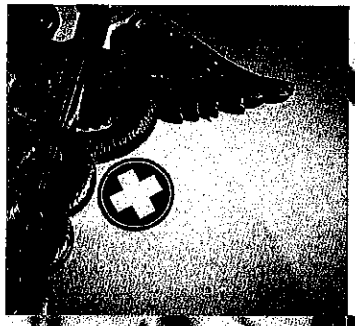
# EMPLOYEE BENEFITS GUIDE

***January 1, 2020 - December 31, 2020***

*A guide to enrolling in your employee benefit programs.*

# M&M Cartage

Family-owned since 1972



MEDICAL

DENTAL

BASIC & VOLUNTARY LIFE AND AD&D

VOLUNTARY SHORT & LONG TERM DISABILITY

VOLUNTARY ACCIDENT / CRITICAL ILLNESS

Fifth Third Insurance

HELPING YOU LOVE INSURANCE

# CONTACTS & ELIGIBILITY

## *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 #918460
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

**FIFTH THIRD INSURANCE**
1-502-805-3742

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 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.

Employees covering dependents for medical, dental and/or vision will be required to provide documentation to certify that the dependent(s) meets the plan eligibility definition. A dependent defined as an eligible spouse or child under age 26.

**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.*

## Important Information Regarding Health Insurance and Premiums:

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/status system. If you complete a biometric screening and health assessment, you will receive points based on where you fall on the range for BMI, tobacco usage, cholesterol, glucose, etc. In addition to the biometric screening and health assessment, you will have other opportunities throughout the year to earn points.

The information from your health 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 assessment. The biometric screenings are handled by an onsite nurse practitioner from Sentry Health. The Nurse Practitioner will send your results to a wellness coordinator at our insurance broker at 5/3. The only information we receive is what tier you should be in.

Here is a list of what will be measured during the biometric screening:

- BMI
- Tobacco Usage
- Cholesterol Panel (HDL, LDL, Triglycerides)
- Fasting Glucose
- Blood Pressure

Please call Sentry Health at 1-866-584-4163 ASAP to schedule your appointment for your biometric screening. If you are an offsite employee, they will send you to a LabCorp location near you.

The health assessment will need to be completed on Go365 (see attached flyers for more information on how to access this)

**See next page for premium information**

# HEALTH SAVINGS ACCOUNT (HSA)

Employees electing the Health Savings Account (HSA) can contribute up to **$3,550 single or $7,100 family for 2020**. 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 Benefit Wallet. 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:**

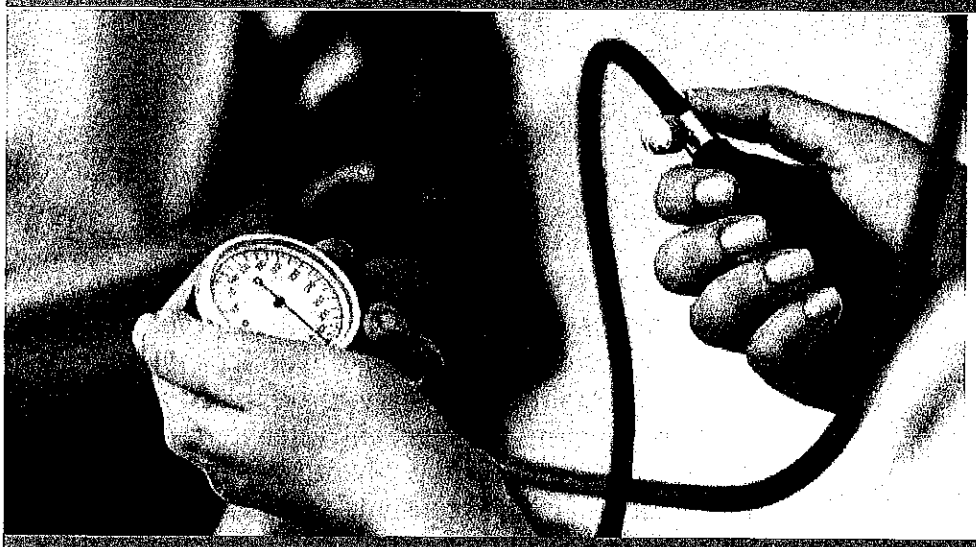
- When picking up your medication, provide them with your UMR insurance card.
- The pharmacy will run it through their system and provide you with a balance due.
- You then use your bank card/HSA check to pay for these expenses at that time.

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.

# SentryHealth

*Solutions. Action. Results.*

## DIABETES, HIGH BLOOD PRESSURE, & HIGH CHOLESTEROL PROGRAMS



TAKE CONTROL OF YOUR HEALTH

-

***1:1 CONFIDENTIAL APPOINTMENTS***

-

***NO COST APPOINTMENTS***

-

***CONVENIENT***

-

***PERSONALIZED CARE & GOAL SETTING***

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

**Appointments are offered onsite at M&M's Geil Lane location.**
**Telephonic appointments are available upon request.**

- *Wednesdays from 9:00am - 5:00pm*
- *Every 3rd Wednesday from 12:00pm - 8:00pm*

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

Schedule by calling 866.584.4163 or online at
bit.ly/MMCartageCCM

TrueScripts Management Services

*Experts in Prescription Benefits*

# Member Services

*Connecting Members to Resources*

Our highly trained Member Care team is here to assist with questions regarding your pharmacy coverage. We can be reached toll free at (844) 257-1955 during business hours, Monday-Friday, 8am-6pm Eastern.

**Please call us for assistance with topics such as:**

- **Drug Cost Inquiries** - the cost of medications can vary from pharmacy to pharmacy so we are here to provide this information to you to make you a better consumer. Please have the medication name, strength & dosage when you call. We will also ask what pharmacies you would like to consider.
- **Plan Design Questions** - not sure what your copay is or what medications are covered? Trying to decide between available plan options? Give us a call so we can help.
- **Therapeutic Alternatives** - if you are prescribed a high cost brand name medication and want to know if there are generic options, we can help!
- **Copay Assistance** - sometimes brand medications are the only option. Our Member Care team can assist in finding coupons or copay cards to help offset that brand copay.

*Creating Meaningful Health Solutions in Innovative Ways*

TrueScripts Management Services • Washington, IN 47501 • (844) 257-1955 • www.truescripts.com

# 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:

UMR
A UnitedHealthcare Company

| TYPE OF CARE | WAIT TIME | COST** |
|---|---|---|
|  **Teladoc℠ - 800-835-2362 or Teladoc.com**<br>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.<br>**When to go***<br>• Cold or flu<br>• Bronchitis<br>• Respiratory infection<br>• Sinus problems<br>• Allergies<br>• Urinary tract infection<br>• Pediatric care<br>• Poison ivy or pink eye | **17 minutes**<br>Approximate wait time for doctor to respond | **QHDHP/HSA Plan**<br>**$45 per consultation**<br>**PPO Plan**<br>**$0 per consultation** |
|  **Retail clinic/convenient care clinic**<br>Retail clinics, sometimes called convenient care clinics, are located in retail stores, supermarkets and pharmacies.<br>**When to go***<br>• Colds or flu<br>• Sinus infections<br>• Allergies<br>• Vaccinations or screenings<br>• Minor sprains, burns or rashes<br>• Headaches or sore throats | **15 minutes**<br>or less, on average | **All Plans**<br>**50-$100 average cost per visit** |
|  **Urgent care/walk-in clinic**<br>Urgent care centers, sometimes called walk-in clinics, are often open in the evenings and on weekends.<br>**When to go***<br>• Sprains and strains<br>• Mild asthma attacks<br>• Sore throats<br>• Minor broken bones or cuts<br>• Minor infections or rashes<br>• Earaches | **20-30 minutes**<br>Approximate wait time | **All Plans**<br>**$150-$200 Average cost per visit** |
|  **Clinical care (your doctor's office)**<br>Seeing your doctor is important. Your doctor knows your medical history and any ongoing health conditions.<br>**When to go***<br>• Preventive services and vaccinations<br>• Medical problems or symptoms that are not an immediate, serious threat to your health or life | **1 week or more**<br>Approximate wait time for an appointment | **HDHP/HSA Plan**<br>**$100-$150 Average cost per visit**<br>**PPO Plan**<br>**$30 Copay** |
|  **Emergency room (ER)**<br>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.<br>**When to go***<br>• Sudden change in vision<br>• Sudden weakness or trouble talking<br>• Large, open wounds<br>• Difficulty breathing<br>• Severe head injury<br>• Heavy bleeding<br>• Spinal injuries<br>• Chest pain<br>• Major burns<br>• Major broken bones | **3 to 12 hours**<br>Approximate wait time for non-critical cases | **All plans**<br>**$1,200-$1,500 Average cost per visit** |

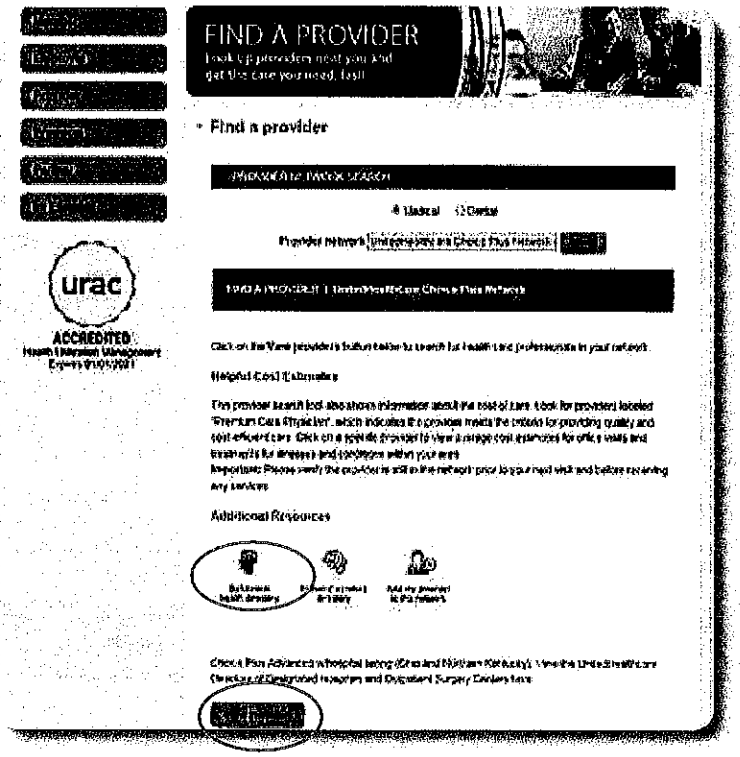
*This is a sample list of services and is not intended to be all*

** 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.*

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

# VSP® Vision Savings Pass™

VSP Vision Care | DELTA DENTAL®

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]

| Service | Reduced prices and savings |
|---|---|
| Wellvision Exam® | • $50 with purchase of a complete pair of prescription glasses.<br>• 20% off without purchase.<br>• 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:<br>• Single vision $40 • Lined trifocals $75<br>• 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. |

## 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]

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.



JOB#2823-16-VCCM 2/16

# 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 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.*

ONEAMERICA®

## 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.*

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

Call: **855.387.9727**
Go online: **guidanceresources.com**

TDD: 800.697.0353
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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## Free Online Will Preparation

*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.*

ONEAMERICA®

*OneAmerica is the marketing name for American United Life Insurance Company(R) (AUL). AUL markets ComPsych services. ComPsych Corporation is not an affiliate of AUL and is not a OneAmerica company.*





**Your ComPsych® GuidanceResources® Program**

CALL ANYTIME
Call: **855.387.9727**
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Online: **guidanceresources.com**
Your company Web ID: **ONEAMERICA3**

**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

## 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* | Treatment | Benefit* |
|---|---|---|---|
| Broken Finger (no surgery) | $175 | Broken Leg (no surgery) | $800 |
| Emergency Treatment | $150 | Emergency Treatment | $150 |
| Follow-up Visit (2) | $50 | Ambulance | $200 |
| **Total Payment** | **$375** | 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.

| 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<br>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**<br>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<br>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<br>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 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.

## 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 | <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**

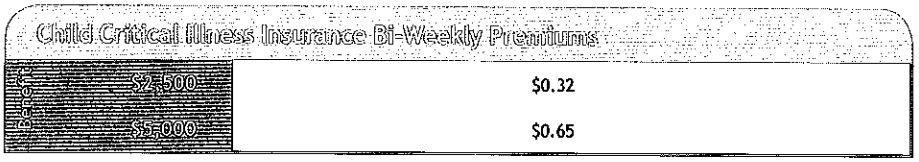
| Issue Age | <30 | 30-39 | 40-49 | 50-59 | 60-69 | 70+ |
|---|---|---|---|---|---|---|
| $5,000 | $2.88 | $4.44 | $8.67 | $15.73 | $28.24 | $48.61 |
| $10,000 | $5.07 | $8.21 | $16.65 | $30.78 | $55.79 | $96.54 |
| $15,000 | $7.26 | $11.97 | $24.64 | $45.82 | $83.34 | $144.48 |
| $20,000 | $9.45 | $15.73 | $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? (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% |




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.**

# 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, 2018 through December 31, 2018. 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, DELTA DENTAL OF KENTUCKY and TOKIO MARINE to pay all claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2018 were $935,381.

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, 2018, the premiums paid under such experience-rated contracts were $99,722, and the total of all benefit claims paid under these experience-rated contracts during the plan year was $80,446.

## 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.

# Driver Incentives

**Clean Inspection Bonus**

Level I – Full Inspection $50

Level II – Driver/Walk around $50

Level III – Driver Only $25

**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

**Referral Bonus Program**

Recruit a qualified M&M driver and earn up to **$2000**! We are looking for new drivers that meet the following qualifications:

- Positive Attitude
- Time Oriented
- Team Player
- Strong Work Ethic
- Attention to Detail
- Safety Oriented

Payment structure of referral bonus:

You will receive a **$2000** bonus to be paid out $500 per quarter over one year, beginning after the new hire's first 90 days of employment. The new hire must remain employed for the entire span of the program for you to receive your full bonus.

| | |
|---|---|
| **FIRST PAY PERIOD AFTER 90 DAYS** | **$500** |
| **FIRST PAY PERIOD AFTER 180 DAYS** | **$500** |
| **FIRST PAY PERIOD AFTER 270 DAYS** | **$500** |
| **FIRST PAY PERIOD AFTER 360 DAYS** | **$500** |

# 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

Beginning in 2014, there is 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.

**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. The open enrollment period each year for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the preceding year. After the open enrollment period ends, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

**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 (adjusted to 9.86% for 2019), 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, including 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.

# FEDERAL REQUIREMENT NOTICES

## 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.