AUTONATION EMPLOYEE ASSISTANCE PROGRAM

2020 Summary Plan Description for the Employee Assistance Program

AUTONATION EMPLOYEE ASSISTANCE PROGRAM

This booklet constitutes the written instrument under which the AutoNation Employee Assistance Program (the "Program") is established and maintained (i.e., Plan Document) for purposes of ERISA section 402(a), and the Summary Plan Description ("SPD") under the Program.

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PROGRAM OVERVIEW	ELIGIBILITY
The AutoNation Employee Assistance Program ("the Program") provides confidential assessments, short-term counseling, referrals, and follow-up services to you and your dependents. The Program addresses an array of issues affecting mental and emotional well-being, such as alcohol and other substance abuse, stress, grief, financial issues, family problems, and psychological disorders. AutoNation provides this coverage at no cost to you. Refer to "What is Covered" for more details.	**Who Is Eligible** You are automatically covered under the Program if you are a regular: ▪ Full-Time Associate of AutoNation, Inc., who is regularly scheduled to work 30 hours or more each week or ▪ Part-Time Associate of AutoNation, Inc., classified as such upon hire ***If Your Company or Location Is Acquired by AutoNation*** If your company or location is acquired by AutoNation, you will be eligible for AutoNation benefits on the date established for the transition to the AutoNation Program (AutoNation will notify you of your Benefit Effective Date)**.** **Eligible Dependents** Eligible dependents include your Spouse and Eligible Dependents who meet the definition of Eligible Dependents in "Important Definitions." **Who Is Not Eligible** You are not eligible for benefits if you are: ▪ A leased Associate ▪ A contract Associate ▪ An Associate who is a nonresident alien receiving no earned income from sources within the United States ▪ Subject to collective bargaining, unless the Plan is specifically included in the bargaining agreement **When Coverage Begins** Coverage for you and your Eligible Dependents begins on your date of hire, if you are eligible. **Your Cost for Coverage** AutoNation provides the Program coverage at no cost to you. Refer to "What is Covered" for more details.

How to Enroll

You are automatically enrolled when you are hired. There is no enrollment form to complete.

ABOUT THE PROGRAM

The Employee Assistance Program ("EAP") is a confidential service, provided by LifeWorks through MetLife, that helps you and your Eligible Dependents solve personal problems that may affect your health, family life and/or job performance. LifeWorks provides professional counseling and referral services for this program.

The Program is available to you as an AutoNation Associate, and your Eligible Dependents, regardless of whether you enroll in any other AutoNation benefits. The Program services can help you and your Eligible Dependents with:

- **Family:** Going through a divorce, caring for an elderly family member, returning to work after having a baby
- **Work:** Job relocation, building relationships with co-workers and managers, navigating through reorganization
- **Money:** Budgeting, financial guidance, retirement planning, buying or selling a home, tax issues
- **Legal Services:** Issues relating to civil, personal and family law, financial matters, real estate and estate planning
- **Identity Theft Recovery**: ID theft prevention tips and help from a financial counselor if you are victimized
- **Health:** Coping with anxiety or depression, getting the proper amount of sleep, how to kick a bad habit like smoking
- **Domestic Abuse:** Recognizing the signs of abuse and where to find help for yourself or a loved one
- **Suicide:** Understand the warning signs and where to turn for support for yourself or someone you care about
- **Everyday Life:** Moving and adjusting to a new community, grieving over the loss of a loved one, military family matters, training a new pet

The Program is available any time, day or night, by calling the Program's toll-free hotline at 1-888-319-7819. When you call, just select "Employee Assistance Program" when prompted. You can speak to a licensed counselor immediately or schedule a confidential phone or video conference appointment. The licensed counselor will help you assess your situation and identify possible solutions and available resources. The Program includes up to 5 phone or video consultations with licensed counselors for you and your Eligible Dependents, per issue, per Program Year. If you need additional counseling sessions, your licensed counselor may assist you in identifying a professional in your area to further assist you.

If you're simply looking for information, the program offers easy to use educational tools and resources, online and through a mobile app. There is a chat feature so you can talk with a consultant to guide you to the information you are looking for or help you schedule an appointment with a licensed counselor. Online information is available at www.autonation.lifeworks.com. Enter your user name: **autonation** and password: **lifeworks** to login.

You can also download the mobile app by searching "LifeWorks" on the iTunes App Store or Google Play. Login with the user name: **autonation** and password: **lifeworks**.

What Is Covered

The EAP offers you and your Eligible Dependents the following services:

- Assessment, consultation and problem solving
- Risk screening and crisis intervention
- Advocacy to help you address your situation
- Referral to a licensed network clinician for **up to five counseling sessions** at no charge per eligible member per issue per Program Year
- Referral to community resources
- Educational materials specific to your issue
- Legal consultation from a licensed network attorney
- Mediation services, and
- Financial counseling from a credentialed financial professional through the Program.

These services include a full range of individual, couple, and family assessments for most types of personal problems including:

- Single parenting
- Eating disorders
- Dual careers
- Anxiety
- Depression
- Parent/child conflict
- Job burnout
- Work-related problems
- Life transition
- Aging parents
- Death and dying
- Unresolved grief
- Marital problems
- Sexual problems
- Retirement concerns
- Career change
- Financial and legal concerns
- Physical abuse
- Alcohol or drug problems
- Problems of adolescence
- Stress, and
- Compulsive gambling.

There can be treatment needs that may fall outside the scope of the Program's short-term counseling. If this is the case, you will be assisted with accessing the appropriate resource.

Work/Life Resource Referrals

You and your Eligible Dependents can also receive assistance through the EAP for referral resources that match your individual family needs:

- Dependent care and related referral services, including resources for childcare, as well as for elderly or disabled
- Adoption assistance
- Pet care and pet training resources
- Education programs and schools for pre-K through grade 12
- College and post-graduate program search, adult learning, and summer camps
- Caregiver resources and tools, and
- Convenience services.

Legal and Financial Consultation Services

You and your Eligible Dependents can also receive assistance through the EAP for legal and financial concerns, such as:

- Legal consultation, including a free half hour consultation with a network attorney in your area. If you decide to retain the network attorney, there is a 25% discount on fees.
- Financial consultation, ranging from individual telephonic sessions focusing on personal finances, to online resource tools to seminars covering such issues as saving for college and retirement planning, and
- ID theft and fraud resolution guidance and support services.

Community Resource Referrals

You and your Eligible Dependents can also receive a referral through the Program to services offered by the community and other local resources such as financial assistance programs and self-help groups.

What Is Not Covered

The Program does not cover the following services:

- Services in excess of five sessions per problem type, per Program Year.
- Services not provided or coordinated by the EAP
- Physician services, including services from a psychiatrist
- Hospital and facility-based services (inpatient and outpatient services)
- Diagnostic laboratory and diagnostic and therapeutic radiological services
- Psychological testing
- Home health services
- Emergency health care services
- Drugs and medications, or
- Legal referrals tied to employment law.

WHEN COVERAGE ENDS

Coverage will end for you when any of the following events occur:

- You are no longer eligible for coverage
- The date your employment with AutoNation ends*
- The date you die
- If AutoNation grants you a Leave of Absence, your personal and, if it applies, dependent coverage under the Program will continue for the period of your approved leave, not to exceed six months
- The date you cease to be in an eligible class

Coverage will end for your dependents when any of the following events occur:

- The date Dependent coverage ends under the Group Policy for all Associates or for your class
- The date the person ceases to be a Dependent
- The date you cease to be in a class that is eligible for Dependent coverage

***Note:** If your employment with AutoNation ends, you and your Eligible Dependents will continue to have access to the Employee Assistance Program for 18 months after coverage would otherwise end due to termination of employment.

Initial Claims

Urgent Claims

An urgent claim is any claim for medical care or treatment where making a determination under the normal time frames could seriously jeopardize your life or health, or your ability to regain maximum function; or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that could not adequately be managed without the care or treatment that is the subject of the claim.

If your claim is determined to be an urgent claim, a notice will be sent as soon as possible taking into account the medical exigencies and in no case later than 72 hours after receipt of the claim or earlier, if required by law. You may receive notice orally, in which case, written notice will be provided within three days of the oral notice. If your urgent claim is determined to be incomplete, you will receive a notice to this effect within 24 hours of receipt of your claim, at which point you will have 48 hours to provide additional information.

If you request an extension of urgent care benefits beyond an initially determined period and make the request at least 24 hours prior to the expiration of the original determination, you will be notified within 24 hours of receipt of the request.

Pre-Service Claims

A pre-service claim is a claim for services that have not yet been rendered and for which the Program requires prior certification.

If your pre-service claim is improperly filed or does not follow the procedures established in this "Claims Procedures" section, you will be sent notification within five days of receipt of the claim. If your pre-service claim is filed properly, a claims determination will be sent within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days from the receipt of the claim. If the Program determines that an extension is necessary due to matters beyond the control of the Program, this time may be extended 15 days.

You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Program expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Program will then make its determination within 15 days from the date the Program receives your information, or if earlier, the deadline to submit your information.

Post-Service Claims

A post-service claim is a claim for services that already have been rendered, or where the Program does not require prior certification.

When you submit a post-service claim and your claim is denied, a notice will be sent within a reasonable time period but no later than 30 days from receipt of the claim. If the Program determines that an extension is necessary due to matters beyond the control of the Program, this time may be extended 15 days. You will receive notice prior to the extension that indicates the circumstances requiring the extension and the date by which the Program expects to render a determination. If the extension is necessary to request additional information, the extension notice will describe the required information, and you will be given at least 45 days to submit the information. The Program then will make its determination within 15 days from the date the Program receives your information, or if earlier, the deadline to submit your information.

Concurrent Care Claims

A concurrent care claim is a claim that arises when there is a reduction or termination of ongoing care.

You will be notified if there is to be any reduction or termination in coverage for ongoing care sufficiently in advance of such reduction so that you will be able to appeal the decision before the coverage is reduced or terminated, unless such a reduction or termination is due to a Plan Amendment or the termination of the Program.

Notice of Determination

If your claim is filed properly and your claim is denied, either in full or in part, you will receive notice of an adverse benefit determination that will:

- State the specific reason or reasons for the adverse benefit determination
- Reference the specific Program provisions on which the determination is based
- Describe additional material or information, if any, needed to perfect the claim and the reasons such as material or information is necessary
- Describe the Program's claim review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), following an adverse benefit determination on review
- Disclose any internal rule, guidelines or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request)
- Explain the scientific or clinical judgment for the determination if the denial is based on a Medical Necessity, Experimental/Investigational treatment or similar limit (or state that such information is available free of charge upon request)

If your claim is approved, you will receive notification if your claim is an urgent or pre-service claim. You will not receive an approval notice for post-service claims.

HOW TO APPEAL A DENIED CLAIM

To initiate an appeal, you must submit a request within 180 days from the receipt of an adverse benefit determination.

Send your appeal to:

LifeWorks US Inc.
Customer Recovery
201 17th Street NW Suite 630
Atlanta, GA 30363

Internal Appeal Process Under The Plan

You will have the opportunity to submit written comments, documents, or other information in support of your appeal, and you will have access to all documents that are relevant to your claim. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgement question, the Program will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved.

If a health care professional was consulted for the initial determination, a different health care professional will be consulted upon appeal. Upon request, the Program will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

A final decision on the appeal will be made within the time periods specified below.

Urgent Claims

You may request an expedited review of any urgent claim. This request may be made orally, and the Program will communicate with you by telephone, facsimile, or similarly rapid communication method. You will be notified of the determination as soon as possible, taking into the medical exigencies, but no later than 72 hours after receipt of the claim.

Pre-Service Claims

When you request a review of a pre-service claim, you will be notified of the determination within a reasonable period of time taking into account the medical circumstances, but no later than 15 days from the date your request is received.

Post-Service Claims

When you request a review of a post-service claim, you will be notified of the determination within a reasonable period of time, but no later than 30 days from the date your request is received.

Second Internal Review of a Denied Claim

If your initial appeal is not approved, you have the right to request a second level of appeal. All second appeals must be submitted within 60 days from the initial appeal decision.

Send your appeal to:

LifeWorks US Inc.
Customer Recovery
201 17th Street NW Suite 630
Atlanta, GA 30363

As a result of the first-level review, you may appeal a partially or totally denied claim by following the same steps outlined in "How to Appeal a Denied Claim." All second-level reviews will be conducted by the Plan Administrator or its designees. Send your second-level appeals to the Claims Administrator. The address can be found on the last page of this Summary Plan Description.

You will be notified in writing of the Plan Administrator's decision within the time frames stated in "How to Appeal a Denied Claim." If the Plan Administrator denies your claim on review, you will receive written notice of the denial that will contain information on "Notice of Appeals Determination." All decisions of the Plan Administrator are final and binding.

Notice of Appeals Determination

If your claim is denied, either in full or in part, you will receive notice of an adverse benefit determination that will:

- State the specific reason or reasons for the adverse benefit determination
- Reference the specific Program provisions on which the determination is based
- Describe any voluntary appeal procedures offered by the Plan and your right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA), following an adverse benefit determination on review
- Disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information is available free of charge upon request)
- Explain the scientific or clinical judgment for the determination if the denial is based on a Medical necessity, Experimental/Investigational treatment or similar limit (or state that such information is available free of charge upon request)
- State that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits

You will also receive a notice if your claim on appeal is approved.

Legal Action

You may not bring a lawsuit to recover benefits under the Program until you have exhausted the administrative process described in this section. No action may be brought at all unless brought no later than three years following a final decision on your claim for benefits under the Plan's Internal Review procedure. The three-year statute of limitations on suits for all benefits shall apply in any forum where you may initiate such suit.

OTHER IMPORTANT INFORMATION

No Guarantee of Employment

Neither this booklet, or the benefits described in it, creates a contract of employment or a guarantee of employment between AutoNation and any Associate. Further, there is no guarantee that benefit levels will not be changed in the future or that the Program will continue indefinitely.

Future of the Program

AutoNation reserves the unfettered and unrestricted right to change, amend or terminate the Program for any reason at any time. AutoNation, pursuant to written action of its Board of Directors, is empowered to amend the Program or any benefit under the Program.

The Employee Benefits Committee ("the Committee"), which is established by the Board of Directors of AutoNation, is empowered to make Amendments to the Program or any benefit under the Program at any time by a written resolution, so long as the Amendment does not significantly increase or affect AutoNation's liability.

Any Amendment which terminates the Program or any portion of the Program or the application of the Program to any class of Associate must be approved by written action of the Board of Directors of AutoNation. If the Program is terminated, the rights of covered persons to benefits are limited to claims incurred up to the date of termination.

The benefits under the Program are not vested and shall not become vested as a result of any oral representations or statements or written document by an AutoNation representative or agent unless such written document is adopted pursuant to the Amendment procedure set forth above.

Statements Made by AutoNation

Any oral representations or statements made to an Associate by an AutoNation representative or agent about benefits coverage under the Program that conflict with Program provisions will not be considered as representations or statements made by, or on behalf of AutoNation or the Program, and will not bind AutoNation or the Program for benefits under the Program.

Plan Administrator

The Plan Administrator has overall responsibility for the operation of the Program and controls the administration of the Program. The Plan Administrator's authority shall include (not by way of limitation) the authority to construe, in its discretion, all terms, provisions, conditions, and limitations of the Program. The Plan Administrator may delegate its authority and responsibility for certain parts of the Program benefits and eligibility for benefits to a Claims Administrator where such person has been appointed to make such determinations. In such case, such other person shall have the duties and powers as the Plan Administrator, including the complete discretion to interpret and construe the provisions of the Program.

Privacy

To the extent required under applicable law, all medical records and other individually identifiable health information shall be kept confidential and shall not be used for any purpose other than payment, treatment and health care operations under the Program. AutoNation and the Program shall establish such practices and procedures as they deem necessary to ensure such confidentiality and to comply with all such applicable laws. The Plan may disclose protected health information to the Plan Sponsor for the purposes of Plan administration functions, as permitted by law. The Plan only may disclose such information upon the receipt of a HIPAA Plan Sponsor Privacy Certification ("Certification"), as required by the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164. This Certification shall be incorporated by reference as a part of this Plan document. Only persons involved with Plan administration functions shall have access to any information disclosed under this section. If the persons to whom information is disclosed violate this section, or applicable law, the Plan shall cease disclosing such information.
The Plan is required by law to: (1) make sure that medical information that identifies you and your covered dependents is kept private; (2) give you the HIPAA Privacy Notice outlining the legal duties and privacy practices with respect to medical information about you and your covered dependents; and (3) follow the terms of the HIPAA Privacy Notice that is currently in effect.

Disclosures to AutoNation

The Plan may disclose participant information to AutoNation, as permitted under the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Parts 160 and 164 ("HIPAA Privacy Regulations"). In addition, the Plan may disclose protected health information to AutoNation as necessary to allow AutoNation to perform plan

administration to other persons. The Plan Administrator shall be deemed to have delegated its responsibilities for determining

Use of PHI

The Plan will not use or disclose PHI that is genetic information for underwriting purposes.

Access to Medical Information

The following employees or individuals under the control of AutoNation shall have access to the Plan's protected health information to be used solely for plan administration functions, as defined in the HIPAA Privacy Regulations:

- The Plan Administrator;
- Members of the benefits, legal, finance, information system, audit, accounting, and human resources departments of the AutoNation to the extent they perform functions with respect to the Plan; and
- Such other individuals or classes of individuals identified by the Plan's Privacy Officer as necessary for the Plan's administration.

AutoNation Agreement to Restrictions

The Plan will not disclose protected health information to AutoNation until AutoNation has certified to the Plan that it agrees to:

- Not use or disclose protected health information other than as permitted or required by law or as specified above;
- Not use or disclose the protected health information in any employment- related decisions or in connection with any other benefit or employee benefit plan of AutoNation;
- Report to the Plan any use or disclosure of protected health information that is inconsistent with the uses and disclosures permitted by law or specified above of which AutoNation becomes aware;
- Make protected health information accessible to the subject individual in accordance with the HIPAA Privacy Regulations;
- Allow the subject individuals to amend or correct their protected health information and incorporate any amendments to protected health information in accordance with the HIPAA Privacy Regulations;
- Make available the information to provide an accounting of its disclosures of protected health information in accordance with the HIPAA Privacy Regulations;
- Make its internal practices, books and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of Health and Human Services for determining compliance;
- Return or destroy the protected health information received, if feasible, after it is no longer needed for the original purpose and retain no copies of such information or if not feasible, restrict access and uses to those that make the return or destruction of the information infeasible as required by the HIPAA Privacy Regulations;
- Ensure that any agents, including a subcontractor, of AutoNation to whom AutoNation provides protected health information shall also agree to these same restrictions;
- Ensure that adequate separation between AutoNation and Plan is established as required under the HIPAA Privacy Regulations and restrict access to protected health information to those classes of employees or individuals identified in this section; and
- Restrict the use of protected health information by those employees identified in this section for plan administration functions within the meaning of the HIPAA Privacy Regulations.

Permitted Disclosure to AutoNation

Notwithstanding the foregoing, the Plan (or a health insurance issuer or HMO with respect to the Plan) may disclose to the AutoNation the following types of information:

- Summary health information may be disclosed to AutoNation if AutoNation requests the summary health information for the purpose of (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan, or (2) modifying, amending, or terminating the Plan.
- Information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

- Information provided pursuant to an authorization within the meaning of Section 164.508 of the HIPAA Privacy Regulations.

- De-identified information, as defined under the HIPAA Privacy Regulations.

Noncompliance

In the event of noncompliance with the restrictions of this section by a designated employee or other individual receiving protected health information on behalf of AutoNation, the employee or other individual shall be subject to discipline in accordance with AutoNation's disciplinary procedures. Complaints or issues of noncompliance by such persons shall be filed with the Plan's Privacy Officer.

HIPAA Security Standards

Safeguards

AutoNation shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan, as required under 45 CFR Part 160 and Subparts A and C of Part 164 (the "HIPAA Security Standards").

Agents

AutoNation shall ensure that any agent, including a subcontractor, to whom it provides electronic protected health information agrees to implement reasonable and appropriate safeguards to protect such information.

Security Incidents

AutoNation shall report to the Plan any security incident under the HIPAA Security Standards of which it becomes aware.

Adequate Separation

AutoNation shall establish reasonable and appropriate security measures to ensure adequate separation between the Plan and AutoNation, in support of the requirements described in this section.

Application

The provisions of this section shall only apply with respect to any health benefits subject to the HIPAA Privacy Regulations or HIPAA Security Standards.

YOUR RIGHTS UNDER ERISA

As a participant in the AutoNation Employee Assistance Program, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that you, as a Program participant, are entitled to the following:

- Examine all documents governing the Program, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Program with the U.S. Department of Labor, without charge at either the Plan Administrator's office or at other specified locations
- Obtain copies of all documents governing the operation of the Program, including insurance contracts and a copy of the latest annual report (Form 5500 Series) and an updated summary Plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies
- Receive a summary of the Program's annual financial report. By law, the Plan Administrator must furnish each participant with a copy of this summary annual report

In addition to creating rights for Program participants, ERISA imposes duties on the people who are responsible for operating this Program. The people who operate your Program, called "fiduciaries," have a duty to do so prudently and in your interest and that of other Program participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied or ignored in whole or in part, you must receive a written explanation of the reason for the denial and you have the right to obtain copies of documents relating to the decision without charge within certain time schedules. You have the right to have the Program Administrator review and reconsider your claim within certain time schedules. Under ERISA, there are steps you can take to enforce these rights. For instance, if you request a copy of Program documents or the latest annual report from the Program Administrator and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If the Program fiduciaries misuse the Program's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees – for example, if it finds your claim is frivolous.

If you have any questions about your Program, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

IMPORTANT DEFINITIONS

These words and phrases have special meaning when used to describe your benefits under the Program.

Associate
An employee of AutoNation, Inc.

Company
AutoNation, Inc., and any of its affiliates.

Effective Date
The date the covered participant's coverage begins under the Program.

Eligible Dependents
Anyone residing in your household.

Employer
AutoNation, Inc., and its affiliates.

Full-Time
An Associate who is regularly scheduled to work at least 30 hours each week.

Leave of Absence
Approved period of time away from work. Types of leaves are limited to the following: Company, disability, leave under the Family and Medical Leave Act (FMLA), military service, personal, or workers' compensation.

Part-Time
An Associate who is regularly scheduled to work less than 30 hours each week.

Program
The AutoNation Employee Assistance Program.

Program Year
January 1 through December 31

Plan Administrator
The entity described in the section "Plan Administrator."

Program/Plan Sponsor
AutoNation, Inc.

United States
The United States of America, its territories and its possessions.

ADMINISTRATIVE INFORMATION

Administrative Information
The following is important identification and administrative information about the AutoNation Employee Assistance Program.

Official Program Name
AutoNation Employee Assistance Program

Plan Type
This Program is a "welfare plan," as defined in Section 3 (1) of the Employee Retirement Insurance Security Act of 1974, as amended.

Plan Number
510

Program/Plan Sponsor, Administrator, and Agent for Service of Legal Process
AutoNation, Inc.
c/o AutoNation Benefits Company
200 Southwest First Avenue, 14th Floor
Fort Lauderdale, FL 33301
954-769-6000

The Plan is administered by the Employee Benefits Committee (the "Plan Administrator"). The Plan Administrator makes all determinations as to the administration and interpretation of the Plan. The Plan Administrator is the agent for service of legal process.

Controlling Law
The laws of the state of Florida shall be the controlling state law in all matters relating to the Program and shall apply to the extent not preempted by the laws of the United States of America.

Employer Identification Number
73-1105145

Program Year
January 1 – December 31

Claims Administrator
MetLife Insurance Company
Attn: LifeWorks EAP Program
201 17th Street NW, Suite 630
Atlanta, Georgia 30363
Claims: 1-877 -409- 9287

All benefits under the Program are fully-insured. MetLife administers all claims under the Program and provides other administrative services as described throughout this Summary Plan Description.

Type of Financing
General assets of AutoNation, Inc., as determined by AutoNation, Inc in its discretion.

Company
AutoNation, Inc. and certain of its affiliates. You can obtain a copy of the complete listing of companies or divisions participating in the Program by writing to the Program Administrator. The list is available for examination by participants and beneficiaries.