Employee Benefits Guide
WELCOME TO YOUR DICK LAVY TRUCKING BENEFITS!

As an Employee of Dick Lavy Trucking you have the opportunity to enroll in valuable benefits to protect the health and financial security of you and your family. Within this guide you will find the highlights of each of the benefits including medical insurance, dental insurance, life insurance, disability insurance, and more! All of these benefits (if elected) will be paid for through convenient payroll deductions as long as you are a benefit-eligible employee of Dick Lavy.

Right now is your chance to elect the coverage you want for yourself and your family in 2022. We encourage you to read through this guide, share it with your family members, and ask us any questions that you may have so that you are educated and empowered to choose the benefits that are best for you.

IF YOU ARE A NEW EMPLOYEE: 
Your benefits will begin the 1st of the month following date of hire. Your medical and life elections will take effect on the first day of the month following date of hire. All other benefits you elect will take effect the first of the month following 90 days of active employment. If you don’t take action now, you will not have the opportunity to enroll again until the next open enrollment period in late 2022, unless you experience a qualifying life event like a birth, adoption, marriage, or divorce before that time.

IF YOU ARE A CURRENT EMPLOYEE: 
Open Enrollment happens in December of each year. This is your chance to add or drop benefits, change your elections, and add or drop dependents. If you do not take action now, you won’t have another chance until the next open enrollment period or if you experience a qualifying life event like a birth, adoption, marriage, or divorce.

If you are a new employee - Welcome to Dick Lavy Trucking! If you are a current employee, thank you again for your service to the company and we look forward to an outstanding 2022!

Sincerely,
Dick Lavy, Owner
The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from your HR Department.
ELIGIBILITY, ENROLLMENT & CHANGES

Eligibility
All full-time employees actively at work and working more than 30 hours per week on a regular basis are eligible for medical benefits. Some non-medical benefits have different eligibility requirements.

Elected coverage for medical and life insurances for each eligible employee and their eligible dependents (see definitions below) will become effective on the first day of the month following date of hire.

All other voluntary benefits (if elected) will become effective on the first day of the month following 90 days of active employment.

Your Eligible Dependents
• Your legally married spouse or domestic partner. A spouse or domestic partner may only be covered under Dick Lavy plan if he or she is not offered qualified coverage elsewhere.
• Dependent children under the age of 26 (natural, adopted, stepchildren, grandchildren that you are the sole “parent” of).
• Children who meet the requirements of the Coverage Pursuant to a Qualified Medical Child Support Order
• Your unmarried children of any age who are mentally or physically handicapped and unable to support themselves

Pretax Elections
Some Employee premiums will be deducted on a pre-tax basis through payroll deduction unless requested by the employee. Due to IRS rules, contributions cannot be revoked or changed during the plan year, unless you experience a qualifying “Status Change” as described to the right.

Benefit election changes during the year may be made for the following reasons:
• Changes in the Employee’s legal marital status such as marriage, divorce, separation, or the death of a spouse.
• A change in the number of dependents such as birth, death, or adoption.
• Changes in employment status of the employee or of the employee’s spouse or dependents. This includes the beginning or ending of employment, new or different work hours, change from
• Full-time to part-time status or vice versa, the beginning or end of an unpaid leave of absence.
• A dependent becomes eligible or ceases to be eligible for coverage due to age.
• Employee, spouse or dependent becoming, or ceasing to be, eligible for Medicare or Medicaid.
• A judgment, decree, or order that results from a divorce or legal separation.

An election change must be made within 30 days of the qualifying event.
BENEFIT CONTACT INFORMATION

<table>
<thead>
<tr>
<th>COVERAGE</th>
<th>CARRIER</th>
<th>PHONE NUMBER</th>
<th>WEBSITE/EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance</td>
<td>GPA</td>
<td>800-716-2852</td>
<td><a href="mailto:gpacustomerservice@gpatpa.com">gpacustomerservice@gpatpa.com</a></td>
</tr>
<tr>
<td>Physician Network</td>
<td>PHCS</td>
<td></td>
<td>Visit <a href="http://www.multiplan.com">www.multiplan.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Click on “PHCS Network” and then click “go”.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Click on “doctor” and click “continue”</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>IMPORTANT:</strong> Do not click on “facility”. You may see your in-network doctor at any facility.</td>
</tr>
<tr>
<td>24/7 Nurse Line</td>
<td>Nurse Navigator</td>
<td>800-716-2852</td>
<td><a href="mailto:nursenavigator@gpatpa.com">nursenavigator@gpatpa.com</a></td>
</tr>
<tr>
<td>Prescription Drugs</td>
<td>CVS/Caremark</td>
<td>800-334-8134</td>
<td><a href="mailto:RxHelp@rxbenefits.com">RxHelp@rxbenefits.com</a></td>
</tr>
<tr>
<td></td>
<td>powered by RxBenefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre-Certification</td>
<td>Health Watch</td>
<td>972-238-7900 or 1-800-827-7223</td>
<td></td>
</tr>
<tr>
<td>Telemedicine</td>
<td>United Concierge Medicine</td>
<td>844-484-7362</td>
<td><a href="mailto:customersupport@ucmnow.com">customersupport@ucmnow.com</a></td>
</tr>
<tr>
<td>Life and AD&amp;D</td>
<td></td>
<td></td>
<td>Contact Dick Lavy Benefits Department</td>
</tr>
<tr>
<td>Vision Insurance</td>
<td>SunLife</td>
<td>800-432-1102</td>
<td><a href="http://www.sunlife.com/us">www.sunlife.com/us</a></td>
</tr>
<tr>
<td>Dental insurance</td>
<td>SunLife</td>
<td>800-432-1102</td>
<td><a href="http://www.sunlife.com/us">www.sunlife.com/us</a></td>
</tr>
<tr>
<td>Disability Insurance</td>
<td>SunLife</td>
<td></td>
<td>Contact Dick Lavy Benefits Department</td>
</tr>
<tr>
<td>Critical Illness &amp; Cancer</td>
<td>SunLife</td>
<td></td>
<td>Contact Dick Lavy Benefits Department</td>
</tr>
<tr>
<td>ELAP Services</td>
<td></td>
<td>Phone: 1-800-716-2852</td>
<td><a href="mailto:BalanceBill@elapservices.com">BalanceBill@elapservices.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fax: 1-888-560-2447</td>
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</tbody>
</table>

Dick Lavy Trucking Benefits Contact
Krista Wulber
HR & Safety Director
8848 State Route 121 Bradford, OH 45308
937-448-6030

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HOW MY MEDICAL PLAN WORKS

Medical Plans
Dick Lavy Trucking provides you with the choice between 2 medical plans: a traditional plan and a Health Savings Account Qualified plan.

Both plans utilize a “network” for physicians. This means the physicians who are part of the network have agreed to offer services to Dick Lavy employees at discounted prices. For more information on your network and how to locate a doctor or other provider within the network, contact GPA at 800-716-2852.

When it comes to the hospital or facility you visit there is no “network” and you may go to ANY hospital/facility as long as you see a network provider at that location. Your deductible and coinsurance will not change if you seek out-of-network care.

Traditional Plan
The Traditional Plan has a lower deductible and convenient office visit and Rx copays. This plan is ideal for people who are frequent healthcare users and are willing to pay higher premiums in exchange for earlier plan cost-sharing. On the traditional plan, office visit and Rx copays are in place before your deductible is met but other services like hospitalization are subject to your deductible.

HSA Qualified Plan
The HSA Plan has much lower weekly premiums and can be used with the tax-advantaged Health Savings Account, but you pay for the entire cost of your care until meeting the annual deductible. This plan is ideal for people who are not big healthcare users and want to enjoy lower premiums but still be fully covered in the case of large medical needs.

Individual vs. Family Deductibles
On both Dick Lavy health plans, your individual deductible is “embedded” within the family deductible. This is a valuable advantage when you have more than one person on the plan.

For example:
On the traditional plan, if one family member incurs $3,500 of claims they have met their “embedded individual deductible” and the plan will pay coinsurance on their care for the rest of the plan-year. However, the plan will not pay coinsurance on any other family members until the other person, or combination of other people satisfy the entire $7,000 family deductible.

On the HSA Plan, individual and family deductibles work the same way except for the deductible amounts being higher.

Cost-Plus
In order to keep employee premiums under control, our health plan utilizes a method known as “Cost-Plus” to pay medical claims. This will not affect the way you use healthcare and you will still have your deductible, copays, and coinsurance to pay according to the plan you choose (see page 12 for plan details and options).

However - There will be some differences you should be aware of. Please read the below carefully!

Under the 2022 Dick Lavy Health Plan:

- When you visit a physician’s office (primary care or specialist) you will be responsible for your copay or the full cost of the visit up to your deductible - based on the plan you choose. When possible, wait for your Explanation of Benefits to ensure you are paying the correct amount.
- When you visit a hospital, clinic, emergency room, or other facility that is not a doctor’s office, you will receive an Explanation of Benefits (EOB) in the mail which tells you what portion of the medical services are yours to pay. You will never be asked to pay more than your portion based on the plan you have chosen. It is very important that you read this EOB and keep it on-hand for future reference. You may also receive bills from your hospital or facility that say you owe larger amounts but you are truly only responsible for paying what your EOB states is your responsibility. You should always pay what your EOB says but you should never pay any other amount on a bill without verifying that it’s accurate. If you ever receive a “balance bill” or any bill that says you owe more than your EOB says is your responsibility you must call ELAP to allow them to handle the bill for you.
HOW MY MEDICAL PLAN WORKS CONTINUED

Pre-Certification/Utilization Review
The Dick Lavy health plan requires certain services such as scheduled inpatient hospitalization, surgeries, admission to skilled nursing facilities, admission to rehabilitation facilities, inpatient mental health and substance abuse, chemotherapy & radiation, hospice services, and others to be submitted to the Utilization Review (UR) Company.

Failure to obtain pre-certification may result in additional fees and denial of claims. It is vital that you follow the plan’s utilization review requirements by contacting: HealthWatch prior to any scheduled (non-emergency) admissions and procedures OR within 2 business days of emergency admissions and procedures. Contact HealthWatch: 800-716-2852.

Locate a Network Physician
As a member of the Dick Lavy Trucking Health Plan you may use any hospital/facility you choose as long as the provider you visit is In-Network. Locate an In-Network doctor by visiting www.multiplan.com (see page 5 for detailed instructions).

ELAP Services
If you ever receive a balance bill from a medical provider or collection firm, contact ELAP services immediately. Phone: 800-716-2852 or BalanceBill@elapservices.com.

Terms to Know

**GPA:** The administrator of the Dick Lavy Health Plan. You will receive a health insurance ID card from GPA and they will send your EOB to inform you of your financial responsibility after seeking care.

**Physician Network:** The doctors that participate in the plan by accepting negotiated discounts to their fees. These doctors work at nearly every hospital and clinic in the country so you will always be able to find one.

**Co-Pay:** A flat dollar amount that you are required to pay at the time of service for Medical or Rx Drugs. Not all Health Plans use copays.

**Deductible:** Your initial portion of Healthcare costs that you will pay before your plan begins cost-sharing.

**Coinsurance:** The percentage of the cost you will pay after meeting your deductible.

**Out-of-Pocket Maximum:** The maximum amount that you could be responsible for paying in any plan year, including your deductible and coinsurance, before the health plan covers 100% of remaining eligible expenses.

**Explanation of Benefits (EOB):** The first document you will receive in the mail after seeking health care. This document will come from GPA and tell you what portion of the medical care is your responsibility to pay.

**Balance Bill:** A bill you may receive, especially on larger claims, asking you to pay more than your EOB says is your responsibility. DO NOT PAY THIS BILL. If you receive a balance bill, call ELAP as soon as possible to give them authority to handle the bill.

**ELAP:** A firm contracted by Dick Lavy Trucking to protect the health plan and you personally from any excessive billing by hospitals or facilities.
UNDERSTANDING YOUR MEDICAL BILLS

Medical Bills vs. EOBS
For every service you receive under the Dick Lavy Health Plan, you will receive a medical bill and an Explanation of Benefits (EOB).

The medical bill will be from the hospital or clinic that you visited. The EOB will be from our insurance carrier: GPA.

The EOB from GPA will explain how much the insurance was billed for your services and how much of that is your part to pay—according to the plan you are on.

You never have to pay more than your EOB states. Do not pay more than your EOB states.

You may receive bills from hospitals for more than your EOB states, however, you should not pay them. Instead, call ELAP to turn over the bill to them.

This is an example of what an EOB looks like. Note the “total due to provider” is the amount you are responsible for paying. You should not pay any other numbers you see listed on this EOB.

Always use your EOB to pay your medical bills.

Never pay more than stated on this line!

If you receive a MEDICAL BILL stating you owe more than the EOB, call ELAP immediately at: 1-800-716-2852

ELAP is a team of lawyers that will protect you from hospitals and hospital creditors at no cost to you. If you ever get a bill you don’t understand or aren’t sure about, involve ELAP. They’re here to help you!
The GPA Nurse Navigator program includes Registered Nurses and Benefit Advocates who are ready to assist you 24 hours per day, 7 days per week!

The Nurse Navigator Hotline can be used to:
- Identify options for your medical care.
- Explain your benefit information if you have questions.
- Assist with claims questions.
- Provide clinical education regarding your medical conditions and treatment options.

Make sure to use the Nurse Navigator Hotline when:
- You need to see a physician for a symptom you are having, but you do not know who to see.
- You need help locating a physician and scheduling an appointment.
- You have any questions regarding your benefits and how to use them.
- You would like to speak to a licensed healthcare provider regarding a medical concern without visiting a doctor.

The Nurse Navigator Hotline is provided as part of the Dick Lavy Trucking Medical Plan to employees enrolled on the plan— at no charge!
HEALTH SAVINGS ACCOUNT

Available to employees enrolled on the HSA Qualified plan.

Health savings accounts (HSAs) are a great way to save money and budget for qualified medical expenses. HSAs are tax-advantaged savings accounts that accompany a Health Savings Account Qualified Plan, such as a High Deductible Health Plan (HDHP). HDHPs offer lower monthly premiums in exchange for a higher deductible (the amount you pay before insurance kicks in).

What Are the Benefits of an HSA?
There are many benefits of using an HSA, including the following:
• **It saves you money.** HDHPs have lower monthly premiums, meaning less money is being taken out of your paycheck.
• **It is portable.** The money in your HSA is carried over from year to year and is yours to keep, even if you leave the company.
• **It is a tax-saver.** HSA contributions are made with pre-tax dollars. Since your taxable income is decreased by your contributions, you’ll pay less in taxes.

HSA Contribution Limits
The maximum amount that you can contribute to an HSA is $3,650 (individual) or $7,300 (family) in 2022. If you are age 55 or older, you may make an additional “catch-up” contribution of $1,000. You may change your contribution amount at any time throughout the year as long as you don’t exceed the annual maximum.

HSA Case Study
Justin is a healthy 28-year-old single man who contributes $1,000 each year to his HSA. His plan’s annual deductible is $1,500 for individual coverage. Here is a look at the first two years of Justin’s HSA plan, assuming the use of in-network providers. This example only includes HSA contribution amounts and does not reflect any investment earnings.

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSA Balance</td>
<td>$1,000</td>
</tr>
<tr>
<td>Total Expenses: Prescription drugs: $150</td>
<td>(-$150)</td>
</tr>
<tr>
<td>HSA Rollover to Year 2</td>
<td>$850</td>
</tr>
</tbody>
</table>

Since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.

Once again, since Justin did not spend all of his HSA dollars, he did not need to pay any additional amounts out-of-pocket this year.
HSA FREQUENTLY ASKED QUESTIONS

How do I manage my HSA?
The HSA account is your account and the HSA dollars are your dollars. Since you are the account holder or HSA beneficiary, you manage your HSA account. You may choose when to use your HSA dollars or when not to use your HSA dollars. HSA dollars pay for any qualified medical expense. Most commonly, the HSA account holder will pay their out-of-pocket expenses (i.e. deductible and coinsurance) associated with their high deductible health plan with HSA dollars.

What expenses are eligible for reimbursement from my HSA?
HSA dollars may be used for qualified medical expenses incurred by the account holder and his or her spouse and dependents. Qualified medical expenses are expenses for medical care and are outlined within IRS Section 213(d). In summary, the IRS Section 213(d) states that “the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness.” For a complete list of eligible expenses, refer to IRS publication 502 which can be found at www.irs.gov/publications/p502/

In addition to qualified medical expenses, the following insurance premiums may be reimbursed from an HSA account:

• COBRA premiums;
• Health insurance premiums while receiving unemployment benefits;
• Qualified long-term care premiums;
• Any health insurance premiums paid, other than for Medicare supplemental policy, by individuals age 65 and over.

What expenses are NOT eligible for reimbursement from my HSA?

• Premiums for Medicare supplemental policies;
• Expenses covered by another insurance plan; or
• Expenses incurred prior to the date the HSA was established.

What happens when my HSA funds run out?
You may be financially responsible for expenses not covered by your health insurance once you have depleted your HSA funds.

Can I use my HSA dollars for non-eligible expenses?
Money withdrawn from an HSA account to reimburse non-eligible medical expense is taxable income to the account holder and is subject to a 20% tax penalty unless you are over age 65, disabled, or upon death of the account holder.

When can I start using my HSA dollars?
You can use your HSA dollars immediately following your HSA account activation and once contributions have been made. You can only use HSA dollars that have been put into the account, however, you can save your receipts and get reimbursed later in the year for medical expenses you incur earlier in the year.

When and how often can I contribute to my HSA?
You can contribute to your HSA account through payroll deductions. You can contribute as often as you like, provided you do not exceed the annual contribution limits:

• $3,650 for individual coverage or $7,300 for family coverage.
• Individuals that are age 55 or older may contribute an additional $1,000 per year.
MEDICAL PLAN SUMMARY & RATES
GPA

See page 6 for a detailed explanation of the differences between the Traditional Plan and the HSA Plan. You can compare the benefits and weekly premiums of each plan below

For a complete list of your in-network and out-of-network benefits, please refer to your Medical Insurance Summary Plan Description, provided by Human Resources.

<table>
<thead>
<tr>
<th>MEDICAL COVERAGE HIGHLIGHTS</th>
<th>Traditional Plan</th>
<th>HSA Qualified Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,500</td>
<td>$5,000</td>
</tr>
<tr>
<td>Family</td>
<td>$7,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Coinsurance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plans Pays You Pay</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>Out-of-Pocket Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$5,000</td>
<td>$5,000</td>
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<tr>
<td>Family</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
<tr>
<td>Overview of Benefits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered 100%</td>
<td>Covered 100%</td>
</tr>
<tr>
<td></td>
<td>(deductible waived)</td>
<td>(deductible waived)</td>
</tr>
<tr>
<td>Office Visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Physicians Specialist</td>
<td>$45 copay</td>
<td>Covered 100%</td>
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<tr>
<td></td>
<td>$50 copay</td>
<td>after deductible</td>
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<tr>
<td>Emergency Room</td>
<td>$200 copay</td>
<td>Covered 100%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after deductible</td>
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<tr>
<td>Hospitalization</td>
<td>20% coinsurance</td>
<td>Covered 100%</td>
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<tr>
<td></td>
<td>after deductible</td>
<td>after deductible</td>
</tr>
<tr>
<td>Generic/Mail Order</td>
<td>$15 copay</td>
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</tr>
<tr>
<td>Formulary/Mail Order</td>
<td>$25 copay</td>
<td>Covered 100%</td>
</tr>
<tr>
<td>Non Formulary/Mail Order</td>
<td>$50 copay</td>
<td>after deductible</td>
</tr>
<tr>
<td>Specialty</td>
<td>50% ($500 Max)</td>
<td></td>
</tr>
</tbody>
</table>

*Note: There is a separate $6,850 per person deductible for Mercer Community Hospital.
*Note: There is a separate $13,700 per person out-of-pocket for Mercer Community Hospital.

<table>
<thead>
<tr>
<th>Per-Paycheck Employee Premiums</th>
<th>Traditional PPO</th>
<th>HSA Qualified Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$54.24</td>
<td>$19.92</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$150.96</td>
<td>$102.96</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$162.24</td>
<td>$123.36</td>
</tr>
<tr>
<td>Family</td>
<td>$224.16</td>
<td>$147.12</td>
</tr>
</tbody>
</table>
Welcome To ScriptSourcing!
You may have received an enrollment package in the mail or heard about our international prescription program through an employee communication. If you are ready to join, or need more information, the best option is to CALL SCRIPTSOURCING FIRST! We will answer all of your questions including; program eligibility and medication availability, and then all you need to do is submit your enrollment form and prescription(s).

Program Enrollment
Enrollment forms and prescriptions can be submitted via fax or mail. As a safety measure, we only accept prescriptions that are faxed directly from your doctor’s office. In order to have a continuous supply of medication on hand, we request that you submit a prescription for a **3-month quantity, with 3 refills**. If your prescription does not cover a full year, we can still accept it – but it must be written for a **minimum** 3-month supply.

If you did not contact us prior to enrolling, we will call you once we receive your paperwork and welcome you to the program! We will confirm the following:
- Your personal information
- Medication availability
- Shipping time
- Refill schedule
- And answer any questions you may have

**Enroll only once – and at any time!** There is no need to enroll now, unless you are ready to order through the program.

See what medications are available by visiting: [http://www.scriptsourcingmeds.com/](http://www.scriptsourcingmeds.com/)

Pack Sizes
Our program **ONLY** supplies **Brand Name medications**, dispensed in the **manufacturer’s original sealed container**. Pack sizes vary from country to country. For example, a standard container quantity might be 84. We factor this in when scheduling your refill call.

Refills
Refills are not automatic, but they’re easy – we call you! As an added safety measure before processing a refill, we need to confirm how much medication you have on hand and whether you’ve had any health or medication changes. We contact you **one month prior** to ensure you always have sufficient supply of medication on-hand.

Generic Medications
Generic medications provide the greatest savings to your health care plan. Therefore, if you are currently taking a Generic medication, you are not eligible to order the Brand Name medication through this program.

Shipping
Your medication will be shipped directly from an international pharmacy to your home **AT NO COST TO YOU**, via regular mail. Please allow **20 business days** (1 month) for your package to arrive.
A 24/7 Virtual ER at Your Fingertips For All Your Acute Medical Needs.

- No Co-Pay for Traditional Plan members.
- $10 copay for HSA Plan Members.

*Watch how easy it is to get quality care!*
https://vimeo.com/206677187

We are proud to offer you UCM's Virtual ER. We have partnered with United Concierge Medicine (UCM) to provide you access to Emergency Trained providers 24/7/365. These services can save you and your family valuable time and money by avoiding unnecessary trips to the hospital, ER and Urgent Care.

You and your family will have unlimited access to emergency trained, board certified, compassionate Physicians and Physician Assistants via phone, picture and secure video for treatment and triage of any acute medical problem you have. They can diagnose, prescribe medications when appropriate, order labs/diagnostic imaging and make recommendations to the best specialist in the area if needed.

UCM does not replace your Primary Care Provider for well visits or any Specialist for a chronic illness/disease; however, **for all other illness and injury**, call UCM's Virtual ER first for treatment and triage.

**Please be sure to download the UCMnow App as this is the best way to reach out for a consult whenever you need them.** You can download the App and find out much more information on their website at [www.UCMnow.com](http://www.UCMnow.com).

Please don't hesitate to contact us anytime day or night, call 844-4-VIP-DOC (844-484-7362) or email customersupport@ucmnow.com if you have any questions about the services.
COMPANY-PAID LIFE & AD&D INSURANCE

All active full time employees regularly working over 30 hours per week will be enrolled in the Dick Lavy Trucking Group Life and AD&D Insurance. This coverage is provided by Dick Lavy Trucking at no cost to you and your benefit becomes effective the first day of the month following date of hire. Your basic Life and AD&D benefit amount (covered by Dick Lavy Trucking) is $25,000, which doubles if death is caused by a covered accident.

REMINDER: Even though all eligible employees are automatically enrolled in this coverage when eligible, it is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

VOLUNTARY LIFE/AD&D INSURANCE

While the company offers basic life insurance, some employees may want to purchase additional coverage. Think about your personal circumstances. Are you the sole provider for your household? What other expenses do you expect in the future (for example, college tuition for your child)? Depending on your needs, you may want to consider buying supplemental coverage.

HOW MUCH LIFE INSURANCE COVERAGE DO YOU NEED?

Depending on your personal situation, you may wish to purchase additional coverage that you can buy at affordable group rates.

Use this worksheet to estimate how much additional life insurance you need and see the details of the voluntary life on the following page.

When considering how much life insurance you need, it’s important to think about your outstanding debt, ongoing expenses and the future plans of your family. Fill in the blanks to figure out how much life insurance you may wish to purchase.

<table>
<thead>
<tr>
<th>Outstanding Debt – How much will be left for your family to pay?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mortgage balance</td>
</tr>
<tr>
<td>Other debt (credit cards, loans, car payment)</td>
</tr>
<tr>
<td>TOTAL (A)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ongoing Expenses – How much do your dependents need each year?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Utilities (electric, phone, cable, internet)</td>
</tr>
<tr>
<td>Medical costs, insurance</td>
</tr>
<tr>
<td>Food, clothing, gasoline</td>
</tr>
<tr>
<td>Saving contributions</td>
</tr>
<tr>
<td>TOTAL (B)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Future Plans – How much will loved ones need for the future?</th>
</tr>
</thead>
<tbody>
<tr>
<td>College</td>
</tr>
<tr>
<td>Other (retirement, long term care)</td>
</tr>
<tr>
<td>TOTAL (C)</td>
</tr>
</tbody>
</table>

| Grand Total (A+B+C)                                          | $___________ |

Subtract existing coverage                                    $___________
Subtract company-paid life                                    $___________
Consider this amount of life insurance                         $___________

*AD&D pays a benefit for loss of life or dismemberment resulting from a covered accidental bodily injury. Your beneficiary may receive up to 100% of the AD&D amount if you die as the result of a covered accidental injury. You may receive an accidental dismemberment benefit for loss of a hand, a foot, or the sight of an eye due to an accidental injury. See the policy for exact schedule of losses and benefits.

Please review the full summary plan documents for a list of your exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. Please refer to your certificate booklet for your complete plan description. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.
With voluntary life insurance, you are responsible for paying the full cost of coverage through payroll deductions. You can purchase coverage for yourself in increments of $10,000 up to $500,000 with a guarantee issue amount of $150,000 when you are first eligible for coverage.

**ONE TIME GUARANTEE ISSUE NOTICE!** You are only eligible for the guarantee issues amount if this is your first opportunity to elect this coverage. If you did not take advantage of this benefit when initially eligible, but then wish to enroll at a later date, you will be subject to evidence of insurability (answer medical questions) and could be turned down.

### VOLUNTARY LIFE/AD&D COVERAGE HIGHLIGHTS

<table>
<thead>
<tr>
<th>Life/AD&amp;D Benefit Amount</th>
<th>Employee: $10,000 increments to $500,000.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Portability</td>
<td>to age 65</td>
</tr>
<tr>
<td>Conversion</td>
<td>Anytime</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Guarantee Issue Amount (without providing medical evidence)</th>
<th>Employee: $150,000</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Reduction Schedule</th>
<th>65 year old: 65%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>70 year old: 50%</td>
</tr>
</tbody>
</table>

If your employment terminates prior to age 65, you can port or convert this policy and take it with you.

If your employment terminates after you’ve reached 65, you can convert this policy and take it with you.
VOLUNTARY DENTAL PLAN SUMMARY & RATES

SunLife

Dick Lavy Trucking offers you dental coverage through SunLife. When you use an in-network dentist, your annual cleanings, exams, and routine x-rays are covered at no charge without a deductible and you never have to file claims or worry about paying additional money above your normal percentage.

When you use an out-of-network provider, the charges you incur may be above the maximum allowable fee and you may be left with a balance to pay.

<table>
<thead>
<tr>
<th>Deductible</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>$50</td>
<td>Reimburses 100% deductible waived</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
<td>Reimburses 100% deductible waived</td>
</tr>
<tr>
<td>Annual Maximum Benefit</td>
<td>$1,000 per person</td>
<td></td>
</tr>
</tbody>
</table>

Coverage Levels (NOTE: Out-of-Network coverage reimburses based on preferred dentist program fees and you may be responsible for a remaining balance if your provider charges more.)

<table>
<thead>
<tr>
<th>Type</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type A- Diagnostic &amp; Preventive</td>
<td>Covered 100% deductible waived</td>
<td>Reimburses 100% deductible waived</td>
</tr>
<tr>
<td>Type B- Basic Restorative</td>
<td>Covered 90% after deductible</td>
<td>Reimburses 80% after deductible</td>
</tr>
<tr>
<td>Type C- Major Restorative</td>
<td>Covered 60% after deductible</td>
<td>Reimburses 50% after deductible</td>
</tr>
<tr>
<td>Type D- Orthodontia (Applies only to dependents up to age 19)</td>
<td>Covered 50% with Lifetime maximum of $1,000</td>
<td>Reimburses 50% after deductible with Lifetime maximum of $1,000</td>
</tr>
</tbody>
</table>

Annual Benefit Max/Person

<table>
<thead>
<tr>
<th>Per-Paycheck Employee Premiums</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$4.70</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$10.02</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$11.77</td>
</tr>
<tr>
<td>Family</td>
<td>$17.77</td>
</tr>
</tbody>
</table>

BE SMILEY! It’s important to see a dentist twice a year, and not just for your teeth! Did you know that gum disease has been linked to heart disease, strokes, osteoporosis, diabetes, and Alzheimer’s? Taking care of your mouth is taking care of your body.
VOLUNTARY VISION PLAN SUMMARY & RATES

SunLife

Dick Lavy Trucking gives you the option to purchase Vision Insurance through SunLife at competitive group rates. The benefit provides you and all covered dependents with annual eye exams and contact lenses or glasses for only small copays. When you use a VSP network provider you do not have to worry about filing claims or receiving reimbursements, simply visit your eye doctor and pay for services as indicated below.

You may also choose to see a non-network provider but will be responsible for paying in full and filing claims for reimbursement through SunLife. See your full plan documents for out of network reimbursement levels.

<table>
<thead>
<tr>
<th>Benefit Overview</th>
<th>When You See A Network Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well Vision Exam</td>
<td>$10 copay (once every 12 months)</td>
</tr>
<tr>
<td>Glasses Copay (Includes lenses and frames)</td>
<td>$25 copay (once every 12 months for lenses or 24 months for frames)</td>
</tr>
<tr>
<td>Frames</td>
<td>$130 allowance towards price after copay (once every 24 months)</td>
</tr>
<tr>
<td></td>
<td>20% savings on additional cost above allowance</td>
</tr>
<tr>
<td>Lenses (Single vision, lined bifocal, lined trifocal)</td>
<td>Included in glasses copay, no additional charge</td>
</tr>
<tr>
<td>Lens Enhancements</td>
<td>Standard progressive lenses: $55</td>
</tr>
<tr>
<td></td>
<td>Premium progressive lenses: $95-105</td>
</tr>
<tr>
<td></td>
<td>Custom progressive lenses: $150-175</td>
</tr>
<tr>
<td></td>
<td>Average savings of 20-25% on other lens enhancements</td>
</tr>
<tr>
<td>Contact Lens Fitting Exam Copay</td>
<td>Copay not to exceed $60 (once every 12 months)</td>
</tr>
<tr>
<td>Contact Lenses (Instead of glasses) Medically Necessary</td>
<td>$130 allowance (once every 12 months) Covered at 100%</td>
</tr>
</tbody>
</table>

Per-Paycheck Employee Premiums

<table>
<thead>
<tr>
<th>Employee Premiums</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$1.66</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$2.80</td>
</tr>
<tr>
<td>Employee + Children</td>
<td>$2.86</td>
</tr>
<tr>
<td>Family</td>
<td>$4.60</td>
</tr>
</tbody>
</table>
VOLUNTARY SHORT-TERM DISABILITY INCOME REPLACEMENT
SunLife

Dick Lavy Trucking, Inc. believes in the importance of protecting your income and is happy to partner with SunLife to offer short term and long term disability coverage at exclusive group rate pricing.

Short-Term Disability is available to full-time employees working over 32 hours per week and your benefit depends on your salary.

<table>
<thead>
<tr>
<th>Short-Term Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Levels</td>
</tr>
<tr>
<td>Employees earning $35,000 per year: 100% of your weekly salary up to $500 per week maximum.</td>
</tr>
<tr>
<td>Employees earning $35,000 or less per year: 100% of your weekly salary up to $400 per week maximum.</td>
</tr>
<tr>
<td>Benefit Period</td>
</tr>
<tr>
<td>Lasting 13 weeks following the elimination period.</td>
</tr>
<tr>
<td>Elimination Period</td>
</tr>
<tr>
<td>7 days (Benefit is paid starting on the 8th day of illness/injury)</td>
</tr>
<tr>
<td>Pre-Existing Conditions</td>
</tr>
<tr>
<td>This plan does have a pre-existing condition exclusion which limits payment of benefits during the first 12 months of your policy for conditions existing during the 3 months prior to your coverage effective date. Please refer to your plan documents for the definition of pre-existing condition.</td>
</tr>
</tbody>
</table>

**IMPORTANT:** If you do not elect SHORT-TERM DISABILITY or LONG-TERM DISABILITY at your initial opportunity (upon hire) and you choose to elect them at a future open enrollment, you may be subject to evidence of insurability and have to answer medical questions.

**Can You Afford a Disability?**

If you were injured or ill and unable to work, do you have enough cash savings to pay up to 3 months of housing, food, utilities, gasoline, insurance premiums, medical bills, and other daily needs?

**NO?**

Then how can you afford not to spend a few dollars per paycheck to make sure you won’t ever be in that position?
VOLUNTARY LONG-TERM DISABILITY INCOME REPLACEMENT

SunLife

Long-Term Disability is available to full-time employees who work over 32 hours per week. See the chart below that corresponds to your income level to review your options. Because weekly premiums vary based on age and income level, please contact Krista at Dick Lavy HR to obtain a specific price for your weekly premium.

<table>
<thead>
<tr>
<th>Long Term Disability</th>
<th>For employees earning less than $40,000 per year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Levels</strong></td>
<td>Option 1: 60% of your monthly earnings up to $1,500 monthly benefit maximum.</td>
</tr>
<tr>
<td></td>
<td>Option 2: 60% of your monthly earnings up to $1,500 monthly benefit maximum.</td>
</tr>
<tr>
<td><strong>Benefit Period</strong></td>
<td>Option 1: Maximum of 5 years</td>
</tr>
<tr>
<td></td>
<td>Option 2: Social Security Normal Retirement Age</td>
</tr>
<tr>
<td><strong>Elimination Period</strong></td>
<td>90 days</td>
</tr>
<tr>
<td><strong>Additional Features</strong></td>
<td>Waiver of premium, Work Incentive Benefit, Rehabilitation Incentive Income, Recurrent Disability, Worksite Modification, Survivor Benefit, Day Care Benefit, Vocational Rehabilitation Services, Social Security Assistance, Worldwide Emergency Travel Assistance program, Work-Life Balance employee assistance program</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Long Term Disability</th>
<th>For employees earning $40,000 or more per year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Benefit Levels</strong></td>
<td>Option 1: 60% of your monthly earnings up to $2,000 monthly benefit maximum.</td>
</tr>
<tr>
<td></td>
<td>Option 2: 60% of your monthly earnings up to $2,000 monthly benefit maximum.</td>
</tr>
<tr>
<td><strong>Benefit Period</strong></td>
<td>Option 1: Maximum of 5 years</td>
</tr>
<tr>
<td></td>
<td>Option 2: Social Security Normal Retirement Age</td>
</tr>
<tr>
<td><strong>Elimination Period</strong></td>
<td>90 days</td>
</tr>
<tr>
<td><strong>Additional Features</strong></td>
<td>Waiver of premium, Work Incentive Benefit, Rehabilitation Incentive Income, Recurrent Disability, Worksite Modification, Survivor Benefit, Day Care Benefit, Vocational Rehabilitation Services, Social Security Assistance, Worldwide Emergency Travel Assistance program, Work-Life Balance employee assistance program</td>
</tr>
<tr>
<td><strong>Pre-Existing Conditions</strong></td>
<td>Both of the above plan options have a pre-existing condition exclusion which limits payment of benefits during the first 12 months of your policy for conditions existing during the 3 months prior to your coverage effective date. Please refer to your plan documents for the definition of pre-existing condition.</td>
</tr>
</tbody>
</table>

Can You Afford a Disability?

If you were injured or ill and unable to work, do you have enough cash savings to pay up to 5 years of housing, food, utilities, gasoline, insurance premiums, medical bills, and other daily needs?

**NO?**
Then how can you afford not to spend a few dollars per paycheck to make sure you won’t ever be in that position?
VOLUNTARY CRITICAL ILLNESS & CANCER INSURANCE
SunLife

If you are diagnosed with a covered critical illness, you could receive up to $10,000 as a single sum payment (depending on the amount of coverage you elect). This money is yours to do what you want with and can help you cover out-of-pocket medical expenses or other daily needs at a time when you are receiving medical care and possibly unable to work. Coverage is available for eligible employees and your eligible spouse and dependent children.

Covered Conditions

<table>
<thead>
<tr>
<th>Stroke</th>
<th>Coronary Artery Disease</th>
<th>Advanced ALS (Lou Gehrig’s Disease)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Attack</td>
<td>Major Organ Failure</td>
<td>Advanced Parkinson’s Disease</td>
</tr>
<tr>
<td>Invasive Cancer</td>
<td>Benign Brain Tumor, Paralysis or</td>
<td></td>
</tr>
<tr>
<td>Skin Cancer</td>
<td>Coma</td>
<td></td>
</tr>
<tr>
<td>Carcinoma in Situ</td>
<td>Advanced Alzheimer’s Disease</td>
<td></td>
</tr>
</tbody>
</table>

Program Features

**Benefit Payment and Maximums**

Depending the diagnosis, SunLife will pay either the full benefit or a partial benefit. The plan may pay for a second diagnosis of the same illness, under some circumstances. Refer to the full plan document.

**Pre-Existing Conditions**

This plan does have pre-existing condition limitations. You must be covered by the plan before diagnosis in order to receive the benefit. The plan also excludes (for the first 12 months of your coverage) any condition for which you had symptoms or treatment for during the 12 months prior to your coverage. Please refer to the full plan document from SunLife for full details of these provisions.

**Wellness Benefit**

Each enrolled member can receive a $50 cash wellness benefit per year if the member completes a wellness test/screening such as a blood lipids test, blood glucose test, mammogram, colonoscopy, pap smear, PSA test, and many others.

Available Coverage

Employees- Who are actively at work- $10,000
Spouse- If Employee is enrolled- $10,000
Dependent Children- $5,000

Your Cost

Your cost is based on your age and smoking status as well as the amount of coverage you wish to elect. Please refer to the full plan information that you will receive from the Dick Lavy Benefits Department for your personal cost to enroll.

IMPORTANT:

If you do not elect this benefit at your first opportunity and you choose to elect it at a future open enrollment, you may be subject to evidence of insurability and have to answer medical questions.
INFORMATION FOR THOSE ELIGIBLE FOR MEDICARE

What Are My Options Once I Turn 65?
Will you retire or will you decide to stay in the workforce? If you continue to work full-time, you may remain on the company medical plan as long as you meet eligibility requirements. However, you may also be eligible for Medicare and a supplement policy that costs you less out-of-pocket. Please read the summary below and explore your options.

Working Beyond Age 65
Save some money:
If you are purchasing medical insurance through your employer, a Medicare plan could help you save money on your health care expenses. Medicare can coordinate with your employer-sponsored coverage or be purchased in lieu of it. It may make sense for you to sign up for Medicare in addition to OR instead of the coverage you have today.

It starts with basic coverage at no cost (Part A):
Many people who choose to work past age 65 enroll in Part A (Hospital Coverage) because there is no monthly premium. Many choose to enroll in both Parts A and B together. Part B (Physician Coverage) requires a small monthly premium. A Supplement Plan, along with a Medicare Part D (Prescription coverage) plan, can also be purchased to cover most out-of-pocket costs for a very affordable premium. In some cases, these options are far less costly than staying on an employer sponsored plan. It is recommended that you explore all options to determine what is best for you. You may also shop for and change plans each year based on your specific needs.

Understanding Your Options
If you continue working:
If you are enrolled in Medicare, your coverage can either coordinate with the company plan or it can be elected separately. Paying for both may not be cost effective.

An employee still working may drop the company medical plan to enroll in Medicare and/or a Medicare Supplement Policy at any time throughout the year – as this is considered a Qualifying Event. If you drop the company plan to pursue coverage under Medicare separately, keep your health insurance coverage records so you can prove that you had creditable coverage past your Initial Enrollment Period for Medicare. If your spouse or dependents need coverage, they could be eligible for COBRA or Medicare (if also age 65 or older).

Making Changes to Your Medicare Plans:
Health care needs can change from year to year. Be sure to review your needs (upcoming surgeries, current prescription drugs, new wellness goal) so you can find a plan to best meet them.

Medicare Open Enrollment Period
You can enroll in or change your plan once a year during the Open Enrollment Period (OEP) even if you do not have a qualifying event. The OEP is a seven-week period from October 15 through December 7.

Retiring At or After Age 65
Are you ready?
Whether you retire or decide to work part-time, once you turn age 65 you will be eligible for Medicare (Parts A and B) and other Medicare Supplement Plans. If you don’t have employer-sponsored coverage, you should consider enrolling during your Initial Enrollment Period. You can enroll any time within the 3 months before your 65th birthday month, your birthday month or 3 months after.

Multiple Medicare Resources Available
It is important to note that Medicare resources and options vary by state. Each state has a SHIP (Senior Health Insurance Information Program) that offers free education and assistance specific to their state. To find your state resource and get the number to speak to a licensed counselor, you may either
Visit: www.shiptacenter.org, call 877-839-2675 or email: info@shiptacenter.org

Additional Information (Government resources):
• Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov
ANNUAL REQUIRED NOTICES

Dick Lavy Trucking
Health Law Notices

Michelle’s Law Notice
If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage.

Benefits During Family Medical Leave
Assuming the Plan Administrator meets certain criteria during the preceding calendar year, the Plan will comply with the Family and Medical Leave Act (FMLA) of 1993 as amended, which provides benefit continuation rights during an approved medical leave of absence. If the Plan Administrator is subject to the law, an employee and any dependents covered under a health benefit plan may be eligible to continue the coverage under that plan for a certain period of time.

Any employer contributions made under the terms of the Plan shall continue to be made on behalf such employee electing to maintain coverage while on FMLA leave. An employee on FMLA leave must make any applicable contributions to maintain coverage. To the extent required under the FMLA and in accordance with procedures established by the Plan Administrator such employee contributions may be payable:
- prior to the employee taking the leave; or
- during the leave; or
- repaid to the employer through payroll deductions upon return to work following the leave.

Contact the Plan Administrator for additional information on the FMLA leave policy or to request leave. Certain rights under specific state family leave laws may also apply.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)
Under USERRA, an employer is required to offer COBRA-like continuation of coverage to covered employees in the uniformed services if their absence from work during military duty would result in a loss of coverage as a result of such active duty. The maximum length of USERRA continuation of coverage is the lesser of 24 months beginning on the date of the employee’s departure, or the period beginning on the date of the employee’s departure and ending on the date on which the employee failed to return from active duty or apply for reemployment within the time allowed by USERRA. If an employee elects to continue coverage pursuant to USERRA, such employee, and any covered dependents, will be required to pay up to 102% of the full premium for coverage elected. For military leaves of 30 days or less, the employee is not required to contribute more than the amount he or she would have paid as an active employee. Continued coverage under this provision pursuant to USERRA will reduce any coverage continuation provided under COBRA Continuation.

Premium Assistance Under Medicaid and The Children’s Health Insurance Program (CHIP) – Applies to Group Health Plans Only
If an Employee or an Employee’s children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, contact they may State Medicaid or CHIP office to find out if premium assistance is available.

If an Employee or his/her dependents are NOT currently enrolled in Medicaid or CHIP, and they think they (or any of their dependents) might be eligible for either of these programs, they can contact the State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If they qualify, ask if the state has a program that might help pay the premiums for an employer-sponsored plan.

If an Employee or his/her dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under their employer plan, the employer must allow the Employee to enroll in the employer plan if they are not already enrolled.

This is called a “special enrollment” opportunity, and the Employee must request coverage within 60 days of being determined eligible for premium assistance. If the Employee has questions about enrolling in the employer’s plan, contact the Department of Labor at www.askebsha.dol.gov or call 1-866-444-EBSA (3272).

Employees living in one of the following States, may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2020. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsha/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA-Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA-Medicaid
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS-Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

COLORADO-Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHIP+)
Health First Website: https://https://www.healthfirstcolorado.com/
Phone: 1-800-221-3943
CHIP+ Website: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
Phone: 1-800-359-1991
Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program
Phone: 1-855-692-6442

FLORIDA-Medicaid
Website: https://www.fldmedicaiddpirecovery.com/flmedical dpirecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA-Medicaid
Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA-Medicaid
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: https://www.in.gov/medicaid/
Phone: 1-800-457-4584

IOWA-Medicaid and CHIP (Hawki)
Medicaid Website: https://dhs.iowa.gov/rme/members
Phone: 1-800-338-8366
Hawki Website: http://dhs.iowa.gov/Hawki
Phone: 1-800-257-8563

KANSAS – Medicaid
Website: http://www.kdhks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY-Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child’s medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is “qualified.” If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace? The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals may get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?

Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace? Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.56% of household income for the year, or if the coverage the employer provides does not meet the “minimum value” standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.

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

How Can Individuals Get More Information? For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

The Marketplace can help when evaluating coverage options, including 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 the area.

*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% of such costs.

Special Enrollment Periods

Special Enrollment Rights – If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan on the date listed in your plan document.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP) - If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply. The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP.

HIPAA Notice of Privacy Practices Effective Date: March 1, 2013

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices The Dick Lavy Trucking Group Medical Plan (the “Plan”), which includes medical and dental coverages offered under the Dick Lavy Trucking Plans, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA’s privacy rule) to take reasonable
steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures Dick Lavy Trucking has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual’s Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA’s privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual’s coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan’s participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor: As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law: When required to do so by any federal, state or local law.

4. Health Oversight Activities: To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety: As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual’s health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes: To a law enforcement official for certain law enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation: If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions: For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers’ Compensation: As necessary to comply with workers’ compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
Dick Lavy Trucking is required maintain the privacy of PHI; to provide individuals with this notice of the Plan’s legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in
accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

**Individual Rights with Respect to Personal Health Information:** Each individual has the following rights under the Plan’s policies and procedures, and as required by HIPAA’s privacy rule:

**Right to Request Restrictions on Uses and Disclosures:** An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308, (937) 448-6030.

**Right to Inspect and Copy Individual Health Information:** An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308, (937) 448-6030. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

**Right to Amend Your Health Information:** You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308, (937) 448-6030. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

**Right to an Accounting of Disclosures:** An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308, (937) 448-6030. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

**Right to Receive Confidential Communications:** An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308, (937) 448-6030. The Plan will attempt to honor all reasonable requests.

**Right to a Paper Copy of this Notice:** Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308, (937) 448-6030 to make this request.

**The Plan’s Duties:** The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

**Complaints and Contact Person:** If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or
file a complaint with the Plan, they must contact the HIPAA Contact Person, at Dick Lavy Trucking, 8848 State Route 121, Bradford OH 45308 , (937) 448-6030 . They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated.

Important Notice from Dick Lavy Trucking About Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Dick Lavy Trucking 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. Dick Lavy Trucking has determined that the prescription drug coverage offered by the Dick Lavy Trucking Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide To Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Dick Lavy Trucking coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Dick Lavy Trucking coverage, be aware that you and your dependents will 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 Dick Lavy Trucking 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 person listed below for further information. NOTE: You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Dick Lavy Trucking 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: 01/01/2022
Name of Entity/Sender: Dick Lavy Trucking
Contact--Position/Office: Human Resources
Address: 8848 State Route 121, Bradford OH 45308
Phone Number: (937) 448-6030