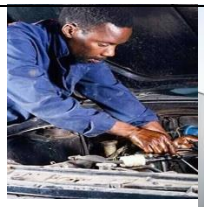
2022 EMPLOYEE BENEFITS GUIDE

Hickman Transport Co., Inc.

FULL TIME

SCA

EMPLOYEES



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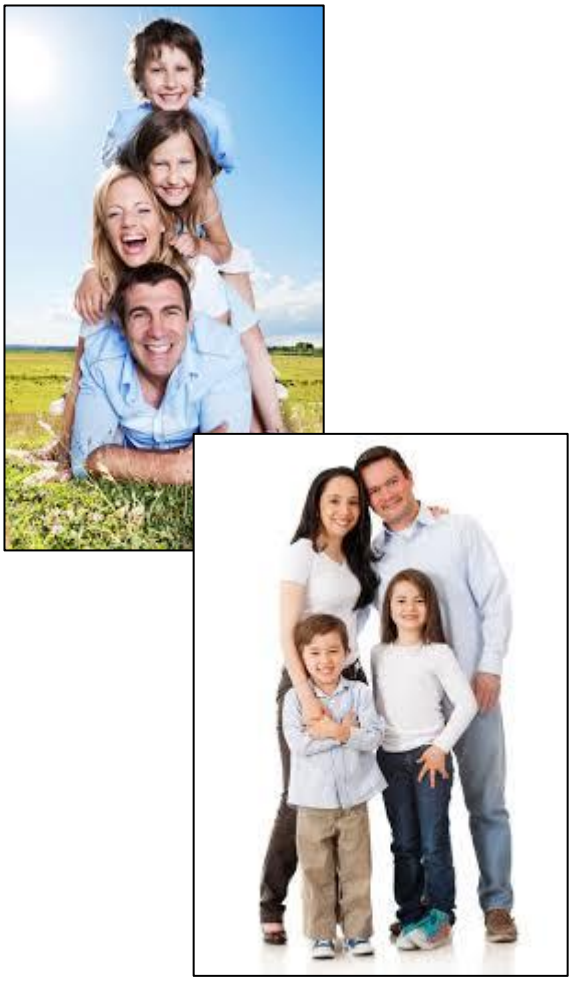


In this Guide, we use the term Company to refer to Hickman Transport Co., Inc. This Guide is intended to describe the eligibility requirements, enrollment procedures, and coverage effective dates for the benefits offered by the Company. It is not a legal plan document and does not imply a guarantee of employment or continuation of benefits. While this Guide is a tool to answer most of your questions, full details of the plans are contained in the Summary of Benefits and Coverage (SBCs), which govern each plan's operation. Whenever an interpretation of a plan benefit is necessary, the actual plan documents will be used.

WELCOME TO OUR TEAM!

At Hickman Transport Co. Inc., we are committed to your health and well-being. We are proud to provide you and your family with valuable and significant benefits. This Guide is an overview of the benefits available to you and their impact on your compensation as a whole. Please read it carefully in order to make the best choices for you and your family in the **2022 Plan Year.**

Questions Regarding Your Benefits?
If you have questions regarding your 2022 Plan Year benefits through Hickman Transport, please contact:

Hannah Hannah
Hickman Transport
hannah@hickmantransport.com
229-247-4150
229-247-0513 FAX

Kyle Gosdeck
STAFFCORE Benefit Administration
Kyle.gosdeck@assuredpartners.com
608-441-3035 x5
608-441-3036 FAX

ELIGIBILITY & ENROLLMENT

You and your family have unique needs, which is why Hickman Transport offers a variety of benefit plans from which you may choose. Consider your spouse's benefits through his or her place of employment and your dependents' eligibility when weighing each option.

Eligibility

You must work at least 30 hours per week to be eligible to participate in the medical, dental, vision, short-term disability, and life insurance plans.

When Does Coverage Begin?

There are different benefit waiting periods based on the following scenarios.

- **New Hire:** Coverage for all benefits begins on the first day of the month following 60 days of employment. Due to IRS regulations, once you have made your choices for the 2022 Plan Year, you won't be able to change your benefits until the next open enrollment period, unless you experience a qualifying life event.

- **Newly Eligible:** If you become benefits eligible due to an increase in hours, your benefits are effective on the first of the month following 60 days after your status change. As with a New Hire, once you have made your choices for the 2022 Plan Year, you won't be able to change your benefits until the next open enrollment period, unless you experience a qualifying life event.

- **Open Enrollment:** Any changes made to your benefit elections during the open enrollment period are effective on March 1.

- **Qualifying Life Event:** Any changes you make to your benefits due to a qualifying life event go into effect the first of the month following the date of that event.

Eligible Dependents

Dependents eligible for coverage in the Hickman Transport medical, dental, and vision plans include:

- Your legal spouse or domestic partner
- Children up to age 26, which include
  - birth children
  - stepchildren
  - legally adopted children
  - children placed for adoption
  - foster children
  - children whom legal guardianship has been awarded to you or your spouse
- Dependent children, regardless of age, provided he or she is incapable of self-support due to a mental or physical disability, is fully dependent on you for support as indicated on your federal tax return, and is approved by your medical plan to continue coverage past age 26.

Qualifying Life Events

When one of the following events occurs, you have 30 days from the date of the event to Hickman Transport and/or request changes to your coverage.

- Change in your legal marital status (marriage, divorce, or legal separation)
- Change in the number of your dependents (for example, through birth or adoption, or if a child is no longer an eligible dependent)
- Change in your spouse's or domestic partner's employment status (resulting in a loss or gain of coverage)
- Change in your employment status from full-time to part-time, or part-time to full-time, resulting in a gain or loss of coverage

Preparing to Enroll

Hickman Transport provides its employees the best coverage possible. As a committed partner in your health, Hickman Transport absorbs some of the costs associated with your benefits. Your share of contributions for the medical, dental, and vision dependent premiums is deducted from your paycheck on a pre-tax basis, which lessens your tax liability.

Keep in mind that you may select any combination of medical, dental, and/or vision plan coverage categories. For example, you can select medical coverage for you and your entire family but select dental and vision coverage only for yourself. The only requirement is that you, as an eligible employee of Hickman Transport, must elect coverage for yourself in order to elect dependent coverage. You have the option to select coverage from the following categories:

- Employee Only
- Employee + Spouse/Domestic Partner
- Employee + Child(ren)
- Family

Be sure to have the Social Security numbers and birthdates for any eligible dependent(s) that you plan to enroll. <u>You cannot enroll your dependent(s) without this information</u>.

How to Enroll

1. Understand Your Choices

This Guide contains very useful reference material to help you prepare for your enrollment. Keep it handy so you can refer to it throughout the year.

2. Review Your Options with Your Family

Make sure you include any other individuals who will be affected by your elections in the decision-making process.

3. Submit Your Forms

Completed forms can be sent to:

Hannah Hannah
Hickman Transport Co. Inc.
200 East Gordon Street
Valdosta, GA 31601
FAX (229) 247-0513
hannah@hickmantransport.com

FRINGE BENEFIT DOLLARS

As a federally contracted Mail Hauler, you earn a contract-specific dollar amount for every hour you work, up to a maximum of 40 hours per week. This amount, referred to as Fringe Benefit Dollars (or "fringe"), is provided by Hickman Transport to pay for your group Health and Welfare benefit premiums.

What are Fringe Benefits?

The Service Contract Act applies to every contract with the principal purpose to furnish services to the United States through the use of service employees. As a service employee performing government contract work, you earn a specific **fringe benefit dollar amount** per hour worked (up to 40 hours maximum per week). This amount is separate and in addition to your hourly rate of pay.

Your fringe benefit dollars are used to pay for medical, disability, and life insurance premiums, as well as dental and/or vision premiums (if elected), for yourself only. Fringe earned in the current month is applied to the next month's premiums (i.e., fringe earned in February will pay for March premiums). Any amount remaining after premium payment is paid to you in cash on your paycheck at the end of the following month,

Your Benefit Reserve Account

At time of hire, a benefit reserve account is established for you. The purpose of the reserve account is to create a pool of dollars to use for premiums payments in the event you do not earn enough fringe to fund your monthly premiums. Reasons include sick time, a leave of absence, or a reduction in your schedule. The amount held in reserve is the total of one month of premiums.

After your date of hire, any fringe earned is used to pay your monthly premiums. Any remaining fringe is placed in your reserve account. Once your reserve account is fully funded, any remaining fringe benefit dollars after premium payments are paid out to you in cash on your paycheck at the end of the following month. In the event you leave employment, any amount remaining in your reserve account will be paid out to you in cash on your paycheck.

The McNamara-O'Hara Service Contract Act

The McNamara-O'Hara Service Contract Act (SCA) was enacted by Congress in 1965. The purpose of the SCA is to provide labor standards for certain persons employed by Federal contractors to furnish services to Federal agencies.

MEDICAL BENEFITS

Our medical coverage helps you maintain your well-being through preventative care and access to an extensive network of providers, as well as affordable prescription medication. Medical benefits are offered through Humana. It is up to you to choose the plan that best matches your needs. Please keep in mind that the option you elect will be in place for the entire Plan Year, unless you have a Qualifying Life Event.

Humana BASIC Medical Plan

As a full-time SCA employee, you are **required** to enroll in the BASIC medical plan with Employee Only coverage ***unless you provide a valid waiver of coverage, or if the BUY UP medical plan is elected***. A valid waiver is participation in another group plan such as your spouse's insurance, TRICARE, or VA, or an individual plan that meets the minimum essential benefits as defined by the Affordable Care Act.

The **BASIC** Medical Plan offers an in-network annual deductible of $5,000 for single coverage ($10,000 for dependent coverage) and 20% coinsurance. All medical services and prescription drugs are subject to the deductible and coinsurance.

Humana BUY UP Medical Plan

The **BUY UP** Medical Plan offers a $0 in-network annual deductible for both single and dependent coverage with 0% coinsurance up to the annual out-of-pocket maximum of $7,150 for single coverage or $14,300 for dependent coverage. There are copays for medical services and prescription drugs.

Medical Premium Payments

BASIC Medical Plan. The Employee Only portion of the premium is funded by fringe dollars. If dependent coverage is elected, the difference between the Employee Only premium and the dependent premium is paid by you through pre-tax payroll deduction.

BUY UP Medical Plan. The Employee Only portion of the premium is funded by fringe dollars at the rate of the *BASIC Medical Plan* Employee Only premium, with the difference and dependent premiums (if elected) paid by you through pre-tax payroll deduction.

Find a Humana Doctor

Call **800-448-6262** OR

1. Visit **www.humana.com**
2. Go to **Member Resources**
3. Select **Find a doctor**
4. Select **Insurance through your employer**
5. Enter your zip code
6. Selection **ChoicePOS**
7. Search by preference

IMPORTANT NOTE ABOUT MEDICARE WAIVERS

Medicare is ***not*** a valid waiver of coverage. The Centers for Medicare and Medicaid state that because health insurance coverage is offered and available through Hickman Transport, Medicare does not allow you to decline your employer's insurance if you are working full-time (more than 30 hours per week). At age 65, you are able to enroll in Medicare; however, Medicare is considered your **secondary** coverage. As a result, you must remain enrolled in the coverage offered through Hickman Transport while you are working full-time.

Medical Plan Summary & Employee Contributions

The chart below provides a summary of the 2022 Plan Year medical coverage provided by Humana, as well as the premium contributions that are deducted from your paycheck on a pre-tax basis. Please refer to the Summary of Benefits & Coverage for detailed information regarding your medical coverage.

	BASIC MEDICAL PLAN		BUY UP MEDICAL PLAN	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
ANNUAL CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$5,000	$12,000	$0	$5,000
FAMILY	$10,000	$24,000	$0	$10,000
ANNUAL CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$6,750	$19,050	$7,150	$13,300
FAMILY	$13,500	$38,100	$14,300	$42,900
COINSURANCE & COPAYS				
COINSURANCE	20%	40%	0%	30%
PREVENTATIVE	No Charge	40%[1]	No Charge	30%[1]
PRIMARY CARE	20%[1]	40%[1]	$55	30%[1]
SPECIALIST	20%[1]	40%[1]	$110	30%[1]
URGENT CARE	20%[1]	40%[1]	$125	30%[1]
EMERGENCY	20%[1]	20%[1]	$850	$850
DIAGNOSTIC TEST	20%[1]	40%[1]	No Charge	30%[1]
IMAGING	20%[1]	40%[1]	$850	30%[1]
HOSPITAL OUTPATIENT	20%[1]	40%[1]	$2,350/visit	30%[1]
HOSPITAL INPATIENT	20%[1]	40%[1]	$2,350/day	30%[1]
PRESCRIPTION COPAYS				
TIER 1	20%[1]		$10	
TIER 2	20%[1]		$50	
TIER 3	20%[1]		$100	
TIER 4	Not Covered		25%	
BI-WEEKLY EMPLOYEE CONTRIBUTIONS				
EMPLOYEE ONLY	**$0.00**		**$63.78**	
EMPLOYEE + SPOUSE/DP	**$236.08**		**$363.65**	
EMPLOYEE + CHILD(REN)	**$200.66**		**$318.67**	
EMPLOYEE + FAMILY	**$436.74**		**$618.53**	

[1] After deductible

PLEASE NOTE: This is a summary only. Any discrepancies will be resolved by the Plan Documents.

DENTAL & VISION BENEFITS

Routine preventative dental care, such as regular dental checkups, can help lower your risk of stroke and heart disease. Even those with perfect eyesight should have their vision checked on a regular basis. Hickman Transport's dental and vision coverage will provide you and your family affordable options for overall health. Coverage is available from The Standard.

Dental Coverage

You have the option to enroll yourself, your spouse/domestic partner, child(ren), or entire family in the dental plan with coverage through the Ameritas network.

The plan covers diagnostic and preventative services, as well as basic and major services, and features a $1,000 annual benefit maximum per member on the plan. There is no waiting period for services. Preventative services are covered at 100%, with basic restorative services at 80% and major restorative services at 50%.

Vision Coverage

You have the option to enroll yourself, your spouse/domestic partner, child(ren), or entire family in the vision plan with coverage through the VSP network.

The plan features exam and material copays and provides an annual exam and one pairs of lenses every 12 months. One set of frames is available every 24 months. If you wear contacts, you are able to get a new supply every 12 months in lieu of lenses and/or frames.

Dental & Vision Premiums

The Employee Only portion of both the dental and vision premium is funded by fringe dollars. If dependent coverage is elected, the difference between Employee Only and the dependent premium is paid by you through pre-tax payroll deduction.

Refer to the Plan Documents section of this Guide for the complete dental and vision benefit plan summaries.

Find a Dental Provider

To find a dental provider, visit **standard.com** (click on **Find a Dentist**) or call **800-547-9515**

Find a Vision Provider

To find a vision provider, visit **vsp.com** (click on **Find a Doctor**), or call **800-877-7195**.

Dental Plan Summary & Employee Contributions

Dental plan benefits are available to you on a voluntary basis. The chart below provides a summary of the 2022 Plan Year dental coverage through The Standard, as well as the premium contributions that are deducted from your paycheck on a pre-tax basis. All out-of-network services are subject to Reasonable and Customary (R&C) limitations.

	THE STANDARD DENTAL PLAN (AMERITAS NETWORK)	
	IN NETWORK	OUT OF NETWORK
CALENDAR YEAR DEDUCTIBLE		
INDIVIDUAL	$50	$50
FAMILY	$150	$150
CALENDAR YEAR MAXIMUM		
PER MEMBER	$1,000	$1,000
COVERED SERVICES		
PREVENTATIVE *Oral exams, cleanings, fluoride treatment, x-rays*	100%	100%
BASIC *Fillings, emergency, sealants, simple extractions, space maintainers*	80%	80%
MAJOR *Crowns, bridges, dentures, endodontics, periodontics, complex oral surgery*	50%	50%
WAITING PERIOD	None	None
SEMI-MONTHLY EMPLOYEE CONTRIBUTIONS		
EMPLOYEE ONLY	**$0.00**	
EMP + SPOUSE/DP	**$10.26**	
EMP + CHILD(REN)	**$14.10**	
EMP + FAMILY	**$24.79**	

Find a Provider

To find an in-network dentist, visit **www.standard.com** then click on **Find a Dentist** and enter your city, state or zip code. You may also call **800-547-9515**.

PLEASE NOTE: This is a summary only. Any discrepancies will be resolved by the Plan Documents.

Vision Plan Summary & Employee Contributions

Vision plan benefits are available to you on a voluntary basis. The chart below provides a summary of the 2022 Plan Year vision coverage through The Standard, as well as the premium contributions that are deducted from your paycheck on a pre-tax basis.

	THE STANDARD VISION PLAN (VSP NETWORK)	
	IN NETWORK	OUT OF NETWORK
COPAYS		
EXAM	$10	Up to $45 reimbursement
MATERIALS	$25	Not applicable
COVERED MATERIALS		
LENSES		
SINGLE VISION	Covered in full after material copay	Up to $30 reimbursement
BIFOCAL	Covered in full after material copay	Up to $50 reimbursement
TRIFOCAL	Covered in full after material copay	Up to $65 reimbursement
LENTICULAR	Covered in full after material copay	Up to $100 reimbursement
CONTACT LENSES		
NECESSARY	Covered in full after material copay	Up to $210 reimbursement
ELECTIVE	$150 allowance	Up to $120 reimbursement
FRAMES		
RETAIL FRAMES	$150 allowance after material copay	Up to $75 reimbursement
BENEFIT FREQUENCY		
EXAM	12 Months	12 Months
LENSES	12 Months	12 Months
CONTACTS *(in lieu of Lenses/Frames)*	12 Months	12 Months
FRAMES	24 Months	24 Months
SEMI-MONTHLY EMPLOYEE CONTRIBUTIONS		
EMPLOYEE ONLY	**$0.00**	
EMP + SPOUSE/DP	**$3.30**	
EMP + CHILD(REN)	**$3.64**	
EMP + FAMILY	**$6.94**	

Find a Provider

To find an in-network provider, please visit **vsp.com** (click on **Find a Doctor**) or call **800-877-7195**.

PLEASE NOTE: This is a summary only. Any discrepancies will be resolved by the Plan Documents.

SURVIVOR BENEFITS

Discussing what might happen to your family if you were not around to provide for them isn't always the easiest conversation, but it is necessary. Survivor benefits provide financial assistance in an absence, so you can plan for the unexpected. If you have life insurance now, chances are you can take comfort in knowing that those who depend on you will be provided for.

Basic Group Term Life & Accidental Death and Dismemberment (AD&D) Insurance

Life and AD&D benefits are essential to the financial security of you and your family. As such, it is important to understand how your plan works and what benefits you will receive.

If you regularly work more than 30 hours per week, you are automatically covered with a Basic Life and AD&D insurance benefit of $25,000 through The Standard. This benefit covers you only; there is no coverage for dependents. Benefits are payable to your beneficiary if you die, or to you if you lose a limb or suffer paralysis in an accident.

The monthly premium is $9.50. The benefit amount reduces to $16,250 at age 65 (monthly cost of $6.18) and to $12,500 at age 70 (monthly cost of $4.75). The premiums are funded by fringe dollars.

Refer to the Plan Documents section of this Guide for the complete life insurance benefit plan summaries.

Beneficiary Designation

A beneficiary is the person you designate to receive your life insurance benefits in the event of your death. This includes any benefits payable under Basic Life offered by Hickman Transport.

It is important that your beneficiary designation is clear so there is no question as to your intentions. It is also important that you name a primary and secondary beneficiary. When naming your beneficiary(ies), please indicate their full name, address, Social Security Number, relationship, date of birth, and distribution percentage. If the beneficiary is not legally related, print the words "Not Related" in the relationship field.

If you name more than one beneficiary with unequal shares, please show the amount of insurance to be paid to each beneficiary in percentages.

Naming Your Beneficiary

If you are married and name someone other than, or in addition to, your spouse as primary beneficiary, then your spouse must waive his/her rights to your life insurance benefits by signing the Spousal Consent Form. The signature must be notarized.

INCOME PROTECTION

Hickman Transport offers disability coverage to protect you against an unfortunate or debilitating injury. This insurance protects a portion of your income until you can return to work.

Short Term Disability (STD) Insurance

As a full-time employee, you are automatically covered under this plan through The Standard. This coverage is for you only; there is no coverage for dependents.

STD insurance protects a portion of your income if you become partially or totally disabled for a short period of time. It replaces 60% of your income, up to a maximum weekly benefit of $500, depending on your current weekly earnings. You must be sick or disabled for at least seven calendar days before you can receive a benefit payment. Payments may last up to 12 weeks. Certain exclusions, along with any pre-existing condition limitations, may apply.

The plan also allows for partial disability benefits, so you may still receive a portion of your short-term disability benefit to help fill the gap in your income. Short-term disability benefits for pregnancy are provided the same as for a disability caused by an illness.

The monthly premium, which is funded by fringe dollars, is based on your weekly earnings at a rate of $0.42 per $10 of coverage. The premium averages $21 per month.

Refer to the Plan Documents section of this Guide for the more information regarding your life and short-term disability insurance, as well as other valuable benefits available to you through The Standard.

Applying for Short-Term Disability

If you are unable to work due to disability or illness, you are able to apply for benefits directly with The Standard. First, contact Human Resources to let them know you will be filing a claim. HR will be able to provide you with the necessary claim forms. Next, file your claim with The Standard. There are four ways to file a claim:

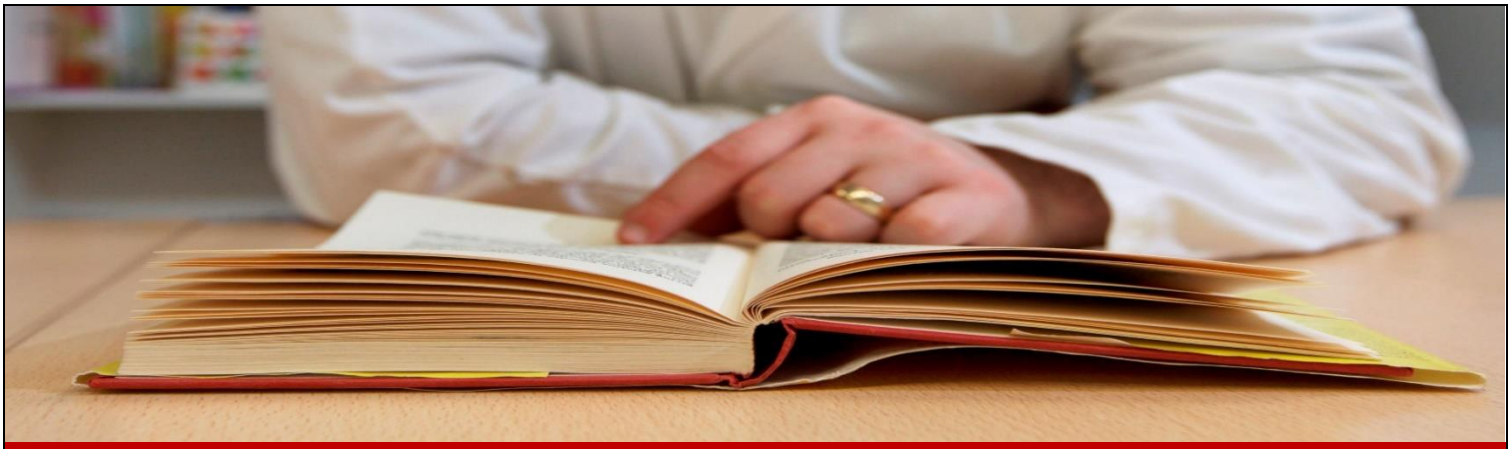
- **Online:** Register at **standard.com/individual/file-claim**
- **Fax:** 1-800-378-6053
- **Email:** SecureSTDForms@standard.com
- **Mail**: Standard Insurance Company
  Attn: Disability Claims
  PO Box 2800
  Portland, OR 97208

Other Benefits Through The Standard

Travel Assistance. Travel Assistance is available when you travel more than 100 miles from home, or internationally, for up to 180 days for business or pleasure. It offers aid before and during your trip.

Life Services Toolkit. Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

Refer to the Plan Documents section of this Guide for more information regarding other benefits!



GLOSSARY

Coinsurance: Your share of the cost of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service, typically after you meet your deductible. For instance, if your plan's allowed amount for an office visit is $100 and you've met your deductible (but haven't yet met your out-of-pocket maximum), your coinsurance payment of 20% would be $20. Your plan sponsor or employer would pay the rest of the allowed amount.

Copay: The fixed amount, as determined by your insurance plan, you pay for health care services received.

Deductible: The amount you owe for health care services before your health insurance or plan sponsor (employer) begins to pay its portion. For example, if your deductible is $1,000, your plan does not pay anything until you've met your $1,000 deductible for covered health care services. This deductible may not apply to all services, including preventative care.

Employee Contribution: The amount you pay for your insurance coverage.

Explanation of Benefits (EOB): A statement sent by your insurance carrier that explains which procedures and services were provided, how much they cost, what portion of the claim was paid by the plan, and what portion is your liability, in addition to how you can appeal the insurer's decision. These statements are also posted on the carrier's website for your review.

High Deductible Health Plan (HDHP): A plan option that provides choice, flexibility, and control when it comes to spending money on health care. Preventative care is covered at 100% with in-network providers, there are no copays, and all qualified employee-paid medical expenses count toward your deductible and your out-of-pocket maximum.

In-Network: In-network providers are doctors, hospitals, and other providers that contract with your insurance company to provide health care services at discounted rates.

Out-of-Network: Out-of-network providers are doctors, hospitals, and other providers that are not contracted with your insurance company. If you choose an out-of-network doctor, services will not be provided at a discounted rate.

Out-of-Pocket Maximum: The most you pay during a policy period (usually a 12-month period) before your health insurance or plan begins to pay 100% of the allowed amount. This limit does not include your premium, charges beyond Reasonable & Customary, or health care your plan doesn't cover. Check with your health insurance carrier to confirm what payments apply to the out-of-pocket maximum.

Over-the-Counter (OTC) Medications: Medications typically made available without a prescription.

Prescription Medications: Medications prescribed to you by a doctor. Cost of these medications is determined by their assigned tier: Generic, Preferred Brand Name or Non-Preferred Brand Name.

- ***Generic Drugs:*** Drugs approved by the U.S. Food and Drug Administration (FDA) to be chemically identical to corresponding Preferred Brand Name or Non-Preferred Brand Name versions. The color or flavor of a Generic medicine may be different, but the active ingredient is the same. Generic drugs are usually the most cost-effective version of any medication.

- ***Preferred Brand Name Drugs:*** Brand-name drugs on your provider's list of approved drugs. You can check online with your provider to see this list.

- ***Non-Preferred Brand Name Drugs:*** Brand-name drugs not on your provider's list of approved drugs. These drugs are typically newer and have higher copayments.

Reasonable and Customary (R&C) Allowance: Also known as an eligible expense or the Usual and Customary (U&C). The amount your insurance company will pay for a medical service in a geographical region based on what providers in the area usually charge for the same or similar medical service.

Summary of Benefits and Coverage (SBC): Mandated by health care reform, your insurance carrier or plan sponsor will provide you with a clear and easy to follow summary of your benefits and plan coverage.

NOTES

IMPORTANT CONTACTS

COVERAGE	CONTACT
MEDICAL AND PHARMACY	Humana 800-787-3311 www.humana.com Group #: 837241
DENTAL	The Standard 800-547-9515 www.standard.com Group #: 167196
VISION	The Standard 800-547-9515 www.standard.com Group #: 167196
LIFE AND AD&D	The Standard 800-628-8600 www.standard.com Group #: 167196
SHORT-TERM DISABILITY	The Standard 800-368-2589 www.standard.com Group #: 167196
HICKMAN TRANSPORT BENEFITS	STAFFCORE Benefit Administration LLC Kyle Gosdeck 608-441-3035 x5 608-441-3036 FAX Kyle.gosdeck@assuredpartners.com

AssuredPartners
STAFFORD FINANCIAL GROUP

STAFFCORE

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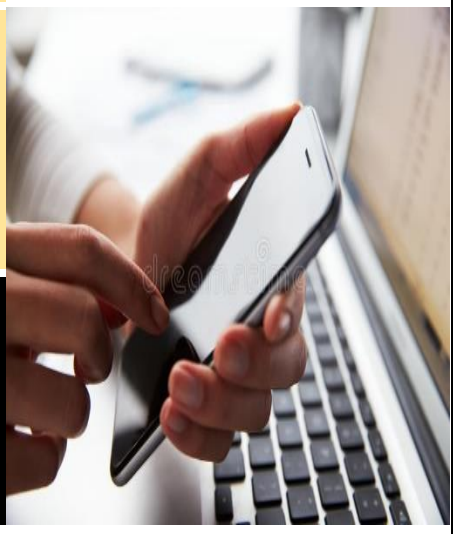


PLAN DOCUMENTS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $5,000 individual / $10,000 family; Non-Network: $15,000 individual / $30,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network Providers: Yes. Preventive Non-Network Providers: No.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers: $6,750 individual / $13,500 family For non-network providers: $20,250 individual / $40,500 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Telehealth or telemedicine services: 20% coinsurance Primary care visit: 20% coinsurance	Telehealth or telemedicine services: 40% coinsurance Primary care visit: 40% coinsurance	None
	Specialist visit	20% coinsurance	40% coinsurance	None
	Preventive care/screening/ immunization	No charge; deductible does not apply	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	Imaging: Preauthorization may be required - if not obtained, penalty will be 40%.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.humana.com/2022-Rx4-HDHP	Generic and brand-name drugs	(Retail) 20% coinsurance (Mail) 20% coinsurance	(Retail) 20% coinsurance (Mail) 20% coinsurance	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	20% coinsurance	20% coinsurance after network deductible	None
	Emergency medical transportation	20% coinsurance	20% coinsurance after network deductible	
	Urgent care	20% coinsurance	40% coinsurance	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%.
If you are pregnant	Office visits	No charge; deductible does not apply	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	Depending on the type of services, a coinsurance or deductible may apply.
	Childbirth/delivery facility services.	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	100 visits per year. Preauthorization may be required - if not obtained, penalty will be 40%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 20% coinsurance	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 40% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40%. Physical, occupational, speech, cognitive, audiology therapy and manipulations: For network, 60 visits per year combined. For non-network, 10 visits per year combined. Network and non-network visit limits reduce each other.
	Habilitation services	Physical, occupational, speech, audiology therapy and manipulations: 20% coinsurance	Physical, occupational, speech, audiology therapy and manipulations: 40% coinsurance	
	Skilled nursing care	20% coinsurance	40% coinsurance	60 days per year. Preauthorization may be required - if not obtained, penalty will be 40%.
	Durable medical equipment	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%. Excludes vehicle and home modifications, exercise, and bathroom equipment.
	Hospice services	20% coinsurance	40% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture, if it is prescribed by a physician
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery, if to correct a functional impairment
- Dental care (Adult), if for dental injury of a sound natural tooth
- Hearing aids, $3000 per hearing aid to age 19; 1 aid per ear per 48 months

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- www.humana.com or 1-866-4ASSIST (427-7478).
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information on how to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Georgia Office of Insurance and Safety Fire Commissioner: 1-800-656-2298 or www.oci.ga.gov.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478) (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$5,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$6,520**

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$5,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,000
Copayments	$0
Coinsurance	$100
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$5,100**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	$5,000
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$2,800
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,800**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**. Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you.

1-866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

GCHJV5REN 0220

Language assistance services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit www.groupcertificate.humana.com or by calling 1-866-4ASSIST (427-7478). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-866-4ASSIST (427-7478) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Network: $0 individual / $0 family; Non-Network: $5,000 individual / $10,000 family	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Network Providers: Not Applicable. Non-Network Providers: Yes. Emergency Room Care and Prescription Drugs	This plan does not have a network deductible. This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $7,150 individual / $14,300 family For non-network providers $21,450 individual / $42,900 family	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover, penalties, non-network transplant, non-network prescription drugs, non-network specialty drugs, non-network immune effector cell therapy	Even though you pay these expenses, they don't count toward the out–of–pocket limit.

Will you pay less if you use a network provider?	Yes. See www.humana.com/directories or call 1-866-4ASSIST (427-7478) for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	Telehealth or telemedicine services: $55 copay/office visit Primary care visit: $55 copay/office visit	Telehealth or telemedicine services: 30% coinsurance Primary care visit: 30% coinsurance	None
	Specialist visit	$110 copay/visit	30% coinsurance	None
	Preventive care/screening/ immunization	No charge	30% coinsurance	
If you have a test	Diagnostic test (x-ray, blood work)	No charge	30% coinsurance	Imaging: Preauthorization may be required - if not obtained, penalty will be 40%.
	Imaging (CT/PET scans, MRIs)	$850 copay/visit	30% coinsurance	
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at** https://www.humana.com/2020-rx4/	Level 1 - Low-cost generic and brand-name drugs	(Retail) $10 copay/prescription (Mail) $25 copay/prescription	(Retail) $10 copay/prescription; deductible does not apply (Mail) $25 copay/prescription; deductible does not apply	(Retail) 30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug. (Mail Order) 90 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Level 2 - Higher-cost generic and brand-name drugs	(Retail) $50 copay/prescription (Mail) $125 copay/prescription	(Retail) $50 copay/prescription; deductible does not apply (Mail) $125 copay/prescription; deductible does not apply	
	Level 3 - High-cost, mostly brand-name drugs	(Retail) $100 copay/prescription (Mail) $250 copay/prescription	(Retail) $100 copay/prescription; deductible does not apply (Mail) $250 copay/prescription; deductible does not apply	
	Level 4 - Highest-cost drugs	(Retail) 25% coinsurance (Mail) 25% coinsurance	(Retail) 25% coinsurance; deductible does not apply (Mail) 25% coinsurance; deductible does not apply	
	Specialty Drugs	Preferred network specialty pharmacy: 25% coinsurance Network specialty pharmacy: 35% coinsurance	50% coinsurance; deductible does not apply	30 day supply. Preauthorization may be required - if not obtained, member is responsible for 100% of the cost of the drug.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$2350 copay/visit	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need immediate medical attention	Emergency room care	$850 copay/visit	$850 copay/visit; deductible does not apply	Emergency room care: Copayment waived if admitted.
	Emergency medical transportation	$850 copay/transport	$850 copay/transport; deductible does not apply	
	Urgent care	$125 copay/visit	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$2350 copay/day	30% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 40%.
	Physician/surgeon fees	No charge	30% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Therapy: $55 copay/visit Other outpatient non-surgical services: No charge	Therapy: 30% coinsurance Other outpatient non-surgical services: 30% coinsurance	None
	Inpatient services	$2350 copay/day	30% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 40%.
If you are pregnant	Office visits	No charge	30% coinsurance	Cost sharing does not apply for preventive services.
	Childbirth/delivery professional services	No charge	30% coinsurance	Depending on the type of services, a copayment may apply.
	Childbirth/delivery facility services.	$2350 copay/day	30% coinsurance	3 days for copay per day per admission. Preauthorization may be required - if not obtained, penalty will be 40%. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
If you need help recovering or have other special health needs	Home health care	$110 copay/visit	30% coinsurance	100 visits per year. Preauthorization may be required - if not obtained, penalty will be 40%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Non-Network Provider (You will pay the most)	
	Rehabilitation services	Physical, occupational, speech, cognitive, audiology therapy and manipulations: $110 copay/visit	Physical, occupational, speech, cognitive, audiology therapy and manipulations: 30% coinsurance	Therapies: Preauthorization may be required - if not obtained, penalty will be 40%. Physical, occupational, speech, cognitive, audiology therapy and manipulations: For network, 60 visits per year combined. For non-network, 10 visits per year combined. Network and non-network visit limits reduce each other.
	Habilitation services	Physical, occupational, speech, audiology therapy and manipulations: $110 copay/visit	Physical, occupational, speech, audiology therapy and manipulations: 30% coinsurance	
	Skilled nursing care	$110 copay/day	30% coinsurance	60 days per year. Preauthorization may be required - if not obtained, penalty will be 40%.
	Durable medical equipment	No charge	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%. Excludes vehicle and home modifications, exercise, and bathroom equipment.
	Hospice services	No charge	30% coinsurance	Preauthorization may be required - if not obtained, penalty will be 40%.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of other excluded services.)

- Bariatric surgery
- Child dental check-up
- Child eye exam
- Child glasses
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your **plan** document.)

- Acupuncture, if it is prescribed by a physician
- Chiropractic care - spinal manipulations are covered
- Cosmetic surgery, if to correct a functional impairment
- Dental care (Adult), if for dental injury of a sound natural tooth
- Hearing aids, $3000.00 per aid per 48 months; 1 aid per ear per 48 months

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is:

- www.humana.com or 1-866-4ASSIST (427-7478).
- For group health coverage subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- www.humana.com or 1-866-4ASSIST (427-7478).
- Department of Labor Employee Benefits Security Administration: 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- Georgia Office of Insurance and Safety Fire Commissioner: 1-800-656-2298 or www.oci.ga.gov.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet Minimum Value Standards? Yes.

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-866-4ASSIST (427-7478) (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of **in-network** pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$110**
Hospital (facility) copayment	**$2350**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$4,700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$10
The total Peg would pay is	**$4,710**

Managing Joe's type 2 Diabetes
(a year of routine **in-network** care of a well-controlled condition)

The plan's overall deductible	**$0**
Specialist copayment	**$110**
Hospital (facility) copayment	**$2350**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$2,100
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$2,100**

Mia's Simple Fracture
(**in-network** emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$110**
Hospital (facility) copayment	**$2350**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,400**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender identity, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-866-427-7478** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.

Complaint forms are available at **https://www.hhs.gov/ocr/office/file/index.html**.

Auxiliary aids and services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

GCHJV5REN 1018

Language assistance services, free of charge, are available to you. 1-866-427-7478 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。

فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.

Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę niká'adoowoł.

العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك

Hickman Transport Co Inc

Group Dental Insurance

Help protect your oral health with regular dental exams and procedures.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered dental care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Dental Plan Summary **Effective Date: 3/1/2020**

Plan Benefit	
Type 1 (Preventive)	100%
Type 2 (Basic)	80%
Type 3 (Major)	50%
Waiting Period	None
Deductible	$50/Calendar Year Type 2 & 3
	Waived Type 1
	$150/family
Maximum *(per person)*	$1,000 per calendar year
Allowance	80% usual and customary
Max Builder[SM]	Included
Annual Eye Exam	None
Annual Open Enrollment	Included

Sample Procedure Listing (*Current Dental Terminology* © American Dental Association.)

Type 1	Type 2	Type 3
• Routine Exam (2 per benefit period) • Bitewing X-rays (1 per benefit period) • Full Mouth/Panoramic X-rays (1 in 5 years) • Periapical X-rays • Cleaning (2 per benefit period) • Fluoride for Children 13 and under (1 per benefit period)	• Sealants (age 13 and under) • Space Maintainers • Restorative Amalgams • Restorative Composites • Simple Extractions	• Onlays • Crowns (1 in 10 years per tooth) • Crown Repair • Endodontics (nonsurgical) • Endodontics (surgical) • Periodontics (nonsurgical) • Periodontics (surgical) • Denture Repair • Prosthodontics (fixed bridge; removable complete/partial dentures) (1 in 5 years) • Complex Extractions • Anesthesia

Monthly Rates	
Employee Only (EE)	$19.62
EE + Spouse	$40.02
EE + Children	$47.66
EE + Spouse & Children	$68.90

Hickman Transport Co Inc

Max Builder℠

This dental plan includes a valuable feature that allows plan participants to carry over part of their unused annual maximum. A participant must submit at least one claim during the benefit year while staying at or under the plan-specific threshold amount. Earns an extra reward, called the PPO Bonus, by seeing a Network Provider. Employees and their covered dependents may accumulate rewards up to the stated maximum carry-over amount, then use those rewards for any covered dental procedures subject to applicable coinsurance and plan provisions. If a plan participant doesn't submit a dental claim during a benefit year, all accumulated rewards will be lost; but he or she can begin earning rewards again the very next year.

Benefit Threshold	$500	Dental benefits received for the year cannot exceed this amount
Annual Carryover Amount	$250	Max Builder amount is added to the following year's maximum
Annual PPO Bonus	$100	Additional bonus is earned if the participant sees a network provider
Maximum Carryover	$1,000	Maximum possible accumulation for Max Builder and PPO Bonus combined

Dental Network Information

Employees and dependents have access to an extensive nationwide network of member dentists. The cost-saving benefits of visiting a network member provider are automatically available to all employees and dependents who are covered by any of The Standard's dental plans and who live in areas where the nationwide network is available. To find member dentists in your area, visit **http://www.standard.com/services** and click on "Find a Dentist."

Pretreatment

While we don't require a pretreatment authorization form for any procedure, we recommend them for any dental work you consider expensive. As a smart consumer, it's best for you to know your share of the cost up front. Simply ask your dentist to submit the information for a pretreatment estimate to our customer relations department. We'll inform both you and your dentist of the exact amount your insurance will cover and the amount that you will be responsible for. That way, there won't be any surprises once the work has been completed.

Open Enrollment

If a member does not elect to participate when initially eligible, the member may elect to participate at the policyholder's next enrollment period. This enrollment period will be held each year and those who elect to participate in this policy at that time will have their insurance become effective on March 1.

Submitting a claim

Your policy requires all claims be received by The Standard within 90 days of the date of service. You may submit a claim, or your Dentist can file your claim on your behalf and you can assign payment to your Dentist. If the 90 day deadline is missed, you will be responsible for covering the cost of the service. *Requirements for claims submission vary by state, please consult your group certificate for details.

Prior Extraction Limitation

Your policy has a prior extraction limitation, also known as the "missing tooth clause". This means that if you had a tooth extracted prior to enrolling in your plan with The Standard, we may or may not pay for any benefits towards replacing that tooth. Please review your policy or contact Customer Service for details.

Hickman Transport Co Inc

Late Entrant Provision

We strongly encourage you to sign up for coverage when you are initially eligible. If you choose not to sign up during this initial enrollment period, you will become a late entrant. Late entrants will be eligible for only exams, cleanings, and fluoride applications for the first 12 months they are covered.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Customer Service

Customer service is available to plan participants through our well-trained and helpful service representatives. Call or go online to locate the nearest network provider, view plan benefit information and more.

Call Center: 800.547.9515

- Service representative hours:
  5 a.m. to 10 p.m. Pacific Monday through Thursday
  5 a.m. to 4:30 p.m. Pacific Friday
- Interactive Voice Response available 24/7

View plan benefit information at:
www.standard.com/services.

About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

Hickman Transport Co Inc

Group Vision Insurance

Help protect your eye health with coverage for exams, glasses and contacts.

This summary of benefits and coverage shows how you and The Standard would share the cost for covered vision care services.
NOTE: This is only a summary; for detailed information on coverage, please consult your certificate of coverage.

Plan 1: Balanced Care Vision I Plan Summary **Effective Date: 3/1/2020**

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	Participant cost up to $60	Not covered
Elective	Up to $150	Up to $120
Medically Necessary	Covered in full	Up to $210
Frame Allowance	$150**	Up to $75
Frequencies (months)		
Exam/Lens/Frame	12/12/24	12/12/24
	Based on date of service	Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco allowance will be the wholesale equivalent.*

Lens Options (participant cost)*

	VSP Choice Network + Affiliates	Out of Network
	(Other than Costco)	
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	Not covered
Solid Plastic Dye	$15 (except Pink I & II)	Not covered
Plastic Gradient Dye	$17	Not covered
Photochromatic Lenses (Glass & Plastic)	$31-$82	Not covered
Scratch Resistant Coating	$17-$33	Not covered
Anti-Reflective Coating	$43-$85	Not covered
Ultraviolet Coating	$16	Not covered

**Lens Option participant costs vary by prescription, option chosen and retail locations.*

Hickman Transport Co Inc

Monthly Rates	
Employee Only (EE)	$4.88
EE + Spouse	$11.46
EE + Children	$12.12
EE + Spouse & Children	$19.36

Additional Balanced Care Vision I Choice Network Features	
Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for participants is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Retail Chain Affiliate Providers Available With Balanced Care Vision I Plans

Retail chain affiliate providers, which include Costco® Optical and Visionworks, give participants added convenience and additional retail choices. Costco Optical has 400 locations across the country, while Visionworks manages nearly 400 optical stores in 37 states and DC, including well-known stores such as EyeMasters, Visionworks, Dr. Bizer's VisionWorld, Eye DRx, and Hour Eyes, to name a few. Participants enjoy a covered-in-full benefit experience with equivalent frame benefit at any of these retail chain locations.

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Vision Plan Participant Service

Balanced Care Vision I from The Standard features the money-saving eye care network of VSP. Customer service is available to plan participants through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more.

VSP Call Center: 800.877.7195

- Service representative hours: 5 a.m. to 7 p.m. Pacific Monday through Friday, 6 a.m. to 2:30 p.m. Pacific Saturday
- Interactive Voice Response available 24/7

Locate a VSP provider at:
www.standard.com/services

Hickman Transport Co Inc

About The Standard

For more than 100 years, we have been dedicated to our core purpose: to help people achieve financial well-being and peace of mind. Headquartered in Portland, Oregon, The Standard is a nationally recognized provider of group employee benefits. To learn more about products from The Standard, visit us at **www.standard.com**.

The Standard is a marketing name for StanCorp Financial Group, Inc. and subsidiaries. Insurance products are offered by Standard Insurance Company of Portland, Oregon, in all states except New York. Product features and availability vary by state and are solely the responsibility of Standard Insurance Company.

This form is a benefit highlight, not a certificate of insurance. This policy has exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or terminated. Please contact The Standard or your employer for additional information, including costs and complete details of coverage.

Standard Insurance Company
Hickman Transport, Inc.
Group Policy #167196
Effective Date March 1, 2020

Group Short Term Disability Insurance

Group Short Term Disability insurance from Standard Insurance Company helps provide financial protection for insured members by promising to pay a weekly benefit in the event of a covered disability.

The cost of this insurance is paid by Hickman Transport, Inc. and may be added to your gross monthly income. If premium payments are made with "after-tax" dollars, benefits are federally tax-free under current federal tax law.

Eligibility

Definition of a Member	You are a member if you are a regular employee of Hickman Transport, Inc., actively working at least 30 hours per week, and a citizen or resident of the United States or Canada. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 60 consecutive days as a member.

Benefits

Weekly Benefit	60 percent of the first $833 of weekly predisability earnings as of the date of disability, reduced by deductible income (e.g., work earnings, workers' compensation, state disability, etc.)
Maximum Weekly Benefit	$500
Minimum Weekly Benefit	$15
Benefit Waiting Period	Your weekly benefit becomes payable after you have been continuously disabled for 7 days for disability caused by accidental injury and after 7 days for disability caused by physical disease, pregnancy or mental disorder.

Definition of Disability	For the benefit waiting period and while the Short Term Disability benefits are payable, you are considered disabled if you: • Are unable – as a result of physical disease, injury, pregnancy or mental disorder – to perform with reasonable continuity the material duties of your own occupation, and • Suffer a loss of at least 20 percent of your predisability earnings when working in your own occupation You are not considered disabled merely because your right to perform your own occupation is restricted, including a restriction or loss of license. You will no longer be considered disabled when your earnings from any occupation meet or exceed 80 percent of your predisability earnings.
Maximum Benefit Period	90 days

Other Features and Services

- Reasonable Accommodation Expense Benefit
- Return to Work Incentive
- Temporary Recovery Provision

This information is only a brief description of the group Short Term Disability insurance policy sponsored by Hickman Transport, Inc. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reduction in benefits, exclusions and when The Standard and Hickman Transport, Inc. may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13275-D-GA-167196 (1/20)
6313130-490954

Standard Insurance Company
Hickman Transport, Inc.
Group Policy #167196
Effective Date March 1, 2020

Group Basic Life and Accidental Death and Dismemberment Insurance

Group Basic Life insurance from Standard Insurance Company helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance may provide an additional amount in the event of a covered death or dismemberment as a result of an accident.

The cost of this insurance is paid by Hickman Transport, Inc.

Eligibility

Definition of a Member	You are a member if you are an active employee of Hickman Transport, Inc. and regularly working at least 30 hours each week. You are not a member if you are a temporary or seasonal employee, a full-time member of the armed forces, a leased employee or an independent contractor.
Eligibility Waiting Period	You are eligible on the first of the month that follows 60 consecutive days as a member.

Benefits

Basic Life Coverage Amount	Your Basic Life coverage amount is $25,000.
Basic AD&D Coverage Amount	For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount. For other covered losses, a percentage of this benefit will be payable.
Life Age Reductions	Basic Life and AD&D insurance coverage amount reduces to 65 percent at age 65, to 50 percent at age 70 and to 35 percent at age 75.

Other Basic Life Features and Services

- Accelerated Benefit
- Life Services Toolkit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Seat Belt Benefit

This information is only a brief description of the group Basic Life/AD&D insurance policy sponsored by Hickman Transport, Inc. The controlling provisions will be in the group policy issued by The Standard. The group policy contains a detailed description of the limitations, reductions in benefits, exclusions and when The Standard and Hickman Transport, Inc. may increase the cost of coverage, amend or cancel the policy. A group certificate of insurance that describes the terms and conditions of the group policy is available for those who become insured according to its terms. For more complete details of coverage, contact your human resources representative.

Standard Insurance Company
1100 SW Sixth Avenue
Portland OR 97204

www.standard.com

SI 13279-D-GA-167196 (1/20)
6313130-490953


TheStandard®
Explore the world with confidence.
Rely on Travel Assistance when you're away from home.
Standard Insurance Company

Things can happen on the road. Passports get stolen or lost. Unforeseen events or circumstances derail travel plans. Medical problems surface at the most inconvenient times. Travel Assistance can help you navigate these issues and more at any time of the day or night.

You and your spouse are covered with Travel Assistance[1] — and so are kids through age 25 — with your group insurance from Standard Insurance Company (The Standard).

Security That Travels with You

Travel Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including:

Passport, visa, weather and currency exchange information, health hazards advice and inoculation requirements

Emergency ticket, credit card and passport replacement, funds transfer and missing baggage

Help replacing prescription medication or lost corrective lenses and advancing funds for emergency medical payment

Emergency evacuation to the nearest adequate medical facility and medically necessary repatriation to the employee's home, including repatriation of remains[2]

Connection to medical care providers, interpreter services, a local attorney, consular office or bail bond services

Return travel companion if travel is disrupted due to emergency transportation services or return dependent children if left unattended due to prolonged hospitalization[2]

Logistical arrangements for ground transportation, housing and/or evacuation in the event of a natural disaster, political unrest and social instability

Contact Travel Assistance

866.455.9188
United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda

+1.240.330.1380
Everywhere else

ops@gga-usa.com

standard.com/travel

Travel Assistance is available if you travel more than 100 miles from home or in a foreign country.

Travel Risk Intelligence Portal
standard.com/travel

For first time activation, use the following information:
Group ID: D2STD
Activation Code: 181002

Contact
866.455.9188: United States, Canada, Puerto Rico, U.S. Virgin Islands and Bermuda
+1.240.330.1380: Everywhere else
ops@gga-usa.com

In all cases, the medical professionals, medical facilities or legal counsel suggested by Generali Global Assistance (GGA) to provide services to Participants are not employees or agents of The Standard or GGA, and the final decision to utilize any such medical professional, medical facility, or legal counsel is the Participant's choice alone. The Standard and GGA are not responsible and shall not be liable for any wrongful act or omission of any transportation provider, healthcare professional or legal counsel who is not an employee of The Standard or GGA, as applicable. Generali Global Assistance is the marketing name for GMMI, Inc.

1 Travel Assistance is provided by Generali Global Assistance. Generali Global Assistance (GGA) is the marketing name used by GMMI, Inc. for their services, which is not affiliated with The Standard. Travel Assistance is subject to the terms and conditions, including exclusions and limitations of the Travel Assistance Program Description. GGA is solely responsible for providing and administering the included service. Travel Assistance is not an insurance product. This service is only available while insured under The Standard's group policy.

2 Must be arranged by Generali Global Assistance. The Combined Single Limit (CSL) for these services is $1 million. One service or combination of the services may exceed the CSL. The insured is responsible for payment of any expenses that exceed the CSL.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

SI **14684**

Travel Assistance EE
(1/19)

The Life Services Toolkit

Resources and Tools to Support You and Your Beneficiary

Group Life insurance through your employer gives you assurance that your family will receive some financial assistance in the event of a death. But coverage under a group Life policy from Standard Insurance Company (The Standard) does more than help protect your family from financial hardship after a loss. We have partnered with Morneau Shepell to offer a lineup of additional services that can make a difference now and in the future.

Online tools and services can help you create a will, make advance funeral plans and put your finances in order. After a loss, your beneficiary can consult experts by phone or in person, and obtain other helpful information online.

The Life Services Toolkit is automatically available to those insured under a group Life insurance policy from The Standard.

Services to Help You Now

Visit the Life Services Toolkit website at **standard.com/mytoolkit** and enter user name "assurance" for information and tools to help you make important life decisions.

- **Estate Planning Assistance:** Online tools walk you through the steps to prepare a will and create other documents, such as living wills, powers of attorney and health care agent forms.
- **Financial Planning:** Consult online services to help you manage debt, calculate mortgage and loan payments, and take care of other financial matters with confidence.
- **Health and Wellness:** Timely articles about nutrition, stress management and wellness help employees and their families lead healthy lives.
- **Identity Theft Prevention:** Check the website for ways to thwart identity thieves and resolve issues if identity theft occurs.
- **Funeral Arrangements:** Use the website to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements in advance.

If you are a recipient of an Accelerated Benefit,[1] you may access the services for beneficiaries outlined on the next page.

continued on reverse

1 An Accelerated Benefit allows a covered individual who becomes terminally ill to receive a portion of the Life insurance proceeds while living, if all other eligibility requirements are met.

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

Life Services Toolkit
SI **17526** (10/17) EE

Services for Your Beneficiary

Life insurance beneficiaries[2] can access services for 12 months after the date of death. Recipients of an Accelerated Benefit can access services for 12 months after the date of payment.

These supportive services can help your beneficiary cope after a loss:

- **Grief Support:** Clinicians with master's degrees are on call to provide confidential grief sessions by phone or in person. Your beneficiaries are eligible for up to six face-to-face sessions and unlimited phone contact.

  Our clinicians may offer your beneficiaries additional grief support through books sent to their home, based on each individual's needs. As part of this program, age-appropriate books can be sent for children and teens.

- **Legal Services:** Your beneficiaries can obtain legal assistance from experienced attorneys. They can:

  - Schedule an initial 30-minute office and a telephone consultation with a network attorney. Beneficiaries who wish to retain a participating attorney after the initial consultation receive a 25 percent rate reduction from the attorney's normal hourly or fixed-fee rates.

  - Obtain an estate-planning package that consists of a simple will, a living will, a health care agent form and a durable power of attorney.

- **Financial Assistance:** Your beneficiaries have unlimited phone access to financial counselors who can help with issues such as budgeting strategies, and credit and debt management, including hour-long sessions on topics requiring more in-depth discussion.

- **Support Services:** During an emotional time, your beneficiaries can receive help planning a funeral or memorial service. Work-life advisors can guide them to resources to help manage household repairs and chores; find child care and elder care providers; or organize a move or relocation.

- **Online Resources:** Your beneficiaries can easily access additional services and features on the Life Services Toolkit website for beneficiaries, including online resources to calculate funeral costs, find funeral-related services and make decisions about funeral arrangements.

Beneficiaries can participate in phone consultations or in-person meetings with trained grief counselors.

For beneficiary services, visit standard.com/mytoolkit (user name = support) or call the assistance line at 800.378.5742.

2 The Life Services Toolkit is not available to Life insurance beneficiaries who are minors or to non-individual entities such as trusts, estates, charities.

The Life Services Toolkit is provided through an arrangement with Morneau Shepell and is not affiliated with The Standard. Morneau Shepell is solely responsible for providing and administering the included service. This service is not an insurance product.

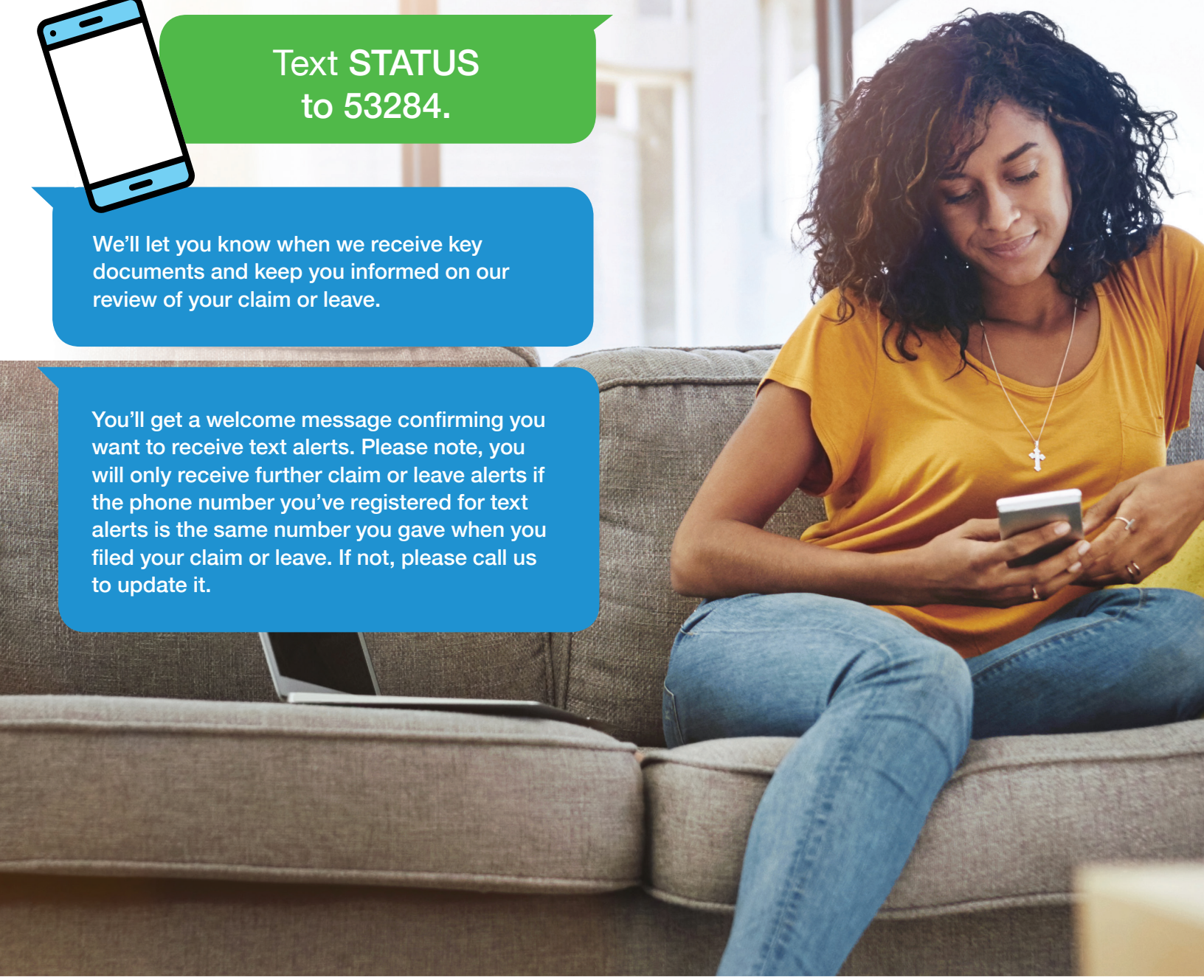
Get text alerts on the status of your claim or leave.

TheStandard®

Text **STATUS** to 53284.

We'll let you know when we receive key documents and keep you informed on our review of your claim or leave.

You'll get a welcome message confirming you want to receive text alerts. Please note, you will only receive further claim or leave alerts if the phone number you've registered for text alerts is the same number you gave when you filed your claim or leave. If not, please call us to update it.



Frequency and number of messages will vary based on your claim or leave. Message and data rates may apply. You can text STOP to 53284 any time to unsubscribe and stop receiving messages. Go to standard.com/sms for our terms and conditions and to review our Privacy Notice.

The text messages are offered to provide status updates but do not replace written communications you will receive by mail. The information sent via text message is based on information at the time of the message only; a change of information could change your claim or leave. Please review all written communications you receive from The Standard related to your claim.

When you're sick or injured, your main focus should be on your health – not untangling medical bills, scheduling appointments and coordinating your care with specialists and other providers.

Help is Only a Phone Call Away

Fortunately, you don't have to take on the healthcare system by yourself. While you're out on a short term disability claim, you can connect with a Personal Health Advocate who'll help you navigate the complexities of the healthcare system. Simply take advantage of Health Advocacy Select, a service that's included with your group Short Term Disability insurance coverage through Standard Insurance Company (The Standard).

An Expert by Your Side

At no additional cost, you can contact Health *Advocate*™ [1] and be assigned a Personal Health Advocate, typically a registered nurse, who will remain on your case until it's fully resolved. From start to finish, you'll work with one person sparing you the headache of explaining your concerns to someone who might be unfamiliar with your situation.

Your Personal Health Advocate can assist you in quickly and efficiently working through healthcare management issues.

Some ways they can help you are:

- **Understand** and take maximum advantage of your medical benefits.
- **Make sense** of your diagnosis and research treatment options.
- **Find and schedule appointments** with the right doctors and specialists, particularly for complex medical conditions where a second opinion is appropriate.
- **Locate specialists** for high-risk pregnancies and find pediatricians.
- **Manage your out-of-pocket expenses** by finding alternative services and cost information.
- **Locate** necessary post pregnancy support in the event of a difficult delivery or when complications arise.
- **Resolve** medical claims and billing issues.
- **Find resources** for services that may not be covered through your employer's health benefits program.

All cases are managed in compliance with state and federal privacy laws. Your personal medical information is kept strictly confidential.

TheStandard®

Personal Health Advocates available Monday - Friday, 8 a.m. - 12 a.m., Eastern at:

844.450.5543

Standard Insurance Company
1100 SW Sixth Avenue
Portland, OR 97204

standard.com

1 Health Advocacy services are provided through an arrangement with Health Advocate, a leading health advocacy and assistance company. Health Advocate is not affiliated with The Standard or any insurance or third-party provider, and does not replace health insurance coverage, provide medical care or recommend treatment.

Health Advocacy Select
SI **18390** (5/17) EE

REQUIRED NOTICES

These required notices must be distributed to all employees on an annual basis and are **informational only**. **No action is needed on your part.**

GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS
Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 after the qualifying event occurs. You must provide this notice to your employer.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee

or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Matthew White
Hickman Transport Co., Inc.
200 East Gordon Street
Valdosta, GA 31601
229-247-4150
matt@hickmantransport.com

HIPAA PRIVACY AND SECURITY STANDARDS

General

If a Health Benefit Program is not exempted from the requirements of the Privacy Standards and the Security Standards, then this Section shall apply. The Plan intends to comply with any applicable state laws relating to privacy and security.

Privacy and Security Standards

The Plan shall not disclose Protected Health Information to any member of an Employer's workforce unless each of the conditions set out in this Section are met. "Protected Health Information" shall have the same definition as set forth in the Privacy Standards but generally shall mean individually identifiable information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment. "Protected Health Information" shall include "genetic information," as defined in the Privacy Standards. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

Protected Health Information disclosed to members of Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan treatment, payment functions and health care operations. The terms "treatment," "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" shall include activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for health care. Genetic information shall not be used or disclosed for "underwriting" purposes, as defined in the Privacy Standards.

The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for that person to perform his or her duties with respect to the Plan. "Members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer. The Employer shall keep an updated list of those authorized to receive Protected Health Information.

1) An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.
2) In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by this Section and the Privacy Standards, the incident shall be reported to the Plan's privacy officer. The privacy officer shall take appropriate action, including:

    a. investigation of the incident to determine whether the breach occurred inadvertently, through negligence or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

    b. appropriate sanctions against the persons causing the breach which, depending upon the nature of the breach, may include oral or written reprimand, additional training, or termination of employment;

    c. mitigation of any harm caused by the breach, to the extent practicable; and documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

3) By executing the Adoption Agreement, the Company and all Employers agree to:

a. Not use or further disclose the information other than as permitted or required by the Plan documents or as required by law;

b. Implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan.

c. Ensure that any agent or subcontractor, (i) to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information, and/or (ii) to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

d. Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

e. Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures permitted by this Section, or required by law;

f. Make available Protected Health Information to individual Plan members as required by Section 164.524 of the Privacy Standards;

g. Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information as required by Section 164.526 of the Privacy Standards;

h. Make available the Protected Health Information required to provide an accounting of disclosures to individual Plan members as required by Section 164.528 of the Privacy Standards;

i. Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

j. If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

k. Ensure the adequate separation between the Plan and members of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards and set out in (d) above, and to use reasonable and appropriate security measures to comply with this provision.

HIPAA - SPECIAL ENROLLMENT OPPORTUNITIES

There are certain situations where the employee may enroll as a late enrollee, such as loss of other coverage, marriage and birth or adoption of a child.

If you are declining enrollment for yourself or your dependents (including your spouse) because of other group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, domestic partnership, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage; or 60 days after a birth, adoption, or placement for adoption.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical benefits.

NATIONAL MEDICAL SUPPORT NOTICE

State and federal laws provide for a special enrollment opportunity for children in certain cases when ordered by a court. The enrollment opportunity is for eligible children who are not currently covered, and it may provide an enrollment opportunity not otherwise available. When the court orders such coverage for a child or children, a copy of the National Medical Support Notice should be attached to the application.

If the parent named in the notice is currently enrolled, the child(ren) will be added to his or her current plan. If the parent is not enrolled, in most circumstances the issuing agency will select the plan for family coverage. If the issuing agency does not, the employee will be enrolled in the company's default plan.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not 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 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier. Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other Health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceeds 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

PATIENT PROTECTION AND AFFORDABLE CARE ACT

If a Health Benefit Program is not exempted under ERISA § 732 from the requirements of Title I of the Patient Protection and Affordable Care Act of 2010, the Health Benefit Program shall be operated in accordance with such requirements.

If the plans and issuers **require or allow for the designation of primary care providers** by participants or beneficiaries:

> Employers medical plan requires/allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance coverage designates a primary care provider automatically, until you make this designation, the group health plan or health insurance issuer will designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator or issuer.

If the plans and issuers require or allow for the designation of a primary care provider for a child: you may designate a pediatrician as the primary care provider.

If the plans and issuers that provide coverage **for obstetric or gynecological care and require the designation by a participant or beneficiary of a primary care provider**:

> You do not need prior authorization from the group health plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator or issuer.

“Underwriting” includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

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

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

WOMEN'S HEALTH AND CANCER RIGHTS ACT NOTICE

The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. The WHCRA which amends ERISA, requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies.

Because your group health plan offers coverage for mastectomies, WHCRA applies to your plan. The law mandates that a participant who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy will also receive coverage for:

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual deductible, coinsurance and/or copayment provisions otherwise applicable under the policy/plan.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

GINA prohibits a group health plan from adjusting group premium or contribution amounts for a group of similarly situated individuals based on the genetic information of members of the group.

The term "genetic information" means, with respect to any individual, information about:

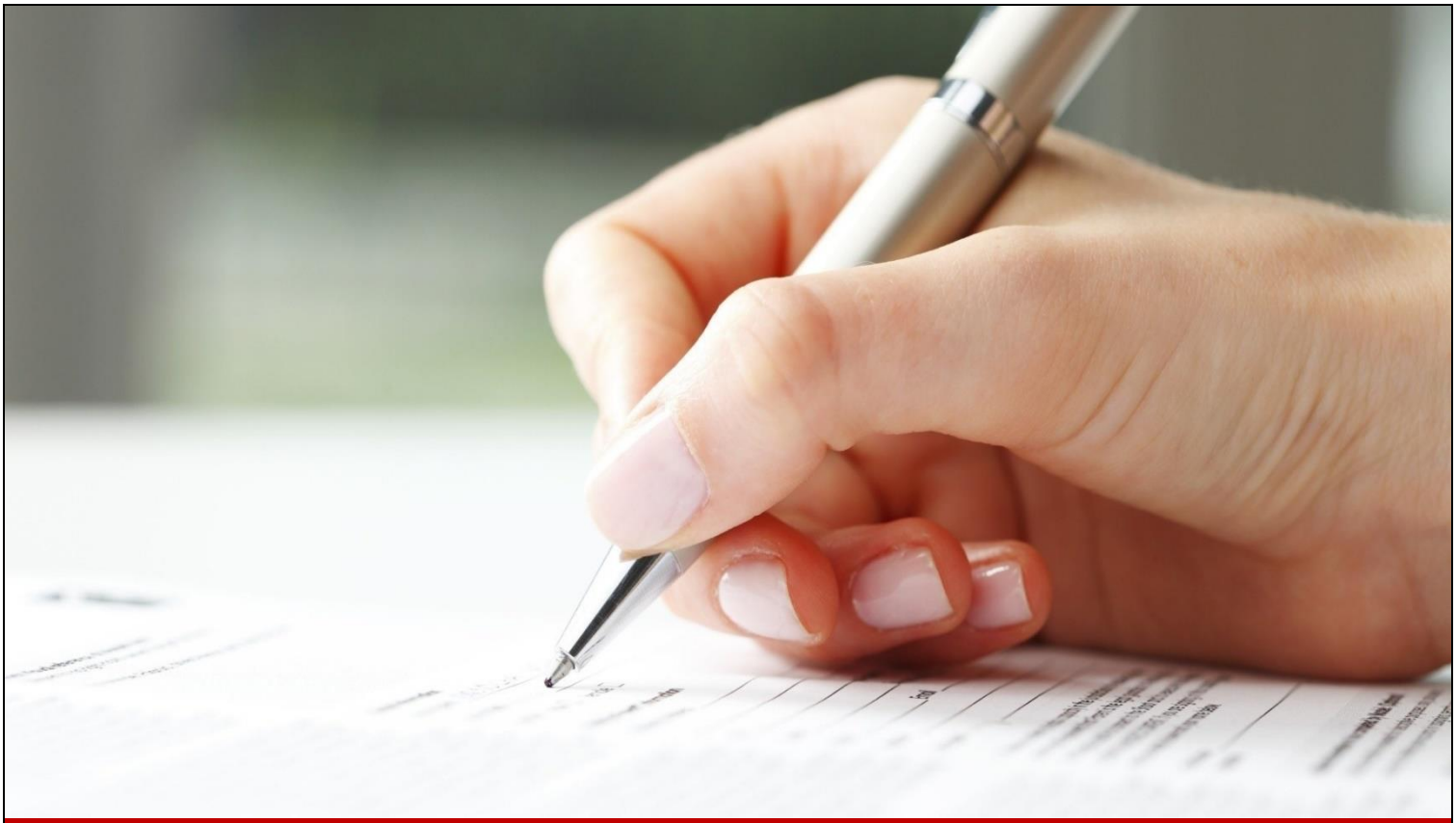
1) Such individual's genetic tests;

2) The genetic tests of family members of such individual; and

3) The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

"Family members" include dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption.



ENROLLMENT FORMS

BENEFIT ENROLLMENT/CHANGE FORM

Full-Time SCA Employee

EMPLOYEE INFORMATION

Employee Name		Social Security Number
Address, City, State, Zip		Date of Birth
Phone Number	Email Address	Date of Hire

ENROLLMENT TYPE AND DEADLINES

REASON FOR ENROLLMENT OR CHANGE **DATE OF EVENT:**_____

- ☐ New Hire/Newly Eligible
- ☐ Open Enrollment
- ☐ Marriage/Divorce
- ☐ Birth/Adoption of Child
- ☐ Loss of Other Coverage
- ☐ Death of Spouse/Child
- ☐ Other: _____

You have 30 days from your event date to complete and return this form. **New Hire/Newly Eligible:** If your form is not returned within 30 days, you will be automatically enrolled in required benefits only. Changes to your election will be allowed only during the Open Enrollment period, if you experience a qualifying event, or cancel your coverage. **Qualifying Life Event:** If your form is not returned within 30 days of your event date, no changes will be made to your existing benefit enrollments. You will only be allowed to change your elections during the Open Enrollment period, if you experience another qualifying event, or cancel your coverage.

MEDICAL ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ Humana BASIC Medical Plan
- ☐ Humana BUY UP Medical Plan
- ☐ Decline Medical Coverage

Please complete the **Waiver of Group Medical Insurance Coverage** form if waiving the group medical insurance. Proof of other medical coverage (i.e., spousal plan, VA, TRICARE, individual plan that meets ACA guidelines) must be provided. **Medicare and Medicaid are not valid waivers.**

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family

DENTAL ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ The Standard Dental Plan
- ☐ Decline Dental Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family

VISION ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ The Standard Vision Plan
- ☐ Decline Vision Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Spouse/Domestic Partner
- ☐ Employee + Child(ren)
- ☐ Employee + Family

DEPENDENT COVERAGE INFORMATION

IDENTIFY DEPENDENTS AND COVERAGE *(include additional page if necessary):*

Circle One	First and Last Name	Date of Birth	Gender	SSN	Check Coverage
ADD REMOVE	**Spouse/Domestic Partner**				☐ Medical ☐ Dental ☐ Vision
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision

AUTHORIZATION AND SIGNATURE – READ, SIGN AND DATE

I hereby authorize Hickman Transport Co., Inc. to deduct the necessary premiums, if any, from my paycheck. I understand that my contributions for premiums shall be taken from my salary prior to the calculation of taxes, thus reducing my gross taxable salary. I understand that there will be no withholding of Federal or State Income Tax amounts reported as income to me on my W-2 statement. I understand that my elections are irrevocable during the plan year except for Qualified Life Event changes, change in eligibility status, or during the annual Open Enrollment period.

_____ _____

Employee Signature *Date*

_____

Employee Name (please print)

SUBMIT YOUR FORM TO:

	By US Mail or In Person	By Fax	By Email
Hannah Hannah Hickman Transport	200 East Gordon Street Valdosta, GA 31601	229-247-0513	hannah@hickmantransport.com

For more information regarding your plan benefits, please contact Kyle Gosdeck at 608-441-3035 x5 or kyle.gosdeck@assuredpartners.com

FOR STAFFCORE USE ONLY

Date Received	**Date of Hire**	**Benefit Effective Date**
Enrolled in Medical	**Enrolled in Dental**	**Enrolled in Vision**
Enrolled in STD/Life	**Completed by**	

WAIVER OF GROUP MEDICAL COVERAGE

EMPLOYEE INFORMATION

Employee Name		**Social Security Number**
Address, City, State, Zip		**Date of Birth**
Phone Number	**Email Address**	**Date of Hire**

STATEMENT OF WAIVER

I am waiving the group medical insurance coverage offered through Hickman Transport Co., Inc. due to my:

- ☐ Major medical coverage under my spouse's or domestic partner's group plan
- ☐ Major medical coverage under a federal plan (i.e., TRICARE, VA, retiree plan)
- ☐ Major medical coverage under my parent's plan
- ☐ Major medical coverage through my individual plan

Name of Carrier	
Policy ID	**Group ID (if applicable)**

Please attach a copy of your current insurance card or proof of insurance.

AUTHORIZATION AND SIGNATURE – READ, SIGN AND DATE

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependent(s) (if any), through my employer. I understand that I am declining enrollment for myself or my eligible dependent(s) (if any) as indicated above. I also understand that I may be able to enroll myself and my eligible dependent(s) (if any) in this plan if I lose, or my eligible dependent(s) lose, eligibility for other coverage that is currently in effect.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends. If I do not do so, I will not be able to enroll until my employer's next annual open enrollment period. In addition, I understand that if I have a newly eligible dependent as a result of a marriage, birth, adoption, or placement for adoption (a Qualified Life Event or QLE), I may be able to enroll myself and my eligible dependent(s). However, I must request enrollment within 30 days after the aforementioned QLE. I understand that in order to request special enrollment or obtain more information, I should contact Human Resources.

_____ _____

Employee Signature *Date*

_____

Employee Name (please print)

SUBMIT YOUR FORM TO:

	By US Mail or In Person	By Fax	By Email
Hannah Hannah Hickman Transport	200 East Gordon Street Valdosta, GA 31601	229-247-0513	hannah@hickmantransport.com

DESIGNATION OF LIFE BENEFICIARY

EMPLOYEE INFORMATION

Employee Name		**Social Security Number**
Address, City, State, Zip		**Date of Birth**
Phone Number	**Email Address**	**Date of Hire**

PRIMARY BENEFICIARY INFORMATION

Name	**Relationship**	**Address**	
Social Security Number	**Birthdate**	**City, State, Zip**	**% of Benefit**

Name	**Relationship**	**Address**	
Social Security Number	**Birthdate**	**City, State, Zip**	**% of Benefit**

SECONDARY BENEFICIARY INFORMATION

Name	**Relationship**	**Address**	
Social Security Number	**Birthdate**	**City, State, Zip**	**% of Benefit**

Name	**Relationship**	**Address**	
Social Security Number	**Birthdate**	**City, State, Zip**	**% of Benefit**

I RESERVE THE RIGHT TO REVOKE OR CHANGE ANY BENEFICIARY DESIGNATION. I HEREBY REVOKE ALL PRIOR DESIGNATIONS (IF ANY) OF PRIMARY AND SECONDARY BENEFICIARIES. The trustee will pay all sums payable under the plan by reason of my death to the primary beneficiary, if he or she survives me. If no primary beneficiary survives me, then all sums will be payable to the secondary beneficiary. If no named beneficiary survives me, then the trustee will pay all amounts in accordance with the plan's death beneficiary provisions.

_____ _____

Employee Signature *Date*

_____

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SPOUSAL CONSENT FORM

*This form must be completed **by the employee's spouse only if** the employee designates a primary beneficiary who is someone other than, or in addition to, their spouse.*

SPOUSAL AUTHORIZATION AND SIGNATURE

I, the undersigned spouse of _____ named in the foregoing "Designation of Beneficiary," hereby certify that I have read the Designation of Beneficiary and fully understand the property subject to the designation of my spouse's benefit under the Plan, in which I possess a beneficial interest, provided I survive my spouse. Being fully satisfied with the provisions of the designation, I hereby consent to and accept the beneficiary designation, without regard to whether I survive or predecease my spouse. This consent is irrevocable unless my spouse changes the designation. If my spouse changes the designated beneficiary (choose either "a" or "b"):

_____ (a) I understand I must sign a similar consent to agree with any changes in the designation, or my consent is no longer effective; OR,

_____ (b) I waive my right to withhold my consent to a change in designation. I understand that I do have the right to limit my consent to the specific beneficiary designated on the life insurance or request for change form by checking line (a) above.

I have executed this consent this _____ day of _____, 20_____

_____

Signature of spouse of participant

WITNESS BY NOTARY

STATE OF_____

COUNTY OF_____

Before me, as the undersigned Notary Public, personally appeared _____ who executed the above Spousal Consent as a free and voluntary act.

In witness whereof, I have signed my name and affixed by official notarial seal this _____ day of _____, 20_____.

_____

Notary Public

(SEAL)

My commission expires:_____