benefits Guide

May 1, 2025 - April 30, 2026

Benefits Designed with You in Mind

What's Inside

Benefits Overview

Southeast Texas Classic Automotive, Inc. ("SETCA") is pleased to continue to offer a comprehensive and cost-effective benefits program for you and your family. We recognize that you are critical to our success, and we strive to offer you value through the compensation and benefit programs we provide. It is the goal of SETCA to maintain the benefit programs that you have historically enjoyed and to maintain employer paid Basic Term Life for all employees. Please take a moment to read through this entire benefits summary to ensure that you are taking advantage of the valuable benefit plans available.

Medical Benefits – BlueCross BlueShield of Texas
We understand that a comprehensive health plan is the key to maintaining a healthy workforce. SETCA contributes a high percentage of the total premium costs for our eligible employees. You have three (3) medical plans to choose from: 1) a Low PPO Plan, 2) a High PPO Plan, and 3) a High Deductible Health Plan ("HDHP"), which includes a Health Savings Account ("HSA"). Please review the options carefully to ensure that the medical plan you elect matches yours and your family's needs.

Telemedicine Services – MDLive
You and your family have 24/7/365 access to physicians for telephone and email consultations to diagnose and treat common conditions and prescribe medications, as necessary. When you enroll in the medical plan, you will automatically be eligible for MDLive services.

Health Savings Account - HSABank
If you elect the HDHP, you will be able to contribute to a Health Savings Account (HSA). An HSA is established exclusively for the purpose of paying for qualified healthcare expenses on a pre-tax basis. You may defer pre-tax dollars from your paycheck to fund your Health Savings Account up to the maximum limits established by the IRS. These funds can be carried over from year-to-year and there is no "Use It or Lose It" rule on an HSA.

Dental Benefits – BlueCross BlueShield of Texas
Our Dental coverage provides a PPO plan with a $50 individual deductible and $1,000 calendar year maximum with 100% coverage for preventive services, 80% coverage for basic restorative services and 50% coverage for major services. Orthodontic services are covered for dependent children up to age 19.

Vision Benefits – BlueCross BlueShield of Texas
Our vision coverage provides a $10 exam copay and a $25 copay for lenses. Your allowance is $100 for frames with a 20% discount off the remaining balance and $100 for contact lenses.

Life/AD&D – BlueCross BlueShield of Texas
Our benefits program includes Life/AD&D insurance coverage for employees at no cost. You can also purchase additional Life insurance for yourself, spouse, and children.

Short-Term Disability – MetLife
Short-Term Disability coverage provides salary protection for you in the case you are unable to work due to a short-term disability. This coverage is provided on a voluntary basis. Benefits are available up to 60% of weekly earnings for up to 52 weeks.

Travel and Beneficiary Resource Services – BlueCross BlueShield of Texas
Travel Resource Services are available to assist you with invaluable services when you are traveling 100 miles or more from your home. Beneficiary Resource Services is a program that combines family wellness and security at the most difficult of times. Services include grief and financial consulting, funeral planning, legal support, as well as online will preparation.

Disability Resource Services – BlueCross BlueShield of Texas
Disability Resource Services offers unlimited telephonic support (24/7) to employees and their immediate family convenient, confidential resources to help address emotional, legal and financial issues. Services also include face to face sessions and web-based services.

Open Enrollment

Having trouble accessing the enrollment site?

Call **855.400.0792** or email **support@getebm.com** for assistance.

Or access your "MyBenefits2Go" mobile app for a more detailed guide on navigating the system. "**ebm Quick Start Guide**"

What is Open Enrollment?

Open Enrollment occurs one time each year and is your opportunity to review the benefit programs, select what plans you want to enroll in and which dependents you will cover. Our open enrollment effective date for all coverages will be **May 1, 2025.**

- Elections made during the Open Enrollment will be effective through the end of the plan year - April 30.
- Benefits will continue to accumulate on a calendar year basis (deductibles and out-of-pocket maximums).

After open enrollment, **you will not be able to make any plan changes until the next open enrollment period unless you experience a qualified status change.**

How to Enroll during the Open Enrollment Period?

- Follow the link, **employeenavigator.com/benefits/account/login.**
- If you are a new user, click **Register as New User** and enter the required information to create your account.
- To begin your enrollment, click the **Start Enrollment** button on the homepage.
- Enter or update your information for each of the required fields on the **Personal Information** screen and update your address on the **Address** screen.
- On the **Dependent Information** screen, click **Add Dependent** to add each of your dependents to the portal, even if you do not want to cover them under your plan.
- You will have the option to elect or waive each benefit plan you are eligible for. Click **Save & Continue** to proceed to the next benefit option.
- Once all benefit plans have been elected or waived, a final review and confirmation step is required to ensure that your benefit elections are shown as intended.
- **That's it!** You can print a copy of your Enrollment Summary by clicking the Print button or you can login at anytime to view your Enrollment Summary in the system.

Important Open Enrollment Information:

Basic Life/AD&D

- If you elect a benefit that requires either a Beneficiary or if you need to complete an EOI document, you will be prompted to complete the necessary information in order to finalize your enrollment.

Voluntary Life

- Reminder: If you previously waived the vol life coverage, you are considered a late entrant. Late entrants and individuals wishing to increase their level of coverage are required to provide Evidence of Insurability ("EOI"). You will be prompted within the system to complete the steps. Your initial election or increased election will not be effective until you are approved by the carrier for the new amount elected.

Health Savings Account

- If you are enrolled in the HDHP and you wish to make contributions to your Health Savings Account ("HSA") for the new plan year, you must elect the amount you wish to contribute for the new plan year. This election will not rollover year to year.

PLEASE NOTE:

We are having a Passive Enrollment!

Meaning… your current elections will rollover to the new plan year. BCBS will map you over to the plan closest to the plan you are currently enrolled in unless you make a plan change or waive coverage for the upcoming plan year.

You **MUST** login to **Employee Navigator,** elect or waive benefits if you are enrolling for the first time or making a plan change, then finalize and confirm your plan elections for the upcoming plan year.

employeenavigator.com/benefits/account/login

Company ID: SETexasClassicAuto

Eligibility

Who is Eligible?

Full-time employees working 30 or more hours per week are eligible for benefits after completion of your waiting period. If you enroll in the medical and prescription drug plan, the dental plan, or the vision plan, your eligible dependents can participate in those plans as well. Children may remain on your medical plan until they turn 26 regardless of student or marital status. Benefits will terminate at the end of the month in which they attain age 26. Dependent children who are deemed disabled and are dependent on you for support can remain on the plan after attainment of age 26. See Human Resources for additional information if you have a disabled dependent child as additional paperwork will be needed to add or maintain medical coverage for this individual.

Open enrollment elections are effective **May 1, 2025**. If you are a new employee, your benefits will become effective on the first of the month following 60 days of full-time employment.

How to Make Changes?

Your benefits election will be effective for the entire plan year (May 1, 2025, through April 30, 2026), unless you experience a qualified status change.

Events described in Section 125 IRS regulations allow you to make a change to your benefit coverage at times other than open enrollment, if you experience any of the following:

- Marriage or divorce
- Death
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy the plan's eligibility requirements
- Loss of or significant change to your current coverage
- Judgment, decree or court order
- Enrollment/ceasing to be enrolled in Medicare or Medicaid
- Ceasing to be enrolled in Children's Health Insurance Program (CHIP)

If you have a qualified status change that would allow you to make changes to your coverage elections or dependents, you MUST notify Human Resources within 31 days of the change (or event date). Failure to make timely notice means you will have to wait until the next Open Enrollment period to make the applicable change.

Medical

PPO plans provide you with the freedom to visit any doctor or specialist of your choice without a physician referral. As a plan participant, you are not required to elect a primary care physician. The level of benefits you receive is dependent upon your choice of an in-network PPO provider or an out-of-network provider. The following chart shows you a brief side-by-side look at the estimated amounts you will pay when you utilize in-network providers under the three (3) plans available. Out of network benefits are available under all three plans but will be at a much higher cost to the member at time of service.

To find a provider, visit www.bcbstx.com or by calling 1.800.527.2227.

All deductibles and out of pocket amounts accumulate on a ***calendar year basis***.

MEDICAL	Low PPO Plan	High PPO Plan	HSA Eligible Plan High Deductible Plan
	In-Network	In-Network	In-Network
	You Pay	You Pay	You Pay
Calendar Year Deductible Individual | Family	$5,000 | $14,700	$3,500 | $10,500	$3,500 | $7,000
Out-of-Pocket Maximum Individual | Family	$7,350 | $14,700	$7,900 | $15,800	$3,500 | $7,000
Member Coinsurance	20% Member 80% BCBSTX	20% Member 80% BCBSTX	100% Member 70% BCBSTX
Office Visits Primary Care Physician Specialist	 $45 Copay $90 Copay	 $35 Copay $70 Copay	 0% after Deductible 0% after Deductible
MDLive Telemedicine	$45 Copay	$35 Copay	$48 Charge*
Preventative Care Services	Covered at 100%	Covered at 100%	Covered at 100%
Urgent Care	$75 Copay	$75 Copay	0% after Deductible
Emergency Room Facility Fee ER Physician Charge	 $500 copay; then 20% 20% after Deductible	 $500 copay; then 20% after Deductible	 0% after Deductible 0% after Deductible
Hospital – Inpatient/Outpatient	20% after Deductible	20% after Deductible	0% after Deductible
Prescription Drug Retail: 30-day Supply Generic Preferred Brand Name Non-Preferred Brand Name **Mail Order:** 90 Day Supply	 Mandatory Generic Program** $0 or $10 Copay $50 Copay $100 Copay 3x Retail Copay	 Mandatory Generic Program** $0 or $10 Copay $50 Copay $100 Copay 3x Retail Copay	 0% after Deductible 0% after Deductible 0% after Deductible 3x Retail Copay
Specialty Drugs	$150 Copay Preferred $250 Copay Non-Preferred Must use the Specialty Pharmacy Network call 877.627.6337	$150 Copay Preferred $250 Copay Non-Preferred Must use the Specialty Pharmacy Network call 877.627.6337	0% after Deductible Available at any Retail Pharmacy

**On the HDHP, MDLive is a cost of $48 per virtual visit until the Network Deductible has been met.*

*** If you choose the Brand Name Drug when a Generic Equivalent is available, you will pay the cost difference between the Generic and Brand name, plus the applicable Copay. If "Dispense As Written" is indicated on the prescription by your provider, you will only be subject to the Brand Copay that is applicable.*

CVS Pharmacy is no longer a covered pharmacy on all 3 plans.

Medical Payroll Deductions

Below is a summary of the costs to you on a monthly, semi-monthly and weekly basis. Southeast Texas Classic Automotive continues to subsidize a significant portion of the premiums for the employee.

Medical Plan Contributions

Low PPO Plan	Monthly **Employee** Contribution	**Semi-Monthly Contribution**	Weekly **Employee** Contribution
Employee Only	**$110.00**	**$55.00**	**$27.50**
Employee + Spouse	**$1,073.18**	**$536.59**	**$268.29**
Employee + Child(ren)	**$733.41**	**$366.70**	**$183.35**
Employee + Family	**$1,515.71**	**$757.86**	**$378.93**
High PPO Plan	Monthly **Employee** Contribution	**Semi-Monthly Contribution**	Weekly **Employee** Contribution
Employee Only	**$275.15**	**$137.58**	**$68.78**
Employee + Spouse	**$1,184.09**	**$592.05**	**$296.02**
Employee + Child(ren)	**$819.00**	**$409.50**	**$204.75**
Employee + Family	**$1,659.61**	**$829.81**	**$414.90**
High Deductible Plan	Monthly **Employee** Contribution	**Semi-Monthly Contribution**	Weekly **Employee** Contribution
Employee Only	**$309.01**	**$154.51**	**$77.25**
Employee + Spouse	**$1,262.55**	**$631.28**	**$315.64**
Employee + Child(ren)	**$879.54**	**$439.77**	**$219.89**
Employee + Family	**$1,761.39**	**$880.69**	**$440.35**

Virtual Visits powered by MDLIVE

Speak with a doctor or therapist

Anytime, Anywhere

With your virtual visits benefit, provided by BlueCross and BlueShield of Texas (BCBSTX) and powered by MDLIVE, the doctor is in 24/7/365. You can see a doctor or behavioral health specialist without leaving the comfort of your own home.

Virtual visits allows you to consult an independently contracted, board-certified doctor or therapist for non-emergency situations by phone, mobile app or online video anytime, anywhere. Speak to a doctor or schedule an appointment at a time that works best for you.

Virtual Visits, provided by Blue Cross and Blue Shield of Texas (BCBSTX) and powered by MDLIVE®, are a convenient alternative for treatment of more than 80 health conditions, including:

- Allergies
- Anxiety
- Asthma
- Cold / Flu
- Depression
- Ear infections (age 12+)
- Fever (age 3+)
- Headaches
- Insect bites
- Nausea
- Pink eye
- Rash
- Sinus infections
- Stress management
- And more

Activate your MDLIVE account today

- Call MDLIVE at 888-680-8646
- Go to MDLIVE.com/bcbstx
- Text BCBSTX to 635-483
- Download the MDLIVE app

Why virtual visits?

- 24/7 access to an independently contracted, board-certified MDLIVE doctor
- Access via phone, online video or mobile app from almost anywhere
- Average wait time of less than 20 minutes
- If needed, get a prescription sent to your local pharmacy

Where Should I Go For Care?

Helping You Choose the Right Care Center

Do you know where to seek care when an unexpected health situation happens? Make sure you are ready when you must make an urgent healthcare decision. Review some of the choices of locations of care that are available, so you know where to go the next time you need treatment.

Being prepared is important because knowing where to go for care can help you receive faster treatment and an overall better experience.

Know Before You Go!

MDLive

- Available 24 / 7 / 365
- Minor illnesses
- Minor infections
- Cold & flu
- Allergies
- After-hours care
- Via phone or web

Doctor's office

- Routine care
- Immunizations
- Flu shots
- General health management
- Easy point of entry to health care
- Knows your health history
- No costs for preventive care

Convenience Care Clinic

- Non-urgent condition when your doctor is unavailable
- Common infections
- Flu shots
- Minor cuts
- Cold or sore throat
- Earaches
- Conveniently located at stores such as CVS, Target, HEB, Kroger & Walgreens

Urgent Care Clinic

- Minor illness or injury and your doctor is not available
- You need care quickly, but it's not an emergency
- Sprains
- Strains
- Minor broken bones
- Minor infections
- Minor burns
- Shorter wait time than emergency room
- Xray & Lab Services
- Open evenings & weekends

Emergency room

- Immediate treatment of a very serious or critical condition
- Uncontrolled bleeding
- Large wounds
- Chest pain
- Signs of heart attack
- Spinal injuries
- Severe head injury
- Difficulty breathing
- Possible stroke

Do not ignore an emergency. If a situation seems life-threatening, take action

Call 911

Or your local emergency number right away

Blue Access for Members℠

Get all the advantages your health plan offers

Get information about your health benefits, anytime, anywhere. Use your computer, phone or tablet to access the Blue Cross and Blue Shield of Texas (BCBSTX) secure member website, Blue Access for Members (BAM℠).

With BAM, you can:

- Check the status or history of a claim
- View or print Explanation of Benefits statements
- Locate a doctor or hospital in your plan's network
- Find Spanish-speaking providers
- Request a new ID card – or print a temporary one

When you use bcbstx.com, you'll have 24/7 access to easy-to-use tools and resources that help you:

- Find network doctors
- Estimate the cost of care
- See claims
- Manage pharmacy benefits
- Get wellness support & health advice
- View authorization guidelines
- And much more!

It's easy to get started

1. **Go to bcbstx.com/member**
2. **Click Register Now**
3. **Use the information on your BCBSTX ID card to complete the registration process.**

Text* BCBSTXAPP to 33633 to get the BCBSTX App that lets you use BAM while you're on the go.

*Message and data rates may apply

BlueCross BlueShield of Texas

Health Savings Account | HSA

Employees enrolled in the HDHP plan may choose to open a Health Savings Account (HSA). Here's how it works:

1	**Deductible -** You must meet the entire calendar year deductible of $3,500 (in-network) before the plan starts to pay your medical and prescription drug benefits (excluding in-network preventive care).
2	**Coinsurance -** Once you've met the plan's annual deductible, you are responsible for 0% of in-network medical and prescription drug expenses incurred in the calendar year. This portion is called coinsurance.
3	**Out-of-Pocket Maximum -** Once your calendar year is met, the HDHP plan will start to pay 100% of the in-network eligible covered charrges for the remainder of the calendar year.
4	**Health Savings Account (HSA) -** You may deposit dollars into an HSA through pre-tax payroll deductions. An HSA is exclusively for the purpose of paying qualified medical, prescription drug, dental and vision expenses for yourself, your legal spouse and your tax dependent children. The HSA account belongs to you and will maintain any unused funds year after year, even if you leave the company or change medical plans in the future. The account earns interest and can be invested if over the minimum required balance. The guidelines for contribution maximums are set by the IRS each year. The maximum amount that can be contributed into an HSA is outlined below.

2025 HSA Contribution Limits	
Employee Only	$4,300
Employee + 1 or More	$8,550
Catch-Up (age 55+)	$1,000

Important HSA Facts

- The money in your HSA is yours to keep. The money will grow year after year and remains with you, even if you change medical plans, leave the company, or retire.
- There is no "use-it-or-lose-it" rule associated with an HSA. Any funds left over in your account at the end of the plan year will carry into the next plan year.
- You decide when to use your HSA to pay for qualified expenses. This provides a strong incentive for you to spend wisely on your health care, just as you do on other items you purchase.
- You can use your HSA funds to pay for qualified health-related expenses for yourself, your spouse, your tax-dependent children, and others you claim as dependents on your federal tax return, even if they are not covered under your medical plan.

Be a Better Healthcare Consumer

Practice prevention. Get annual physicals, take any prescribed medication as directed, wash your hands often during cold & flu season, and get a flu shot each year. Healthy lifestyle habits, like eating well, exercising, and not smoking, can be as good for your wallet as they are for your body and mind.

Understand the true costs of your care. Find out the actual costs of healthcare services and prescription drugs. You'll find there are often cheaper treatment options (such as generic drugs) that can save you money while providing you the care you need. Go to www.abcbenefits.com to find helpful tools.

Stay in-network. When receiving medical care, be sure to use doctors, hospitals, pharmacies, and labs inside your network. In-network providers and services will always cost less than those out of the network.

Talk with doctors. Share information openly with doctors and ask questions so you can get the care you need, when you need it. Prepare questions before visiting your doctor to make the most of your visit.

Take responsibility for your self-care. Take an active role in your health by researching and understanding your health issues, following recommended treatment plans, and working to prevent further symptoms.

Dental

Dental benefits are provided by BlueCross BlueShield of Texas. This plan offers both in and out-of-network benefits. For out-of-network claims, you will be responsible for any applicable cost sharing, charges in excess of the benefit maximum, charges in excess of the 80th percentile of reasonable and customary, and charges for non-covered services.

When the course of treatment will be in excess of $300, a predetermination request should be submitted to BCBSTX in advance of the treatment by your provider.	In-Network
Calendar Year Maximum (Class I, II, and III expenses)	$1,000*
Annual Deductible Individual | Family	$50 | $150
Class I: Preventative and Diagnostic Care Periodic Oral Evaluations, for established patients Comprehensive Oral Evaluations for new or established patients (2 time every 12 months) Prophylaxis - Routine Cleaning (2 every 12 months in combination with Periodontal Maintenance) Bitewing X-rays (1 time in 12 months) Periapical X-rays (6 times every 12 months) Fluoride Treatment (up to age 19; 2 times in 12 months) Sealants (1 per permanent molar per lifetime, up to age 16) Space Maintainers (limited to a lifetime max or 1 appliance per missing tooth site; up to age 19)	100%
Class II: Basic Restorative Care Amalgam Restorations (limited to 1 per tooth surface every 24 months) Resin Based Composite Restorations (limited to 1 per tooth surface every 12 months) Simple Extractions – Removal of Retained Coronal Remnants of Erupted Tooth or Exposed Root	80%
Class III: Major Restorative Care Periodontal Scaling and Root Planning (1 time per quadrant every 24 months) Full Mouth Debridement (1 time every 12 months) Periodontal Maintenance (2 times every 12 months in combination with routine oral prophylaxis) Deep sedation, General Anesthesia Root Canal Therapy Surgical Periodontal Services Complete and Removable Partial Dentures (1 time per 60 months)	50%
Class IV: Orthodontia Coverage Lifetime Maximum Eligibility	50% $1,000 Dependent Child to age 19

*Graduated Annual Benefits applies. Each covered member will receive an increase of $150 per year to their annual maximum. The annual maximum will be limited to 3 incremental increases or $1,450 whichever comes first.

To locate an in-network provider, visit
www.bcbstx.com/find-care/providers-in-your-network/find-a-dentist
and select "**BlueCare Dental**".

Employee Contributions	Monthly	Semi-Monthly	Weekly (48 Pay)
Employee Only	$20.00	$10.00	$5.00
Employee + One	$42.00	$21.00	$10.50
Employee + One or more	$70.00	$35.00	$17.50

Vision

Vision benefits are provided through BlueCross BlueShield of Texas. BlueCross BlueShield of Texas offers a vast selection of network providers through Eyemed. You may see out-of-network vision providers, but you will only be reimbursed based upon a fee schedule.

	In-Network	Out-of-Network
Exam (Once every plan year)	$10 Copay	Reimbursed up to $30
Frames (Every 2 plan years)	$0 Copay, $100 Allowance, 20% off balance over $100	Reimbursed up to $50
Lenses for Eyeglasses (Once every plan year)		
Single	$25 Copay	Reimbursed up to $25
Bifocal	$25 Copay	Reimbursed up to $40
Trifocal	$25 Copay	Reimbursed up to $55
Lenticular	$25 Copay	Reimbursed up to $55
Standard Progressive	$90 Copay	Reimbursed up to $40
Contact Lenses in lieu of glasses (Once every plan year)	$0 Copay, $100 Allowance, 15% off balance	Reimbursed up $80
Medically Necessary	Paid in Full	Reimbursed up to $210

To locate an in-network provider, visit https://eyedoclocator.eyemedvisioncare.com/bcbstx/en

Employee Contributions	Monthly	Semi-Monthly	Weekly (48 Pay)
Employee Only	$4.13	$2.07	$1.03
Employee + Spouse	$8.25	$4.13	$2.06
Employee + Child(ren)	$10.30	$5.15	$2.58
Employee + Family	$15.45	$7.73	$3.86

Life & AD&D

Basic Life & AD&D:

Southeast Texas Classic Automotive provides all full-time, regular employees with company-paid group life and accidental death and dismemberment (AD&D) insurance. BlueCross BlueShield of Texas underwrites the Life and AD&D plans. Life insurance provides financial benefits to a designated beneficiary in the event of the death of a covered person.

Company-Paid Basic Life & AD&D for Employees	
Life Benefit Amount	Class 1: $10,000 Class 2: $15,000 Class 3: $25,000 Class 4: $40,000 Class 5: $80,000
AD&D Benefit Amount	An amount equal to your Basic Life
Age Reduction	Benefits reduce to 65% at age 65; 40% at age 70; 25% at age 75

Benefit terminates at retirement. Benefit is both portable and convertible if you leave employment.

Additional Life:

Employees who want to supplement their basic insurance benefits may purchase additional coverage through BlueCross BlueShield of Texas. When you enroll yourself and/or your dependents in this benefit, you pay the full cost through payroll deductions.

If you join when you are first eligible, you and your dependents may elect up to the full Guarantee Issue amount without any medical questions. If you or your dependents decide to join later, Evidence of Insurability (EOI) will be required before coverage is approved.

	Benefit Maximum	Guaranteed Issue
Employee	Up to 3x your basic annual earnings to $500,000	100,000
Spouse	Increments of $5,000 to the lesser of $250,000 or 50% of Employee's Voluntary Life Insurance	$50,000
Children	Birth to 6 mths: $1,000 6 mths - 26 years: $10,000	10,000

Employee & Spouse	
Age:	Monthly cost per $1,000 of coverage
<35	$0.10
35-39	$0.18
40-44	$0.27
45-49	$0.45
50-54	$0.71
55-59	$1.16
60-64	$1.91
65-69	$2.74
70-74	$5.30
75+	$10.70
Child Life per $1,000: $0.136 ($1.36 per month, per family)	

To calculate your monthly contribution, choose your desired benefit amount. Then multiply the amount of coverage by the rate for your age from the chart and divide by $1,000.
(Spouse rate is based on employee's age)

$_____ x $_____ ÷ $1,000 = $_____
Coverage Amount | **Rate from chart** | **Your monthly contribution**

Employees who are currently covered on Voluntary Life can increase **by $10,000** up to $100,000 without EOI.

Short-Term Disability

Southeast Texas Classic Automotive offers all full-time active employees the opportunity to purchase Voluntary Short-Term Disability through MetLife. These premiums will be payroll deducted. Short-Term disability benefits replace a portion of your income in the event that you become disabled due to a non-work-related injury or illness.

What is the Benefit Amount?

You select the amount of weekly benefit that is right for you. Choose any weekly benefit amount in increments of $50 per week if you already have coverage. If you are enrolling for the first time, you may apply for up to $100. Your benefit amount can be up to 60% of your basic weekly earnings, up to the $500 maximum.

When do benefits begin and how long do they continue?

Benefits begin after the 1st day for an injury and after the 8th day for an illness. Benefits continue for as long as you are disabled up to a maximum duration of 52 weeks of disability.

Pre-Existing Conditions Apply

A Pre-Existing Condition is a sickness or injury for which the insured employee received treatment within 3 months before his or her coverage effective date. The policy does not cover disabilities resulting from pre-existing conditions unless the disability begins after

- 6 months without treatment for the condition; or
- the coverage is in effect for 12 months.

Buy weekly benefits in increments of $50 (starting at $100)			
To Buy	$100	You must earn at least this amount weekly	$166
	$150		$250
	$200		$344
	$250		$417
	$300		$500
	$350		$584
	$400		$667
	$450		$750
	$500		$834

If you are currently enrolled in the short-term disability insurance, you can increase your benefit at open enrollment by $50 as long as it doesn't exceed 60% of your current gross pay.

If you are already eligible for coverage but have declined coverage in the past, you can enroll at $100/week benefit. (No EOI is required)

Coverage	Age	Monthly Cost	Coverage	Age	Monthly Cost	Coverage	Age	Monthly Cost
$100	<40	$8.50	$250	<40	$21.25	$400	<40	$34.00
	40-44	$8.70		40-44	$21.75		40-44	$34.80
	45-49	$8.90		45-49	$22.25		45-49	$35.60
	50-54	$9.15		50-54	$22.88		50-54	$36.60
	55-59	$11.20		55-59	$28.00		55-59	$44.80
	60-64	$11.55		60-64	$28.88		60-64	$46.20
	65+	$19.40		65+	$48.50		65+	$77.60
$150	<40	$12.75	$300	<40	$25.50	$450	<40	$38.25
	40-44	$13.05		40-44	$26.10		40-44	$39.15
	45-49	$13.35		45-49	$26.70		45-49	$40.05
	50-54	$13.73		50-54	$27.45		50-54	$41.18
	55-59	$16.80		55-59	$33.60		55-59	$50.40
	60-64	$17.33		60-64	$34.65		60-64	$51.98
	65+	$29.10		65+	$58.20		65+	$87.30
$200	<40	$17.00	$350	<40	$29.75	$500	<40	$42.50
	40-44	$17.40		40-44	$30.45		40-44	$43.50
	45-49	$17.80		45-49	$31.15		45-49	$44.50
	50-54	$18.30		50-54	$32.03		50-54	$45.75
	55-59	$22.40		55-59	$39.20		55-59	$56.00
	60-64	$23.10		60-64	$40.43		60-64	$57.75
	65+	$38.80		65+	$67.90		65+	$97.00

Call the Benefit Resource Center ("BRC"), We're Here To Help!

We speak insurance.

Our Benefits Specialists can help you choose the right plan for you and your family, translate confusing jargon, answer questions about which benefits are on your plan and which aren't, work directly with insurance carriers to resolve tricky issues regarding claims and denials of service—and more!

Benefit Resource Center

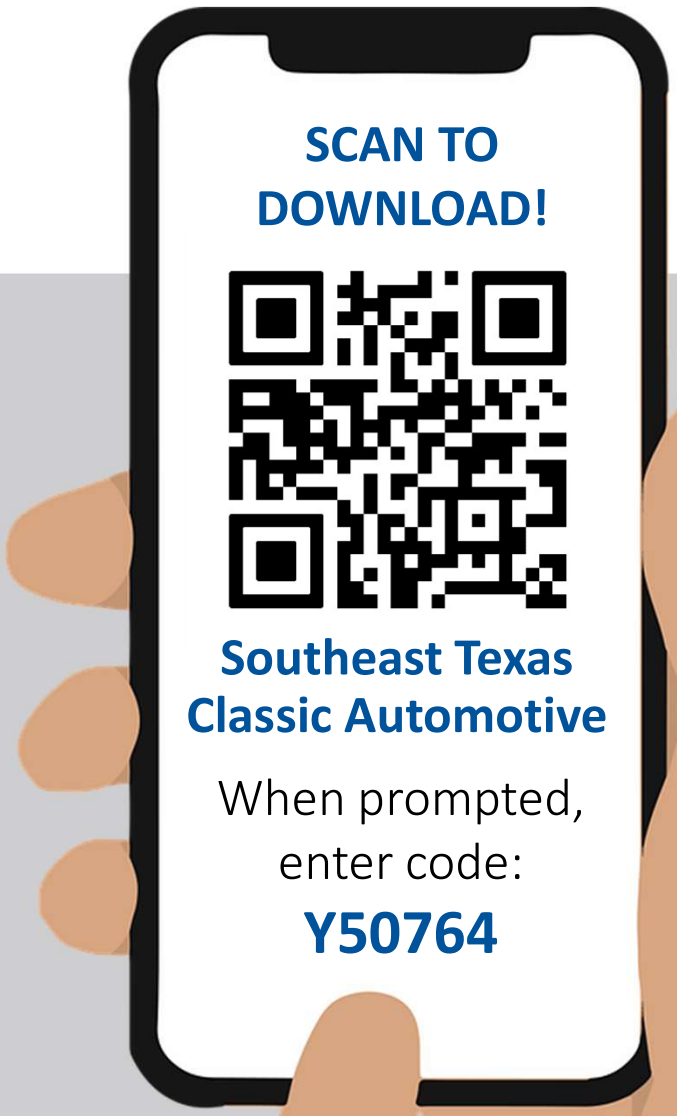
BRCSouthwest@usi.com | Toll Free: 855-874-0110

Monday through Friday 8:00am to 5:00pm Eastern & Central Standard Time

MyBenefits2GO

Free Benefits App for iPhone & Android

You and your enrolled dependents can access benefit summaries and other important information about our group plans using MyBenefits2GO. View up-to-date plan information, store photos of ID cards, and easily locate carrier and HR contact information—all in one place.



Stay organized, store ID cards, and easily contact carriers!

Quick Start Guide: Benefits Enrollment

Employee Navigator is your benefits portal, where you can enroll in benefits offered to you by your employer, view your current coverage details and plan summaries, add or update beneficiaries, retrieve insurance carrier contact information, and access documents and content related to your benefits all throughout the year.

You can access your benefits portal via the web browser on any computer, laptop, tablet, or mobile device.

If at any time you need technical assistance, such as help logging in or navigating through your enrollment, please contact ebm by calling **855-400-0792** or emailing support@getebm.com. A member of our support team will be happy to help during our normal business hours, Monday through Friday 8:30am-5pm ET.

Contents

Logging into your benefits portal

1. Click the link below, or open your web browser and copy paste the following into the address bar: employeenavigator.com/benefits/account/login
2. If you received a registration email and previously registered your account, enter your username and password.
3. If this is your first time registering, click **Register as New User** and enter the required information to create your account:
    - First and Last Name
    - Company ID: SETexasClassicAuto
    - Last four digits of your Social Security Number
    - Date of Birth

HAVING TROUBLE LOGGING IN?

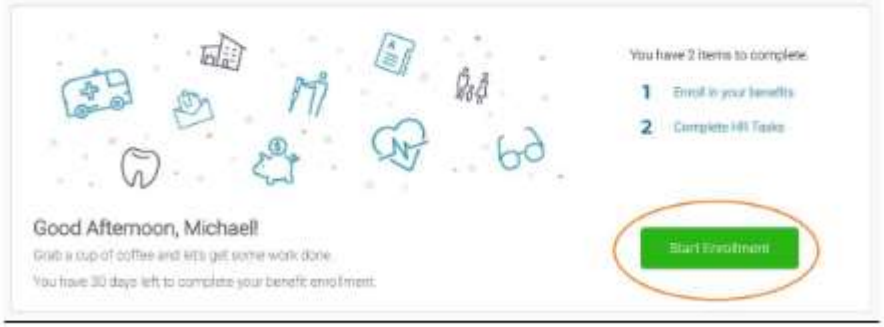
We're here to help. Call **855-400-0792** or email support@getebm.com for assistance from a member of our support team.

Enrolling in benefits

Prior to beginning the enrollment process, you'll want to have your personal information and information for your dependents ready. This includes information such as:

- First & Last Name
- Date of Birth
- Social Security Number
- Address

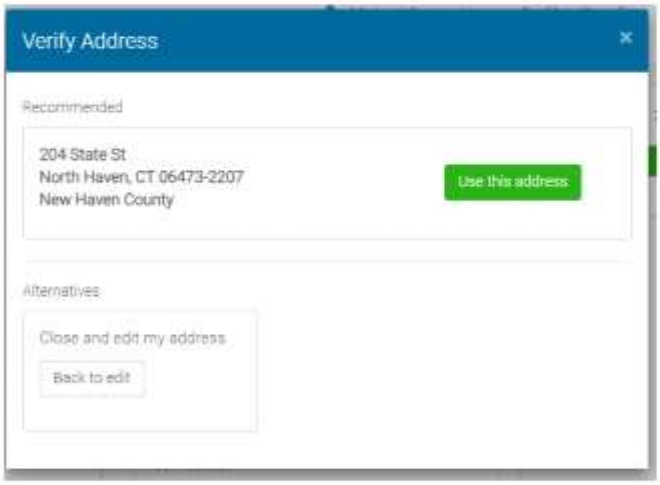
To begin your enrollment, select the **Start Enrollment** button on the homepage.



If you wish to go back to a previous screen at anytime during the enrollment process, click **View steps** from the progress bar shown on the right side of your screen. A menu will appear showing all available steps within your enrollment. Simply click on a step to navigate to the screen you wish to return to.

PERSONAL INFORMATION

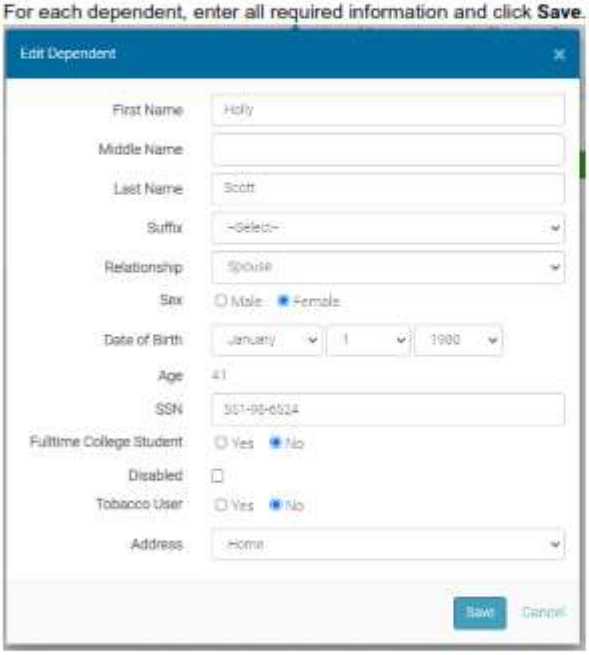
1. Enter or update your information for each of the required fields on the Personal Information screen. Click **Save & Continue** to proceed the next screen.
2. Enter or update your address on the Address screen. Click **Save & Continue**. A pop-up may appear with the recommended address for you to verify. Select **Use this address** to use the recommended address, or **Back to edit** to make changes.



DEPENDENT INFORMATION

1. On the Dependent Information screen, click **Add dependent** to add each of your dependents to the portal, regardless of whether they will be covered. You will have the opportunity to elect or waive coverage for each dependent for all available plan types at the next step. If you do not have any dependents, click Save & Continue.

2. For each dependent, enter all required information and click **Save**.



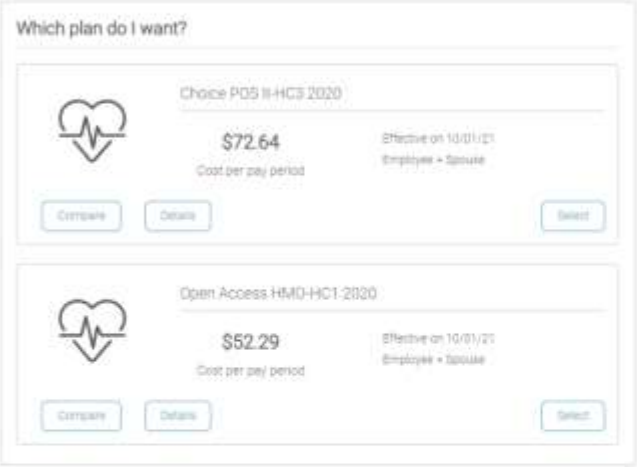
3. Once you have entered all your dependents, click **Save & Continue**.

ELECTING & WAIVING BENEFITS COVERAGE

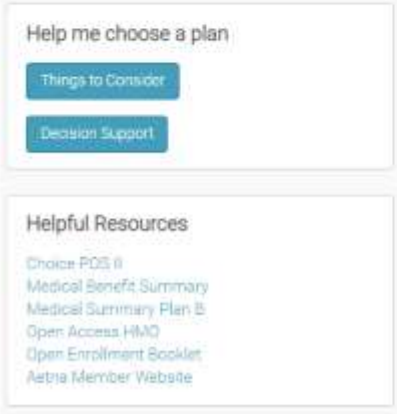
You will have the option to elect or waive all benefits that you are eligible for. Each benefit offering that you are eligible for will ask "Who am I enrolling?". For plans that allow dependent coverage, applicable dependents will appear for you to select.

All available plans will be displayed with information about the plan including your cost per pay period, the date coverage will take effect if the plan is elected, and whether you have chosen to cover dependents.

You can compare the details of plans side-by-side by clicking **Compare**, or can click **Details** to view plan summary information for a specific plan.

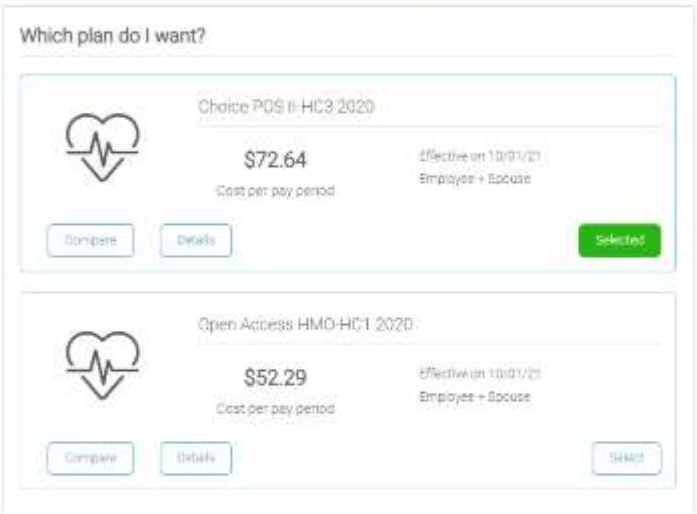


If you're not sure which plan to choose, you can access the tools within the "Help me choose a plan" section. We also encourage you to explore all information about your plan options by reviewing each of the items within the "Helpful Resources" section.



1. If you wish to enroll a dependent in the plan, simply **select the circle next to their name**. If you do not wish to cover a dependent under the plan, leave the circle unselected.

2. To elect a plan, click **Select** for the plan in which you wish to enroll.

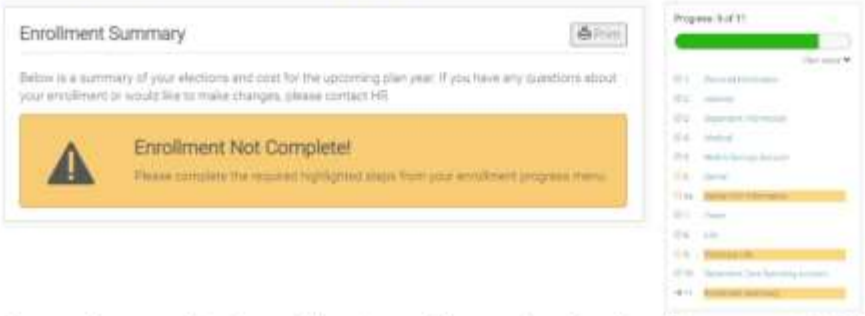


3. Click **Save & Continue** to proceed to the next benefit option.
4. To waive a benefit, click **Don't want this benefit?**. If prompted, select the reason that you are declining coverage and click **Apply**.
5. If you elect a benefit that requires either a Beneficiary, Primary Care Physician, or a completed EOI document, you will be prompted to complete the necessary information in order to complete your enrollment.

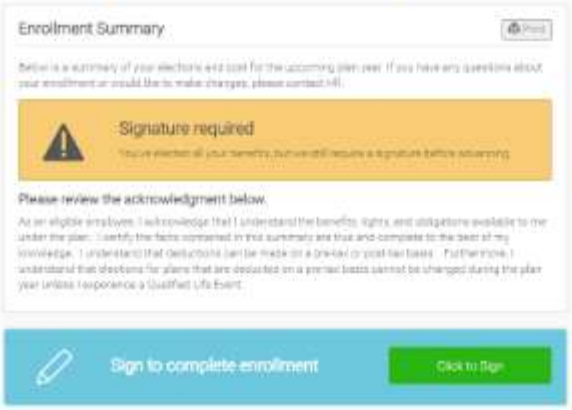
ENROLLMENT SUMMARY & SUBMISSION

Once all benefit offerings have been selected, a final review and confirmation step is required to ensure that you have correctly made your desired elections. The Enrollment Summary screen will breakdown the plans you've enrolled in, your costs per pay period, the dependent(s) you've elected to cover under each plan, and the date each benefit will take effect. It will also display a summary of all benefits that you've declined coverage for.

1. If you have missed any steps or did not fill out all required information, a message will appear with the highlighted steps for you to return to and complete.



2. Once you have completed any missing steps and have reviewed your benefit summary, select **Click to Sign** to submit your electronic acknowledgement.



3. **That's it!** You may print a copy of your Enrollment Summary by clicking the **Print** button, or can login at anytime to view your Enrollment Summary directly within the system.

You will be able to update or change any elections if you are currently in an Enrollment Window. If a change is made after signing the benefit summary, you will need to resign to affirm the change request was processed.

IMPORTANT PATIENT PROTECTION AND AFFORDABLE CARE ACT NOTICES, ERISA NOTICES AND CONTACTS FOR MORE INFORMATION

The legal notices describe important rights that you have under the terms of the Southeast Texas Classic Automotive Health Plan. If you need a copy via email or a printed copy of these notices or have any questions about them, you may contact:

Your Employer Representative
Southeast Texas Classic Automotive
Barbara Peckham, Human Resources
409.434.4821
barbara@myclassicgm.com

or by mail at:
Southeast Texas Classic Automotive
1000 IH-10 North
Beaumont, TX. 77702
Attn: Human Resources

Important Legal Notices

- CHIPRA Notice (Children's Health Insurance Program Reauthorization Act)
- WHCRA Notice (Women's Health and Cancer Rights Act)
- Patient Protection Choice of Providers
- HIPAA Special Enrollment Rights Notice
- Medicare Creditable & Non-Creditable Notices

IMPORTANT NOTICE: The legal notices are provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.

Southeast Texas Classic Automotive Inc.

Important Legal Notices

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage.

Please see pages 35-36 for more details.

***IMPORTANT NOTICE**: This document is provided to help employers understand the compliance obligations for Health & Welfare benefit plans, but it may not take into account all the circumstances relevant to a particular plan or situation. It is not exhaustive and is not a substitute for legal advice.*

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: $5,000-80%, $3,500- 80%, and $3.500- 100%.

NEWBORNS ACT DISCLOSURE – FEDERAL

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

NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

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

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

PATIENT PROTECTION MODEL DISCLOSURE

You do not need prior authorization from BCBS 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 Barbara Peckham at 409-924-3450

STATEMENT OF ERISA RIGHTS

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

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.
No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan reviewed and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Barbara Peckham
1000 IH-10 North
Beaumont, Texas United States 77702
409-434-4821
barbara@myclassicgm.com

Your Information. Your Rights. Our Responsibilities.

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****.*
Contact information for questions or complaints is available at the end of the notice.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing, usually within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for up to six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/hipaa/filing-a-complaint/index.html.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.
In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- In these cases, we never share your information unless you give us written permission:
  Marketing purposes
  Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Pay for your health services
We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan
We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

Run our organization
- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

Example: We use health information about you to develop better services for you.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Help with public health and safety issues
We can share health information about you for certain situations such as:
- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.

Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/hipaa/for-individuals/guidance-materials-for-consumers/index.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site (if applicable), and we will mail a copy to you.

Other Instructions for Notice

- 05/01/2025
- Barbara Peckham / barbara@myclassicgm.com / 409.434.4821

MODEL INDIVIDUAL **CREDITABLE COVERAGE** DISCLOSURE NOTICE LANGUAGE FOR USE ON OR AFTER APRIL 1, 2011

If you are receiving a copy of this notice electronically, you are responsible for providing a copy of it to any Part-D eligible dependents covered under the group health plan.

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

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

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. **Southeast Texas Classic Automotive, Inc** has determined that the prescription drug coverage offered by the BCBS for the plan year 2025 is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered **Creditable Coverage**. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

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

If you decide to join a Medicare drug plan, the following options may apply:

- You may stay in the BCBS and not enroll in the Medicare prescription drug coverage at this time. You may be able to enroll in the Medicare prescription drug program at a later date without penalty either:
    - During the Medicare prescription drug annual enrollment period, or
    - If you lose BCBS creditable coverage.
- You may stay in the BCBS and also enroll in a Medicare prescription drug plan. The **BCBS plan** will be the primary payer for prescription drugs and Medicare Part D will become the secondary payer.
- You may decline coverage in the BCBS plan and enroll in Medicare as your only payer for all medical and prescription drug expenses. If you do not enroll in the BCBS plan, you are not able to receive coverage through the plan unless and until you are eligible to reenroll in the plan at the next open enrollment period or due to a status change under the cafeteria plan or special enrollment event.

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

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

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

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through **Southeast Texas Classic Automotive, Inc.** changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

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

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

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

Date:	05/01/2025
Name/Entity of Sender:	Southeast Texas Classic Automotive, Inc.
Contact Position/Office:	Barbara Peckham
Address:	1000 IH-10 North Beaumont, TX 77702
Phone Number:	409.434.4821

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
Website: http://myalhipp.com/ Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
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+)

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

FLORIDA – Medicaid

Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid

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)

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

KANSAS – Medicaid

Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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

LOUISIANA – Medicaid

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

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

MASSACHUSETTS – Medicaid and CHIP

Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid

Website: https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3739

MISSOURI – Medicaid

Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid

Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid

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

Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid

Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid

Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP

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

Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP

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
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
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
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid
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)

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

Name of Entity/Sender: Southeast Texas Classic Automotive, Inc. / Barbara Peckham
Contact--Position/Office: Human Resources
Address: 1000 IH-10 North Beaumont, TX 77702

Phone Number: 409.434.4821

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

PART B: Information About Health Coverage Offered by Your Employer

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

1. Employer Name Southeast Texas Classic Automotive, Inc.		2. Employer Identification Number (EIN) 76-06063797
3. Employer address 1000 IH-10 North		4. Employer phone number 409-434-4821
5. City Beaumont	6. State TX	7. ZIP code 77702
8. Who can we contact about employee health coverage at this job? Barbara Peckham		
11. Phone number (if different from above)	12. Email address barbara@myclassicgm.com	

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

- As your employer, we offer a health plan to:
  - [X] All employees. Eligible employees are:

    All Active EEs working 30+ hours

  - [ ] Some employees. Eligible employees are:

- With respect to dependents:
  - [X] We do offer coverage. Eligible dependents are:

    Spouse and legal child dependents as described in the Certificate of Coverage.

  - [ ] We do not offer coverage.

[X] If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower

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Important Contacts

Benefit	Contact / Group #	Contact Information
Benefit Admin Platform (NEW Enrollment Site)	EBM Employee Navigator	**855.400.0792** Email: support@getebm.com
Medical	**BCBSTX** **Group # 267301**	**800.521.2227** www.bcbstx.com/member
Virtual Visits	**MDLive** **BCBSTX member ID number**	**888.680.8646** www.mdlive.com/bcbstx
Dental	**BCBSTX** **Group # 267303**	**800.521.2227** www.bcbstx.com/member
Vision	**BCBSTX** **VF024186**	**855.556.8796** https://eyedoclocator.eyemedvisioncare.com/bcbstx/en
Life & AD&D	**BCBSTX** **Group # VF024186**	**800.348.4512** www.bcbstx.com/ancillary
Short-Term Disability	**MetLife** **Group # GR099462**	**800.858.6506** www.metlife.com
Travel Resource Services	**BCBSTX** **Group # VF024186**	**800.872.1414** ops@us.generaliglobalassistance.com
Beneficiary Resource Services	**BCBSTX** **Group # VF024186**	**800.769.9187** www.beneficiaryresource.com Username: beneficiary
Disability Resource Services	**BCBSTX** **Group # VF024186**	**866.899.1363** www.guidanceresources.com Company ID: BCBSTX
Southeast Texas Classic Automotive	**Human Resources**	Payroll clerk at your location
Benefits Resource Center (“BRC”)	**USI Southwest** **Group: SETCA**	**855.874.0110** BRCSouthwest@usi.com

Southeast Texas Classic Automotive, Inc.

Wishing you good health in the 2025-2026 plan year!