TAP Automotive Holdings, LLC Employee Benefit Plan

Summary Plan Description

Amended and Restated Effective

July 1, 2010

This document, together with the certificates of insurance, is your Summary Plan Description. If you have not received the certificates of insurance, then you should contact TAP Automotive Holdings, LLC to request a copy.

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1. Introduction

Introduction

TAP Automotive Holdings, LLC maintains the TAP Automotive Holdings, LLC Employee Benefit Plan (Plan) to provide health benefits to its eligible employees, their eligible spouses, and eligible dependents.

Benefits of the Plan are provided under an insurance contract entered into between TAP Automotive Holdings, LLC and various Insurance Companies (Insurers) and through benefit programs funded or partially funded by the general assets of the Company for the benefits that are self-insured (the "Self-Insured Benefits").

You Must Enroll to Receive Benefits. You must affirmatively enroll to receive benefits under this Plan, as explained in Section 3 on Eligibility.

Benefits under the Plan are listed in Appendix A (which may be revised from time to time) and described in the certificate of insurance booklet issued by each Insurer. You must read the booklet(s) to understand your benefits.

Purpose of this Document

TAP Automotive Holdings, LLC is providing this document to give you an overview of the Plan and to address certain information that may not be addressed in the certificate of insurance booklet(s). This document, together with the certificate of insurance booklet issued by the Insurers, is the Summary Plan Description (SPD) required by ERISA. This document is not intended to give you any substantive rights to benefits that are not already provided by the certificate of insurance booklet(s).

2. General Information About the Plan

Plan Name

The name of the Plan is the TAP Automotive Holdings, LLC Employee Benefit Plan.

Type of Plan

The Plan is a group health plan (a type of welfare benefit plan that is subject to the provisions of ERISA).

Plan Year

The plan year is January 1-December 31.

Plan Number

The plan number is 501.

Effective Date

The effective date of the Plan is July 1, 2010. The original effective date was September 1, 2000. The plan has been amended several times since then.

Funding Medium and Type of Plan Administration

The benefits offered under this Plan are insured and self-insured from the general assets of the Company. Please refer to Appendix A for a list of which benefits are insured or self-insured. Benefits are provided under a group insurance contract entered into between TAP Automotive Holdings, LLC and the Insurers. Claims for benefits are sent to the Insurers.

The Insurers (not TAP Automotive Holdings, LLC) are responsible for paying benefits. Note that the Insurers and TAP Automotive Holdings, LLC share responsibility for administering the plan, as discussed in Section 6.

Insurance premiums for employees and their families are paid in part by the Plan Sponsor out of its general assets, and in part by employee payroll deductions. TAP Automotive Holdings, LLC provides a schedule of the applicable premiums; contact the Human Resources Manager of TAP Automotive Holdings, LLC if you need another copy.

Employee payroll deductions shall be used in their entirety prior to using Plan Sponsor contributions to pay for premiums under this plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under the group insurance contract entered into between TAP Automotive Holdings, LLC and the Insurers shall be allocated, consistent with the fiduciary obligations imposed by ERISA, to reimburse TAP Automotive Holdings, LLC for premiums that it has paid.

Plan Sponsor

TAP Automotive Holdings, LLC
400 West Artesia Blvd.
Compton, CA 90220
310-900-5500

Plan Sponsor's Employer Identification Number

TAP Automotive Holdings, LLC's employer identification number (EIN) is 20-3650857.

Plan Administrator and Named Fiduciary

TAP Automotive Holdings, LLC
400 West Artesia Blvd.
Compton, CA 90220
310-900-5500
Attention: Human Resources Manager

Named Fiduciary (for Benefit Claims)

Fully – Insured: Insurers as listed in Appendix A
Self – Insured: TAP Automotive Holdings, LLC
400 West Artesia Blvd.
Compton, CA 90220
310-900-5500

Agent for Service of Legal Process
TAP Automotive Holdings, LLC
400 West Artesia Blvd.
Compton, CA 90220
310-900-5500

Service of legal process may also be made on the Plan Administrator.

Important Disclaimer

Please note that this information is only a summary of the health plans, including applicable medical, dental and life insurance benefits. The plan described herein is governed by its plan documents, including any contracts with insurance companies and other providers of benefits. If there are any discrepancies between the information

included herein and the plan documents, the plan documents will govern, unless superseded by applicable law.

3. Eligibility and Participation Requirements

Eligibility

Eligibility to participate in the plans listed in Appendix A is governed by the Plan Sponsor's own policy. Additional rules regarding eligibility are set forth in the certificate of insurance booklet(s) issued by each Insurer listed in Appendix A.

Eligibility for enrollment and re-enrollment is not based on health status, medical condition (including both physical and mental illness), claims experience, receipt of health care services, medical history, genetic information, or evidence of insurability or disability if not otherwise specified by the Plan.

For periods on leave of absence please refer to your Plan Sponsor's policy.

Time Limits for Enrollment

Eligible employees must complete an application form (available through the Human Resources Manager of TAP Automotive Holdings, LLC) to enroll themselves and/or their eligible spouses and dependents. New employees must enroll within certain time periods after being hired, as described in the certificate of insurance booklet issued by the Insurers. Otherwise, enrollment generally is limited to the annual open enrollment period.

Special Enrollment Rights

In certain circumstances, enrollment may occur outside the open enrollment period. A special enrollment opportunity occurs if an individual with other health insurance loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption. When the employee or dependent of an employee loses other health coverage, if the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. If the other coverage was not COBRA continuation coverage, special enrollment can be requested when the individual loses eligibility for the other coverage.

You must notify the Plan of your request for special enrollment within 30 days after the loss of other coverage or within 30 days of having (or becoming) a new dependent. In the case of loss of coverage or marriage, the resulting coverage must be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received. In the case of birth, adoption or placement for adoption, enrollment is required to be effective not later than the date of such birth, adoption or placement for adoption.

Eligible employees and their eligible dependents who are eligible for coverage but not enrolled, shall be eligible to enroll for coverage within 60 days after (a) coverage under a Medicaid or any state children's health insurance plan (CHIP) is terminated as a result of loss of eligibility or (b) any eligible employee or dependent becomes eligible for premium assistance to purchase coverage under the Plan under either Medicaid or the state's CHIP program.

The Plan's Special Enrollment Notice also contains important information about the special enrollment rights that you may have. Contact the Human Resources Manager of TAP Automotive Holdings, LLC if you need another copy.

When Coverage Begins

For information about when coverage begins, please read the eligibility information contained in the certificate of insurance booklet(s) issued by each Insurer.

Termination of Coverage

Your eligibility for Plan benefits terminates on the last day of the month in which you terminate employment with TAP Automotive Holdings, LLC. Coverage will also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons described in the certificate of insurance booklet(s). Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the certificate of insurance booklet(s) (for example, divorce, dependent's attaining age limit, and other reasons). Benefits will also cease for employees, spouses, and dependents upon termination of the Plan.

Continuation Coverage

If coverage for you, your eligible spouse, or your eligible dependents ceases because of certain "qualifying events" (e.g., termination of employment, reduction in hours, divorce, death, child's ceasing to meet the plan's definition of dependent) specified in a federal law called COBRA, then you, your eligible spouse, or your eligible dependents may have the right to purchase continuing coverage under the Plan for a limited period of time. For more information about COBRA rights, see the Initial COBRA Notice which has been provided separately. Please contact the Human Resources Manager of TAP Automotive Holdings, LLC if you need another copy.

Continuation and reinstatement rights may also be available if you are absent from employment due to service in the Uniformed Services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). More information about coverage available pursuant to USERRA is included in the certificate of insurance booklet(s) and from the Human Resources Manger.

Assignment of Benefits

Your rights and benefits under the Plan cannot be assigned, sold, or transferred to anyone else except under limited circumstances (e.g. qualified medical child support order or assignment to your health provider).

4. Summary of Plan Benefits

Benefits Provided

The Plan provides health insurance to eligible employees and their eligible spouses and dependents. These benefits are provided under a group insurance contract entered into between TAP Automotive Holdings, LLC and the Insurers as listed in Appendix A, which may be amended or revised from time to time. A summary of the benefits provided under the Plan is set forth in the certificate of insurance booklet(s) issued by the Insurers. You must read the booklet to understand your benefits.

Women's Health and Cancer Rights Act of 1998

The medical options provide benefits related to breast reconstruction in compliance with the Women's Health and Cancer Rights Act of 1998. This Federal law states that group health plans provide medical and surgical benefits for mastectomy and must provide certain additional benefits related to breast reconstruction

If you (or a covered dependent) are receiving mastectomy benefits and elect breast reconstruction in connection with the mastectomy, the medical plans will provide coverage for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses and physical complications of mastectomy, including lymphademas.

Benefits will be provided as they would for any other surgical expense.

Maternity

The Plan may not, under federal law, restrict benefits for any hospital 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, the mother's or the newborn's attending provider, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, no pre-authorization from your Plan is needed for a stay of up to 48 hours (or 96 hours).

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order is an order or judgment from a court or administrative body, which directs the plan to cover a child as a participant under the health plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a Qualified Medical Child Support Order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid. Coverage under the plan pursuant to a Qualified Medical Child Support Order will not become effective until the Plan Administrator determines that the order is a Qualified Medical Child Support Order. If you have any questions or would like to receive a copy of the written procedure

for determining whether a Qualified Medical Child Support Order is valid, please contact the Plan Administrator (the Human Resources Manager of TAP Automotive Holdings, LLC).

5. Circumstances That May Affect Benefits

Denial, Loss, or Recovery of Benefits

Your eligibility for Plan benefits terminates on the last day of the month in which you terminate employment with TAP Automotive Holdings, LLC. Coverage will also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you submit false claims, and for certain other reasons described in the certificate of insurance booklet issued by the Insurer. Coverage for your spouse and dependents stops when your coverage stops and for other reasons specified in the certificate of insurance booklet (for example, divorce, dependent's attaining age limit, and other reasons). Benefits will also cease for employees, spouses and dependents upon termination of the Plan.

Depending on the reason that coverage was terminated, you and your covered spouse and dependents might have the right to continue coverage temporarily under COBRA and/or USERRA.

The Plan may recover overpaid benefits through its rights to subrogation and reimbursement. These Plan rights are described in detail in the certificate of insurance booklet(s).

Preexisting Conditions and Other Exclusions

Other circumstances that can result in the termination, reduction, loss or denial of benefits (including exclusions due to preexisting conditions and exclusions for certain medical procedures) are described in the certificate of insurance booklet(s) issued by the Insurer. Please read the booklet(s) carefully. The Plan's Initial Preexisting Condition Exclusion (PCE) Notice and the Plan's Special Enrollment Notice contain important information about the exclusions due to preexisting conditions and special enrollment rights that you may have. Please contact the Human Resources Manager of TAP Automotive Holdings, LLC if you need another copy.

6. How the Plan Is Administered

Plan Administration

The Plan is administered by TAP Automotive Holdings, LLC (Plan Administrator). The Human Resources Manager of TAP Automotive Holdings, LLC is the person who acts on behalf of the Plan Administrator. TAP Automotive Holdings, LLC has agreed to indemnify the Human Resources Manager for any liability that he or she incurs as a result of acting on behalf of the Plan Administrator, unless such liability is due to his or her gross negligence or misconduct.

TAP Automotive Holdings, LLC as Plan Administrator, shall retain the authority to delegate to officers and employees of TAP Automotive Holdings, LLC such responsibilities as are imposed on TAP Automotive Holdings, LLC by ERISA and by terms of this instrument, together with the authority to control and manage the operation and administration of the Plan.

TAP Automotive Holdings, LLC also hereby appoints each Insurer listed in Appendix A (as may be amended from time to time) as a named fiduciary with such powers as may be necessary to determine the benefits payable under the insurance policies and resolve all questions pertaining to the applicability of the benefit provisions of the insurance policies.

TAP Automotive Holdings, LLC hereby intends that each Insurer shall be deemed to have complied with the requirements of ERISA Act Section 503 (claims procedure) in its exercise of its authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

For self funded plans TAP Automotive Holdings, LLC has final authority on claims appeals. TAP Automotive Holdings, LLC also hereby appoints the Third Party Administrator as a named fiduciary of the self-insured Medical and Dental plan with such powers as may be necessary to determine the benefits payable with respect to said Plans and to resolve all questions pertaining to the applicability of the benefit provisions of those plans.

TAP Automotive Holdings, LLC hereby intends that the Third Party Administrator shall be deemed to have complied with the requirements of ERISA Act Section 503 (claims procedure) in its exercise of its authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Power and Authority of Insurance Company

This plan is fully insured and self-funded. Benefits are provided under a group insurance contract entered into between TAP Automotive Holdings, LLC and the Insurers. Claims for benefits are sent to the Insurance Company. The Insurance Company, not TAP Automotive Holdings, LLC, is responsible for paying claims.

The Insurance Company is the Named Fiduciary for benefit claims and is responsible for:

- determining eligibility for and the amount of any benefits payable under the Plan; and
- providing the claims procedures to be followed and the claims forms to be used by eligible individuals pursuant to the Plan.

The Insurance Company also has the authority to require eligible individuals to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Your Questions

If you have any general questions regarding the Plan, please contact TAP Automotive Holdings, LLC, as Plan Administrator.

However, if you have questions regarding eligibility for and/or the amount of any benefits payable under the Plan, please contact the Insurer.

7. Amendment or Termination of the Plan

Amendment or Termination

TAP Automotive Holdings, LLC, reserves the right to change or end the Plan at any time. TAP Automotive Holdings, LLC's decision to change or end any of the plans may be due to changes in the federal or state laws governing benefits, the requirements of the Internal Revenue Code or ERISA, the provisions of a contract or a policy involving an insurance company, or any other reason.

The Plan may be amended or terminated by a written instrument signed by the TAP Automotive Holdings, LLC President or the Human Resources Manager, both of whom are authorized to amend or terminate the Plan and to sign insurance contracts with the Insurance Company or other carriers, including amendments to those contracts. In addition, termination of the group insurance contract entered into between TAP Automotive Holdings, LLC and the Insurer will constitute termination of the Plan, unless TAP Automotive Holdings, LLC exercises its sole discretion to obtain a substitute contract of insurance.

8. No Contract of Employment

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and TAP Automotive Holdings, LLC to the effect that you will be employed for any specific period of time.

9. Claims Procedures

Benefit Claim

The Insurance Company is responsible for evaluating all benefit claims under the Plan. The Insurance Company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA.

Claims are processed according to the claims procedures described in the insurance documents provided by the applicable insurance carrier, or if the insurance documents do not provide a procedure, according to the rules described below.

A person who files a claim for benefits under the Plan is called a "claimant". The insurance claims administrator or other person authorized to review claims is called the "claims reviewer."

A claimant can be you, your beneficiary or a representative you authorize to act on your behalf. To authorize a representative, you and the representative must sign a statement to that effect. You must print your name and provide your social security number or plan identification number under your signature. Written designation of an authorized representative protects against disclosure of information about you except to your authorized representative.

Each health care claim will be classified as one of the following types of claim:

- Urgent care claims-any claim for medical care where:
  - The claimant's life or health, or the claimant's ability to gain maximum function, is in jeopardy or
  - In the opinion of the claimant's doctor, the claimant is subject to severe pain which cannot be adequately managed without the care or treatment proposed in the claim.
  - Concurrent care clams-any claim for medical care previously approved as an ongoing course of treatment to be provided over a period of time or over a number of treatments where:
  - The care is either reduced or terminated by the Plan, or
  - The claimant request that the care be extended.
- Pre-service claims-any claim for non-urgent medical care that must be decided before the claimant will be given access to the care (that is, pre-authorization of the claim). A pre-service claim may also be classified as urgent care claim and, if so, the rules applicable to urgent care claims supersede the rules applicable to pre-service claims.
- Post-service claims-any claim for non-urgent medical care that has already been provided involving the payment or reimbursement of costs for the care.

A claims reviewer who has to make a decision whether to approve or deny a health care claim has to do so within the following time frames, depending on the claim's classification:

- For urgent care claims-as soon as possible, taking into account the medical circumstances, but not later than 72 hours after the claims reviewer receives the claim, unless more information is needed to process the claim. If more information is needed, the claims reviewer has 24 hours to notify the claimant of the specific information needed, the claimant has 48 hours from receipt of the notice to provide the information, and the claims reviewer must make a decision within 48 hours after the earlier of the receipt of the needed information or the end of the claimant's 48-hour period to provide the information.
- For concurrent care clams –as soon as possible, taking into account the medical circumstances, but not later than within 24 hours of a claimant's request for an extension of care if the request was made at least 24 hours before the treatment is to end. A claimant must be given sufficient advance notice of any premature reduction or termination of an ongoing treatment by the Plan to permit the claimant to appeal and obtain a determination on review before the reduction or termination goes into effect.
- For pre-service claims-within a reasonable period of time appropriate to the medical circumstance, but not later than 15 days after the claims reviewer receives the claim, except that an extension of an additional 15 days may be taken in circumstances beyond control of the claims reviewer with notice to the claimant before the initial 15-day period expires. If the circumstances involve the need for more information, the claimant has 45 days from receipt of notice to provide the information, and the claims reviewer must make a decision within 15 days after the earlier of the receipt of the needed information or the end of the claimant's 45-day period to provide the information.
- For post-service claims-within a reasonable period of time, but not later than 30 days after the claims reviewer receives the claim, except that an extension of an additional 15 days may be taken in circumstances beyond control of the claims reviewer with notice to the claimant before the initial 30-day period expires. If the circumstances involve the need for more information, the claimant has 45 days from receipt of notice to provide the information, and the claims reviewer has to make a decision within 15 days after the earlier of the receipt of the

needed information or the end of the claimant's 45-day period to provide the information.

Whenever an urgent or concurrent claim is approved, the claims reviewer must give verbal notice of the approval to the claimant followed within three days by written or electronic notice.

Whenever a claim is denied, the claims reviewer must give notice of the denial to the claimant in writing or electronically. The denial notice will include the specific reason(s) for the denial (including an explanation of the scientific or clinical basis used to support a finding that the proposed care is not medically necessary or experimental), specific reference to applicable Plan provisions on which the denial was based (including disclosure of any internal rule, guideline or protocol relied on in making the determination), a description of any additional information needed to complete the claim with an explanation of why it is necessary, instructions to be followed if the claimant wishes to appeal the denial (including how to appeal on an expedited basis if the denial pertains to an urgent or concurrent care claim), and a statement about the claimant's right to bring a civil suit under ERISA following the appeal.

If a rule described in this section is more favorable to a claimant than the rule under state law, this section's rule may supersede the rule required by state law.

Appealing Denied Claim

An appeal of the denied claim will be processed according to the procedures described in the insurance documents or, if the insurance documents do not described the appeal procedures used, according to the procedures described below.

To appeal a denied claim, the claimant must write a letter (as described below) to the plan's claims reviewer authorized to review appeals within 180 days following the claimant's receipt of the denial notice pertaining to the claim. If the denial notice pertains to an urgent or concurrent care claim, an expedited appeals process is available upon oral or written request of the claimant. All necessary information, including the decision on appeal, will be transmitted between the administrator reviewing the appeal and the claimant by telephone, facsimile or another method which is similarly expeditious.

No form of communication other than a letter (for example, telephone or e-mail) will constitute an appeal. The appeal letter should include the reasons why the claimant believes the claim was improperly denied, as well as any other data, questions or comments the claimant believes the claimant deems appropriate. The appeal letter also must be in the form directed by the claims reviewer and include all information required by the claims reviewer. If the claimant has any questions about how to file an appeal with a claims reviewer, he or she should call the claims reviewer directly.

When a denied claim is appealed the claimant has the right to submit written comments, documents, records, and other information relating the denied claim. The claimant also can access or obtain copies of any documents, records and other information relevant to the denied claim upon request and without charge.

The claims reviewer authorized to review a claimant's appeal will be someone other than the decision maker of the initial claim determination. In making a decision, the claims reviewer will not defer to the findings and conclusions made with respect to the initial claims determination. If the denied claim being appealed is based in whole or in part on

a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), the claims reviewer must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved with the initial claims determination. The carrier or claims administrator making the initial claim determination must identify the medical and vocational experts whose advice was obtained on behalf of the Plan in connection with that determination, regardless of whether the advice was relied upon in making the determination.

The claims reviewer must decide upon the appeal within the applicable timeframes described below:

- For urgent and concurrent care claims-as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claimant's appeal.
- For pre-service claims-within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the claimant's appeal.
- For post-service claims-within a reasonable period of time, but not later than 60 days after receipt of the claimant's appeal.

When a decision regarding an appeal is made, the claimant will receive written or electronic notice from the claims reviewer. If the decision upholds the initial claim denial (that is, if an adverse determination is made on appeal), the notice will include:

- The specific reason(s) for the adverse determination (including an explanation of the scientific or clinical basis used to support a finding that the proposed care is not medically necessary or experimental);
- Specific reference to applicable plan provisions on which the decision was based (including disclosure of any internal rule, guideline or protocol relied on in making the determination);
- A statement that the claimant is entitled to receive, upon request and free of charge; reasonable access to and copies of all documents, records and other information relevant to the denied claim;
- A statement regarding any voluntary appeal procedures offered by the plan and how to obtain information about those procedures;
- A statement about your right to bring a civil suit under ERISA; and
- If applicable, a statement about other voluntary alternative dispute resolution options available.

If the claimant decides to start a legal action regarding the denied claim, he or she must first follow the claim and appeal procedures applicable to the denied claim and comply with the time limits for taking legal action that are described in the applicable insurance documents, if any.

If a rule described in this summary is more favorable to a claimant than the rule under state law, this summary's rule may supersede the rule required by state law.

Important Appeal Deadlines

If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which generally is a condition for bringing suit in court).

See above and the certificate of insurance booklet issued by the Insurer for information about how to appeal a denied claim and for details regarding the Insurance Company's claims procedures.

10. Statement of ERISA Rights

Your 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 plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at TAP Automotive Holdings, LLC's principal office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Human Resources Manager of TAP Automotive Holdings, LLC, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description (SPD). TAP Automotive Holdings, LLC may make a reasonable charge for the copies.

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case TAP Automotive Holdings, LLC, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA and HIPAA Rights

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan 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 Plan benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require TAP Automotive Holdings, LLC, as 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 because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan (discussed in Section 8), 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, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Human Resources Manager of TAP Automotive Holdings, LLC. 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 contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 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.

APPENDIX A

LIST OF CONTRACTS/BENEFIT PLANS INCLUDED IN
TAP AUTOMOTIVE HOLDINGS, LLC PLAN # 501

Insurance Company or Administrator	Contract Number	Plans	Employer or Employee Paid	Insured or Self Insured
Aetna 1385 E. Shaw Ave. Fresno, CA 93710 Aetna Inc. P.O. Box 14089 Lexington, KY 40512-4089 877-204-9186	861440	Medical PPO and EPO	Both	Self Insured
Universal Health Alliance 700 Bishop Street, Suite 300 Honolulu, HI 96813 800-458-4600 This benefit is available to employees residing in Hawaii.	36160001	Medical HMO	Both	Insured
Aetna P.O. Box 14094 Lexington, KY 40512-4094 877-238-6200	861440	Dental PPO	Both	Self Insured
Aetna P.O. Box 14094 Lexington, KY 40512-4094 877-238-6200	861440	Dental HMO	Both	Insured
Hawaii Dental Services Royal State Benefits Corporation 819 S. Beretania Street Honolulu, HI 96813 808-539-1796 This benefit is available to employees residing in Hawaii.	5446	Dental PPO	Both	Insured

Insurance Company or Administrator	Contract Number	Plans	Employer or Employee Paid	Insured or Self Insured
ReliaStar Life Insurance Company 3702 Paysphere Circle Chicago, IL 60674 800-955-7736 ING Employee Benefits Disability Claims PO Box 1290 Minneapolis, MN 55440 800-328-4090	374466	Voluntary Short-term disability	Employee	Insured
ReliaStar Life Insurance Company 3702 Paysphere Circle Chicago, IL 60674 800-955-7736 ING Life Claims PO Box 1548 Minneapolis, MN 55440 888-238-4840 ING Employee Benefits Disability Claims PO Box 1290 Minneapolis, MN 55440 800-328-4090	65764-6	Life and AD&D	Employer	Insured
ReliaStar Life Insurance Company 3702 Paysphere Circle Chicago, IL 60674 800-955-7736 ING Employee Benefits Disability Claims PO Box 1290 Minneapolis, MN 55440 800-328-4090	65764-6	Long-term disability	Employer	Insured
ReliaStar Life Insurance Company 3702 Paysphere Circle Chicago, IL 60674 800-955-7736 ING Life Claims PO Box 1548 Minneapolis, MN 55440 888-238-4840	374466	Voluntary Life	Employee	Insured

Insurance Company or Administrator	Contract Number	Plans	Employer or Employee Paid	Insured or Self Insured
ReliaStar Life Insurance Company 3702 Paysphere Circle Chicago, IL 60674 800-955-7736 ING Employee Benefits Disability Claims PO Box 1290 Minneapolis, MN 55440 800-328-4090	374466	Voluntary Accident	Employee	Insured