EMPLOYEE BENEFITS GUIDE

January 1, 2019 - December 31, 2019

A guide to enrolling in your employee benefit programs.

MEDICAL

DENTAL

BASIC & VOLUNTARY
LIFE AND AD&D

VOLUNTARY SHORT &
LONG TERM DISABILITY

VOLUNTARY ACCIDENT /
CRITICAL ILLNESS

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We offer the following services:

- **Personal Health Benefits**
  - Medicare
  - Dental / Vision
- **Personal Insurance**
  - Home / Renters
  - Auto / Motorcycle / Boat / RV / Aviation

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EPICINSURANCESOLUTIONS.COM
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Service Provider Information

MEDICAL INSURANCE
Group #76-411431
UMR / UHC
1-513-619-3587
www.myuhc.com

DENTAL INSURANCE
Group #688540
DELTA DENTAL
1-502-736-5000
www.deltadentalky.com

BASIC & VOLUNTARTY LIFE AND AD&D INSURANCE
Group #617706
ONE AMERICA
1-800-553-5318
www.employeebenefits.aul.com

VOLUNTARY SHORT & LONG TERM DISABILITY INSURANCE
Group #617706
ONE AMERICA
1-800-553-5318
www.employeebenefits.aul.com

VOLUNTARY ACCIDENT & CRITICAL ILLNESS INSURANCE
Group #5474515
SUNLIFE formerly ASSURANT
1-816-474-2345
www.sunlife.com

HEALTH SAVINGS ACCOUNT (HSA)
MY BENEFIT WALLET
1-877-472-4200
www.mybenefitwallet.com

RETIREMENT SERVICES / 401K ADVISORS
Brett Mahle
1-502-394-4006
Email: Brett.Mahle@morganstanley.com

EPIC INSURANCE SOLUTIONS
1-502-805-EPIC (3742)

June Lanham - Account Executive
1-502-371-4035
June.Lanham@53.com

CLAIMS & ENROLLMENT
Pamela Brandon - Account Manager
1-502-371-4039
Pamela.Brandon@53.com

M&M Cartage knows that our employees have different needs, so we offer employees a wide range of comprehensive benefit plans to let you choose the benefits that best suit your particular situation.

ELIGIBILITY
The eligibility period for enrollment is first of the month following 30 days from date of hire. Employees working thirty (30) hours a week or more are eligible for all benefits outlined in this summary. Eligible employees may elect to cover a spouse and dependents. ***If your spouse is employed and has coverage available to him or her through their employer, your spouse is not eligible to be covered under M&M Cartage Employee Benefit Plan.*** If at anytime your spouse becomes employed by an employer who does provide health care coverage, he or she will need to enroll in their employer's plan as the will no longer be eligible under M&M Cartage Employee Benefit Plan.

Dependents are covered to age 26 on the medical and dental plans.

401K eligibility period for enrollment is on the 1st day of the month after working 90 days.

HOW TO ENROLL
Please sign on to APS (Advanced Payroll System)
https://secure.advancedpayroll.com/ta/APS5633.login

- Your username is your first initial and last name, no spaces. Your password is the last 6 of your social security number. When you first log in, you will be prompted to change your password.
- Once you are logged in, go to My Account > My Benefits> Review/Select and then select "Start New Employee Enrollment" from the menu. You will go through each benefit tab, making your selections and adding dependents and beneficiary information. Once you have made all of your selections, please submit your enrollment.
- If you have any questions or need assistance completing the enrollment online, please contact your HR Manager, Stacey, at ext. 236.
- Once you have made your elections, you will not be able to change them until the next open enrollment period, unless you have a valid qualifying event.
- All elections must be submitted within 3 weeks of your hire date. If there is no response, we will assume you are waiving all coverage. You will then not be able to enroll unless there is qualifying event, or during open enrollment.

QUALIFYING EVENTS
Changes to your elections may not be made outside Open Enrollment unless you have a Qualifying Event. Qualifying Events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, commencement or termination of adoption proceedings, or change in spouse's benefits. If you need to make a change outside Open Enrollment due to a Qualifying Event please contact the Human Resource Department within 30 days of that event. If the request is not received within 30 days of the event then all changes must wait until Open Enrollment.

The following information is a quick overview of the benefits plans currently provided and is not to be interpreted as a complete disclosure of plans entitlement to any of the benefits described. The company reserves the right to adjust, amend and revise benefits plans. In all cases of specific plan interpretations, receipt of benefits or entitlements, the actual plan document shall rule. You can contact your HR Department for the actual plan documents.

MEDICAL INSURANCE

	Buy-Up PPO	Base HSA
Deductible* (Single/Family) In-Network**	$2,500 / $5,000	$3,000 / $6,000
Out-of-Pocket Limit (Single/Family) (excludes pharmacy only) In-Network**	$3,000 / $6,000	$3,000 / $6,000
Primary Care Physician*	$30 Copay	0%, After Deductible
Specialist*	$30 Copay	0%, After Deductible
Preventive Care Services include but are not limited to: *See the following pages for coverage details*	Covered at 100%	Covered at 100%
Urgent Care*	30%, After Deductible	0%, After Deductible
Emergency Room* (copay waived if admitted)	30%, After Deductible	0%, After Deductible
Inpatient Hospital*	30%, After Deductible	0%, After Deductible
Hospital / Alternative Care Facility*	30%, After Deductible	0%, After Deductible
Retail Pharmacy – 30 Day Supply*	$10 / $30 / 50%	0%, After Deductible
Mail Order – 90 Day Supply*	$20 / $60 / $125	N/A

**Per ACA guidelines these costs apply to your Out-of-Pocket Limit*
***As noted above these are In-Network benefits. For Out-of-Network benefits please see the complete benefit summary.*

For premium rates please refer to the chart on the following page.

M&M Cartage contributes to employee's Health Savings Accounts $500 a year for single and $1,000 a year for family.

SPOUSAL WAIVER:

If your spouse is employed and has coverage available to him or her through their employer, your spouse is not eligible to be covered under the M&M Cartage Employee Benefit Plan. If at any time your spouse becomes employed by an employer who does provide health care coverage, he or she will need to enroll in their employer's plan as they will no longer be eligible under M&M Cartage Employee Benefit Plan.

To locate a network provider in your area go to:
www.myuhc.com
Select: Choice Plus Network

This summary is intended only to highlight some of the most commonly used benefits.
Please refer to your Certificate of Coverage for an exact description of coverage, exclusions and limitations.

Important Information Regarding Health Insurance:

M&M Cartage offers a 4-tier premium structure, which means instead of a standard premium for the coverage you selected, you will have the opportunity to qualify for four different pricing tiers. Where you fall on the tier will depend on a points system. If you complete a biometric screening and health risk assessment (M&M offers this yearly), you will receive points based on where you fall on the range for BMI, tobacco usage, cholesterol, glucose, etc. Please see the chart below for an example. Participating in educational programs will also earn you points.

The information from your health risk assessment and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. M&M will not see your results from your biometric screening and health risk assessment. This is all handled by a third party company, Healthsync, who has been completing these screenings for us for years.

Tier 1: 500-600 Tier 2: 300-499 Tier 3: 1-299 Tier 4: Non-Wellness Participants

Below is a complete listing of how points can be earned yearly.

Measure	Range	Point
Online HRA	Completed	25
Body Mass Index (BMI)	BMI < 30	25
Tobacco Usage	Non-user	125
Cholesterol	HDL > 40 LDL < 130 Triglycerides < 150	50 50 75
Fasting Glucose	Glucose < 100	75
Blood Pressure	BP < 140/90	75
Educational Programs Includes: Onsite Educational classes offered, Exercise Class, Onsite Disease Mgt Clinic participation)	50 pts per class, max 2	100
Total Points Available per person on health plan		600

2019 Bi-Weekly Rates						
Current Employee Bi-Weekly Rates			Tier 1	Tier 2	Tier 3	Tier 4
			500 points +	300-499 Points	1-299 Points	0 Points
PPO						
Employee Only	$78.04		$64.20	$78.04	$91.89	$105.73
Employee/Spouse	$185.01		$171.17	$185.01	$198.86	$212.70
Emp/Child(ren)	$168.16		$154.32	$168.16	$182.01	$195.85
Family	$322.03		$308.18	$322.03	$335.88	$349.72
H.S.A.						
Employee Only	$17.73		$3.89	$17.73	$31.58	$45.42
Employee/Spouse	$109.38		$95.53	$109.38	$123.23	$137.07
Emp/Child(ren)	$103.80		$89.95	$103.80	$117.65	$131.49
Family	$215.12		$201.27	$215.12	$228.96	$242.81

The biometric screenings and educational programs are offered annually. (For new hires, you have 30 days from your hire date to complete the biometric screening, health risk assessment, and educational programs.) Your participation and results will determine your points and where you fall on the tier (see chart on previous page). No participation in the wellness programs offered will place you in Tier 4. The rate table above will show you what the premiums will be on a bi-weekly basis.

If you have any questions, please contact the HR Manager, Stacey, at ext 236.

HEALTH SAVINGS ACCOUNT (HSA)

Employees electing the Health Savings Account (HSA) can contribute up to **$3,500 single or $7,000 family for 2019**. Individuals 55 and over can make an additional $1,000 catch-up contribution annually. Your account is owned by you and is funded with tax-exempt dollars to help pay for eligible medical expenses not covered by your insurance plan (deductibles, co-insurance). These annual contribution maximums include the employer contribution. M&M Cartage offers an HSA account administered by Mellon Bank. Please contact Human Resources regarding the process for opening an account.

What is a Health Savings Account?

- An alternative to traditional health insurance.
- A savings account that offers a different way for consumers to pay for their health care.
- Enables you to pay for current health expenses and save for future qualified medical and retiree health expenses on a tax-free basis.
- Can only be utilized with a HDHP(High-Deductible Health Plan).
- Allows you to be more in control of your medical expenses.
- Unused funds can be "rolled over" from year to year tax free. If you leave M&M Cartage your HSA account goes with you.
- You can change your HSA contribution amount during any payroll period.
- You (the plan holder) cannot be enrolled in Medicare, be a dependent on another person's tax return.
- You cannot have a Flexible Spending Account (FSA) if you have an HSA account unless it is a Limited FSA for dental and vision expenses only.

When visiting a physician, hospital, or other facility:

- When arriving for your appointment, provide them with your UMR insurance card.
- After your visit, your claim will be submitted to UMR for processing.
- After the health care provider has received notification from UMR that the claim has been processed, you will receive a billing statement outlining the balance for which you are responsible.
- You then use your bank card/HSA check to pay for these expenses.

When going to the Pharmacy:

- When picking up your medication, provide them with your UMR insurance card.
- The pharmacy will run it through their system and provide you with a balance due.
- You then use your bank card/HSA check to pay for these expenses at that time.

Contributions made by the employee are done via payroll deduction through a Section 125 plan. By doing this, the contributions are not subject to individual or employment taxes. This means if you contribute $1,000 of your gross pay into the HSA, the impact on your net pay is about $700 since you did not have to pay tax on your HSA contributions. In this example, you would save about $300.

This summary is intended only to highlight some of the most commonly used benefits.
Please refer to your Certificate of Coverage for an exact description of coverage, exclusions and limitations.

Getting started **with Teladoc**

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. Set up your account today so when you need care now, **a Teladoc doctor is just a call or click** away.

SET UP YOUR ACCOUNT

Set up your account by phone, web or mobile app.

Online:
Go to Teladoc.com and click **"set up account".**

Mobile app:
Download the app and click **"Activate account"**. Visit teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you register your account over the phone.

PROVIDE MEDICAL HISTORY

Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis.

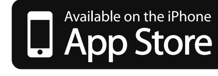
REQUEST A CONSULT

Once your account is set up, request a consult anytime you need care. And talk to a doctor by phone, web or mobile app.

Talk to a doctor anytime for **$45 or less!**

Teladoc.com

1-800-Teladoc



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DIABETES & HIGH BLOOD PRESSURE PROGRAMS

TAKE CONTROL OF YOUR HEALTH TODAY

-

ONE-ON-ONE CONFIDENTIAL APPOINTMENTS

-

FREE TO ELIGIBLE MEMBERS

-

ONSITE APPOINTMENTS

-

PERSONALIZED CARE & GOAL SETTING

M&M Cartage has partnered with SentryHealth to offer **Diabetes** and **High Blood Pressure** Management Programs at ***NO CHARGE*** to M&M Health Plan Members.

Appointments are offered onsite M&M's Geil Ave. location - or over the phone!

BONUS! Participating M&M Cartage members will receive **NO COST PRESCRIPTIONS** for medications related to their chronic care needs.

Schedule by calling 502-569-1044 or online at https://healthward.sentryhealth.com/info/mmcartage

FREQUENTLY ASKED QUESTIONS

Who is SentryHealth?

SentryHealth is a health and wellness company focused on preventative care, chronic condition management, and wellness coaching. We offer one-on-one appointments to M&M Cartage health plan members looking to improve their current health situation.

Why is M&M Cartage using SentryHealth?

M&M Cartage is committed to the health and wellness of their employees. Partnering with a third-party wellness provider has a positive impact on employee health and productivity while also reducing health care expenses. M&M Cartage is dedicated to helping their employees become more aware of their current health situation. The goal of working with SentryHealth is to improve the health and quality of life of each individual employee.

What is the benefit?

M&M Cartage health plan members will receive education, coaching, clinical assessments, as well as personalized wellness goals and care plans. Through the SentryHealth program, we hope to empower participants to better manage their health and encourage a healthier lifestyle both at work and home.

Will my employer know my personal medical history?

Absolutely not! SentryHealth is a third-party wellness provider and will not share individual information with your employer. SentryHealth follows strict confidentiality standards, meeting all federal, state and HIPAA requirements.

Do I have to change my Doctor?

SentryHealth does not replace your primary care doctor or any specialist you currently see. SentryHealth's clinics are to be used as an additional health resource. SentryHealth has the ability to share records with other physicians upon your request and consent.

How much will this cost me?

M&M Cartage provides Diabetic and High Blood Pressure appointments at a $0 out of pocket cost to you! In addition, any related program medications will be covered at a $0 copay - NO COST to you!

Where will I meet SentryHealth?

SentryHealth offers appointments onsite at M&M Cartage's Geil Ave location. SentryHealth also offers appointments over the phone if you are unable to meet us in person.

Meet Amanda Jones

Amanda Jones is a board-certified Family Nurse Practitioner. Amanda received her Master's in Nursing as a Family Nurse Practitioner from the University of Louisville in 2011. Amanda has experience in neuroscience, nursing education, primary care, acute care, and aesthetics. Her passion is in preventative medicine and health and wellness education. Amanda is married with two rambunctious fur babies, Hank and Stella. When Amanda is not working, she enjoys reading, camping, hiking, boating, and traveling.

Contact SentryHealth

https://healthward.sentryhealth.com/info/mmcartage

502.569.1044

SentryHealth

Solutions. Action. Results.

Step Therapy Program
Frequently Asked Questions

OptumRx®, your pharmacy benefit manager, is committed to maximizing the value of your prescription drug benefit and lowering prescription costs. The Step Therapy Program is a clinical program designed to help meet these goals.

What is a Step Therapy Program?
A Step Therapy Program is an approach to medication therapy that requires you to first try a more cost-effective medication (usually a generic medication) that has proven effective for most people with your condition before you can receive coverage for a similar, more expensive, brand name medication. These are considered "steps" of therapy.

How does a Step Therapy Program work?
If your doctor writes a prescription for a medication that requires a Step Therapy, the requested medication may not be covered until a more cost-effective medication "step" is tried first.

What if I need to skip a step?
Your doctor may contact us to request prior authorization approval. This is a review between your doctor and OptumRx to determine coverage for your medication.

Why do some medications need Step Therapy?
Some medications are extremely costly. If lower-cost, clinically-effective medications exist, it may be prudent to try these first. In some cases, there are also specific dosages and quantities that should be used based on medical guidelines.

Who decides what medications will need Step Therapy?
A team of independent, licensed doctors, pharmacists and other medical experts review and discuss the latest medical guidelines and research, then decide which medications should be included in the Step Therapy Program.

How do I know if my medication requires a Prior Authorization?
The pharmacist will let you know when you pick up your prescription at the pharmacy. You may also call the member services phone number on your pharmacy card for more information.

Where can I get more help?
Visit the member website or call the customer service phone number listed on your member ID card.

optumrx.com

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products. We are an Optum® company — a leading provider of integrated health services. Learn more at **optum.com**.

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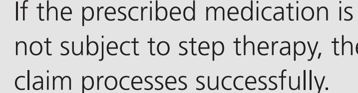
Step Therapy Program

Member submits prescription to a dispensing pharmacy.

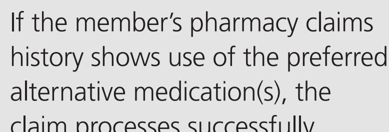
Dispensing pharmacy processes member's prescription.

The OptumRx online claims processing system automatically screens the prescribed medication against a list of medications identified as part of the Step Therapy Program.



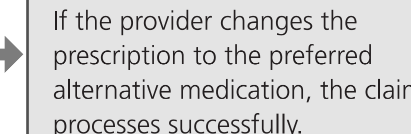
If the prescribed medication is not subject to step therapy, the claim processes successfully.

If the prescribed medication is identified as part of the Step Therapy Program, the OptumRx online claims processing system automatically screens the member's pharmacy claims history for prior use of preferred alternative medication(s).



If the member's pharmacy claims history shows use of the preferred alternative medication(s), the claim processes successfully.

If the member's pharmacy claims history does not show use of the preferred alternative medication(s), the claim does not process and the pharmacist is advised to contact the prescribing provider.



If the provider changes the prescription to the preferred alternative medication, the claim processes successfully.

If the provider chooses to submit a prior authorization request for coverage of the original prescription, the prior authorization process is initiated.

To learn more about OptumRx, please email us at optumrxsales@optum.com or visit **optumrx.com**.

2300 Main Street, Irvine, CA 92614

OptumRx specializes in the delivery, clinical management and affordability of prescription medications and consumer health products.
We are an Optum® company — a leading provider of integrated health services. Learn more at **optum.com**.

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Choose the right health care setting

Where you go for medical services can make a big difference in how much you pay and how long you wait to see a health care provider. The chart below can help you select the right setting for your needs:

TYPE OF CARE	WAIT TIME	COST**

Teladoc[SM] - 800-835-2362 or Teladoc.com

You may request a consultation from a board-certified doctor any time of day, seven days a week, by phone or online. Teladoc physicians can diagnose routine ailments, recommend treatments and prescribe medications.

When to go*

- Cold or flu
- Bronchitis
- Respiratory infection
- Sinus problems
- Allergies
- Urinary tract infection
- Pediatric care
- Poison ivy or pink eye

Wait time: **17 minutes** Approximate wait time for doctor to respond

Cost: **QHDHP/HSA Plan** **$45 per consultation**; **PPO Plan** **$0 per consultation**

Retail clinic/convenient care clinic

Retail clinics, sometimes called convenient care clinics, are located in retail stores, supermarkets and pharmacies.

When to go*

- Colds or flu
- Sinus infections
- Allergies
- Vaccinations or screenings
- Minor sprains, burns or rashes
- Headaches or sore throats

Wait time: **15 minutes** or less, on average

Cost: **All Plans** **50-$100 average cost per visit**

Urgent care/walk-in clinic

Urgent care centers, sometimes called walk-in clinics, are often open in the evenings and on weekends.

When to go*

- Sprains and strains
- Mild asthma attacks
- Sore throats
- Minor broken bones or cuts
- Minor infections or rashes
- Earaches

Wait time: **20-30 minutes** Approximate wait time

Cost: **All Plans** **$150-$200 Average cost per visit**

Clinical care (your doctor's office)

Seeing your doctor is important. Your doctor knows your medical history and any ongoing health conditions.

When to go*

- Preventive services and vaccinations
- Medical problems or symptoms that are not an immediate, serious threat to your health or life

Wait time: **1 week or more** Approximate wait time for an appointment

Cost: **HDHP/HSA Plan** **$100-$150 Average cost per visit**; **PPO Plan** **$30 Copay**

Emergency room (ER)

Visit the ER only if you are badly hurt. If you are not seriously ill or hurt, you could wait hours and your health plan may not cover non-emergency ER visits.

When to go*

- Sudden change in vision
- Sudden weakness or trouble talking
- Large, open wounds
- Difficulty breathing
- Severe head injury
- Heavy bleeding
- Spinal injuries
- Chest pain
- Major burns
- Major broken bones

Wait time: **3 to 12 hours** Approximate wait time for non-critical cases

Cost: **All plans** **$1,200-$1,500 Average cost per visit**

** This is a sample list of services and is not intended to be all-inclusive.*

*** Costs are averages only and not tied to a specific condition or treatment. Out-of-pocket costs will vary based on your medical plan design.*

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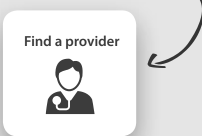
Find a provider

Finding a network provider on umr.com has never been easier

1 Go to **umr.com** and select **“Find a provider”**



2 Search for **UnitedHealthcare Choice Plus Network** using our alphabet navigation or type **UnitedHealthcare Choice Plus** into the search box

Find a provider on-the-go using our umr.com mobile site

continued on the back »

3 For medical providers, choose **View Providers**.
For behavioral health providers (including counseling and substance abuse), select **Behavioral health directory**.

REMEMBER:
Get the most from your benefit plan – use participating network health care providers whenever possible.

UnitedHealthcare Choice Plus:

The UnitedHealthcare online provider directories include network hospitals, primary physicians and specialists. The following information is available:

- Provider name, address and phone number
- Hospital affiliation
- Board certification
- UnitedHealth Premium® Quality & Cost Efficiency designations that highlight physicians by quality of care and cost standards in their specialty
- Average costs for care in your area and how different providers compare to the local average
- Provider ID number
- Office language capabilities (English, Spanish, etc.)
- Map and directions to each office

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DENTAL INSURANCE

	Preventive Plus
Deductible (Single/Family) In-Network*	$50 / $150
Calendar Year Maximum **Orthodontic Lifetime Maximum**	$1,250
Waiting Period	12 Months on Major Services
Diagnostic and Preventive Services Exams, cleanings, emergency palliative treatment, sealants, x-rays	Covered at 100%
Basic Services Minor restorative services - fillings and crown repair, endodontic services - root canals, oral surgery services - extractions and dental surgery, denture repair	20%, After Deductible
Major Services Periodontics services - to treat gum disease, major restorative services -crowns, fixed prosthodontic repair - to bridges, implant repair - implant maintenance, repair, and removal, relines and rebase - to dentures, adjustment to dentures - adjustments to partial or complete dentures, prosthodontic services - bridges, implants and dentures.	50%, After Deductible
Orthodontic Services Dependent children to age 19	Not Covered

**As noted above these are In-Network benefits. For Out-of-Network benefits please see the complete benefit summary.*
***Please note when seeing an Out-of-Network dentist you may be billed the full amount at the time of service and then have to wait to be reimbursed.*

Your Cost Per Pay	
Employee	$ 9.72
Employee + Spouse	$19.85
Employee + Child(ren)	$19.26
Family	$31.90

To locate a network provider in your area go to:
www.deltadentalky.com

This summary is intended only to highlight some of the most commonly used benefits.
Please refer to your Certificate of Coverage for an exact description of coverage, exclusions and limitations.

VSP® Vision Savings Pass™

VSP Vision Savings Pass is a discount vision program that offers immediate savings on eye care and eyewear. This is not an insurance plan.

See the Savings

- Access to discounts through a trusted, private-practice VSP doctor
- One rate of $50 for an eye exam[1]
- Special pricing on complete pairs of glasses and sunglasses
- 15% savings on a contact lens exam[2]
- Unlimited use on materials throughout the year
- Exclusive Member Extras, like rebates and special offers

Unlimited Annual Material Use[3]

Your VSP Vision Savings Pass can be used as often as you like throughout the year. With the best choices in eyewear, we make it easy to find the perfect frame that's right for you, your family, and your budget. Choose from great brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more.[4]

How to Use Your VSP Vision Savings Pass

1. Find a VSP doctor at **vsp.com** or call **800.877.7195**.
2. Save immediately on an eye exam[1] and eyewear at the time of service.
3. Take advantage of your VSP Vision Savings Pass over and over—use is unlimited on materials.[3]

Service	Reduced prices and savings
Wellvision Exam®	• $50 with purchase of a complete pair of prescription glasses. • 20% off without purchase. • Once every calendar year.
Retinal Screening	• Guaranteed pricing with Wellvision Exam, not to exceed $39.
Lenses	With purchase of a complete pair of prescription glasses: • Single vision $40 • Lined trifocals $75 • Lined bifocals $60 • Polycarbonate for children $0
Lens Enhancements	• Average savings of 20-25% on lens enhancements such as progressive, scratch-resistant, and anti-reflective coatings.
Frames	• 25% savings when a complete pair of prescription glasses is purchased.
Sunglasses	• 20% savings on unlimited non-prescription sunglasses from any VSP doctor within 12 months of your last Wellvision Exam.
Contact Lenses	• 15% savings on contact lens exam (fitting and evaluation).
Laser Vision Correction	• Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities.

SEE WHY WE'RE CONSUMERS' #1 CHOICE IN VISION CARE[5]

Contact us.
vsp.com | 800.877.7195

1. This cost is only available with the purchase of a complete pair of prescription glasses; otherwise, you'll receive 20% off an eye exam only.
2. Applies only to contact lens exam, not materials. You are responsible for 100% of the contact lens material cost.
3. Unlimited use is for materials only. An eye exam is limited to once a year per member.
4. Brands subject to change.
5. Blueocean Market Intelligence National Vision Plan Member Research, 2014.

THIS PLAN IS NOT INSURANCE and is not intended to replace health insurance. This plan is not a Qualified Health Plan under the Affordable Care Act. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN. There is no cost to join this discount program. The plan provides discounts at certain health care providers for services. The range of discounts will vary depending on the type of provider and service. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have agreed to provide discounts. The plan and its administrators have no liability for providing or guaranteeing service by providers or the quality of service rendered by providers. This plan is not available in Washington. Void where prohibited.

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JOB#2823-16-VCCM 2/16

M & M Cartage, Inc.

What you need to know:

- **Are you eligible?** Benefits are available to employees who are actively at work on the effective date of coverage and working the minimum number of hours per week stated in the contract.
- **Your premiums and benefits may vary.** Actual premiums and benefit amounts will be calculated by OneAmerica and may change upon reaching certain ages, according to contract terms, and are subject to change. Volumes and benefit amounts shown may be subject to reductions due to age.
- **Enroll timely for guaranteed issue coverage.** You may be eligible for coverage without having to answer any health questions if you enroll during the initial enrollment period when benefits are first offered by OneAmerica®, or if you enroll as a newly hired employee within 31 days after any applicable waiting period.
- **Enrolling later requires approval.** If you decline coverage now, you will lose your only chance to apply for group insurance coverage without having to first undergo medical underwriting. If you decide to enroll later, you will need to submit a Statement of Insurability form for review. OneAmerica will then decide to approve or deny your coverage based on your health history. You may not be approved for any type of coverage at a later date if you have any current or future medical conditions.

What you need to do:

- **Carefully review the contents of this packet.** Enclosed is personal information about the benefits offered to you by OneAmerica on behalf of your employer. This is your opportunity to learn more about group insurance from OneAmerica, but it is not a complete explanation of benefits. For more information, consult the contract about exclusions, limitations, reduction of benefits, and terms under which the contract may be continued in force or discontinued.
- **Review the Notices and Limitations.** Visit www.employeebenefits.aul.com to find the Notices and Limitations, G-14320 (05 NonPrudent) 12/28/12. Go to Forms, Policy/Employee Admin, and Notices and Limitations.
- **Submit your enrollment form.** Please return your completed enrollment form to your employer.

Note: *Products issued and underwritten by American United Life Insurance Company® (AUL), a OneAmerica company. Not available in all states or may vary by state.*

Protecting the ones you care about most

"How will my loved ones be taken care of when I'm gone?" This question isn't something anyone wants to think about, but if someone depends on you for financial support, then life insurance is your answer.

Income protection for your loved ones
No matter what your current situation is: single, married, with or without children; life insurance helps replace your income, and will assist your family in paying final expenses. It will also allow your loved ones to continue any future plans, such as college education or savings.

Why you need it
There are several reasons you need life insurance. In addition to paying for burial expenses, consider life insurance an option to pay for the mortgage, medical expenses and fund college education. If you work or have savings, then you have the income to pay these bills. However, consider what happens when your loved ones no longer have your financial support.

How much is enough
Figuring out how much life insurance you need is hard to decide. You want to make sure you have enough to protect your family. To help you answer this question, use the calculator to estimate your expenses to think about which bills would need income protection.

Estimate your expenses below

Income and possessions	Amount
Annual income	
Number of years until retirement	
Subtotal *(annual income x years)*	
Debt and final expenses	
Mortgage/rent	
Credit card(s), car payment(s), etc.	
Funeral and burial expenses ($7,000 is a good estimate)	
Subtotal *(debt)*	
Educational costs	
College expenses *(Approximately $32,405/year for private, $9,410 for state residents at public schools and $23,893 for out-of-state residents attending public universities)*	
Subtotal *(education)*	
Total needed for your life insurance	**$**

Typically, life insurance offered through work is less expensive than if you purchased it on your own. Consider purchasing life insurance today.

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What you need to know about your Basic Life and AD&D Benefits

Guaranteed Issue: Employee: $10,000

Accidental Death and Dismemberment (AD&D): Additional life insurance benefits may be payable in the event of an accident which results in death or dismemberment as defined in the contract. Additional AD&D benefits include seat belt, air bag, repatriation, child higher education, child care, paralysis/loss of use, severe burns, disappearance, and exposure.

Accelerated Life Benefit: If diagnosed with a terminal illness and have less than 12 months to live, you may apply to receive 25%, 50% or 75% of your life insurance benefit to use for whatever you choose.

Reductions: Upon reaching certain ages, your original benefit amount will reduce to the percentage shown in the following schedule.

Age:	65	70
Reduces To:	65%	50%

Basic Employee Life and AD&D Coverage

Your Life and AD&D insurance coverage amount is $10,000.

Coverage is provided at no cost to you.

OneAmerica® is the marketing name for the companies of OneAmerica.

What you need to know about your Voluntary Term Life and AD&D Benefits

Flexible Options: Employee: $10,000 to $500,000, in $1,000 increments, not to exceed 5 times your annual salary

Spouse under age 70: $5,000 to $250,000, in $500 increments, not to exceed 50% of the employee's amount

Guaranteed Issue: Employee: $200,000   Spouse: $50,000   Child: $10,000

Dependent Life Coverage: Optional dependent life coverage is available to eligible employees. You must select employee coverage in order to cover your spouse and/or child(ren).

Accidental Death and Dismemberment (AD&D): You must select Life coverage in order to select any AD&D coverage. Additional life insurance benefits may be payable in the event of an accident which results in death or dismemberment as defined in the contract.

Accelerated Life Benefit: If diagnosed with a terminal illness and have less than 12 months to live, you may apply to receive 25%, 50% or 75% of your life insurance benefit to use for whatever you choose.

Guaranteed Increase In Benefit: You may be eligible to increase your coverage annually until you reach your maximum amount without providing evidence of insurability.

Reductions: Upon reaching certain ages, your original benefit amount will reduce to the percentage shown in the following schedule. The amounts of dependent life insurance and dependent AD&D principal sum will reduce according to the employee's reduction schedule.

Age:	70	75
Reduces To:	67%	45%

Payroll Deduction Illustration: Bi-Weekly
Employee Options

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$.44	$.44	$.44	$.49	$.63	$1.00	$1.37	$2.20	$3.72	$5.75	$9.03	$14.29	$25.27
$40,000	$1.77	$1.77	$1.77	$1.96	$2.51	$3.99	$5.46	$8.79	$14.88	$23.00	$36.11	$57.16	$101.10
$60,000	$2.66	$2.66	$2.66	$2.94	$3.77	$5.98	$8.20	$13.18	$22.32	$34.50	$54.17	$85.74	$151.64
$80,000	$3.54	$3.54	$3.54	$3.91	$5.02	$7.98	$10.93	$17.58	$29.76	$46.01	$72.22	$114.31	$202.19
$100,000	$4.43	$4.43	$4.43	$4.89	$6.28	$9.97	$13.66	$21.97	$37.20	$57.51	$90.28	$142.89	$252.74
$120,000	$5.32	$5.32	$5.32	$5.87	$7.53	$11.96	$16.39	$26.36	$44.64	$69.01	$108.33	$171.47	$303.29
$140,000	$6.20	$6.20	$6.20	$6.85	$8.79	$13.96	$19.13	$30.76	$52.08	$80.51	$126.39	$200.05	$353.83
$160,000	$7.09	$7.09	$7.09	$7.83	$10.04	$15.95	$21.86	$35.15	$59.52	$92.01	$144.44	$228.63	$404.38
$180,000	$7.98	$7.98	$7.98	$8.81	$11.30	$17.94	$24.59	$39.54	$66.96	$103.51	$162.50	$257.21	$454.93
$200,000	$8.86	$8.86	$8.86	$9.78	$12.55	$19.94	$27.32	$43.94	$74.40	$115.02	$180.55	$285.78	$505.48

Spouse Options

Life & AD&D	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	$.22	$.22	$.22	$.24	$.31	$.50	$.68	$1.10	$1.86	$2.88	$4.51
$20,000	$.89	$.89	$.89	$.98	$1.26	$1.99	$2.73	$4.39	$7.44	$11.50	$18.06
$30,000	$1.33	$1.33	$1.33	$1.47	$1.88	$2.99	$4.10	$6.59	$11.16	$17.25	$27.08
$40,000	$1.77	$1.77	$1.77	$1.96	$2.51	$3.99	$5.46	$8.79	$14.88	$23.00	$36.11
$50,000	$2.22	$2.22	$2.22	$2.45	$3.14	$4.98	$6.83	$10.98	$18.60	$28.75	$45.14

Child Options

Life & AD&D	Child(ren) 6 months to age 19, or 25 if full-time student	Child(ren) live birth to 6 months	Deduction amount Child(ren)
Option 1:	$10,000	$1,000	$1.04

Note: Employee and Spouse premiums are based on your age as of 01/01 and amount of coverage chosen. Child premiums are for all eligible children combined.

OneAmerica® is the marketing name for the companies of OneAmerica.

Protect your paycheck

You insure your home, car and other valuable possessions, so why not also protect what pays for all those things? Your income. Without it, think about how your mortgage/rent, groceries or credit card bills would get paid. That's where disability insurance can help.

A disability can happen to anyone at any time and it can last for a short or long period of time. Purchasing disability insurance through your workplace is a way to replace a portion of your pre-disability earnings if you get sick or hurt and are unable to work. Being prepared can help ease the financial burden for you.

Things to think about
A severe injury or illness can leave you unable to work for years. Workers' compensation only covers injuries that happen on the job and, to qualify for coverage, you must meet certain eligibility requirements. Additionally, medical insurance will only help cover your medical costs.

You might be able to dip into savings or borrow money from loved ones, but if you don't have these options, can you really afford not to have disability insurance?

Protect yourself and your income with disability insurance.

Disability insurance can provide you with the income protection you need. Consider purchasing it today.

Let's figure it out
Everyone's circumstances are different. This calculator can help you figure out how much you need to protect your lifestyle and the lifestyles of those you love if you become disabled.

Estimate your essential monthly expenses

Living expenses	Amount
Monthly housing *(e.g., mortgage, rent, insurance, taxes)*	
Utilities *(e.g., telephone, electricity, gas, oil, cable, TV, Internet)*	
Food	
Transportation *(e.g., car payments, gasoline, insurance)*	
Subtotal =	
Debt expenses	
Education *(e.g., tuition, books, supplies)*	
Health care *(e.g., out-of-pocket costs, insurance premiums)*	
Debt payments *(e.g., credit cards, other debt)*	
Subtotal =	
Other expenses	
Dependent care	
Life insurance premiums	
Subtotal =	
Minimum monthly amount to cover with disability insurance	**$**

Note: Products issues and underwritten by American United Life Insurance Company® (AUL), Indianapolis, IN, a OneAmerica company.

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What you need to know about your Worksite Short Term Disability Benefits

Elimination Period: This is a period of consecutive days of disability before benefits may become payable under the contract.

Maximum Benefit Duration: This is the length of time that you may be paid benefits if continuously disabled as outlined in the contract.

Pre-Existing Condition Period: Certain disabilities are not covered if the cause of the disability is traceable to a condition existing prior to your effective date of coverage.

Worksite Short Term Disability Coverage Option 1

You may select a minimum weekly benefit of $50 up to a maximum Weekly benefit of $1,150, in increments of $50, not to exceed 60% of your weekly pre-disability earnings.

Elimination Period	Maximum Benefit Duration	Pre-Existing Condition Period
14 days injury / 14 days sickness	26 weeks	3 months / 12 months

Option 1 Payroll Deduction Illustration: Bi-weekly

If your annual salary is at least:	You may select a Weekly benefit of:	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$4,333	$50	$1.84	$1.84	$1.84	$1.84	$1.84	$1.84	$2.13	$2.13	$2.13	$2.81	$2.81	$2.81	$2.81
$8,667	$100	$3.68	$3.68	$3.68	$3.68	$3.68	$3.68	$4.27	$4.27	$4.27	$5.63	$5.63	$5.63	$5.63
$21,667	$250	$9.21	$9.21	$9.21	$9.21	$9.21	$9.21	$10.66	$10.66	$10.66	$14.07	$14.07	$14.07	$14.07
$34,667	$400	$14.73	$14.73	$14.73	$14.73	$14.73	$14.73	$17.06	$17.06	$17.06	$22.50	$22.50	$22.50	$22.50
$43,333	$500	$18.42	$18.42	$18.42	$18.42	$18.42	$18.42	$21.33	$21.33	$21.33	$28.13	$28.13	$28.13	$28.13
$52,000	$600	$22.10	$22.10	$22.10	$22.10	$22.10	$22.10	$25.59	$25.59	$25.59	$33.76	$33.76	$33.76	$33.76
$65,000	$750	$27.62	$27.62	$27.62	$27.62	$27.62	$27.62	$31.99	$31.99	$31.99	$42.20	$42.20	$42.20	$42.20
$78,000	$900	$33.15	$33.15	$33.15	$33.15	$33.15	$33.15	$38.39	$38.39	$38.39	$50.63	$50.63	$50.63	$50.63
$86,667	$1,000	$36.83	$36.83	$36.83	$36.83	$36.83	$36.83	$42.65	$42.65	$42.65	$56.26	$56.26	$56.26	$56.26
$99,667	$1,150	$42.35	$42.35	$42.35	$42.35	$42.35	$42.35	$49.05	$49.05	$49.05	$64.70	$64.70	$64.70	$64.70

Note: Premiums are based on your weekly salary and your age as of 01/01.

OneAmerica® is the marketing name for the companies of OneAmerica.

What you need to know about your Worksite Long Term Disability Benefits

Elimination Period: This is a period of consecutive days of disability before benefits may become payable under the contract.

Maximum Benefit Duration: This is the length of time that you may be paid benefits if continuously disabled as outlined in the contract.

Pre-Existing Condition Period: Certain disabilities are not covered if the cause of the disability is traceable to a condition existing prior to your effective date of coverage.

Worksite Long Term Disability Coverage Option 1

You may select a minimum monthly benefit of $500 up to a maximum monthly benefit of $5,000, in increments of $100, not to exceed 60% of your monthly pre-disability earnings.

Elimination Period

180 days injury / 180 days sickness

Maximum Benefit Duration

Age When Total Disability Begins	Maximum Duration
Less than age 61	5 years
61	Lesser of Social Security Full Retirement Age or 5 years
	Greater of Social Security Full Retirement Age or:
62	3.5 years
63	3 years
64	2.5 years
65	2 years
66	21 months
67	18 months
68	15 months
69 and over	12 months

Pre-Existing Condition Period

6 months / 12 months

Option 1 Payroll Deduction Illustration: Bi-weekly

If your annual salary is at least:	You may select a Monthly benefit of:	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$10,000	$500	$.48	$.48	$.59	$.77	$1.05	$1.58	$2.52	$4.07	$6.21	$9.81	$9.81	$9.81	$9.81
$20,000	$1,000	$.97	$.97	$1.18	$1.55	$2.11	$3.16	$5.05	$8.13	$12.42	$19.63	$19.63	$19.63	$19.63
$30,000	$1,500	$1.45	$1.45	$1.77	$2.32	$3.16	$4.74	$7.57	$12.20	$18.62	$29.44	$29.44	$29.44	$29.44
$40,000	$2,000	$1.94	$1.94	$2.35	$3.09	$4.21	$6.31	$10.10	$16.26	$24.83	$39.25	$39.25	$39.25	$39.25
$50,000	$2,500	$2.42	$2.42	$2.94	$3.87	$5.26	$7.89	$12.62	$20.33	$31.04	$49.06	$49.06	$49.06	$49.06
$60,000	$3,000	$2.91	$2.91	$3.53	$4.64	$6.32	$9.47	$15.15	$24.40	$37.25	$58.88	$58.88	$58.88	$58.88
$70,000	$3,500	$3.39	$3.39	$4.12	$5.41	$7.37	$11.05	$17.67	$28.46	$43.45	$68.69	$68.69	$68.69	$68.69
$80,000	$4,000	$3.88	$3.88	$4.71	$6.18	$8.42	$12.63	$20.20	$32.53	$49.66	$78.50	$78.50	$78.50	$78.50
$90,000	$4,500	$4.36	$4.36	$5.30	$6.96	$9.47	$14.21	$22.72	$36.59	$55.87	$88.31	$88.31	$88.31	$88.31
$100,000	$5,000	$4.85	$4.85	$5.89	$7.73	$10.53	$15.79	$25.25	$40.66	$62.08	$98.13	$98.13	$98.13	$98.13

Note: Premiums are based on your monthly salary and your age as of 01/01.

Call Your ComPsych® GuidanceResources® program anytime for confidential assistance.

Call: **855.387.9727**
TDD: 800.697.0353
Go online: **guidanceresources.com**
Your company Web ID: **ONEAMERICA3**

Personal issues, planning for life events or simply managing daily life can affect your work, health and family. Your GuidanceResources program provides support, resources and information for personal and work-life issues. The program is company-sponsored, confidential and provided at no charge to you and your dependents. This flyer explains how GuidanceResources can help you and your family deal with everyday challenges.

Confidential Counseling

3 Session Plan

This no-cost counseling service helps you address stress, relationship and other personal issues you and your family may face. It is staffed by GuidanceConsultants℠—highly trained master's and doctoral level clinicians who will listen to your concerns and quickly refer you to in-person counseling (up to 3 sessions per issue per year) and other resources for:

- Stress, anxiety and depression
- Relationship/marital conflicts
- Problems with children
- Job pressures
- Grief and loss
- Substance abuse

Financial Information and Resources

Discover your best options.

Speak by phone with our Certified Public Accountants and Certified Financial Planners on a wide range of financial issues, including:

- Getting out of debt
- Credit card or loan problems
- Tax questions
- Retirement planning
- Estate planning
- Saving for college

Legal Support and Resources

Expert info when you need it.

Talk to our attorneys by phone. If you require representation, we'll refer you to a qualified attorney in your area for a free 30-minute consultation with a 25% reduction in customary legal fees thereafter. Call about:

- Divorce and family law
- Debt and bankruptcy
- Landlord/tenant issues
- Real estate transactions
- Civil and criminal actions
- Contracts

Work-Life Solutions

Delegate your "to-do" list.

Our Work-Life specialists will do the research for you, providing qualified referrals and customized resources for:

- Child and elder care
- Moving and relocation
- Making major purchases
- College planning
- Pet care
- Home repair

GuidanceResources® Online

Knowledge at your fingertips.

GuidanceResources Online is your one stop for expert information on the issues that matter most to you...relationships, work, school, children, wellness, legal, financial, free time and more.

- Timely articles, HelpSheets℠, tutorials, streaming videos and self-assessments
- "Ask the Expert" personal responses to your questions
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Get peace of mind.

EstateGuidance® lets you quickly and easily write a will on your computer. Just go to www.guidanceresources.com and click on the EstateGuidance link. Follow the prompts to create and download your will at no cost. Online support and instructions for executing and filing your will are included. You can:

- Name an executor to manage your estate
- Choose a guardian for your children
- Specify your wishes for your property
- Provide funeral and burial instructions

Just call or click to access your services.

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Your company Web ID: **ONEAMERICA3**

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Providing you peace of mind when traveling

Emergencies happen, but help is now only a phone call or email away. Generali Global Assistance® offers a suite of services to help you in your time of need — from small inconveniences like losing your medication to life-threatening situations — all delivered with a caring, human touch.

Find comfort in knowing you and your loved ones are protected by the Travel Assistance benefit when traveling more than 100 miles from home on a trip that lasts 90 days or less for business or pleasure. The Travel Assistance benefit protects you when covered under a OneAmerica® group life insurance contract. It also extends coverage to your spouse, domestic partner and children, even when they are traveling without you. The Travel Assistance benefit requires no additional premium; however, exclusions do apply.

Medical assistance services

Medical and dental referral to assist in finding physicians, dentists and medical facilities.

Replacement of medication or eyeglasses that have been lost or stolen, with guarantee of reimbursement by you.

Medical monitoring and review of documentation utilizing professional case managers and medical professionals to ensure appropriate care is received.

Visitation with a family member or a friend if you are traveling alone and must be hospitalized for at least seven days or are listed as in critical condition.

Dependent children assistance in the event you are hospitalized, including payment for their trip home and a qualified escort to accompany them.

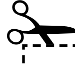
Traveling companion assistance in the event they must cancel their travel arrangements due to medical emergencies.

Emergency evacuation in the event you must be transported to a medical facility or home under medical supervision.

Repatriation or cremation of remains in the event of death while traveling.

Trip interruption to arrange alternate transportation and accommodations necessary due to a medical emergency.

Emergency medical payment to cover medical and dental care expenses in the case of sudden, unexpected illness or injury during your trip, with guarantee of reimbursement by you.



For assistance call:
1-866-294-2469 (US/Canada)
+**1-240-330-1509** (call collect from other locations)
or email **ops@europassistance-usa.com**

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Personal assistance services

Pre-trip informational services including: visa, passport, immunization requirements, weather conditions, travel advisories and more.

Language interpretation for all major languages.

Location or replacement of lost or stolen items such as luggage, documents and personal possessions.

Emergency cash advance subject to guarantee of reimbursement by you.

Emergency travel arrangements when appropriate, such as airline changes or hotel and car rental reservations.

Legal assistance and advanced bail bond will be arranged, where permitted by law, with guarantee of reimbursement by you.

Emergency message relay via toll-free, direct or collect access.

Vehicle return arranged and paid for if you become physically unable to operate a non-commercial vehicle due to a medical emergency.

Pet return home coordinated if covered traveler is hospitalized.

Upon verification of coverage, Generali Global Assistance will arrange and cover the cost of the following services, subject to policy limits and eligibility:

- **Emergency evacuation:** $1,000,000 Combined Single Limit (CSL)
- **Medically necessary repatriation:** Included in CSL
- **Repatriation or cremation of remains:** Up to $25,000

If traveling alone:

- **Visit of family member or friend:** Up to $5,000
- **Return of minor children:** Up to $5,000
- **Traveling companion transportation:** Up to $5,000
- **Vehicle return:** Up to $2,500
- **Bereavement transportation:** Up to $2,500
- **Pet return:** Up to $1,000

Note: Group life products are issued and underwritten by American United Life Insurance Company® (AUL), Indianapolis, In., a OneAmerica company. Not available in all states or may vary by state. Travel assistance provided by Generali Global Assistance. Generali Global Assistance is not an affiliate of AUL, and is not a OneAmerica Company. Generali Global Assistance provides noted services worldwide for covered individuals. Services may be unavailable in countries currently under U.S. economic or trade sanctions. A list of affected counties is available at treasury.gov/resource-center/sanctions/Programs/Pages/Programs.aspx. Please refer to your policy for covered limits and eligibility details.

When contacting Generali Global Assistance, be prepared to provide:

- The name of your employer
- A phone number where you can be reached

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Choosing to expect the unexpected

Accident Insurance

Have you ever thought about what you would do if you or a family member were accidentally injured or died as a result of an accident?

Accidents are unexpected and can strike any member of your family. The costs associated with treatment can mount quickly.

- One in six U.S. residents require medical treatment from an injury each year.[1]
- Over 40 million Americans visit a physician's office for unintentional injuries each year.[2]
- The 2007 national economic impact of unintentional injuries mounted to $684.4 billion.[2]

How can accident insurance help?

For covered accidental injuries, fixed benefits are paid directly to you regardless of any other coverage you may have and you can spend it any way you choose. Benefits are paid according to a fixed schedule that includes benefits for hospitalization, fractures and dislocations, emergency room visits, major diagnostic exams, physical therapy and more.

If you or a covered dependent should die as a result of an accidental injury within 365 days while the coverage remains in force, a death benefit is payable.

How do I know if I'm eligible to participate in this plan?

You are eligible to participate if you are an active full-time employee as defined by your employer and meet any other policyholder defined eligibility requirements.

This product is inappropriate for those persons who are eligible for Medicaid coverage.

Key Advantages of This Plan

- **Provides coverage for off-the-job accidents.**
- **Benefits are payable directly to you to be spent any way you choose.**
- **Pays in addition to any other coverage you may have.**
- **No health questions or pre-existing conditions limitations.**
- **Fast and accurate claims service.**
- **Coverage is fully portable - if you change jobs you can take your coverage with you.**

Sources: [1] Center for Disease Control, Congressional Testimony, May 1, 2008
[2] National Safety Council, "Injury Facts" 2008

This is an accident only insurance policy. It provides limited benefits and has some specific benefit limits. It does not pay benefits for sickness or loss from any other cause and is not a policy of Workers' Compensation. Please refer to the issued insurance policy for complete details and all benefit requirements including all limitations, exclusions and restrictions. We reserve the right to cancel the policy with advance written notice to the policyholder. Insurance policies and certain policy benefits are subject to state variations and may not be available in all states. Issued insurance contracts det mine all plan features and benefits.

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Accident Q&A

Q. What about coverage for my family?

A. If you elect coverage for yourself, you can elect coverage for your eligible family members. Eligible family members include your spouse and children from live birth to less than age 26. See your certificate or group insurance policy for additional eligibility details.

Q. When will my coverage become effective?

A. Your coverage starts on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties. If a family member is in a hospital on the day insurance would otherwise take effect, then insurance will take effect on the day after the family member leaves the hospital.

Q. What is the Annual Wellness Screening Benefit?

A. If you and your dependents enroll in the plan, each of you are eligible for $50 per benefit year for any one Wellness Screening test from a list of more than 20 covered tests. Covered tests include: cardiac exercise stress; test fasting blood glucose test; blood test for lipids including total cholesterol, LDL, HDL and triglycerides; breast ultrasound or mammography; CA15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); CEA (blood test for colon cancer); chest x-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; pap smear; PSA (blood test for prostate cancer); serum protein electrophoresis; carotid doppler; electrocardiogram; echocardiogram. In order to receive this benefit, the wellness screening test must be performed after your coverage effective date.

How much does Accident insurance cost?

The financial assistance that Accident insurance provides doesn't have to take a big bite out of your wallet. Review the costs and benefits below to determine if Accident insurance is right for you. We've included an example of how benefits can be paid under this plan to help you with your decision.

Treatment	Benefit*
Broken Finger (no surgery)	$175
Emergency Treatment	$150
Follow-up Visit (2)	$50
Total Payment	**$375**

Treatment	Benefit*
Broken Leg (no surgery)	$800
Emergency Treatment	$150
Ambulance	$200
Initial Hospitalization	$1,000
Hospital Benefit (1 day)	$250
Crutches	$125
Follow-up Visit (3)	$75
Physical Therapy (2x)	$50
Total Payment	**$2,650**

**These hypothetical examples are for illustrative purposes only.*

Your Bi-Weekly Premium Deduction	
Non-occupational Coverage	
For you	$9.64
For you and your spouse	$12.99
For you and your child(ren)	$14.32
For you and your family	$17.67

Premiums will not change due to age changes.

What benefits are payable for covered accidents?

Accident Insurance Schedule	
Initial Emergency Treatment: Pays a benefit for accident emergency treatment, ambulance transportation for medical treatment of a covered accident and certain other services.	
Ambulance*	**$200** - Ground ambulance **$1,500** - Air ambulance
Accident Emergency Treatment*	**$150** - Emergency Room **$75** - Non-Emergency Room Limited to once each accident and once in any 24-hour period.
Major Diagnostic Exams	**$200** per benefit year. Initial treatment must be provided within 6 days of the accident.
Blood/Plasma/Platelets	**$200** payable once for any accident
Hospital Care: *Traditional health insurance policies may have deductibles and co-payments associated with hospital stays. Accident benefits can help cover your out-of-pocket costs resulting from a hospital admission due to a covered accident.*	
Initial Accident Hospitalization	**$1,000** limited to once per benefit year. Increases to **$1,500** if immediately admitted to the ICU.
Daily Hospital Confinement	**$250** not to exceed 365 days
Daily Intensive Care Unit Confinement	**$500** not to exceed 15 days per Accident. Paid in addition to the daily Hospital Confinement Benefit.
Accidental Injuries: *Benefits are payable for many injuries.*	
Dislocation (Separated Joint)*	Up to **$4,000** for Open Reduction (Surgical). Up to **$1,000** for Closed Reduction (repair by manipulation). Limited to 2 dislocations per accident. If reduction is administered without general anesthesia, 25% of the Closed Reduction benefit is payable.
Fractures (Broken Bones)	Up to $5,000 for Open Reduction (Surgical). Up to **$2,500** for Closed Reduction (repair by manipulation). Limited to 2 fractures per accident. Chip fractures and other fractures not reduced by Open or Closed Reduction will be payable at 25% of the amount otherwise payable for the Closed Reduction.
Emergency Dental Work*	**$200** – Broken teeth repaired with crowns **$65** – Broken teeth resulting in extractions Limited to 1 benefit per accident.
Concussion*	**$100**
Eye Injury	**$300** – Surgical repair **$65** – Removal of foreign body by a doctor
Lacerations*	**$35** to **$500**
Burns*	Third Degree Burns – $1,000 to $20,000** Second Degree Burns - $400 to $2,000** Skin Grafts – **50%** of the total burn benefit* payable *****Burn benefit is a fixed amount determined by the surface area burned.***
Surgical Care: *Provides a benefit for covered surgical procedures performed within 90 days of the accident.*	
$1,250	Open abdominal (including exploratory laparotomy), cranial (head), hernia, or thoracic (chest) surgery.
$625	Repair of tendons and/or ligaments, torn rotator cuffs, ruptured discs, or torn knee cartilages.
$300	Arthroscopy without surgical repair, or miscellaneous surgery requiring general anesthesia that is not covered by any other specific-sum injury benefit. Miscellaneous surgery limited to one surgery per 24-hour period.

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Transportation: *Assists when you or your covered dependent require medical care or treatment as prescribed by an attending doctor that is not available within 100 miles of the accident or your or your covered dependent's residence.*	
Transportation	**$600** limited to 3 round trips per benefit year for you and each covered dependent. Benefit is payable upon completion of the round trip. Excludes ground or air ambulance.

Lodging Assistance: *If you or your covered dependent are hospital confined more than 100 miles from your or your covered dependent's residence due to an injury, the Accident policy can help with costs.*	
Lodging	**$100** per day Limited to one benefit per day and 30 days per accident per benefit year.

Accidental Death and Dismemberment: *If injury results in death or dismemberment, a lump sum benefit is payable.*	
Accidental Death Benefit	Employee – **$25,000**; Spouse – **$25,000**; Child – **$5,000**
Common Carrier Death Benefit	Employee – **$100,000**; Spouse – **$100,000**; Child – **$20,000** Either the accidental death or the common carrier accidental death benefit will be paid, but not both.
Dismemberment	Loss of Finger, Toe, Hand, Foot, Arm, Leg, Eye – **$750** to **$15,000**

Follow-up care: *Helps with expenses for additional care or support that might be required after the initial treatment for an accident. Certain benefits may not be payable if provided on the same day.*	
Follow-up Treatment*	**$25** per day, not to exceed 6 payments
Physical Therapy*	**$25** per day, for up to 10 days of treatments
Appliances	**$125** - Wheelchairs, leg or back braces, crutches or walkers Limited to one appliance per accident
Rehabilitation Unit	**$150** per day; limited to 30 days per period of confinement and limited to 60 days per benefit year
Prosthesis	**$500** limited to one per accident

Serious Accidents: *Serious accidents can result in life changing losses. Benefits are payable for the following conditions as a result of a covered accidental injury.*	
Coma	**$20,000**
Paralysis	**$50,000** for Quadriplegia; **$25,000** for Paraplegia Payable only once per lifetime

*Initial treatment must be provided within 72 hours of the accident.

Important Definitions

Hospital means an institution which is primarily engaged in providing, by and under the supervision of doctors, diagnostic and therapeutic services for medical diagnosis, treatment and care of injured, disabled, or sick persons; or rehabilitation services of injured, disabled, or sick persons. It must meet all of the following requirements: maintain clinical records on all patients; have every patient be under the care of a doctor; provide 24-hour nursing service provided by a licensed practical or registered nurse and supervised by a registered professional nurse; be licensed or be approved by the state or local licensing agency; meet other health and safety requirements found necessary by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and is not primarily a clinic, nursing, rest or convalescent home.

Hospital confined or hospital confinement means admission to a hospital as an inpatient for at least 24 consecutive hours by a doctor for an injury. A hospital stay that does not result in charges to you or your covered dependent is not a hospital confinement under this policy unless there is no charge because the hospital is a United States government facility.

State variations can exist; please contact Assurant Employee Benefits for additional information.

Limitations, exclusions, restrictions and reductions

Please carefully review the Other Important Plan Provisions section for additional important plan limitations, exclusions, restrictions and reductions that may apply.

Critical Illness Insurance

ASSURANT Employee Benefits®

Can your finances survive a serious illness?

Maybe it's happened to someone you know. A sudden illness such as a heart attack or stroke can cause devastating physical and financial consequences.

- 1.5 million Americans will declare bankruptcy this year, 60% due to medical bills.[1]
- An estimated 83.6 million American adults (greater than 1 in 3) have cardiovascular disease.[2]
- Fewer than 1 in 4 Americans (24%) have enough savings to cover at least 6 months' expenses.[3]

How can critical illness insurance help?

For many, a critical illness can expose an individual to an unexpected gap in protection. While health plans may help cover many of the direct costs associated with a critical illness, related expenses such as lost income, child care, travel to and from treatment, high deductibles and co-pays may quickly diminish savings.

Critical illness insurance pays a fixed benefit if you are diagnosed after your coverage effective date with a covered critical illness.

How do I know if I'm eligible to participate in this plan?

You are eligible to participate if you are an active full-time employee as defined by your employer and meet any other policyholder defined eligibility requirements.

This product is inappropriate for those persons who are eligible for Medicaid coverage.

Key Advantages of This Plan

- **Benefits are payable directly to you to be spent any way you choose.**
- **Pays in addition to any other coverage you may have.**
- **Flexible coverage options to meet your individual needs.**
- **Fast and accurate claims service.**
- **Coverage is fully portable - if you change jobs you can take your coverage with you.**

Sources: [1] Facts About Critical Illness Insurance Coverage and Costs, 2012
[2] American Heart Association 2013
[3] 2013 research from Bankrate.com

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This critical illness only insurance policy provides limited benefits. This limited policy has some specific benefit limits and is not a medical insurance policy, a Medicare Supplement policy or a high deductible health plan or a policy of Workers' Compensation insurance. Please refer to the issued insurance policy for complete details and all benefit requirements, including all limitations, exclusions, restrictions and reductions. We reserve the right to cancel the policy with advance written notice to the policyholder. Insurance policies and certain policy benefits are subject to state variations and may not be available in all states. Issued insurance contracts determine all plan features and benefits. Cont t Assurant Employee Benefits for additional details.

Critical Illness Q&A

Q. I'm not signed up for Critical Illness insurance. Can I enroll now?

A. Yes! Whether you've just become eligible for this coverage or didn't sign up in the past, now is the time to enroll.

If you first became eligible for this coverage within the last 90 days, you can enroll for amounts up to **$15,000** for yourself without answering health questions. To enroll for more coverage than the amount shown above, you'll need to answer a simple health statement.

If you were offered this coverage more than 90 days ago, but chose not to enroll, you can join the plan now, but you'll need to provide proof of good health. Once approved, a pre-existing conditions limitation will apply.

A pre-existing condition means an injury, sickness, symptom or physical finding, or any related injury, sickness, symptom or physical finding, for which you or your covered dependent consulted with or received advice from a licensed medical or dental practitioner; or received medical or dental care, treatment or services, including taking drugs, medicine, insulin or similar substances in the 12 months that end on the day before you or your covered dependent became insured under the policy. We will not pay benefits for claims resulting, directly or indirectly, from a pre-existing condition unless you or your covered dependent are initially diagnosed with a critical illness or undergo a procedure after 12 consecutive months during which you or your covered dependent are continuously insured under this plan.

See your certificate for additional pre-existing condition details.

Q. What benefits are provided under this plan?

A. If you are diagnosed with a covered critical illness, you could receive up to **$50,000 as a single sum payment** depending on the amount of coverage you elect. You must be diagnosed after your coverage effective date and qualify for the benefit as defined by the policy. Your plan also includes a Wellness Screening benefit. Each critical illness pays a specified percentage of your election amount as shown below:

Covered Illness or Procedure	Initial Diagnosis Benefit Percent of Elected Benefit Payable
• Heart Attack	100%
• Stroke	100%
• End Stage Kidney Disease	100%
• Major Organ Failure	100%
• Occupational HIV/Hepatitis, B,C or D	100%
• Coronary Bypass Surgery	25%
• Angioplasty	5%
Your plan also includes expanded coverage for these additional conditions:	
• Cancer - Invasive Cancer	100%
• Cancer - Carcinoma in Situ	25%
• Cancer - Skin Cancer	5%
• Blindness, Loss of Speech, or Loss of Hearing	100%
• Benign Brain Tumor, Paralysis or Coma	100%
• Advanced ALS (Lou Gehrig's Disease)	100%
• Advanced Alzheimer's Disease	25%
• Advanced Parkinson's Disease	25%

Q. What if I am diagnosed with the same condition again?

A. If you have received benefits under this plan for a covered critical illness and are diagnosed a second time with the same critical illness, you may qualify for the recurrence benefit. Recurrence benefits are available only for the critical illnesses shown below:

Covered Illness or Procedure	Recurrence Benefit Percent of Elected Benefit Payable
• Heart Attack	100%
• Stroke	100%
• End Stage Kidney Disease	100%
• Major Organ Failure	100%
• Coronary Bypass Surgery	25%
• Angioplasty	5%

The second diagnosis must occur at least 12 consecutive months after the initial diagnosis and you must not have been receiving treatment for the initial diagnosis for at least 12 consecutive months between the initial diagnosis and the second diagnosis. Once the recurrence benefit has been paid, no additional benefit will be paid for that critical illness

Q. What is the Annual Wellness Screening Benefit?

A. If you and your dependents enroll in the plan, each of you are eligible for $50 per benefit year for any one Wellness Screening test from a list of more than 20 covered tests. Covered tests include: cardiac exercise stress test; fasting blood glucose test; blood test for lipids including total cholesterol, LDL, HDL and triglycerides; breast ultrasound or mammography; CA15-3 (blood test for breast cancer); CA 125 (blood test for ovarian cancer); CEA (blood test for colon cancer); chest x-ray; colonoscopy; flexible sigmoidoscopy; hemocult stool analysis; pap smear; PSA (blood test for prostate cancer); serum protein electrophoresis; carotid doppler; electrocardiogram; echocardiogram. In order to receive this benefit, the wellness screening test must be performed after your coverage effective date.

Critical Illness Q&A

Q. Can I receive benefits for more than one of these critical illnesses?

A. Yes, you can receive benefits for any covered critical illness shown but there must be at least 6 consecutive months between the diagnosis dates. You can only claim benefits once for each critical illness unless a recurrence benefit is payable.

Q. When will my coverage become effective?

A. Your coverage starts on the entry date specified in the group policy, provided you are at active work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties. If a family member is in a hospital on the day insurance would otherwise take effect, then insurance will take effect on the day after the family member leaves the hospital.

Q. Can I take my insurance with me if I leave my employer?

A. Yes. **Portability** allows you to continue this group critical illness coverage until age 70 after terminating current employment.

How much does Critical Illness Cost?

Your cost depends on:

- How much coverage you select
- Your age as of the effective date. Because issue age rating applies, your premiums will not increase due to age changes.
- Whether or not you or your spouse use tobacco

You may elect coverage for yourself in units of $5,000 up to $50,000. **Your benefit is subject to a 50% reduction, rounded to the next higher $1,000, when you turn age 70.**

Employee Critical Illness Insurance Bi-Weekly Premiums

Non-Tobacco User						
Issue Age / Benefit	<30	30-39	40-49	50-59	60-69	70+
$5,000	$2.41	$3.29	$5.37	$8.69	$13.14	$27.91
$10,000	$4.14	$5.90	$10.05	$16.70	$25.61	$55.14
$15,000	$5.88	$8.51	$14.74	$24.71	$38.07	$82.38
$20,000	$7.61	$11.11	$19.42	$32.71	$50.53	$109.61
$25,000	$9.34	$13.72	$24.11	$40.72	$62.99	$136.84
$30,000	$11.07	$16.33	$28.79	$48.73	$75.45	$164.07
$35,000	$12.80	$18.94	$33.48	$56.74	$87.91	$191.30
$40,000	$14.53	$21.54	$38.16	$64.74	$100.38	$218.53
$45,000	$16.26	$24.15	$42.84	$72.75	$112.84	$245.76
$50,000	$17.99	$26.76	$47.53	$80.76	$125.30	$272.99

Employee Critical Illness Insurance Bi-Weekly Premiums

Tobacco User						
Issue Age / Benefit	<30	30-39	40-49	50-59	60-69	70+
$5,000	$2.88	$4.44	$8.67	$15.73	$28.24	$48.61
$10,000	$5.07	$8.21	$16.65	$30.78	$55.79	$96.54
$15,000	$7.26	$11.97	$24.64	$45.82	$83.34	$144.48
$20,000	$9.45	$15.73	$32.62	$60.87	$110.90	$192.41
$25,000	$11.64	$19.49	$40.61	$75.91	$138.45	$240.34
$30,000	$13.84	$23.25	$48.59	$90.96	$166.01	$288.27
$35,000	$16.03	$27.01	$56.58	$106.01	$193.56	$336.20
$40,000	$18.22	$30.78	$64.56	$121.05	$221.11	$384.13
$45,000	$20.41	$34.54	$72.54	$136.10	$248.67	$432.06
$50,000	$22.61	$38.30	$80.53	$151.14	$276.22	$479.99

Can I buy coverage for my family?

If you cover yourself, you can also purchase Critical Illness insurance for your eligible family members.

Eligible family members include your spouse and children from live birth to less than age 26. See your certificate or group insurance policy for additional eligibility details.

You can buy spouse coverage in units of $2,500 up to the lesser of 50% of your own coverage amount or $25,000.

Spouse Critical Illness Insurance Bi-Weekly Premiums

Non-Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$2,500	$1.55	$1.99	$3.03	$4.69	$6.91	$14.30
$5,000	$2.41	$3.29	$5.37	$8.69	$13.14	$27.91
$7,500	$3.28	$4.59	$7.71	$12.69	$19.38	$41.53
$10,000	$4.14	$5.90	$10.05	$16.70	$25.61	$55.14
$12,500	$5.01	$7.20	$12.39	$20.70	$31.84	$68.76
$15,000	$5.88	$8.51	$14.74	$24.71	$38.07	$82.38
$17,500	$6.74	$9.81	$17.08	$28.71	$44.30	$95.99
$20,000	$7.61	$11.11	$19.42	$32.71	$50.53	$109.61
$22,500	$8.47	$12.42	$21.76	$36.72	$56.76	$123.22
$25,000	$9.34	$13.72	$24.11	$40.72	$62.99	$136.84

Your spouse's premiums are based on **your** age and your **spouse's** tobacco use.

Spouse Critical Illness Insurance Bi-Weekly Premiums

Tobacco User

Benefit / Issue Age	<30	30-39	40-49	50-59	60-69	70+
$2,500	$1.78	$2.56	$4.68	$8.21	$14.46	$24.65
$5,000	$2.88	$4.44	$8.67	$15.73	$28.24	$48.61
$7,500	$3.97	$6.33	$12.66	$23.25	$42.01	$72.58
$10,000	$5.07	$8.21	$16.65	$30.78	$55.79	$96.54
$12,500	$6.16	$10.09	$20.64	$38.30	$69.57	$120.51
$15,000	$7.26	$11.97	$24.64	$45.82	$83.34	$144.48
$17,500	$8.36	$13.85	$28.63	$53.34	$97.12	$168.44
$20,000	$9.45	$15.73	$32.62	$60.87	$110.90	$192.41
$22,500	$10.55	$17.61	$36.61	$68.39	$124.68	$216.37
$25,000	$11.64	$19.49	$40.61	$75.91	$138.45	$240.34

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Can I buy coverage for my family? (continued)

You can buy coverage for your children too in units of $2,500 up to $5,000. A 50% limit also applies to child coverage.

Critical Illness insurance for your children also covers these childhood illnesses:

Covered Illness or Procedure	Percent of Elected Benefit Payable
• Cerebral palsy, cleft lip/palate, cystic fibrosis, Down syndrome muscular dystrophy, spina bifida, Type I diabetes	100%

Child Critical Illness Insurance Bi-Weekly Premiums		
Benefit	$2,500	$0.32
	$5,000	$0.65

For Critical Illness insurance for your children, choose the benefit you want for the corresponding premium. One premium covers all of your dependent children.

Critical Illness Definitions - *Core Covered Conditions*

Heart attack means that while insured under the policy, a covered person has been diagnosed with coronary artery disease that results in a current and new acute myocardial infarction due to blockage of one or more coronary arteries causing death of a portion of the heart muscle with loss of heart function. Diagnosis of the new myocardial infarction must be based on new changes consistent with an evolving infarction on electrocardiogram (EKG) and concurrent with serial measurement of cardiac biomarkers of a pattern and level of enzymes confirming an acute infarction. Old, established or silent myocardial infarctions are excluded.

Stroke means that while insured under the policy, a covered person has been diagnosed with *cerebral vascular disease* resulting in a brain tissue infarction. The basis of the diagnosis must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage. For the purposes of this policy, stroke does not include: Transient Ischemic Attacks (TIAs); Transient Global Amnesia (TGA); or external trauma causing injury to the brain.

Cerebral vascular disease means subarachnoid hemorrhage, intracerebral hemorrhage, brain embolism, brain thrombosis, occlusion and stenosis of precerebral arteries or occlusion of cerebral arteries.

End-stage kidney disease means that while insured under the policy, a covered person has been diagnosed with a renal disease that has resulted in either: the chronic and irreversible failure of both kidneys to function and which requires regular dialysis for a minimum of 90 days; or the need for a kidney transplant. In the event a kidney is transplanted at the same time as other organs, only one benefit is payable.

Major organ failure means that while insured under the policy, a covered person is diagnosed with any end-stage disease as specified by the most current edition of the International Classification of Diseases (ICD) of the heart, liver, lung, small intestine, pancreas or bone marrow that has resulted in the chronic and irreversible failure of the organ to function and which requires the need for a transplant. In order for major organ failure resulting from an end-stage disease to be covered under this policy, the covered person must be registered with the United Network of Organ Sharing (UNOS) or be registered for matching a donor on the National Marrow Donor Program (NMDP). If multiple organs are to be replaced at the same time only one benefit is payable.

Occupational infectious disease means that a covered person is initially diagnosed while insured under the policy with Human Immunodeficiency Virus (HIV) infection or Hepatitis B, C and/or D resulting from accidental exposure to HIV or Hepatitis B, C and/or D by contaminated body fluids during the course of performing a covered person's regular occupation for which remuneration is earned. To prove occupational exposure, all of the following must be submitted: Documentation showing that within five days of the accidental exposure, the exposure was reported and recorded by the appropriate person according to legislation, regulations or standard guidelines that apply to the occupation; A negative antibody for HIV or Hepatitis B, C and/or D test, performed by a state certified and licensed laboratory within five days of exposure; and A positive antibody for HIV or Hepatitis B, C and/or D test, taken in the 90 to 180 days following the exposure. Occupational infectious disease does not include HIV or Hepatitis B, C and/or D that occurs as a result of IV drug use, sexual transmission or is determined not to be accidental. In order for a benefit to be paid, the initial diagnosis of occupational infectious disease must occur while insured under the policy.

Coronary bypass surgery means that while insured under the policy, a covered person has been diagnosed with *coronary artery disease* requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

Coronary artery disease means acute coronary occlusion, coronary atherosclerosis, aneurysm and dissection of the coronary arteries or coronary atherosclerosis due to plaque. *Coronary bypass surgery* means that while insured under the policy, a covered person has been diagnosed with coronary artery disease requiring a procedure to bypass one or more diseased, narrowed or blocked coronary arteries with arterial or venous grafts and is performed by a board certified cardiovascular surgeon. Other procedures such as percutaneous transluminal coronary angioplasty (PTCA) or laser procedures are excluded.

Angioplasty means that while insured under the policy, a covered person has been diagnosed with *coronary artery disease* requiring a procedure to correct the narrowing or blockage of one or more coronary arteries by balloon. Angioplasty does not include a laser based intra-arterial procedure.

State variations can exist; please contact Assurant Employee Benefits for additional information.

401K PLAN

401k Enrollment Guidelines	
Participation	Once you fulfilled the 90 day eligible requirement you will be automatically enrolled in the M&M Cartage 401k Plan and your contribution percentage will be set at 2%.
OPT OUT Period	If you DO NOT want to participate in the 401k plan, you have 30 days to OPT OUT from your date of hire. You will need to complete a Retirement Plan Decline Enrollment Form that can be found in the driver's room in dispatch or on the M&M Cartage Website www.mmcartage.com. At the completion of the 30 day OPT OUT period payroll will set your Contribution Percentage at 2% on the next payroll.
Contribution Match	M&M will match your contribution at 50% up to 6%. The 2% you're automatically enrolled in will be invested into a retirement age based fund. If you would like to increase your contribution, please create an account at http://myaccount.ascensus.com/rplink or contact Ascensus by phone at 1-866-809-8146.
Plan Investment Advisors for Q&A	The Plan Investment Advisors (Brett and his team) also come to the M&M Cartage Driver's Room quarterly to meet individually with any participant in the plan or any employee considering contributing to the M&M Cartage 401k plan.

We encourage you to establish a user name and password and to call Brett Mahle at 502-394-4006 to review your investment options.

SUMMARY ANNUAL REPORT
FOR M AND M CARTAGE CO., INC. EMPLOYEE BENEFIT PLAN

This is a summary of the annual report for the M AND M CARTAGE CO., INC. EMPLOYEE BENEFIT PLAN, EIN 61-0865101, Plan 501, for period January 1, 2017 through December 31, 2017. The annual report has been filed with the Employee Benefits Security Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Insurance Information

The plan has contracts with UNION SECURITY INSURANCE COMPANY and DELTA DENTAL OF KENTUCKY to pay all claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2017 were $539,273.

Because some of these contracts are so-called experience-rated contracts, the premium costs are affected by, among other things, the number and size of claims. Of the total insurance premiums paid for the plan year ending December 31, 2017, the premiums paid under such experience-rated contracts were $117,784, and the total of all benefit claims paid under these experience-rated contracts during the plan year was $76,084.

Your Rights to Additional Information

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

- Financial information and information on payments to service providers
- Insurance information, including sales commissions paid by insurance carriers

To obtain a copy of the full annual report, or any part thereof, write or call the office of M AND M CARTAGE CO., INC., 4106 EASTMOOR ROAD, LOUISVILLE, KY, 40218, 502-456-4586. The charge to cover copying costs will be $2.00 for the full annual report or $0.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan, 4106 EASTMOOR ROAD, LOUISVILLE, KY, 40218 and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

Full time employees are also eligible for the following benefits:

Holiday Pay:

M&M Cartage Co., Inc. observes eight paid holidays each calendar year: New Years Day, Good Friday, Memorial Day, July 4th, Labor Day, Thanksgiving Day, Christmas Eve and Christmas Day.

Vacation Time:

M&M Cartage Co., Inc. believes that vacation is an important employee benefit, which provides a person time away from work so that he/she can pursue personal interest and, in general, relax and enjoy his/her family. Every effort will be made to accommodate employees with respect to their vacation while ensuring an efficient operation is maintained.

Full time employees will be eligible for paid vacation in accordance with the following:

- Less than 1 year, none
- 1 year, 5 paid days
- 3 years or more, 10 paid days
- 10 years or more, 15 paid days

Personal Days:

- 1 day after 2 years of service
- 2 days after 3 years of service
- 3 days after 4 years of service

Bereavement days:

All employees bereaved by the death of an immediate family member may be granted time off up to a maximum of three consecutive days. Normally, the three days will be the day before, day of and day after the funeral.

Immediate family members include: Spouse, children, parents, parents-in-law, brothers, sisters, grandparents, grandchildren, or any person who legally acted in one of the mentioned capacities, or another relative who lived at the employee’s residence.

all of the above needs to be approved by management and is subject to change

Driver Incentives

Clean Inspection Bonus

Level I – Full Inspection $50

Level II – Driver/Walk around $50

Level III – Driver Only $25

Driver Referral Bonus

$250.00 Paid after referred employee works 90 days

Performance Bonus

Paid out monthly and based on the days worked in the previous month. Conditions that apply:

- No call-ins during the previous month
- No accidents in the previous month
- Must complete monthly safety videos by the end of the previous month

Years of Service Bonus

$100.00 / yr. for every year of service to the company

NOTICE REGARDING WELLNESS PROGRAM
M&M Cartage is offering a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a biometric screening, which will include height, weight, body mass index, blood pressure, blood cholesterol and blood glucose. You will also be required to complete online educational videos for points. You are not required to participate.

However, employees who choose to participate in the wellness program will receive an incentive of lower bi-weekly premiums based on a 4 tier point system for the plan year of 2018. Although you are not required to complete the biometric screening, only employees who do so will receive the incentive.

The information of the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the wellness program. You also are encouraged to share your results or concerns with your own doctor.

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

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

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

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

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact your HR Manager, Stacey Murphy.

EXCHANGE NOTICE

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 5-31-2020)

PART A: General Information

When key parts of the health care law take effect in 2014, there will be a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

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. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins October 2018 for coverage starting as early as January 1, 2019.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax 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 meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution -as well as your employee contribution to employer-offered coverage is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact: **Denise Hayden or Stacey Murphy**

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, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored 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.

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.

3. Employer Name		4. Employer Identification Number (EIN)
M&M Cartage		61-0865101
5. Employer Address		**6. Employer Phone Number**
6220 Geil Lane		502-456-4526
7. City	**8. State**	**9. Zip Code**
Louisville	KY	40219
10. Who can we contact about employee health coverage at this job?		
Denise Hayden or Stacey Murphy		
11. Phone Number (if different from above)	**12. Email Address**	
502-555-2222	Denise.hayden@mmcartage.com or Stacey.murphy@mmcartage.com	

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

- As your employer, we offer a health plan to:
  - ☐ All employees. Eligible employees are:
  - ☑ Some employees. Eligible employees are: Any employee who works 30 hours or more per week
- With respect to dependents:
  - ☑ We do offer coverage. Eligible dependents are: Spouse and dependent children
  - ☐ We do not offer coverage.

☑ 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.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM

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 January 31, 2018. Contact your State for more information on eligibility.

KENTUCKY – Medicaid	**INDIANA** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
MICHIGAN – Medicaid	
Website: http://www.michigan.gov/ mdhhs/0,5885,7-339-71547_4860---,00.html Phone: 1-855-275-6424	

To see if any other states have added a premium assistance program since January 31, 2018, 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

OMB Control Number 1210-0137 (expires 12/31/2019)

Women's Health and Cancer Rights Act

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:

1. All stages of reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. 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.

Women's Preventive Care

The Affordable Care Act requires insurance companies to cover additional preventive health benefits for women. Health plans must cover the guidelines on women's preventive services with no cost sharing in plan years starting on or after August 1, 2012. The eight additional services for women that will be covered are:

- Annual Well-Woman Preventive Care Visit
- Gestational Diabetes Screening
- High-Risk Human Papillomavirus DNA Testing
- Sexually Transmitted Infections Counseling
- HIV Screening and Counseling
- Contraception and Contraceptive Counseling
- Breastfeeding Support, Supplies and Counseling
- Interpersonal and Domestic Violence Screening and Counseling

The Newborns' and Mothers' Health Protection Act of 1996

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 hour 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).

Your Rights Under the Uniformed Services Employment and Reemployment Ace (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents for up to 24 months while in the military.
Even if you don't elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions (e.g., pre-existing condition exclusions) except for service-connected illnesses or injuries.

Continuation of Coverage

Your individual coverage terminates when your employment terminates, when you are no longer eligible, when the group policy(ies) terminates, or when you fail to make the required contribution, if any, except to the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") (see, e.g., Code §4980B). If medical or dental coverage for an employee or his or her eligible family members ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death or a child's ceasing to meet the definition of dependent), then the employee and his or her eligible family members may have the right to purchase continuation coverage for a temporary period of time.

A copy of the COBRA Continuation Notice is available to you upon request and at no cost through the office of the Plan Administrator. If you or your dependents' insured benefits end because you cease active work due to injury, sickness, layoff or leave of absence; or you or your dependents cease to be eligible for some other reason, a notice outlining your rights to continue insured coverage through COBRA will be mailed to you. Continuation and reinstatement rights may also be available if an employee is absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Re-employment Rights Act of 1994.

Qualified Medical Support Order (QMCSO)

Federal law requires that medical coverage be provided to an Alternate Recipient in accordance with the requirements of a QMCSO. You are responsible for making sure that any medical child support order relating to your child meets the requirements of a QMCSO. The written requirements and procedures governing QMCSOs may be obtained from the Plan Administrator upon request at no charge.

The Health Insurance Portability and Accountability Act of 1996 HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was signed into law on August 21, 1996. The focus of this law was to facilitate the portability of health coverage when employees move from one job to another. HIPAA addresses portability, access and renewability of health coverage and affects all group health plan sponsors. The Act also addresses significant benefit areas including long term care, medical savings accounts and COBRA. The following information focuses on the portability, access and renewability provisions of HIPAA.

A major feature of HIPAA is that it limits the length of pre-existing condition exclusions for coverage to 12 months after enrollment (or 18 months for a late enrollee) for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the 6 month period ending on the enrollment date in any new health plan. If an individual had a medical condition in the past, but has not received any medical advice, diagnosis, care or treatment within 6 months prior to enrolling in the plan, the old condition is not a "pre-existing condition" for which an exclusion can be applied.

Pre-existing condition exclusions cannot be applied to pregnancy, regardless of whether the individual had previous coverage. In addition, a pre-existing condition exclusion cannot be applied to a newborn or adopted child under age 18 as long as the child became 21 covered under the health plan within 30 days of birth or adoption, provided the individual does not incur a subsequent 63 day or longer break in coverage. To prove creditable coverage to offset the exclusion period, each participant is entitled to receive a certificate indicating the period of creditable coverage. Coverage under a health plan that occurs before a 63 consecutive day break in coverage is not counted, unless the state insurance laws require otherwise.

The certification of creditable coverage must be in writing and must specify the period of creditable coverage under the group health plan, including periods of COBRA continuation coverage. Group health plans must provide the written certification: 1) at the time a participant's coverage under the plan ends; 2) at the time COBRA continuation coverage ends; and 3) upon request of the individual within two years after coverage ceases.

Important Notice from M&M Cartage About Your Creditable 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 M&M Cartage 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. **M&M Cartage has determined that the prescription drug coverage offered by the PPO and HSA Plans 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 15 to December 7.

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, your current coverage will (or will not) be affected. See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance (available at http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current coverage, be aware that you and your dependents will (or will not) (Medigap issuers must insert "will not") be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with M&M Cartage and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Contact the Entity/Sender listed below for further information or call Denise Hayden or Stacey Murphy at (502) 456-4586. **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 M&M Cartage 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: 01/01/2019
Name of Entity/Sender: M&M Cartage

NOTES

Offices in:

Louisville, KY | Lexington, KY | New Albany, IN | Indianapolis, IN |
Evansville, IN | Cincinnati, OH | Cleveland, OH | Atlanta, GA

(502) 805-3742
www.epicinsurancesolutions.com