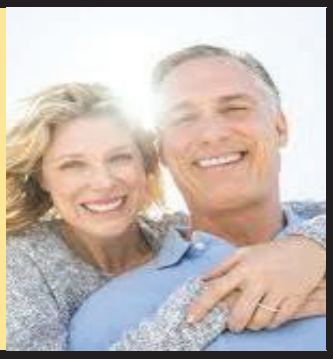
2025 OPEN ENROLLMENT GUIDE

Hickman Transport Co., Inc.

FULL TIME

SCA

EMPLOYEES



Hickman Transport Co., Inc.

2025 ANNUAL BENEFITS ENROLLMENT

Full-Time SCA Employees

OPEN ENROLLMENT ENDS FEBRUARY 21, 2025!

This is the one time of year, without a qualifying event, that will allow you to enroll, change, or add/drop dependents. Hickman Transport encourages you to become familiar with your benefits and review the following important information.

⚠ IMPORTANT ACTION ITEMS!

1. Review this packet in its entirety.

2. Complete the *Benefit Enrollment/Change Form* **ONLY** **if you are making changes to your current benefit elections or are enrolling in benefits for the first time.**

3. If you are waiving medical coverage through Hickman Transport, please complete the *Waiver of Group Medical Coverage* form and attach your proof of medical coverage (i.e., medical ID card).

4. Complete the *Designation of Beneficiary – Life Insurance* form. The *Spousal Consent Form* needs to be completed **only if** you list someone other than, or in addition to, your spouse as the Primary Beneficiary.

5. Return your completed forms by February 21, 2025, to:

   Hannah Hannah
   hannah@hickmantransport.com
   200 East Gordon Street
   Valdosta, GA 31601
   FAX 229-247-0513

6. If you have any questions regarding your benefits, please contact:

   Kyle Gosdeck
   STAFFCORE Benefit Administration
   kyle.gosdeck@assurdedpartners.com
   608-441-3035 x5

PLEASE NOTE: The enrollment period ends on February 21, 2025! Please ensure that your enrollment form is completed and returned by that date!

IMPORTANT BENEFIT INFORMATION

With the new benefit plan year comes very important changes regarding your benefits through Hickman Transport. Please be sure to read this communication, which outlines these changes, so you are informed regarding your benefits.

This is the one time of year that will allow you to enroll in benefits, or make changes to your existing benefit elections, without having to experience a qualifying life event. Any changes that you may wish to make during this Open Enrollment period will be effective March 1, 2025.

IMPORTANT!! BENEFIT ENROLLMENT/CHANGE FORM MUST BE COMPLETED IF YOU WISH TO CHANGE YOUR CURRENT BENEFIT ELECTIONS! If you do not wish to make changes at this time, you will remain enrolled in your current benefit elections.

MEDICAL INSURANCE PLAN

We have researched a number of medical options in order to provide you the most cost-effective option **AND** offer outstanding coverage. We are happy to announce that we will be retaining our **United Healthcare** coverage, which covers numerous providers nation-wide. You have the option to enroll your spouse/domestic partner, your child(ren) to age 26, or entire family in one of the two medical plans available.

TWO HEALTH PLANS EFFECTIVE MARCH 1. We will continue to offer two medical plan designs effective March 1:

1. **The BASIC MEDICAL PLAN** offers an in-network annual deductible of $3,500 for single coverage ($7,000 for dependent coverage) and 30% coinsurance. All medical services and prescription drugs are subject to the deductible and coinsurance.

2. **The BUY UP MEDICAL PLAN** offers a $5,000 in-network annual deductible for single coverage ($10,000 for dependent coverage) with 20% coinsurance up the annual out of pocket maximum of $8,000 for single coverage or $16,000 for dependent coverage. There are copays for medical services and prescription drugs. Premiums are higher for this level of coverage.

MANDATORY MEDICAL COVERAGE. As a full-time employee, you are **required** to enroll in the BASIC Medical Plan with Employee Only coverage **unless you are able to provide a valid waiver of coverage, or if the BUY UP Medical Plan is elected.** If you wish to waive the coverage offered to you by Hickman Transport, you must complete the **Waiver of Group Medical Coverage** form located in this guide. Be sure to include a copy of your current medical ID card or letter from your current medical carrier as proof that you have medical coverage elsewhere.

IMPORTANT NOTE ABOUT MEDICARE/MEDICAID COVERAGE. Medicare and Medicaid are ***not*** valid waivers 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.

FIND A PROVIDER. To find an in-network provider, visit **www.myuhc.com**. Select **Find a Provider**. Select **Medical Directory**. Select **Employer and Individual Plans.** Select **Choice Plus.** You may also call **866-764-7737**.

MEDICAL ID CARDS will be mailed to your home address as soon as possible. Please watch for a plain white envelope in the mail. Many people mistake these envelopes as junk mail and throw them away!

DENTAL INSURANCE PLAN

YOUR BENEFITS. The plan, with coverage through **United Healthcare**, features diagnostic and preventative services, as well as basic and major restorative services, with an annual benefit maximum of $1,000 per member on the plan. There is no waiting period for services. You have the option to enroll yourself, your spouse/domestic partner, your child(ren) to age 26, or entire family in the plan. Enrollment is voluntary.

FIND A PROVIDER. To find an in-network dentist, visit **www.myuhc.com** then click on **Find a Dentist**. Select **Employer and Individual Plans**. Enter your city, state or zip code. Select **National Options PPO 20 network**. You may also call **877-816-3596.**

DENTAL ID CARDS will be mailed to your home address as soon as possible. Please watch for a plain white envelope in the mail. Many people mistake these envelopes as junk mail and throw them away! Employees can also download United Healthcare's mobile app to obtain a digital card. You can also contact Human Resources or STAFFCORE and they can provide you with information about your plan.

VISION INSURANCE PLAN

YOUR BENEFITS. The plan, with coverage through **United Healthcare**, features exam and material copays and provides an annual exam and one pair 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. You have the option to enroll yourself, your spouse/domestic partner, your child(ren) to age 26, or entire family in the plan. Enrollment is voluntary.

FIND A PROVIDER. To find a vision provider, visit **www.myuhc.com** then click on **Find a Vision Provider.** Select **Employer and Individual Plans.** You may also call **800-638-3120**.

VISION ID CARDS United Healthcare does not produce vision ID cards. If you need to use your vision coverage, please tell your eye doctor you have coverage through United Healthcare. Employees can also download United Healthcare's mobile app to obtain a digital card. You can also contact Human Resources or STAFFCORE and they can provide you with information about your vision plan.

SHORT-TERM DISABILITY INSURANCE PLAN

YOUR BENEFITS. You are automatically covered under this plan through **United Healthcare** which replaces 60% of your income, up to a maximum weekly benefit of $500, depending upon your current weekly earnings. You must be sick or disabled for at least seven calendar days before you can receive benefit payment. Benefit payments may last up to 12 weeks. This coverage is for you only; there is no coverage for dependents.

LIFE and ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE PLAN

YOUR BENEFITS. The plan, with coverage through **United Healthcare**, provides a $25,000 life and AD&D benefit for you only; there is no coverage for dependents. You must designate a beneficiary for your plan. If you are married and name someone other than, or in addition to, your spouse as primary beneficiary, your spouse must waive his/her rights to your life insurance benefits by signing the Spousal Consent Form. The signature must be notarized.

PREMIUM PAYMENTS

BASIC MEDICAL PLAN. The Employee Only portion of the premium is funded by fringe benefit dollars. If you elect dependent coverage, the difference between the Employee Only premium and dependent premium is paid by you through a pre-tax payroll deduction.

BUY UP MEDICAL PLAN. The Employee Only BASIC Plan premium **amount** is applied to your fringe benefit dollars, and you pay the difference between BUY UP Plan Employee Only premium and the BASIC Plan Employee Only premium through a pre-tax payroll deduction. If you elect dependent coverage, the difference between the BASIC Plan Employee Only premium and BUY UP Plan dependent premium is paid by you through a pre-tax payroll deduction.

DENTAL & VISION. The Employee Only portion of the premium is funded by fringe dollars. If you elect dependent coverage, the difference between the Employee Only premium and dependent premium is paid by you through a pre-tax payroll deduction.

SHORT-TERM DISABILITY & LIFE INSURANCE. The premiums are funded by fringe dollars.

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 premium payments in the event you do not earn enough fringe to fund your monthly premiums. Reasons include sick time, a leave of absence or reduction in your schedule. The amount held in reserve is the total of one month of premiums.

Your fringe earned is first used to pay your monthly premiums. Any fringe remaining after premium payment is placed in your reserve account. Once your reserve account is **fully funded**, any remaining fringe benefit dollars after premium payments are paid to you in cash. If you end your employment with Hickman Transport, the amount remaining in your reserve account is paid to you in cash.

FRINGE BENEFIT DOLLAR USE EXAMPLES

The following examples illustrate how your fringe benefit dollars will be used on both a monthly and annual basis. Please note that these examples are based on 40 hours worked per week at the contract rate of $4.80, enrollment in the various benefit plan options, and assumes that your reserve account is fully funded. **Your actual numbers will vary based on the hours worked, benefit enrollments, and contract rate.**

ALL BENEFITS ELECTED

BENEFITS	MONTH	ANNUAL
Fringe Benefit Dollars Earned	**$768.00**	**$9,776.00**
Health Insurance	($671.12)	($8,053.44)
Dental Insurance - Optional	($19.93)	($239.16)
Vision Insurance - Optional	($5.11)	($61.32)
Life Insurance (under age 65)	($12.00)	($144.00)
Short Term Disability Insurance	($22.00)	($264.00)
Administrative Fee	($30.72)	($368.64)
Fringe Dollars Remaining	**$7.12**	**$645.44**
Federal Income Tax (30% AVG)	($2.14)	($193.63)
FICA Tax (7.65%)	($0.54)	($49.38)
Fringe Dollars Paid in Cash	**$4.44**	**$402.43**

VALID MEDICAL WAIVER

BENEFITS	MONTH	ANNUAL
Fringe Benefit Dollars Earned	**$768.00**	**$9,776.00**
Health Insurance	$0.00	$0.00
Dental Insurance - Optional	$0.00	$0.00
Vision Insurance - Optional	$0.00	$0.00
Life Insurance (under age 65)	($12.00)	($144.00)
Short Term Disability Insurance	($22.00)	($264.00)
Administrative Fee	$0.00	$0.00
Fringe Dollars Remaining	**$734.00**	**$9,368.00**
Federal Income Tax (30% AVG)	($220.20)	($2,810.40)
FICA Tax (7.65%)	($56.15)	($716.65)
Fringe Dollars Paid in Cash	**$457.65**	**$5,840.95**

2025 BENEFIT PLAN DESCRIPTIONS

Medical Insurance – United Healthcare

	BASIC MEDICAL PLAN		BUY UP MEDICAL PLAN	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUT OF NETWORK
ANNUAL CALENDAR YEAR DEDUCTIBLE				
INDIVIDUAL	$3,500	$10,000	$5,000	$10,000
FAMILY	$7,000	$20,000	$10,000	$20,000
ANNUAL CALENDAR YEAR OUT-OF-POCKET MAXIMUM (MAXIMUM INCLUDES DEDUCTIBLE)				
INDIVIDUAL	$7,500	$15,000	$8,000	$15,000
FAMILY	$15,000	$30,000	$16,000	$30,000
COINSURANCE & COPAYS				
COINSURANCE	30%	40%	20%	40%
PREVENTATIVE	No Charge	40%[1]	No Charge	40%[1]
PRIMARY CARE	30%[1]	40%[1]	$35	40%[1]
SPECIALIST	30%[1]	40%[1]	$75	40%[1]
URGENT CARE	30%[1]	40%[1]	$50	40%[1]
EMERGENCY	30%[1]	30%[1]	20%[1]	20%[1]
DIAGNOSTIC TEST	30%[1]	40%[1]	20%[1]	40%[1]
IMAGING	30%[1]	40%[1]	20%[1]	40%[1]
HOSPITAL OUTPATIENT	30%[1]	40%[1]	20%[1]	40%[1]
HOSPITAL INPATIENT	30%[1]	40%[1]	20%[1]	40%[1]
PRESCRIPTION COPAYS				
TIER 1	30%[1]		$10	
TIER 2	30%[1]		$35	
TIER 3	30%[1]		$70	
TIER 4	30%[1]		Not Covered	
BI-WEEKLY EMPLOYEE CONTRIBUTIONS				
EMPLOYEE ONLY	**$0.00**		**$104.09**	
EMPLOYEE + SPOUSE/DP	**$309.75**		**$517.92**	
EMPLOYEE + CHILD(REN)	**$263.28**		**$455.84**	
EMPLOYEE + FAMILY	**$573.03**		**$869.68**	

[1] After Deductible

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

FIND A PROVIDER. To find an in-network provider, visit **www.myuhc.com**. Select **Find a Provider**. Select **Medical Directory**. Select **Employer and Individual Plans.** Select **Choice Plus.** You may also call **866-764-7737**.

2025 BENEFIT PLAN DESCRIPTIONS

Dental Insurance – United Healthcare

	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
BI-WEEKLY EMPLOYEE CONTRIBUTIONS		
EMPLOYEE ONLY	**$0.00**	
EMP + SPOUSE/DP	**$9.21**	
EMP + CHILD(REN)	**$10.73**	
EMP + FAMILY	**$21.37**	

Find a Provider: Visit **www.myuhc.com** then click on **Find a Dentist**. Select **Employer and Individual Plans**. Enter your city, state or zip code. Select **National Options PPO 20 network**. You may also call **877-816-3596.**

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

2025 BENEFIT PLAN DESCRIPTIONS

Vision Insurance – United Healthcare

	IN NETWORK	OUT OF NETWORK
COPAYS		
EXAM	$10	Up to $40 reimbursement
MATERIALS	$25	Not applicable
COVERED MATERIALS		
LENSES		
SINGLE VISION	Covered in full after material copay	Up to $40 reimbursement
BIFOCAL	Covered in full after material copay	Up to $60 reimbursement
TRIFOCAL	Covered in full after material copay	Up to $80 reimbursement
LENTICULAR	Covered in full after material copay	Up to $100 reimbursement
CONTACT LENSES		
NECESSARY	Covered in full after material copay	Not Covered
ELECTIVE	$150 allowance	Not Covered
FRAMES		
RETAIL FRAMES	$130 allowance after material copay	Up to $45 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
BI-WEEKLY EMPLOYEE CONTRIBUTIONS		
EMPLOYEE ONLY	**$0.00**	
EMP + SPOUSE/DP	**$2.12**	
EMP + CHILD(REN)	**$2.89**	
EMP + FAMILY	**$5.04**	

Find a Provider: Visit **www.myuhc.com** then click on **Find a Vision Provider.** Select **Employer and Individual Plans.** You may also call **800-638-3120**.

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

2025 BENEFIT PLAN DESCRIPTIONS

Basic Group Term Life/AD&D Insurance – United Healthcare

BASIC LIFE AND AD&D	
LIFE/AD&D COVERAGE AMOUNT	$25,000
WHO PAYS	Premiums are funded by fringe dollars
BENEFITS PAYABLE	To your beneficiary or beneficiaries if you die, or to you if you lose a limb or suffer paralysis in an accident
GUARANTEE ISSUE	$25,000
MAXIMUM BENEFIT	$25,000
BENEFIT REDUCTION	$16,250 at age 65 | $12,500 at age 70

Short Term Disability Insurance – United Healthcare

BENEFITS	
WEEKLY BENEFIT	60% of weekly earnings
MAXIMUM WEEKLY BENEFIT	$500
WHO PAYS	Premiums are funded by fringe dollars
ELIMINATION PERIOD	7 days
BENEFIT DURATION	Up to 13 weeks
DEFINITION OF DISABILITY	Total or Partial

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

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:

- ☐ United Healthcare BASIC Medical Plan
- ☐ United Healthcare 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
- ☐ Employee + Child(ren)
- ☐ Employee + Family

DENTAL ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ United Healthcare Dental Plan
- ☐ Decline Dental Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

VISION ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ United Healthcare Vision Plan
- ☐ Decline Vision Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Spouse
- ☐ Employee + Child(ren)
- ☐ Employee + Family

HOSPITAL INDEMNITY ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ UHC Hospital Indemnity Plan
- ☐ Decline Hospital Indemnity Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Employee + Family

ACCIDENT ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ UHC Accident Plan
- ☐ Decline Accident Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Employee + Family

CRITICAL ILLNESS ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ Initial Enrollment *(time of hire or newly eligible)*
- ☐ Late Applicant *(open enrollment or qualifying life event)*
- ☐ Decline Critical Illness Coverage

requires Evidence of Insurability (EOI)

- ☐ Increase Critical Illness Coverage**
- ☐ Reduce Critical Illness Coverage
- ☐ Cancel Critical Illness Coverage

****requires EOI if amount elected exceeds Guarantee Issue***

CHOOSE COVERAGE LEVEL:

Employee must be enrolled in order to enroll spouse and/or child(ren)

EMPLOYEE ELECTION	***Election Amount*** *(must be in $30,000 if enrolling)*
SPOUSE ELECTION	***Election Amount*** *(must be $30,000 if enrolling)*
CHILD ELECTION	***Election Amount*** *(must be in $15,000 if enrolling)*

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**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness

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

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
Home Address *(please include street number, street name, city, state, and zip code)*		Date of Birth
Phone Number	Email Address	Marital Status ☐ Married ☐ Single

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*

_____

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

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:_____

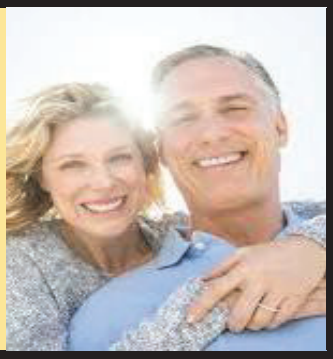
2025 OPEN ENROLLMENT GUIDE

Hickman Transport Co., Inc.

PART TIME

SCA

EMPLOYEES



Hickman Transport Co., Inc.

2025 ANNUAL BENEFITS ENROLLMENT

Part-Time SCA Employees

OPEN ENROLLMENT ENDS FEBRUARY 21, 2025!

This is the one time of year, without a qualifying event, that will allow you to enroll, change, or add/drop dependents. Hickman Transport encourages you to become familiar with your benefits and review the following important information.

⚠ IMPORTANT ACTION ITEMS!

1. Review this packet in its entirety.

2. Complete the *Benefit Enrollment/Change Form* **ONLY** **if you are making changes to your current benefit elections or are enrolling in benefits for the first time.**

3. Return your completed forms by February 21, 2025, to:

   Hannah Hannah
   hannah@hickmantransport.com
   200 East Gordon Street
   Valdosta, GA 31601
   FAX 229-247-0513

4. If you have any questions regarding your benefits, please contact:

   Kyle Gosdeck
   STAFFCORE Benefit Administration
   kyle.gosdeck@assurdedpartners.com
   608-441-3035 x5

PLEASE NOTE: The enrollment period ends on February 21, 2025! Please ensure that your enrollment form is completed and returned by that date!

IMPORTANT BENEFIT INFORMATION

With the new benefit plan year comes very important changes regarding your benefits through Hickman Transport. Please be sure to read this communication, which outlines these changes, so you are informed regarding your benefits.

This is the one time of year that will allow you to enroll in benefits, or make changes to your existing benefit elections, without having to experience a qualifying life event. Any changes that you may wish to make during this Open Enrollment period will be effective March 1, 2025.

IMPORTANT!! BENEFIT ENROLLMENT/CHANGE FORM MUST BE COMPLETED IF YOU WISH TO CHANGE YOUR CURRENT BENEFIT ELECTIONS! If you do not wish to make changes at this time, you will remain enrolled in your current benefit elections.

DENTAL INSURANCE PLAN

YOUR BENEFITS. The plan, with coverage through **United Healthcare**, features diagnostic and preventative services, as well as basic and major restorative services, with an annual benefit maximum of $1,000 per member on the plan. There is no waiting period for services. You have the option to enroll yourself, your spouse/domestic partner, your child(ren) to age 26, or entire family in the plan. Enrollment is voluntary.

FIND A PROVIDER. To find an in-network dentist, visit **www.myuhc.com** then click on **Find a Dentist**. Select **Employer and Individual Plans**. Enter your city, state or zip code. Select **National Options PPO 20 network**. You may also call **877-816-3596.**

DENTAL ID CARDS will be mailed to your home address as soon as possible. Please watch for a plain white envelope in the mail. Many people mistake these envelopes as junk mail and throw them away! Employees can also download United Healthcare's mobile app to obtain a digital card. You can also contact Human Resources or STAFFCORE and they can provide you with information about your plan.

VISION INSURANCE PLAN

YOUR BENEFITS. The plan, with coverage through **United Healthcare**, features exam and material copays and provides an annual exam and one pair 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. You have the option to enroll yourself, your spouse/domestic partner, your child(ren) to age 26, or entire family in the plan. Enrollment is voluntary.

FIND A PROVIDER. To find a vision provider, visit **www.myuhc.com** then click on **Find a Vision Provider.** Select **Employer and Individual Plans.** You may also call **800-638-3120**.

VISION ID CARDS United Healthcare does not produce vision ID cards. If you need to use your vision coverage, please tell your eye doctor you have coverage through United Healthcare. Employees can also download United Healthcare's mobile app to obtain a digital card. You can also contact Human Resources or STAFFCORE and they can provide you with information about your plan.

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PREMIUM PAYMENTS

DENTAL & VISION. The Employee Only portion of the premium is funded by fringe dollars. If you elect dependent coverage, the difference between the Employee Only premium and dependent premium is paid by you through a pre-tax payroll deduction.

SHORT-TERM DISABILITY & LIFE INSURANCE. The premiums are funded by fringe dollars.

FRINGE BENEFIT DOLLAR USE EXAMPLES

The following examples illustrate how your fringe benefit dollars will be used on both a monthly and annual basis. Please note that these examples are based on 20 hours worked per week at the contract rate of $4.80, enrollment in the various benefit plan options, and assumes that your reserve account is fully funded. **Your actual numbers will vary based on the hours worked, benefit enrollments, and contract rate.**

ALL BENEFITS ELECTED		
BENEFITS	**MONTHLY**	**ANNUAL**
Fringe Benefit Dollars Earned	**$384.00**	**$4,888.00**
Dental Insurance - Optional	($19.93)	($239.16)
Vision Insurance - Optional	($5.11)	($61.32)
Fringe Dollars Remaining	**$358.96**	**$4,587.52**
Federal Income Taxes (30% avg)	($107.69)	($1,376.26)
FICA Taxes (7.65%)	($27.46)	($350.95)
Fringe Dollars Paid In Cash	**$223.81**	**$2,860.32**

NO BENEFITS ELECTED		
BENEFITS	**MONTHLY**	**ANNUAL**
Fringe Benefit Dollars Earned	**$384.00**	**$4,888.00**
Dental Insurance - Optional	$0.00	$0.00
Vision Insurance - Optional	$0.00	$0.00
Fringe Dollars Remaining	**$384.00**	**$4,888.00**
Federal Income Taxes (30% avg)	($115.20)	($1,466.40)
FICA Taxes (7.65%)	($29.38)	($373.93)
Fringe Dollars Paid In Cash	**$239.42**	**$3,047.67**

2025 BENEFIT PLAN DESCRIPTIONS

Dental Insurance – United Healthcare

	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
BI-WEEKLY EMPLOYEE CONTRIBUTIONS		
EMPLOYEE ONLY	**$0.00**	
EMP + SPOUSE/DP	**$9.21**	
EMP + CHILD(REN)	**$10.73**	
EMP + FAMILY	**$21.37**	

Find a Provider: Visit **www.myuhc.com** then click on **Find a Dentist**. Select **Employer and Individual Plans**. Enter your city, state or zip code. Select **National Options PPO 20 network**. You may also call **877-816-3596.**

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

2025 BENEFIT PLAN DESCRIPTIONS

Vision Insurance – United Healthcare

	IN NETWORK	OUT OF NETWORK
COPAYS		
EXAM	$10	Up to $40 reimbursement
MATERIALS	$25	Not applicable
COVERED MATERIALS		
LENSES		
SINGLE VISION	Covered in full after material copay	Up to $40 reimbursement
BIFOCAL	Covered in full after material copay	Up to $60 reimbursement
TRIFOCAL	Covered in full after material copay	Up to $80 reimbursement
LENTICULAR	Covered in full after material copay	Up to $100 reimbursement
CONTACT LENSES		
NECESSARY	Covered in full after material copay	Not Covered
ELECTIVE	$150 allowance	Not Covered
FRAMES		
RETAIL FRAMES	$130 allowance after material copay	Up to $45 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
BI-WEEKLY EMPLOYEE CONTRIBUTIONS		
EMPLOYEE ONLY	**$0.00**	
EMP + SPOUSE/DP	**$2.12**	
EMP + CHILD(REN)	**$2.89**	
EMP + FAMILY	**$5.04**	

Find a Provider: Visit **www.myuhc.com** then click on **Find a Vision Provider.** Select **Employer and Individual Plans.** You may also call **800-638-3120**.

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

BENEFIT ENROLLMENT/CHANGE FORM

Part-Time 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 not be enrolled in benefits. 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.

DENTAL ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

☐ United Healthcare Dental Plan

☐ Decline Dental Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

☐ Employee Only

☐ Employee + Spouse

☐ Employee + Child(ren)

☐ Employee + Family

VISION ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

☐ United Healthcare Vision Plan

☐ Decline Vision Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

☐ Employee Only

☐ Employee + Spouse

☐ Employee + Child(ren)

☐ Employee + Family

HOSPITAL INDEMNITY ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ UHC Hospital Indemnity Plan
- ☐ Decline Hospital Indemnity Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Employee + Family

ACCIDENT ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ UHC Accident Plan
- ☐ Decline Accident Coverage

CHOOSE 1 OF THE COVERAGE LEVELS:

- ☐ Employee Only
- ☐ Employee + Child(ren)
- ☐ Employee + Spouse
- ☐ Employee + Family

CRITICAL ILLNESS ENROLLMENT

CHOOSE 1 OF THE PLAN OPTIONS:

- ☐ Initial Enrollment *(time of hire or newly eligible)*
- ☐ Late Applicant *(open enrollment or qualifying life event)*
- ☐ Decline Critical Illness Coverage

requires Evidence of Insurability (EOI)

- ☐ Increase Critical Illness Coverage**
- ☐ Reduce Critical Illness Coverage
- ☐ Cancel Critical Illness Coverage

****requires EOI if amount elected exceeds Guarantee Issue***

CHOOSE COVERAGE LEVEL:

Employee must be enrolled in order to enroll spouse and/or child(ren)

EMPLOYEE ELECTION	***Election Amount*** *(must be in $30,000 if enrolling)*
SPOUSE ELECTION	***Election Amount*** *(must be $30,000 if enrolling)*
CHILD ELECTION	***Election Amount*** *(must be in $15,000 if enrolling)*

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**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness
ADD REMOVE	**Child**				☐ Medical ☐ Dental ☐ Vision ☐ Hospital ☐ Accident ☐ Crit Illness

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

PLAN DOCUMENTS

UnitedHealthcare®
Voluntary National Options PPO 20 Network/covered dental services

dental plan
0P911 /MAC

	NETWORK	NON-NETWORK
Individual Annual Deductible	$50	$50
Family Annual Deductible	$150	$150
Annual Maximum Benefit *(The total benefit payable by the plan will not exceed the highest listed maximum amount for either Network or Non-Network services.)*	$1000 per person per Calendar Year	$1000 per person per Calendar Year
Annual Deductible Applies to Preventive and Diagnostic Services	No	
Waiting Period	No waiting period	

COVERED SERVICES*	NETWORK PLAN PAYS**	NON-NETWORK PLAN PAYS***	BENEFIT GUIDELINES
PREVENTIVE & DIAGNOSTIC SERVICES			
Periodic Oral Evaluation	100%	100%	Limited to 2 times per consecutive 12 months.
Radiographs - Bitewing	100%	100%	Bitewing: Limited to 1 series of films per calendar year. Complete/Panorex: Limited to 1 time per consecutive 36 months.
Radiographs - Intraoral/Extraoral	100%	100%	Limited to 2 films per calendar year.
Lab and Other Diagnostic Tests	100%	100%	
Dental Prophylaxis (Cleanings)	100%	100%	Limited to 2 times per consecutive 12 months.
Fluoride Treatments	100%	100%	Limited to covered persons under the age of 16 years and limited to 2 times per consecutive 12 months.
Sealants	100%	100%	Limited to covered persons under the age of 16 years and once per first or second permanent molar every consecutive 36 months.
Space Maintainers	100%	100%	For covered persons under the age of 16 years, limit 1 per consecutive 60 months.
BASIC DENTAL SERVICES			
Restorations (Amalgam or Anterior Composite)*	80%	80%	Multiple restorations on one surface will be treated as a single filling.
General Services - Emergency Treatment	80%	80%	Covered as a separate benefit only if no other service was done during the visit other than X-rays.
General Services - Occlusal Guards	80%	80%	Limited to 1 guard every consecutive 36 months.
General Services - Anesthesia	80%	80%	When clinically necessary.
Simple Extractions	80%	80%	Limited to 1 time per tooth per lifetime.
MAJOR DENTAL SERVICES			
Oral Surgery - Brush Biopsy	50%	50%	
Oral Surgery - Surgical Extractions	50%	50%	
Oral Surgery - Partial/Bony	50%	50%	
Oral Surgery - Other	50%	50%	
Endodontics - Pulpotomy	50%	50%	
Endodontics - Other	50%	50%	Root Canal Therapy: Limited to 1 time per tooth per lifetime.
Periodontal Maintenance	50%	50%	Limited to 2 times per consecutive 12 months following active and adjunctive periodontal therapy, exclusive of gross debridement.
Periodontics - Non Surgical	50%	50%	Scaling and Root Planing: Limited to 1 time per quadrant per consecutive 24 months.
Periodontics - Surgical	50%	50%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Periodontics - Osseous Surgery	50%	50%	Limited to 1 quadrant or site per consecutive 36 months per surgical area.
Inlays/Onlays/Crowns*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.
Dentures and other Removable Prosthetics	50%	50%	Full Denture/Partial Denture: Limited to 1 per consecutive 60 months. No additional allowances for precision or semi-precision attachments.
Fixed Partial Dentures (Bridges)*	50%	50%	Limited to 1 time per tooth per consecutive 60 months.

* Your dental plan provides that where two or more professionally acceptable dental treatments for a dental condition exist, your plan bases reimbursement on the least costly treatment alternative. If you and your dentist have agreed on a treatment which is more costly than the treatment on which the plan benefit is based, you will be responsible for the difference between the fee for service rendered and the fee covered by the plan. In addition, a pre-treatment estimate is recommended for any service estimated to cost over $500; please consult your dentist.

** The network percentage of benefits is based on the discounted fee negotiated with the provider.

*** The non-network percentage of benefits is based on the allowable amount applicable for the same service that would have been rendered by a network provider.

For additional coverage details and to locate a dentist please visit myuhc.com® or contact Customer Service.

In accordance with the Illinois state requirement, a partner in a Civil Union is included in the definition of Dependent. For a complete description of Dependent Coverage, please refer to your Certificate of Coverage.

The Prenatal Dental Care (not available in WA) and Oral Cancer Screening programs are covered under this plan. The material contained in the above table is for informational purposes only and is not an offer of coverage. Please note that the above provides only a brief, general description of coverage and does not constitute a contract. For a complete listing of your coverage, including exclusions and limitations relating to your coverage, please refer to your Certificate of Coverage or contact your benefits administrator. If differences exist between this Summary Benefits and your Certificate of Coverage/benefits administrator, the Certificate/benefits administrator will govern. All terms and conditions of coverage are subject to applicable state and federal laws. State mandates regarding benefit levels and age limitations may supersede plan design features.

UnitedHealthcare Dental® Voluntary Options PPO Plan is either underwritten or provided by: UnitedHealthcare Insurance Company, Hartford, Connecticut; UnitedHealthcare Insurance Company of New York, Hauppage, New York; Unimerica Insurance Company, Milwaukee, Wisconsin; Unimerica Life Insurance Company of New York, New York, New York; United Healthcare Services, Inc.; or UnitedHealthcare of Kentucky, LTD.

UnitedHealthcare/dental exclusions and limitations

Dental Services described in this section are covered when such services are:

A. Necessary;
B. Provided by or under the direction of a Dentist or other appropriate provider as specifically described;
C. The least costly, clinically accepted treatment; and
D. Not excluded as described in the Section entitled, General Exclusions.

GENERAL LIMITATIONS

1. **PERIODIC ORAL EVALUATION** Limited to 2 times per consecutive 12 months.
2. **COMPLETE SERIES OR PANOREX RADIOGRAPHS** Limited to 1 time per consecutive 36 months.
3. **BITEWING RADIOGRAPHS** Limited to 1 series of films per calendar year.
4. **EXTRAORAL RADIOGRAPHS** Limited to 2 films per calendar year.
5. **DENTAL PROPHYLAXIS** Limited to 2 times per consecutive 12 months.
6. **FLUORIDE TREATMENTS** Limited to covered persons under the age of 16 years, and limited to 2 times per consecutive 12 months.
7. **SPACE MAINTAINERS** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. **SEALANTS** Limited to covered persons under the age of 16 years, and once per first or second permanent molar every consecutive 36 months.
9. **RESTORATIONS (Amalgam or Composite)** Multiple restorations on one surface will be treated as a single filling.
10. **PIN RETENTION** Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. **INLAYS, ONLAYS, AND VENEERS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. **CROWNS** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. **POST AND CORES** Covered only for teeth that have had root canal therapy.
14. **SEDATIVE FILLINGS** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.
15. **SCALING AND ROOT PLANING** Limited to 1 time per quadrant per consecutive 24 months.
16. **ROOT CANAL THERAPY** Limited to 1 time per tooth per lifetime.
17. **PERIODONTAL MAINTENANCE** Limited to 2 times per consecutive 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement.
18. **FULL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. **PARTIAL DENTURES** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
20. **RELINING AND REBASING DENTURES** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
21. **REPAIRS TO FULL DENTURES, PARTIAL DENTURES, BRIDGES** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
22. **PALLIATIVE TREATMENT** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
23. **OCCLUSAL GUARDS** Limited to 1 guard every consecutive 36 months and only covered if prescribed to control habitual grinding.
24. **FULL MOUTH DEBRIDEMENT** Limited to 1 time every consecutive 36 months.
25. **GENERAL ANESTHESIA** Covered only when clinically necessary.
26. **OSSEOUS GRAFTS** Limited to 1 per quadrant or site per consecutive 36 months.
27. **PERIODONTAL SURGERY** Hard tissue and soft tissue periodontal surgery are limited to 1 quadrant or site per consecutive 36 months per surgical area.
28. **REPLACEMENT OF COMPLETE DENTURES, FIXED OR REMOVABLE PARTIAL DENTURES, CROWNS, INLAYS OR ONLAYS** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.
29. **CONE BEAM** Limited to 1 time per consecutive 60 months.

GENERAL EXCLUSIONS

1. Dental Services that are not Necessary.
2. Hospitalization or other facility charges.
3. Any Dental Procedure performed solely for cosmetic/aesthetic reasons. (Cosmetic procedures are those procedures that improve physical appearance.)
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury, or Congenital Anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any Dental Procedure not directly associated with dental disease.
6. Any Dental Procedure not performed in a dental setting.
7. Procedures that are considered to be Experimental, Investigational or Unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in Coverage if the procedure is considered to be Experimental, Investigational or Unproven in the treatment of that particular condition.
8. Placement of dental implants, implant-supported abutments and prostheses.
9. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
10. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
11. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or Congenital Anomalies of hard or soft tissue, including excision.
12. Replacement of complete dentures, fixed and removable partial dentures or crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is Necessary because of patient non-compliance, the patient is liable for the cost of replacement.
13. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jaw bone surgery (including that related to the temporomandibular joint). No Coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
14. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours notice.
15. Expenses for Dental Procedures begun prior to the Covered Person becoming enrolled under the Policy.
16. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
17. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis, and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
18. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
19. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
20. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.

GENERAL EXCLUSIONS

21. Services rendered by a provider with the same legal residence as a Covered Person or who is a member of a Covered Person's family, including spouse, brother, sister, parent or child. This exclusion does not apply for groups situsedin the state of Arizona, in order to comply with state regulations.
22. Dental Services otherwise Covered under the Policy, but rendered after the date individual Coverage under the Policy terminates, including Dental Services for dental conditions arising prior to the date individual Coverage under the Policy terminates.
23. Acupuncture; acupressure and other forms of alternative treatment, whether or not used as anesthesia.
24. Orthodontic Services.
25. Foreign Services are not Covered unless required as an Emergency.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.

Vision Benefit Summary

Powered by UnitedHealthcare Vision Network

Customer Service and Provider Locator: (800) 638-3120

myuhcvision.com

Plan S1004

UnitedHealthcare Vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

	Exam with Materials
Benefit Frequency	
Comprehensive Exam(s)	Once every 12 months
Comprehensive Exam(s) for persons with diabetes	Twice every 12 months
Eyeglass Lenses	Once every 12 months
Frames	Once every 24 months
Contact Lenses instead of Eyeglasses	Once every 12 months
In-Network Services	
Copays	
Exam(s)	$ 10.00
Eyeglasses (lenses and frame)	$ 25.00
Contact lenses instead of Eyeglasses	$ 25.00
Retinal Screening for persons with diabetes	$ 0.00
Frame Benefit (for frames that exceed the allowance, an additional 30% discount may be applied to the overage)[1]	
Private Practice Provider	$130.00 retail frame allowance
Retail Chain Provider	$130.00 retail frame allowance
Lens Options	
Standard Scratch-resistant Coating, Polycarbonate Lenses for Dependent Children (up to age 19) - covered in full.	
Contact Lens Benefit[2]	
Elective contact lenses Allowance is applied toward the purchase of contact lenses. Contact lens copay is waived.	$105.00
Elective contact lens fitting and evaluation Allowance is applied toward the contact lens fitting/evaluation fees.	$30.00
Necessary contact lenses[3]	Covered in full after copay (if applicable).
Children's and Maternity Eye Care Benefit	
Members age 0-12 and members pregnant or breastfeeding are eligible for a 2nd exam 60 days after the initial exam. Members age 0-12 and members pregnant or breastfeeding are also eligible for a replacement frame and lenses if they have a prescription change of 0.5 diopter or more. The 2nd exam and replacement benefits are the same as the initial exam, frame and lens benefits.	
Out-of-Network Reimbursements (Copays do not apply)	
Exam(s)	Up to $40.00
Frames	Up to $45.00
Single Vision Lenses	Up to $40.00
Lined Bifocal and Progressive Lenses	Up to $60.00
Lined Trifocal Lenses	Up to $80.00
Lenticular Lenses	Up to $80.00
Elective Contacts instead of Eyeglasses[2]	Up to $80.00
Contact Lens Fitting and Evaluation	Up to $0.00
Necessary Contacts instead of Eyeglasses[3]	Up to $210.00

UnitedHealthcare®

Discounts

Laser vision
UnitedHealthcare has partnered with QualSight LASIK, the largest LASIK manager in the United States, to provide our members with access to discounted laser vision correction services. Member savings represent up to 35% off the national average price of Traditional LASIK. Contracted prices start at $945 per eye for Traditional LASIK and $1,395 per eye for Custom LASIK. Discounts are also provided on newer technologies such as Custom Bladeless (all laser) LASIK. For more information, visit myuhcvision.com.

Additional Material
At a participating in-network provider you will receive up to a 20% discount on an additional pair of eyeglasses or contact lenses. This program is available after your vision benefits have been exhausted. Please note that this discount shall not be considered insurance, and that UnitedHealthcare shall neither pay nor reimburse the provider or member for any funds owed or spent. Additional materials do not have to be purchased at the time of initial material purchase.

Contact Lens
Order extra contact lenses at uhccontacts.com for 10% off.

Hearing Aids
As a UnitedHealthcare Vision plan member, you can save on custom-programmed hearing aids when you buy them from UnitedHealthcare Hearing. To find out more go to UHCHearing.com. When placing your order use promo code MYVISION to get the special price discount.

Blue Light Eyesafe
UnitedHealthcare Vision has collaborated with Eyesafe® to provide members with a 20% discount off the retail price on blue-light screen filters for their devices. Members can receive the discount by visiting myuhcvision.com and clicking on the Eyesafe link.

[1]30% discount available at most participating in-network provider locations. May exclude certain frame manufacturers. Please verify all discounts with your provider.
[2]Contact lenses are instead of eyeglass lenses and/or eyeglass frames.
[3]Necessary contact lenses are determined at the provider's discretion for certain conditions. If your provider considers your contacts necessary, you should ask your provider to contact UnitedHealthcare Vision confirming the reimbursement that UnitedHealthcare will make before you purchase such contacts.

Important to Remember:

In-Network

- Always identify yourself as a UnitedHealthcare Vision member when making your appointment. This will assist the provider in obtaining your benefit information.
- Patient lens options which are not covered-in-full may be available at a discount at participating providers. Based on state guidelines, lens materials and options may not be available at these discounted prices at all provider locations. Please ask your provider for details. The Lens Options list can be found at myuhcvision.com.

Choice and Access of Vision Care Providers

UnitedHealthcare offers its vision program through a national network including both private practice and retail chain providers. To access the Provider Locator service or for a printed directory, visit our website myuhcvision.com or call (800) 638-3120, 24 hours a day, seven days a week. You may also view your benefits, search for a provider or print an ID card online at myuhcvision.com.
In-Network Provider - Copays and non-covered patient options are paid to provider by program participant at the time of service.
Out-of-Network Provider - Participant pays all billed charges to the provider, and UnitedHealthcare reimburses the participant for services rendered up to the maximum allowance. Copays do not apply to out-of-network benefits. Receipts for payments should be submitted within 90 days after the date of service to the following address: UnitedHealthcare Vision, Attn. Claims Department, P.O. Box 30978, Salt Lake City, UT 84130. If it was not reasonably possible to give written proof in the time required, the Company will not reduce or deny the claim for this reason. However, proof must be filed as soon as reasonably possible, but no later than 1 year after the date of service unless the Covered Person was legally incapacitated.

Customer Service is available toll-free at (800) 638-3120 from 8:00 a.m. to 11:00 p.m. Eastern Time Monday through Friday, and 9:00 a.m. to 6:30 p.m. Eastern Time on Saturday.

READ YOUR PLAN CAREFULLY - THIS BENEFIT SUMMARY PROVIDES A VERY BRIEF DESCRIPTION OF THE IMPORTANT FEATURES OF YOUR PLAN. THIS IS NOT THE INSURANCE CONTRACT. YOUR FULL RIGHTS AND BENEFITS ARE EXPRESSED IN THE ACTUAL PLAN DOCUMENTS THAT ARE AVAILABLE TO YOU UPON YOUR REQUEST TO US.

UnitedHealthcare vision coverage provided by or through UnitedHealthcare Insurance Company, located in Hartford, Connecticut, UnitedHealthcare Insurance Company of New York, located in Islandia, New York, or its affiliates. Administrative services provided by Spectera, Inc., United HealthCare Services, Inc. or their affiliates. Plans sold in Texas use policy form number VPOL.06.TX, VPOL.13.TX or VPOL.18.TX and associated COC form number VCOC.INT.06.TX, VCOC.CER.13.TX or VCOC.18.TX. Plans sold in Virginia use policy form number VPOL.06.VA, VPOL.13.VA or VPOL.18.VA and associated COC form number VCOC.INT.06.VA, VCOC.CER.13.VA or VCOC.18.VA. If you opt to receive vision care services or vision care materials that are not covered benefits under this plan, a participating vision care provider may charge you their normal fee for such services or materials. Prior to providing you with vision care services or vision care materials that are not covered benefits, the vision care provider will provide you with an estimated cost for each service or material upon your request. This cost may be higher than if you had received only covered vision services and you may incur additional out-of-pocket expenses. Eyewear materials may be ordered through our national lab network.

UnitedHealthcare®

Hickman Transport Co., Inc.
Summary of Benefits
Short Term Disability Insurance

Effective Date	March 1, 2023
Eligibility	All Active Full Time Employees working a minimum of 30 Hours per week.
Non-Contributory STD Benefit	60.0% of your weekly Earnings to a maximum of $500 per week. Minimum Benefit: $25 Earnings are defined in the UnitedHealthcare contract with your employer.
Elimination Period	Short Term Disability Insurance benefit begins on the 8th day after your accident or 8th day of sickness.
Benefit Duration	Up to 13 weeks
Lump Sum Survivor Benefit	Lesser of $3,000 or 3 weeks Gross
Offsets	As described later in this summary, your weekly Short Term Disability benefit may be reduced by other income you receive.
Other limitations to enrollment	You must be Actively at Work with your employer on the day your coverage takes effect.

This benefit summary is an overview of your Insurance. Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail

Important Details

This Summary of Benefits sheet is an overview of the Short Term Disability Insurance being offered and is provided for illustrative purposes only and is not a contract. It in no way changes or affects the policy as actually issued. Only the insurance policy issued to the policyholder (your employer) can fully describe all of the provisions, terms, conditions, limitations and exclusions of your insurance coverage. In the event of any difference between the Summary of Benefits sheet and the insurance policy, the terms of the insurance policy apply.

Once a group policy is issued to your employer, a certificate of coverage will be available to explain your benefits in detail.

Exclusions:

You cannot receive Short Term Disability Insurance benefit payments for disabilities that are caused or contributed to by*:

- War or act of war (declared or not)
- The commission of, or attempt to commit a felony
- An intentionally self-inflicted injury
- Any case where your being engaged in an illegal occupation was a contributing cause to your disability
- Sickness or injury for which Workers' Compensation benefits are paid, or may be paid, if duly claimed
- Any injury sustained as a result of doing any work for pay or profit for another employer

You must be under the regular care of a physician to receive benefits.*

Your benefit payments **will be reduced** by other income you receive or are eligible to receive due to your disability, including but not limited to*:

- Social Security Disability Insurance
- Workers' Compensation
- Other employer-based insurance coverage you may have
- Unemployment benefits
- Settlements or judgments for income loss
- Retirement benefits that your employer fully or partially pays for (such as a pension plan)
- Employer's sick leave or salary continuation plan.
- Loss of time or lost wages from no-fault motor vehicle insurance plan.

** Some state variations may apply*

UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company, and certain products in California by Unimerica Life Insurance Company. Texas Coverage is provided on Form LASD-POL-TX (05/03), Form UHCLD-POL 2/2008-TX, or UICLD-POL-TX 4/5.

UnitedHealthcare Insurance Company is located in Hartford, CT; Unimerica Insurance Company and Unimerica Life Insurance Company in Milwaukee, WI.

Hickman Transport Co., Inc.
Cost Summary (Current Monthly Rates)
Short Term Disability Insurance

Eligibility	All Active Full Time Employees working a minimum of 30 Hours per week.
Non Contributory Short Term Disability	100% Company Paid

Basic Life Benefit Summary

The Accidental Death and Dismemberment (AD&D) portion is automatically included with Basic Life and provides the employee with additional insurance coverage for the loss of life or injuries sustained in an accident on or off the job.*

Coverage	Benefit	Description
Flat Amount	$25,000	The Life Insurance Benefit Amount.
Guarantee Issue	Refer to table below	Amount of benefit guaranteed. Benefits over this amount are subject to proof of good health. Evidence of Insurability must be submitted and approved.
Accelerated Benefit	Included	This benefit provides an advanced payout of benefits for covered persons who are terminally ill and not expected to live for more than one year. The benefit pays 50% not to exceed $50,000 of life insurance to the employee.
Waiver of Premium	Included	If eligible employee becomes totally disabled before age 60, life premiums will be waived and life coverage continued until age 65 [annual proof of disability required].
Age Reduction Schedule	65%@65, 50%@70	The benefits will be reduced to 65% of original amount at age 65 and 50% of the original amount at age 70.
Premium Contribution	Non-Contributory	Non-Contributory is when the employer pays 100% of the premium.

✓ Accelerated Death Benefit, Waiver of Premium and Conversion are included.

Guarantee Issue

- Amounts are based on your employer group size and plan benefit levels

Eligible Lives	Guarantee Issue	
51 to 99	Full Amount	

Value-Added Services (All features may not apply. Some states may have restrictions.)

- **Beneficiary Services:** Provides beneficiaries with services for grief consultation, financial/legal assistance and referral to community resources. **For more information, call 866-302-4480.**
  - Toll-free line available 24/7 as well as referrals for face-to-face counseling. Specialists provide in-depth consultation, information and referral to community resources such as grief support groups. Includes access to a national network of credentialed clinicians for grief and loss counseling. Beneficiaries receive two complimentary sessions.**
  - Financial and Legal Services. Telephonic access to financial consultants for assistance with financial decision-making. Includes access to a network of 22,000 attorneys for either a 30-minute telephonic or an in-person consultation. You may retain the same attorney for representation at a discount to their hourly rate. Access to legal services facilitated by CLC, Inc.
  - Communication Support. We provide a "Beneficiary Kit" with informational resources to help beneficiaries with the emotional and financial process that follows the loss of a loved one.
- **Travel Assistance:** Assists domestic and foreign travelers with a variety of emergency travel-related services, such as medical assistance, emergency transportation and pre-trip information. Includes access to Emergency Response Center via toll-free or collect telephone call; available 24/7 from anywhere in the world. Covers up to 90 days on any one trip when traveling 100+ miles from home or office. **For more information, please call 1-410-453-6330 or visit the online Member Center at http:members.uhcglobal.com**. You will need to provide policy number: 358231. Services provided by UnitedHealthcare Global, a subsidiary of UnitedHealth Group.
- **Wealth Management Account:** An enhanced benefit payment process. Life claim proceeds in excess of $5,000 can, at the beneficiary's election, be deposited into an Optum Bank Wealth Management Account (WMA). Beneficiaries receive an FDIC-insured, beneficiary-owned, interest earning account with convenient access to their claim proceeds via debit card or checkbook.***
- **Will & Trust Preparation Services:** Provides information on will & trust preparation and services. **For more information, please call 800-773-0888 or visit** www.CLClegalforms.com. Services provided by CLC.

Additional Notes:

- *The Accidental Death and Dismemberment Benefit is equal to the Life Benefit; refer to the Certificate of Coverage for the complete AD&D Benefit schedule. Coverage includes a Seat Belt Benefit.
- **Beneficiary Services offered thru United Behavioral Health, a company of UnitedHealth Group.
- ***Eligibility for automatic deposit into an Optum Bank Wealth Management Account is subject to qualifying conditions evaluated by Optum Bank and UnitedHealthcare at the time of claim review to include limited availability in certain states. For more information please contact your UnitedHealthcare representative. Optum Bank, Member FDIC, is part of the financial services unit of OptumHealth, a health and wellness company serving more than 60 million people. Optum is a UnitedHealth Group (NYSE:UNH) company.
- Limitations for AD&D: Disease, bodily or mental infirmity, suicide or intentionally self-inflicted injury, commission of an assault or felony, war, use of any drug unless prescribed by physician, driving while intoxicated, engaging in any hazardous activities, or travel in a private aircraft. Additional exclusions may apply depending upon the plan design of the employer.
- Benefit provisions, exclusions and limitations may vary as a result of state specific requirements.
- Premiums may vary by age.
- The Policy will continue, upon timely payment of premium, unless we cancel because the Policyholder did not meet his obligations stated in the Policy, including providing information needed to administer the Policy, or the participation level drops below the level stated in the Policy.
- Individual coverage will continue, upon timely payment of premium, unless terminated because the Covered Person's insurance under the Policy terminates, or the dependent no longer meets the specific eligibility requirements stated in the Policy or the Policy terminates.
- UnitedHealthcare Life and Disability products are provided by UnitedHealthcare Insurance Company and certain products in California by Unimerica Life Insurance Company. Life and Disability products are provided on policy forms LASD-POL (05/03) et al. and UHCLD-POL 2/2008 et al., in Texas on forms LASD-POL-TX (05/03) and UHCLD-POL 2/2008-TX and in Virginia on LASD-POL (05/03) and UHCLD-POL 2/2008. The policies have exclusions, limitations, reductions of benefits, and terms under which the policy may be continued in force or discontinued. For costs and complete details of the coverage, call or write your insurance agent or the company. Some products are not available in all states. UnitedHealthcare Insurance Company is located in Hartford, CT and Unimerica Life Insurance Company in Milwaukee, WI.
- This Benefit Summary is intended only to highlight benefits and should not be relied upon to fully determine coverage. More complete descriptions of benefits and the terms under which they are provided are contained in the Certificate of Coverage received upon enrollment in the plan. If this Benefit Summary conflicts in any way with the Policy issued to the employer, the Policy shall prevail.

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.

Hickman Transport
Group Health and Welfare Benefit Plan

Summary Plan Description Wrap Document

2025 Plan Year

This document together with the application insurance contracts, carrier plan documents and certificate insurance booklets, constitute the Summary Plan Description/written plan document for Hickman Transport Group Health and Welfare Benefit Plan.

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1. INTRODUCTION

This Summary Plan Description Wrap Document presents basic information about all the health and welfare benefits maintained by Hickman Transport (Employer), and your rights and benefits as a Plan participant. Please refer to the applicable description of benefits, certificates of coverage, subscriber agreements, or evidence of coverage booklet for more details on specific items such as benefit coverage, definitions, coordination of benefits, claims procedures and exclusions and limitations. This Summary Plan Description Wrap Document and the separate benefit booklets have been prepared for participating employees, and together constitute the Summary Plan Description for your Group Health and Welfare Benefit Plan. This is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974.

Please read this Document carefully and keep it along with your other benefit booklets for future reference.

2. GENERAL TERMS AND CONDITIONS

This Group Health and Welfare Benefit Plan is established for the purpose of providing the employee welfare benefits listed herein for the benefit of eligible employees and dependents. This plan, together with the adoption agreement and governing documents described herein, constitutes the written plan document required by ERISA §402(a), and is an employee welfare benefit plan (within the meaning of ERISA § 3(I)). The Plan also provides benefits in accordance with the applicable requirements of federal laws such as, Consolidated Omnibus Budget Reconciliation Act (COBRA), Health Insurance Portability Accountability Act (HIPAA), Genetic Information Non-Discrimination Act (GINA), Mental Health Parity Act (MHPA), Newborns' and Mother's Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA).

In addition, if elected in the adoption agreement, some or all of the benefit programs may be offered through a cafeteria plan arrangement under Section 125 of the Internal Revenue Code.

3. PLAN INFORMATION

The name of the Health Insurance Carrier that insures benefits under the Plan is:

United Healthcare

Plan Name:	**Hickman Transport Medical Plan**
Benefit Type:	Fully Insured
Policy Number:	1495777
Plan Year:	March 1 through February 28
Effective Date:	March 1, 2025
Plan Administration:	Hickman Transport
Insurance Carrier Address:	200 E Randolph St., Suite 5300 Chicago, IL 60601-6602
Insurance Carrier Phone:	(866) 414-1959
Insurance Carrier URL:	www.myuhc.com
Eligible Employee:	Regular full-time employee working 30 hours or more per week
Coverage Effective Date:	First of the month following 60 days after the date of hire
Excluded Classes:	Part-time and seasonal employees
Eligible Dependents:	Spouse / Dependents up to 26 years of age
Contributions:	Employer and Employee contributions
Grandfathered:	No

The name of the Dental Insurance Carrier that insures benefits under the Plan is:

United Healthcare

Plan Name:	**Hickman Transport Dental Plan**
Benefit Type:	Fully Insured
Policy Number:	1495777
Plan Year:	March 1 through February 28
Effective Date:	March 1, 2025
Plan Administration:	Hickman Transport
Insurance Carrier Address:	200 E Randolph St., Suite 5300 Chicago, IL 60601-6602
Insurance Carrier Phone:	(866) 414-1959
Insurance Carrier URL:	www.myuhc.com
Eligible Employee:	Regular full-time employee working 30 hours or more per week. Part-time employees working 20-29 hours per week.
Coverage Effective Date:	First of the month following 60 days after the date of hire
Excluded Classes:	Part-time employees working under 20 hours per week and seasonal employees
Eligible Dependents:	Spouse / Dependents up to 26 years of age
Contributions:	Employer and Employee contributions
Grandfathered:	No

The name of the Vision Insurance Carrier that insures benefits under the Plan is:

United Healthcare

Plan Name:	**Hickman Transport Vision Plan**
Benefit Type:	Fully Insured
Policy Number:	1495777
Plan Year:	March 1 through February 28
Effective Date:	March 1, 2025
Plan Administration:	Hickman Transport
Insurance Carrier Address:	200 E Randolph St., Suite 5300 Chicago, IL 60601-6602
Insurance Carrier Phone:	(866) 414-1959
Insurance Carrier URL:	www.myuhc.com
Eligible Employee:	Regular full-time employee working 30 hours or more per week. Part-time employees working 20-29 hours per week.
Coverage Effective Date:	First of the month following 60 days after the date of hire
Excluded Classes:	Part-time employees working under 20 hours per week and seasonal employees
Eligible Dependents:	Spouse / Dependents up to 26 years of age
Contributions:	Employer and Employee contributions
Grandfathered:	No

The name of the Basic Life and AD&D Insurance Carrier that insures benefits under the Plan is:

United Healthcare

Plan Name:	**Hickman Transport Basic Life Insurance Plan**
Benefit Type:	Fully Insured
Policy Number:	370969
Plan Year:	March 1 through February 28
Effective Date:	March 1, 2025
Plan Administration:	Hickman Transport
Insurance Carrier Address:	200 E Randolph St., Suite 5300 Chicago, IL 60601-6602
Insurance Carrier Phone:	(866) 414-1959
Insurance Carrier URL:	www.myuhc.com
Eligible Employee:	Regular full-time employee working 30 hours or more per week
Coverage Effective Date:	First of the month following 60 days after the date of hire
Excluded Classes:	Part-time and seasonal employees
Eligible Dependents:	Spouse / Dependents up to 26 years of age
Contributions:	Employer contributions
Grandfathered:	No

The name of the Short-Term Disability Insurance Carrier that insures benefits under the Plan is:

United Healthcare

Plan Name:	**Hickman Transport Short Term Disability Plan**
Benefit Type:	Fully Insured
Policy Number:	370969
Plan Year:	March 1 through February 28
Effective Date:	March 1, 2025
Plan Administration:	Hickman Transport
Insurance Carrier Address:	200 E Randolph St., Suite 5300 Chicago, IL 60601-6602
Insurance Carrier Phone:	(866) 414-1959
Insurance Carrier URL:	www.myuhc.com
Eligible Employee:	Regular full-time employee working 30 hours or more per week
Coverage Effective Date:	First of the month following 60 days after the date of hire
Excluded Classes:	Part-time and seasonal employees
Eligible Dependents:	Spouse / Dependents up to 26 years of age
Contributions:	Employer contributions
Grandfathered:	No

PLAN ADMINISTRATION

The Administrator shall be responsible for the general administration of the Plan, including the Benefit Programs referenced above, and shall be the "plan administrator" and "named fiduciary" within the meaning of ERISA under the Plan and the Benefit Programs (except to the extent another person or entity is specifically designated; provided, however, for Fully Insured Benefit Programs, unless specifically provided otherwise in the Governing Documents, the Insurer shall be the "named fiduciary," and the claims fiduciary responsible for administering the determining benefits under such Benefit Program, and shall have full authority and discretion to interpret the terms of the Benefit Program for those purposes. With respect to the Plan, including the Benefit Programs, the Administrator shall have, without limitation, the following discretionary authority, duties and powers:

1) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;

2) Except to the extent reserved to the Insurer with respect to a Fully Insured Benefit Program, to interpret the provisions of the Plan, make findings of fact, and correct efforts in, supply omissions from, and resolve inconsistencies or ambiguities in the language of the Plan, and to decide all claims and appeals arising under the Plan;

3) To decide all questions concerning the Plan and the eligibility of any person to participate in the Plan;

4) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and,

5) To allocate and delegate its fiduciary and administrative responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such allocation, delegation, or designation to be in writing. Without limitation, the Administrator may designate other organizations or persons (who also may be employed by an Employer) to carry out the following:

    a. pursuant to an administrative service or claims administration agreement, the responsibility for administering and managing a Benefit Program or Programs, including the processing and payment of claims under the Program and the recordkeeping related thereto;

    b. the responsibility to prepare, report, file and disclose any forms, documents and other information required to be reported and filed by law with any government agency or to be prepared and disclosed to Employees, Participants or other persons entitled to disclose under the Benefit Programs; and,

    c. the responsibility to review claims or claim denials under the Benefit Programs, including discretionary authority to act as claims fiduciary to determine adverse claims determinations within the meaning of the Department of Labor § 2560.503-1.

Subject to applicable law, any interpretation of the provisions of the Plan and the Benefit Programs and any decisions on any matter within the discretion of the Administrator made by the Administrator in good faith shall be binding on all persons. A misstatement or other mistake of fact shall be corrected when it becomes known, and the Administrator shall make such adjustment on account thereof as it considers equitable and practicable. The Administrator shall not be liable in any manner for any determination of fact made in good faith.

4. PLAN CONTACT INFORMATION

Employer
The name, address and telephone number of the **Employer** is:

Hickman Transport Co. Inc.
PO Box 5325
Valdosta, GA 31603
Phone: (229) 247-4150

Plan Sponsor and Plan Administrator
The name, address and telephone number of the **Plan Sponsor** and **Plan Administrator** is:

Hickman Transport Co. Inc.
PO Box 5325
Valdosta, GA 31603
Phone: (229) 247-4150

Third-Party Benefits Plan Administrator
The name, address and telephone number of the **Third-Party Benefits Plan Administrator** is:

Assured Partners STAFFCORE Benefit Administration, LLC
2501 West Beltline Highway, Suite 201
Madison, WI 53713
Phone: (608) 441-3035

Plan Fiduciary
The name, address and telephone number of the **Plan Fiduciary** is:

Hickman Transport Co. Inc.
PO Box 5325
Valdosta, GA 31603
Phone: (229) 247-4150

Agent for Service of Legal Process
The name and address of the **Agent for Service of Legal Process** is:

Hickman Transport Co. Inc.
PO Box 5325
Valdosta, GA 31603
Phone: (229) 247-4150
Service of Legal Process may also be made on the Plan Administrator

Important Disclaimer: Plan benefits are provided under contracts between the Employer and the carriers. If the terms of this summary document conflict with the terms of the Carrier Contract, the terms of the Carrier Contract will control, unless superseded by applicable law.

IDENTIFICATION NUMBERS
The Federal Employer Identification Number of the Plan Sponsor listed above is 58-1847561.

5. SOURCES OF PLAN CONTRIBUTIONS

PLAN YEAR
March 1 through February 28

PLAN CONTRIBUTIONS
Contributions for coverage may be made solely by the Plan Sponsor, solely by participating employees, or by a combination of the Plan Sponsor and participating employees.

Employee contributions will be paid through payroll deduction. Eligible plan premiums may be deducted on a pre-tax basis. Actual contribution rates will be published during the Employer's open enrollment period in each year.

Carrier documentation and/or your open enrollment guide provides the specific contribution information for each plan.

6. CLAIMS AND APPEALS

DEFINITIONS
For purposes of this Section, the following terms shall have the meanings set forth below:

1) *"Non-Grandfathered Plan"* means a Health Benefit Program that is (1) subject to Title I of the Patient Protection and Affordable Care Act of 2010, as amended, and (2) does not meet the requirements for "grandfathered status" within the meaning of that Act.

2) *"Claim"* means any request for a benefit under a Health Benefit Program, made by a Claimant or representative which complies with the reasonable procedures for making benefit Claims under such program.

3) *"Concurrent Care Claim"* means a Claim for an ongoing course of treatment to be provided over a period of time or number of treatments. Any reduction or termination by the Health Benefit Program in the course of treatment (other than by plan amendment or termination) before the end of the period of time or number of treatments originally approved is considered an Adverse Benefit Determination.

4) *"Pre-Service Claim"* means any Claim for a benefit under a Health Benefit Program which conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

5) *"Urgent Care Claim"* means a Pre-Service Claim for medical care or treatment with respect to which the time frame for a non-urgent care determination could seriously jeopardize the life or health of the Claimant; or the ability of the Claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the Claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

6) A physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Health Benefit Program applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination. "Post-Service Claim" means any Claim that is not a Pre-Service Claim.

7) *"Adverse Benefit Determination"* means a total or partial denial of a Claim. For a Non-Grandfathered Plan, a retroactive rescission of coverage due to fraud or misrepresentation shall be treated as an Adverse Benefit Determination.

8) *"Appeal"* means a Claimant's written request for review of an Adverse Benefit Determination in accordance with Appeal Section.

9) *"Final Adverse Benefit Determination"* means an Adverse Benefit Determination issued in connection with the last stage of Appeal as set forth in the Appeals Section.

CLAIMS

All claims for benefits under the Plan and any assignment of benefits to a provider shall be made, processed and paid in accordance with Department of Labor Regulations § 2560.503-1 and other applicable law, and the terms and conditions of the applicable Benefit Program and the related provisions of the Summary Plan Description for each program. The Administrator shall be the claims fiduciary unless this function is delegated to another person or entity under this Section.

NO ESTOPPEL OF PLAN

No person is entitled to any benefit under the Plan except and to the extent expressly provided under the terms and conditions of the applicable Benefit Program. The fact that payments have been made from the Plan in connection with any claim for benefits does not (a) establish the validity of the claim; (b) provide any right to have such benefits continue for any period of time; or (c) prevent the Plan from recovering the benefits paid to the extent that the Administrator determines that there was no right to payment of the benefits under the Plan. Thus, if a benefit is paid and it is thereafter determined that such benefit should not have been paid (whether or not attributable to an error by the Participant or any other person), then the Administrator may take such action as it deems necessary or appropriate to remedy such situation, including without limitation, by deducting the amount of any overpayment theretofore made to or on behalf of such Participant from any succeeding payments to or on behalf of such Participant under the Plan or from any amounts due or owing to such Participant by the Company or under any other plan, program or arrangement benefiting the Employees or former Employees of the Company, or otherwise recovering such overpayment from whomever has benefited from it.

If the Administrator determines that an underpayment of benefits has been made, then the Administrator shall take such action as it deems necessary or appropriate to remedy such situation.

CLAIMS PROCEDURES

The specific guidelines for filing a Claim or a request for a review of a denied claim shall be set out in the summary plan description for each Health Benefit Program. Such procedures shall comply with the general provisions of this Section and shall be designed to ensure the independence and impartiality of the persons involved in making decisions on such Claims. A Claimant must follow all internal claims and appeal procedures and, where applicable, all external review procedures before he can file a lawsuit to contest the decision.

NOTICE TO CLAIMANT OF ADVERSE BENEFIT DETERMINATIONS

Initial Claims

Except with respect to Urgent Care Claims (the notification for which may be oral followed by written or electronic notification within three days of the oral notification), upon its initial determination of a Claim, the Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state, in a manner calculated to be understood by the Claimant, the following:

1) The specific reason or reasons for the adverse determination, including for Non-Grandfathered Plans, the denial code and its corresponding meaning, and a description of the Non-Grandfathered Plan's standard, if any, that was used in denying the Claim.

2) Reference to the specific Health Benefit Program provisions on which the determination was based.

3) A description of any additional material or information necessary for the Claimant to perfect the Claim and an explanation of why such material or information is necessary.

4) A description of the Health Benefit Program's appeal procedures, including any voluntary appeal procedures offered by the Health Benefit Program and for Non-Grandfathered Plans, any external review procedures, and the time limits applicable to such procedures. This will include a statement of the Claimant's right to bring a civil action under section ERISA §502.

5) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge, or a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the Claimant upon request.

6) If the Adverse Benefit Determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Health Benefit Program to the Claimant's medical circumstances, will be provided, or a statement will be included that such explanation will be provided free of charge, upon request.

7) For Non-Grandfathered Plans, information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare provider, the Claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

8) For Non-Grandfathered Plans, information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals procedures and external review process.

Appeals
The Administrator shall also provide written or electronic notice of an Adverse Benefit Determination on Appeal. This notice shall contain the information listed under "Initial Claims" (1) through (8), as well as:

1) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim.

2) In the case of a Final Adverse Benefit Determination for a Non-Grandfathered Plan, a discussion of the decision.

APPEALS

When a Claimant receives an Adverse Benefit Determination, the Claimant has 180 days following receipt of the notification in which to request a review of the decision, unless a shorter time is permitted by law. A Claimant may submit written comments, documents, records, and other information relating to the Claim. If the Claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

1) was relied upon in making the benefit determination;

2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Health Benefit Program documents and Health Benefit Program provisions have been applied consistently with respect to all Claimants; or

4) constituted a statement of policy or guidance with respect to the Health Benefit Program concerning the denied treatment option or benefit.

For Non-Grandfathered Plans, the Administrator shall provide the Claimant any new or additional evidence that is relied upon, considered or generated by or at the direction of the Non-Grandfathered Plan. This new evidence shall be provided free of charge and must be provided to Claimant as soon as possible and sufficiently in advance of the time within which a Final Adverse Benefit Determination is required, to allow the Claimant time to respond.

If a Final Adverse Benefit Determination will be based on a new or additional rationale, the Claimant must be provided with this rationale as soon as possible and sufficiently in advance of the date on which the Final Adverse Benefit Determination must be provided, in order to give the Claimant a reasonable opportunity to respond prior to that date.

The Administrator's review shall take into account all comments, documents, records, and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Health Benefit Program who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Administrator shall consult with a health care professional who was not involved in the original benefit determination, nor a subordinate of any individual involved in the original determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Health Benefit Program in connection with the initial determination will be identified.

If specifically provided under the Health Benefit Program, a Claimant may bring a second Appeal, which shall be subject to the terms of this section.

VOLUNTARY APPEALS

If a Health Benefit Program Provides for a voluntary appeal process, the terms of this section shall apply. During voluntary dispute resolution, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending. The Health Benefit Program waives any right to assert that a Claimant has failed to exhaust administrative remedies because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Health Benefit Program. A Claimant may elect a voluntary appeal after exhaustion of appeals of an adverse benefit determination as explained in the section above, entitled "Appeals."

The Health Benefit Program will provide to the Claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the Claimant's rights to any other benefits under the Health Benefit Program; will list the rules of the appeal; state the Claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker. No fees or costs will be imposed on the Claimant as part of the voluntary level of appeal.

SUBSIDIARY CONTRACT CLAIMS PROCEDURES

This Section will apply for any claim for benefits under a Subsidiary Contract unless the Subsidiary Contract for the benefit has a claims procedure that is compliant with ERISA. If the applicable Subsidiary Contract has a claims procedure that is compliant with ERISA, the claims procedure of the Subsidiary Contract will apply.

A request for benefits is a "claim" subject to these procedures only if it is filed by the Participant or the Participant's authorized representative in accordance with the Plan and any procedures provided by the Plan Administrator. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" for purposes of this section. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this section, unless it is determined by the Plan Administrator in its sole discretion that the inquiry is an attempt to file a claim. If the Plan Administrator or its delegate receives a claim, but there is not enough information to process the claim, the Participant will be given an opportunity to provide the missing information.

Participants may designate an authorized representative by providing to the Plan Administrator or its delegate written notice of such designation and identifying such authorized representative. In the case of a claim for medical benefits involving urgent care, a health care professional who has knowledge of the Participant's medical condition may act as an authorized representative with or without prior notice. A "health care professional" is a physician or other health care professional licensed, accredited, or certified to perform specified health services, consistent with state law.

Timing of Notice of Claim

The Plan Administrator will notify the Claimant of an adverse benefit determination within a reasonable period of time, but not later than the time frame below, depending on the type of benefit being provided under the Subsidiary Contract under which the claim for benefits arises. An "adverse benefit determination" is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan, and including, with respect to a group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

1) The Plan Administrator (or its delegate) will provide notice of an adverse benefit determination within 90 days after receipt of the claim. This period may be extended one time by the Plan for up to 90 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 90-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

2) Group Health Plan Claims

    a. Urgent Care Claims. An "urgent care" claim is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function, or, in the opinion of a physician with knowledge of the Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an "urgent care" claim is determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the Participant's medical condition determines is an "urgent care" claim will be treated as an "urgent care" claim by the Plan.

If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing an urgent care claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 24 hours following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The Plan Administrator will notify the Participant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the Participant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the plan administrator will notify the Participant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the Participant to provide the specified additional information.

b. Pre-Service Claims. A "pre-service" claim is any claim for a benefit under a group health plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. If the Participant or the Participant's authorized representative fails to follow the Plan's procedures for filing a pre-service claim, the Plan Administrator (or its delegate) will notify the Participant of the failure as soon as possible, but not later than 5 days following the failure and of the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Participant or authorized representative. This paragraph applies only to a communication by a Participant or an authorized representative that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific Participant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

   The Plan Administrator will notify the Participant of the Plan's determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

c. Post-Service Claims. A post-service claim is any claim for a benefit under the plan that is not a pre-service claim. In the case of a post-service claim, the Plan Administrator will notify the Participant of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary

due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Participant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Participant will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

d. Concurrent Care Claims. If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Participant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.

   Any request by a Participant to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Participant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

   Notwithstanding anything herein to the contrary, the timeframe for benefit determinations under group health plans will be determined as provided under DOL Reg. section 2560.503-1(f)(2). For purposes of this Section, group health plan means a group health plan as defined in DOL Reg. section 2560.503-1(m)(6).

e. Disability Plan Claims (or Claims Involving Disability). The Plan Administrator will provide notice of an adverse benefits determination to the Participant within 45 days after receipt of the claim. This period may be extended by the Plan for up to 30 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. The period for making the determination may be extended for up to an additional 30 days if Plan Administrator notifies the Participant prior to the expiration of the first 30-day extension period the circumstances of the extension and the date by which the Plan expects to render a decision. Any notice extension under this section will explain the standards on which the entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues, and the Participant will be afforded at least 45 days within which to provide the specified information.

Content of Notice of Adverse Benefit Determination

If a claim is wholly or partially denied, the Plan Administrator will provide the Participant with a written notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) any material or information needed to grant the claim and an explanation of why the additional information is necessary, and (4) an explanation of the steps that the Participant must take if he wishes to appeal the denial including a statement that the Participant may bring a civil action under ERISA.

In addition, if the wholly or partially denied claim is by a group health plan or disability plan under the Plan, the following information must also be included in the written notice: (1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied

upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Participant upon request; or (2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

In the case of a wholly or partially denied urgent care claim by a group health plan under the Plan, the notice must include a description of the expedited review process applicable to such claims. In addition, the information described in this Section may be provided orally within the timeframe required under the above section entitled "Group Health Plan Claims," provided that a written or electronic notification is furnished to the claimant not later than three days after the oral notification.

Appeal of Adverse Benefit Determination

A Participant may appeal the denial of a claim by filing a written appeal with the Plan Administrator on or before the 60th day after he receives the Plan Administrator's written notice that the claim has been wholly or partially denied (the 180th day for claims involving a group health plan or disability benefits). The written appeal will identify both the grounds and specific Plan provisions upon which the appeal is based. The Participant will lose the right to appeal if the appeal is not timely made.

If the claim is for group health plan or disability plan benefits,

1) the review will not afford deference to the initial adverse benefit determination. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

2) in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

3) the Plan will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Participant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and,

4) in the case of an urgent care claim, the Plan will expedite review of the claim such that a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Participant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Participant by telephone, facsimile, or other available similarly expeditious method.

5) The Plan Administrator will ordinarily rule on an appeal of an adverse benefit determination within 60 days following receipt of the claim. However, if special circumstances require an extension and the Plan Administrator furnishes the Participant with a written extension notice during the initial period, the Plan Administrator may extend this period of time by 60 days if written notice of the extension is furnished to the Participant prior to the termination of the initial 60-day period.

If a Committee designated as the appropriate named fiduciary that holds regularly scheduled meetings at least quarterly, the Committee will instead make a benefit determination no later than the date of the meeting of the Committee that immediately follows the Plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later

than the date of the second meeting following the Plan's receipt of the request for review. If special circumstances require a further extension of time for processing, a benefit determination will be rendered not later than the third meeting of the Committee following the Plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the Plan Administrator will provide the Participant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The Plan Administrator will notify the Participant of the benefit determination as soon as possible, but not later than five days after the benefit determination is made.

If the claim is for group health plan or disability plan benefits, the Plan Administrator will notify the Participant of the Plan's benefit determination on review as follows:

1) Urgent Care Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Participant's request for review of an adverse benefit determination by the Plan.

2) Pre-Service Claims. The plan administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

3) Post-Service Claims. The Plan Administrator will notify the Participant of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of the Participant's request for review of an adverse benefit determination.

The period of time within which a benefit determination on review is required to be made will begin at the time an appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended due to a Participant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to the Participant until the date on which the Participant responds to the request for additional information.

Denial of Appeal

If an appeal is wholly or partially denied, the Plan Administrator will provide the Participant with a notice identifying (1) the reason or reasons for such denial, (2) the pertinent Plan provisions on which the denial is based, (3) a statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits, and (4) a statement describing the Participant's right to bring an action under section 502(a) of ERISA. The determination rendered by the Plan Administrator will be binding upon all parties.

In the case of a group health plan or a plan providing disability benefits, the notice will also include:

1) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Participant upon request;

2) if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

3) the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

4) *Exhaustion of Remedies.* A Participant must exhaust all internal remedies before a claim or lawsuit can be filed in court.

Additional Claims Processes

1) Applicability. This Subsection will apply to benefit under (1) a plan that constitutes a group health plan as defined in Treas. Reg. section 54.9801-2 or if the Plan Administrator determines that the plan is subject to HIPAA portability rules, and (2) the plan is not a grandfathered health plan under the Patient Protection and Affordable Care Act.

2) Internal Claims Process. The claims requirements set forth above will apply as the internal claims process, except that

    a. an "adverse benefit determination" will also include any cancellation or discontinuance of coverage under the applicable plan that has retroactive effect.

    b. the Plan will provide the Participant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to the Participant to give the Participant a reasonable opportunity to respond prior to that date.

    c. before the Plan can issue a final internal adverse benefit determination based on a new or additional rationale, the Participant must be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse benefit determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it to the Participant in time for the claimant to have a reasonable opportunity to respond, the period for providing a notice of final internal adverse benefit determination is tolled until such time as the Participant has a reasonable opportunity to respond. After the Participant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator will notify the Participant of the Plan's benefit determination as soon as a Plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

    d. the Plan must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

    e. the plan must provide notice to Participants, in a culturally and linguistically appropriate manner.

    f. the Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

    g. the Plan must provide to Participants, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated

with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

h. the Plan must ensure that the reason or reasons for the adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final internal adverse benefit determination, this description must include a discussion of the decision.

i. the Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal.

j. the Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist Participant's with the internal claims and appeals and external review processes.

k. The Plan will continue to provide continued coverage under the Plan as required by DOL Reg. section 2590.715-2719(b)(2)(iii) pending the outcome of an appeal.

External Claims Process

1) **State Process**. To the extent the Plan is required pursuant to DOL Reg. section 2590.715-2719I(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of DOL Reg. section 2590.715-2719I.

2) **Federal Process**. To the extent the Plan is not required pursuant to DOL Reg. section 2590.715-2719I(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of DOL Reg. section 2590.715-2719(d).

7. MISCELLANEOUS RULES

INFORMATION TO BE FURNISHED BY PARTICIPANTS

Participants under the Plan must furnish the Administrator with such evidence, data or information, as the Administrator considers necessary or desirable to administer the Plan and the Benefit Programs. A fraudulent or knowing misstatement or omission of fact made by a Participant or Dependent in an enrollment form, a claim for benefits or similar manner may result in cancellation of coverage and/or denial of claims for benefits.

RECORDS

As a condition of receiving benefits payable under a Benefit Program, a Participant may be required to provide the Administrator with any evidence and records of expenses incurred by such Participant and each of such Participant's Dependents in such form as the Administrator shall from time to time specify.

RESCISSION

A group health plan may not rescind a participant's coverage (that is, terminate that coverage retroactively) except in the case of fraud or the individual's intentional representation of a material fact, as prohibited by the plan terms. In addition, a group health plan must provide at least 30 days advance written notice to each participant who would be affected before any coverage may be rescinded. Separately, a group health plan may cancel coverage, even retroactively, if the termination of coverage is due to a failure to pay required premiums or contributions toward the cost of coverage on a timely basis.

UNIFORM RULES
The Administrator shall administer the Program and the Benefit Programs on a reasonable and nondiscriminatory basis and shall apply uniform rules to all persons in similar situations.

NO VESTED INTEREST
No person shall have any right, title or interest in or to any contributions made under the Plan and the Benefit Programs, such contributions being made for the sole purpose of providing benefits under the Programs in accordance with their terms. Neither the Company, the Administrator, nor any Employer shall in any way guarantee the payment of any benefit that may be or become due to any person under the Plan or the Benefit Programs.

EMPLOYMENT RIGHTS
Employment rights of an Employee shall not be deemed to be enlarged or diminished by reason of establishment of, or participation in, the Plan or any Benefit Program, nor shall establishment of the Plan and the Benefit Programs confer upon any Employee any right to be retained in the service of an Employer. Cost of Plan and Program Administration The costs and expenses incurred in the administration of the Plan and the Benefit Programs shall be paid, in the discretion of the Administrator, (i) from assets accumulated under the Plan and the Benefit Programs, if any; (ii) from Employee contributions; or (iii) by the Employers in such proportion as the Company or the Administrator shall determine.

EVIDENCE
Evidence required of anyone under the Plan and the Benefit Programs may be by certificate, affidavit, document or other information which the Administrator considers pertinent and reliable, and signed, made or presented by the proper party or parties.

PHYSICAL EXAMINATION AND AUTOPSY
In addition to any rights and privileges granted under a Benefit Program, the Administrator, at its own expense, shall have the right and opportunity to have a physician, designated by the Administrator, examine any individual whose injury or sickness is the basis of a claim under the Plan and the Benefit Programs, when and as often as it may reasonably require during the pendency of a claim or any period of benefits under the Plan and the Benefit Programs and to make an autopsy in case of death, provided it is not otherwise prohibited by law. Notwithstanding the foregoing, a Health Benefit Program that is not an excepted benefit program under ERISA § 732(b), (c) or (d), shall not request or require an individual to undergo a genetic test.

RECOVERY OF BENEFITS
If, because of fraud, mistake or any other reason, a person receives a benefit payment under the Plan and the Benefit Programs that exceeds the benefit payment that should have been made, the Administrator shall have the right to recover the amount of such excess from such person. The Administrator may, however, at its option, deduct the amount of such excess from any subsequent benefits payable to, or for, the Participant or such Participant's Dependents to whom or on whose behalf the excess payment was made.

LAWSUITS CONCERNING BENEFITS
No lawsuit may be brought by any person or entity to recover benefits under the Plan more than three years from the date Plan benefits are finally denied.

WORKERS' COMPENSATION NOT AFFECTED
The Plan is not in lieu of, and does not affect any requirement for, coverage under Workers' Compensation.

SEVERABILITY
In case any provisions of the Plan or any Benefit Program shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining provisions of the Plan or any Benefit Program, and the Plan and all Benefit Programs shall be construed and enforced as if such illegal and invalid provisions had never been set forth in the Plan or Benefit Program.

FAILURE TO ENFORCE
Failure to enforce any provision of the Plan shall not affect the Employer's or Administrator's right thereafter to enforce such provision, nor shall such a failure affect the Employers' or Administrator's right to enforce any other provision of the Plan.

INDEMNIFICATION
The Company shall indemnify and hold harmless any person serving as the Plan Administrator (and its delegate) from all claims, liabilities, losses, damages and expenses, including reasonable attorneys' fees and expenses, incurred by such persons in connection with their duties hereunder to the extent not covered by insurance, except when the same is due to such person's own gross negligence, willful misconduct, lack of good faith, or breach of its fiduciary duties under this Plan or ERISA.

8. SECTION 125 PLAN

GENERAL
If elected in the Adoption Agreement, the Benefit Programs shall include a Cafeteria Plan Arrangement which shall permit Employees to choose between cash (or other taxable benefits) and the Benefit Programs on a non-taxable basis, subject to the requirements of Code § 125 and the regulations thereunder.

ELIGIBILITY
Notwithstanding anything to the contrary contained in the Governing Documents, participation in the Cafeteria Plan Arrangement shall be restricted to Employees, which may include former Employees if permitted in the Governing Documents.

IRREVOCABLE ELECTIONS
An Employee's election under the Cafeteria Plan Arrangement shall be effective for the Program Year, and shall be irrevocable, except to the extent permitted under the Governing Documents and Treasury Regulation § 1.125-4.

ADDITIONAL REQUIRED TERMS
Additional terms required under Code § 125 shall be set forth in the Governing Documents for the Cafeteria Plan Arrangement.

9. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

SPECIAL ENROLLMENT PERIOD
Once you are enrolled you may only make changes to your benefit elections during Open Enrollment or if you have a Change in Status that affects the eligibility of you or your dependents, *and* the requested election change corresponds with the effect on your eligibility.

A qualified change in status includes:

1) A change in your *Legal Marital Status* such as marriage, death of a spouse, divorce, legal separation or annulment

2) A change in your *Number of Dependents* such as birth, adoption, placement for adoption, or death of a child

3) A change in *Employment Status* such as commencement or termination of employment for you, your spouse or your dependent

4) A change in *Work Schedule* such as a reduction or increase in hours including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence for you, your spouse or your dependent

5) If your *Dependent satisfies* or *Ceases to Satisfy the Requirements for Unmarried* if applicable

6) *Dependents* due to factors such as age or dependent status

7) A change in *Residence or Worksite* for you, your spouse or your dependent

8) The receipt of a *Qualified Child Support Order*

9) A change in *Entitlement to Medicare or Medicaid* for you, your spouse or your dependent

10) A change in *Eligibility for COBRA* for you, your spouse or your dependent while you are still an active employee

11) Health Insurance Premium Payment (HIPP) is also an allowed change

In addition, under limited circumstances, your Employer may permit you to make a mid-year election change that corresponds to changes made by your spouse's or dependent's employer plan (i.e., during the other plan's open enrollment period). However, all election changes, with the exception of Medicare/Medicaid change (which is 60 days), must be requested within 30 days of the event in question.

EMPLOYEE ELIGIBILITY—LOOK-BACK MEASUREMENT METHOD

The Company offers coverage under its health plan to full-time employees. A full-time employee is an employee who is employed, on average, for at least 30 hours of service per week or 130 hours of service in a calendar month. Full-time employees may also elect coverage for their Spouse and dependent children up to age 26. Effective January 1, the Company will use a look-back measurement method to determine whether an employee is a full-time employee for purposes of Plan coverage. The look-back measurement method is based on Internal Revenue Service (IRS) final regulations under the Affordable Care Act (ACA). Its purpose is to provide greater predictability for Plan coverage determinations.

The look-back measurement method applies to Company employees and involves three different periods:

1) *A measurement period* for counting an employee's hours of service (also called a standard measurement period or an initial measurement period);

2) *A stability period* when the employee is either treated as full-time or non-full-time for Plan eligibility purposes; and,

3) *An administrative period* that allows time for Plan enrollment and disenrollment.

The Company establishes how long these periods will last, subject to specified IRS parameters. An ongoing employee is one who has been employed by the Company for at least one complete standard measurement period (SMP). If an ongoing employee was employed, on average, for at least 30 hours of service per week (or 130 hours per month) during the SMP, the employee is treated as a full-time employee for a set period into the future, known as the stability period. This means that, as a general rule, the employee is eligible for Plan coverage during the stability

period, regardless of the employee's number of hours of service during the stability period, as long as he or she remains an employee.

To make an election change, contact your Plan Sponsor.

10. COBRA

COBRA DEFINITIONS
For purposes of this Section only, the following definitions shall apply:

1) *"COBRA"* means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

2) *"COBRA Continuation Coverage"* means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage shall be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of this Plan are modified for Similarly Situated Beneficiaries, such coverage shall also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to Similarly Situated Qualified Beneficiaries.

3) *"Continuation Coverage Contribution"* means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for COBRA Continuation Coverage.

4) *"Continuation Coverage Period"* means the applicable time period for which Continuation Coverage may be elected.

5) *"Covered Employee"* means an Employee covered under this Plan on the day prior to the Qualifying Event. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.

6) *"Annual Enrollment Period"* means a period during which an Employee covered under the Plan can choose to be covered under another Plan or under another benefit option within the same plan, or add or eliminate coverage of family members.

7) *"Qualified Beneficiary"* means a Covered Employee or Qualifying Dependent.

8) *"Qualifying Dependent"* means:

    a. a Covered Employee's Spouse or Dependent child covered under this Plan on the day prior to the Qualifying Event; or

    b. a Dependent child who is born to, adopted by or placed for adoption with a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

9) *"Qualifying Event"* means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage in the absence of this provision:

    a. a Covered Employee's Termination of Employment, for any reason other than gross misconduct;

b. a Covered Employee's reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;

c. a Covered Employee's divorce or legal separation;

d. a Qualified Dependent ceasing to qualify as a Dependent under the provisions of this Plan;

e. a Covered Employee's entitlement to benefits under Medicare;

f. the death of a Covered Employee; or

g. the failure of a Covered Employee to return from FMLA leave.

Loss of coverage includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above. The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

10) *"Similarly Situated Beneficiaries"* means Employees or their Dependents, as applicable, who are Participants in this Plan.

CONTINUATION OF BENEFITS UNDER COBRA

Qualified Beneficiaries shall have all continuation rights required by the Consolidated Omnibus Budget Reconciliation Act ("COBRA") for health benefits offered under Welfare Programs within this Plan. To the extent a Welfare Program offering health benefits does not specify COBRA Continuation Coverage rights in accordance with Code Section 4980B, the Plan shall be administered in accordance with Code Section 4980B and 29 CFR Part 2590.606-1 through 2590.606-4, with respect to the final COBRA notice rules and regulations for group health plans. In addition, the Plan Administrator shall adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section.

ELECTION OF COBRA

COBRA Continuation Coverage for Terminated Participants

In the event a Covered Employee, Qualified Dependent or Qualified Beneficiary experiences a Qualifying Event, the Plan Administrator shall provide notice of COBRA Continuation Coverage election that shall inform such individual of his or her rights and obligations with respect to COBRA Continuation Coverage under the Plan.

A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of either of the following Qualifying Events:

1) termination of employment (other than for gross misconduct); or

2) reduction of hours of employment with the Employer.

COBRA Continuation Coverage for Qualifying Dependent

Subject to the Section above, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if:

1) his participation under the Plan would terminate as a result of a Qualifying Event; or

2) the Qualifying Dependent is a child born to, adopted by or placed for adoption with the Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within a maximum of 60 days from the later of:

1) loss of coverage; or

2) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

The Employer shall, in the event of a Qualifying Event that is either a Termination of Employment (other than for gross misconduct) or a reduction of hours, notify the Plan Administrator (or its designee) within 30 days of the later of the date of the Qualifying Event or the date that coverage under the Plan ends. Such notice shall be given in a form and manner as determined by the Plan Administrator, in its sole discretion, in compliance with applicable law. The Plan Administrator shall then notify the Covered Employee and all covered Dependents of their right to elect COBRA Continuation Coverage within 14 days of such notice from the Employer.

Failure to enroll for COBRA Continuation Coverage during this maximum 60-day period will terminate all rights to COBRA Continuation Coverage under this Plan and such right to COBRA Continuation Coverage shall not be reinstated. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or his Spouse shall be deemed to be an election for that Covered Employee's Qualifying Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary). In the event the Plan Administrator determines that a Covered Employee, Qualified Dependent or Qualified Beneficiary who has furnished a notice of Qualifying Event, second Qualifying Event or disability determination is not entitled to COBRA Continuation Coverage, the Plan Administrator shall provide a notice of unavailability of COBRA Continuation Coverage to such affected individual in accordance with 29 CFR Part 2590.606-4I.

PERIOD OF COBRA COVERAGE

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of Termination of Employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to 18 months measured from the date of the Qualifying Event. With respect to all other Qualifying Events, a Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage for up to 36 months from the date of the Qualifying Event.

A Qualified Beneficiary who properly elects and renders payment for the initial Continuation Coverage Contribution shall have such COBRA Continuation Coverage effective on the date of the Qualifying Event.

Coverage under this Section may not continue beyond:

1) the date on which the Employer ceases to maintain a group health plan;

2) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with this Plan;

3) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;

4) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes covered under another group health plan and is no longer subjected to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or

5) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members) receiving COBRA Continuation Coverage under the 11-month extended coverage described in above, the first day of the month that begins more than 30 days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

In the event the Plan Administrator terminates COBRA Continuation Coverage of a Qualified Beneficiary prior to the end of the maximum available Continuation Coverage Period, the Plan Administrator shall provide a notice of such termination to each affected Qualified Beneficiary in accordance with 29 CFR Part 2590.606-4(d). Contribution Requirements for Coverage Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has 45 days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary shall have a 30-day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the 30-day grace period. The 30-day grace period shall not apply to the 45-day period for payment of COBRA premiums as applicable to initial elections.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. Once terminated, COBRA Continuation Coverage shall not be reinstated.

Except as referenced above, the Continuation Coverage Contribution shall be 100% of the cost of coverage plus a 2% administrative fee for a total contribution of 102% of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this Section of this Plan, an amount not significantly less than the amount the Plan requires to be paid shall be defined as the lesser of $50 or 10% of the required payment amount.

LIMITATION ON QUALIFIED BENEFICIARY'S RIGHTS TO COBRA CONTINUATION COVERAGE

If a Qualified Beneficiary loses, or will lose health coverage under the Plan as a result of divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Covered Employee must notify the Plan Administrator within a maximum of 60 days of the divorce, legal separation or loss of Dependent status. Such notice shall be required to comply with the Plan's notice procedures as contemplated by this Plan, in accordance with applicable law. Failure to make timely notification shall result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Plan; such right shall not be reinstated.

A Qualified Beneficiary must notify the Plan Administrator of the birth to, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage. The notice must be provided within a

maximum of 30 days of the child's birth, adoption or placement for adoption with the Qualified Beneficiary, subject to the Plan's notice procedures.

EXTENSION OF COBRA CONTINUATION COVERAGE PERIOD

If a second Qualifying Event that is not a Termination of Employment or reduction in hours occurs during an 18-month extension period explained above, coverage may be continued for a maximum of 36 months from the date of the first Qualifying Event for the affected Qualifying Dependent. A second Qualifying Event will result in an extension of the initial Continuation Coverage Period if such Qualifying Event would have resulted in a loss of coverage under the plan had the first Qualifying Event not occurred. Such extension of COBRA Continuation Coverage applies only to Qualifying Dependents. Therefore, such extension would apply to a child adopted by or placed for adoption with a Qualified Beneficiary, but would not apply to a Spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial 18-month continuation period. Notwithstanding the foregoing, terminating employment after a Qualifying Event that is a reduction in hours of employment does not extend the maximum Continuation Coverage Period beyond 18-months of COBRA Continuation Coverage.

The maximum COBRA Continuation Coverage Period is extended up to 11 months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to 29 months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

1) the Social Security Administration determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or anytime within the first 60 days of COBRA Continuation Coverage, and

2) the disabled Qualified Beneficiary provides evidence to the Plan Administrator of such Social Security Administration determination within 60 days of the date of such determination but not later than the last day of the initial 18-month period of COBRA Continuation Coverage in a manner consistent with the Plan's reasonable notice procedures as contemplated by this Plan. Failure to notify the Plan Administrator of such determination within the time period stated above will result in the loss of the Qualified Beneficiary's right to an extension of the initial 18-month period of COBRA Continuation Coverage and such right will not be reinstated. In such event, if the disabled Qualified Beneficiary is receiving COBRA Continuation Coverage, the Continuation Coverage Contribution shall be 150% of the cost of coverage for the 19th through 29th month of COBRA Continuation Coverage. Otherwise, the Continuation Coverage Contribution shall continue to be 102% of the cost of coverage for the 19th through 29th months of coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the Social Security Administration that he or she is no longer disabled, the Qualified Beneficiary must notify the Plan Administrator within 30 days of the date of that determination in a manner consistent with the Plan's notice procedures as contemplated by this Plan. Such a final determination shall end the disability extension of COBRA coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following 30 days from the final determination date or (ii) the end of the Continuation Coverage Period without regard to the disability extension.

RESPONSES TO INFORMATION REGARDING QUALIFIED BENEFICIARY'S RIGHT TO COVERAGE

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the COBRA Continuation Coverage election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA Continuation Coverage is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

COORDINATION OF BENEFITS – MEDICARE AND COBRA

For purposes of this Section, "Medicare Entitlement" means being entitled to Medicare due to either: (1) enrollment (automatically or otherwise) in Medicare Parts A or B, or (2) being medically determined to have end-stage renal disease ("ESRD"), and (a) having applied for Medicare Part A; (b) having satisfied any waiting period requirement and (c) being either (i) insured under Social Security, (ii) entitled to retirement benefits under Social Security or (iii) a spouse or dependent of a person satisfying either (i) or (ii). Such Medicare entitlement is a COBRA terminating event.

If you already have COBRA when you enroll in Medicare, your COBRA coverage usually ends on the date you enroll in Medicare. Your spouse and dependents may keep COBRA for up to 36 months, regardless of whether you enroll in Medicare during that time.

If you already have Medicare when you become eligible for COBRA, you will be allowed to enroll in COBRA subject to specific language in your plan documents.

RELOCATION AND COBRA COVERAGE

If a Qualified Beneficiary moves outside the service area of a region-specific group health benefit package, alternative coverage, if available to similarly situated active Employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage.

COBRA COVERAGE AND HIPAA SPECIAL ENROLLMENT RULES

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") rules as if the Qualified Beneficiary were an Employee or Participant in the Plan, provided that such family members do not become Qualified Beneficiaries, and who are therefore eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge coverage between this Plan and any future coverage under another group health plan.

PROCEDURES FOR PROVIDING NOTICES

The Plan Administrator shall establish procedures for the furnishing of notices required by a Covered Employee, Qualifying Dependent or Qualified Beneficiary to the Employer and/or Plan Administrator including Qualifying Event notices, notice of disability determination or Medicare entitlement, change in disability determination, and Medicare entitlement. Such procedures may: be described in the Plan's Summary Plan Description; specify the individual or entity designated to receive such notices; specify the form and means of delivery of such notices (including requiring the use of certain forms when submitting such notices); describe the information required by the Plan to provide COBRA Continuation Coverage rights; and shall comply with applicable federal laws regarding requirements for timing and content of such notices. Moreover, the Plan Administrator may select or appoint another entity or individual to handle COBRA administration, where applicable.

11. BENEFIT PLAN PROVISIONS

All documents relating to the Hickman Transport Group Health and Welfare Benefit Plan, including the Evidence/Certificate of Coverage for each plan, Listing of Network Providers, Contribution Rates, General COBRA Notice, General HIPAA, Medicare Creditable Coverage Notice and any other relevant Plan Documents or Notices, are available to employees and their dependents. Plan participants may receive a paper copy of any of the above documents free of charge by contacting the Plan Sponsor.

Please refer to the plan documents which may include a combination of certificates of coverage, plan documents and summary plan descriptions for each plan's specific details. These documents will include the description of benefits, cost-sharing provisions, requirements for use of network providers and circumstances by which benefits may be excluded or denied.

12. STATUTORY PROVISIONS

FAMILY AND MEDICAL LEAVE ACT

To be eligible for the Family and Medical Leave Act of 1993 (FMLA), employees must have worked for covered employers for a total of 12 months and for at least 1,250 hours in the previous 12 months. The 1,250-hour threshold can be met whether employees work full- time or part-time. Employers with multiple worksites are covered by FMLA if the worksites are within a 75-mile radius of each other and the number of employees equals 50 or more by counting employees at all worksites. The 75-mile radius is measured in surface miles, rather than linear miles.

If you go on a qualified unpaid leave under FMLA, the following rules will apply. Only to the extent required by FMLA (among other things, this means only for the duration of a qualifying leave) will the Employer continue to maintain your health plan benefits on the same terms and conditions as though you were still an active employee. Except as otherwise provided by FMLA, your Plan participation will cease when the Plan Administrator learns that you do not intend to return to work after your leave.

If earlier, your Plan participation will immediately cease upon expiration of your FMLA leave, if you fail to return to work at such time. Except as otherwise provided in the FMLA, if you fail to return to work after the FMLA leave, you will be required to reimburse the Employer for the cost of the coverage provided to you while you were on FMLA leave (the cost equals the COBRA premium, without a 2% add-on, and minus any employee contribution you already made). For more information on FMLA, please contact the Employer, where you may obtain a summary of your rights under FMLA without charge. The Employer has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your Employer will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your Employer has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence, coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. Any waiting period for pre-existing conditions or other waiting periods will not apply. However, all accumulated annual and lifetime maximums will apply.

The Plan intends to comply with all existing FMLA regulations. If for some reason the information presented differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

MILITARY LEAVE COVERAGE

The Uniformed Services Employment and Reemployment Rights Act (USERRA) establishes requirements that employers must meet for certain employees who are involved in the uniformed services.

As used in this provision, "Uniformed Services" means:

1) The Armed Forces;

2) The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);

3) The commissioned corps of the Public Health Service; and

4) Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, "Service in the Uniformed Services" or "Service" means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

1) Active duty;

2) Active duty for training;

3) Initial active duty training;

4) Inactive duty training;

5) Full-time National Guard duty,

6) A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;

7) A period for which you are absent from your job for the purpose of performing certain funeral honors duty; and

8) Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this Plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

1) You fail to make a premium payment within the required time;

2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or

3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage described below under the section entitled "COBRA Continuation Coverage."

If your coverage under the Plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.
When coverage under this Plan is reinstated, all of the Plan's provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. This waiver of

limitations does not provide coverage for any illness or injury caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your Employer.)

The Plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the Plan differs from the actual regulations of USERRA, the Plan reserves the right to administer the plan in accordance with such actual regulations.

13. AMENDMENT OR TERMINATION OF THE PLAN

As Plan Sponsor, the Employer has the right to amend or terminate the Plan at any time. You have no vested or permanent rights or benefits under the Plan. Plan benefits will typically change from year-to-year and you should examine all materials provided to you each year to determine the benefits of the Plan.

NO CONTRACT OF EMPLOYMENT

The Plan is not intended to, and does not, either directly or indirectly constitute any form of employment contract or other employment arrangement between you and Employer.

OTHER MATERIALS

The Certificate of Coverage (including the Member Payment Summary, and the Provider & Facility Directory) issued by Plans are part of the Summary Plan Description. Please refer to these materials for other important provisions regarding your participation in the Plan.

14. 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.

15. STATEMENT OF ERISA RIGHTS

As a participant in the Group Health and Welfare Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all group health plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

CONTINUE GROUP HEALTH PLAN COVERAGE
To continue health care coverage for yourself, legal spouse defined by Federal and State Law or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description Wrap Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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.

"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.

MEDICAID

If a Health Benefit Program is subject to ERISA § 609(b), then this Section shall apply. Payment for benefits with respect to a Participant under a Health Benefit Program will be made in accordance with any assignment of rights made by or on behalf of such Participant or a beneficiary of the Participant as required by a State plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

1) The fact that a Participant is eligible for or is provided medical assistance under a State plan for medical assistance approved under title XIX of the Social Security Act will not be taken into account in enrolling such Participant or in determining or making benefit payments for such Participant.

2) To the extent that payment has been made under a State plan for medical assistance approved under title XIX of the Social Security Act in any case in which a Health Benefit Program has a legal liability to make payment for items or services constituting such assistance, payment for benefits under such program will be made in accordance with any State law which provides that the State has acquired the rights with respect to a Participant to such payment for such items or services.

MEDICAL LOSS RATIO ("MLR")

In certain circumstances under the Medical Loss Ratio Standards in section 2718 of the Patient Protection and Affordable Care Act of 2010 (PPACA), rebates may be paid to this Plan. The federal law requires that the issuer of the rebate (the insurance company) provide you a written notice of a rebate, at the time the rebate is paid to the Plan. The rebate will be prorated between the amount attributable to Plan costs paid by the Plan Sponsor and Plan costs paid by participants. The participant portion of the rebate will be used for the benefit of the Plan participants. This can be done by a number of actions, including but not limited to lowering the Plan costs for the participants for the next Plan Year, applied towards the cost of administering the Plan, paid as taxable income to the participants, or in any manner that allocates the rebate to Participants based on each Participant's actual contributions, or to apportion it on any other reasonable basis.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT ("MHPA")

If a Health Benefit Program is subject to ERISA § 712, then the terms of this Section shall apply. A Health Benefit Program that provides both medical and surgical benefits and mental health and/or substance abuse benefits shall not impose any limits on mental health or substance abuse benefits that violate the requirements of ERISA § 712.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT ("NMHPA")

If a Health Benefit Program is subject to ERISA § 711, then this Section shall apply.

1) If such Health Benefit Program provides benefits for hospital lengths of stay in connection with childbirth for a mother or her newborn child, such Health Benefit Program shall not:

2) Except as provided in subsection (b):

    a. restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child, following a cesarean section, to less than 96 hours; or

    b. require that a provider obtain authorization from the Health Benefit Program or the health insurance issuer for prescribing any length of stay required under clauses (i) and (ii).

3) Paragraph (a) shall not apply in connection with any Health Benefit Program or health insurance issuer in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay otherwise required under paragraph (a) is made by an attending provider in consultation with the mother.

4) Such Health Benefit Program shall not:

    a. deny to the mother or her newborn child eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the Health Benefit Program, solely for the purpose of avoiding the requirements referenced above.

    b. provide monetary payments or rebates to mothers to encourage such mothers to accept less than the minimum protections available, referenced above.

    c. penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provided care to an individual Participant or beneficiary as referenced above.

    d. provide incentives (monetary or otherwise) to an attending provider to induce such provider to provide care to an individual Participant or beneficiary in a manner inconsistent with the plan; or

    e. restrict benefits for any portion of a period within a hospital length of stay required, in a manner which is less favorable than the benefits provided for any preceding portion of such stay; provided, nothing herein shall be construed to limit the terms of the Health Benefit Program with respect to deductibles, copayments or other cost-sharing provisions and limitations, except that such terms may not impose greater limits or cost sharing on any length of stay required.

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.

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 are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State in this link (www.medicaid.gov/medicaid-chip-program-information/by-topics/childrens-health-insurance-program-chip/chip-state-program-information.html) you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not 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, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

QUALIFIED MEDICAL CHILD SUPPORT ORDER PROCEDURES

If a Health Benefit Program is subject to ERISA § 609(a), then this Section shall apply. 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.

Such Health Benefit Program shall provide benefits in accordance with the terms of a qualified medical child support order that meets the requirements of ERISA § 609(a). Each Health Benefit Program shall establish reasonable written procedures to determine whether a medical child support order is a qualified medical child support order. Such procedures shall be made available upon request of a Participant at no charge.

WOMEN'S HEALTH AND CANCER RIGHTS ACT

If a Health Benefit Program is subject to ERISA § 713 and provides medical and surgical benefits with respect to a mastectomy, then this Section shall apply. Such Health Benefit Program shall, with respect to a Participant who is receiving benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, provide coverage for the following (subject to applicable deductibles, copayments and other Health Benefit Program limitations):

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) prostheses and physical complications for all stages of mastectomy, including lymphedemas;

This coverage will be provided in consultation with the attending physician and the patient.

SUBROGATION AND RECOVERY

If a Participant incurs covered expenses or receives benefits under a Benefit Program with respect to an injury or illness for which a third party (or its insurer) may be liable, the Plan retains all rights of subrogation, recovery and reimbursement as set out more specifically in the Governing Documents for each Benefit Program.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

16. ENFORCE YOUR RIGHTS

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

RECEIVE A SUMMARY OF THE PLAN'S ANNUAL FINANCIAL REPORT
The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

17. DEFINITIONS

The following terms shall have the meanings set forth below unless otherwise specified herein:

1) *"Beneficiary"* means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

2) *"Claims Administrator"* means the insurance company, third party administrator or other entity designated by the Plan Administrator to determine benefit eligibility and availability and/or pay claims for benefits under this Plan or a Welfare Program under this Plan.

3) *"Code"* means the Internal Revenue Code of 1986, as amended.

4) *"Company"* means Hickman Transport In the event of a reorganization, merger or similar transaction affecting the Company, any successor entity may adopt the Plan for the benefit of Employees of such successor, in which event, the Plan shall continue without any gap or lapse in coverage.

5) *"Dependent"* means a covered Dependent under the Plan as defined under the terms of the respective Welfare Program.

6) *"Effective Date"* of this amendment and restatement means January 1st.

7) *"Employee"* means, unless otherwise specified in a Welfare Program incorporated herein, any person currently employed by the Employer who is receiving compensation for services performed and who is classified by the Employer as a salaried or hourly full-time employee regularly scheduled the number of hours per week as noted in the Eligible Employee Section of the Plan Information Section of this document. Employees on certain leaves of absence are also eligible to participate, subject to additional terms and conditions as specified in this plan. "Employee" shall not include any person classified on the Employer's records as other than an employee. For example, "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, temporary employee or similar classifications, regardless of any subsequent or retroactive reclassification or determination by a governmental agency that any such person is a common-law employee of an Employer. Notwithstanding anything to the contrary contained herein or in the Welfare Programs, Employees who are non-resident aliens and who receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of Code Section 861(a)(3)) shall not be eligible to participate in the Plan.

8) *"Employer"* means the Company, and any other entity that participates in the Plan with the approval of the Plan Administrator. The Plan Administrator shall have the right to terminate any Employer's adoption of the Plan at any time. If an Employer merges or is otherwise consolidated with any affiliate, the successor shall, as to the group of Employees covered by the Plan immediately before such merger or consolidation, be the Employer as defined hereunder, unless the Plan Administrator specifies to the contrary. In case of any other merger or consolidation, the successor shall not be the Employer except to the extent that it acts to adopt the Plan. Each Employer is identified in Appendix A. The Plan Administrator shall amend Appendix A as needed, to reflect an Employer's adoption of the Plan or withdrawal from the Plan, without any need to otherwise amend the Plan. Amendment of Appendix A may be made by any authorized member or representative of the Plan Administrator.

9) *"ERISA"* means the Employee Retirement Income Security Act of 1974, as amended.

10) *"Former Employee"* means any person formerly employed as an Employee of the Employer.

11) *"Participant"* means an Employee or Former Employee of the Employer who meets the requirements for eligibility as set forth in this plan and who properly enrolls in the Plan. A person shall cease to be a Participant when he or she no longer meets the requirements for eligibility.

12) *"Participant Contribution"* means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" includes contributions used for the provision of benefits under a self-funded arrangement of the Company or an Employer as well as contributions used to purchase insurance contracts or policies.

13) *"Plan"* means this Plan, the Hickman Transport Group Health and Welfare Benefit Plan, which consists of this document, and each Welfare Program incorporated hereunder by reference, as amended from time to time.

14) *"Plan Administrator"* shall have the same meaning as set forth in ERISA Section 3(16). The Plan Administrator for the Plan shall be the Company, unless another entity or person is appointed by the Company.

15) *"Plan Year"* means the twelve (12) consecutive month period commencing on June 1 to May 31 of such year.

16) *"SPD"* means any Summary Plan Description, Summary of Material Modifications or other Employee communication that describes the benefits under a Welfare Program, and has been included by the Company and/or Employer as part of this Plan by reference.

17) *"Spouse"* means the legal spouse (as defined by state law, as applicable) of a Participant.

18) *"Welfare Program"* means a Welfare Program Document incorporated into this Plan that is offered by the Company and/or an Employer that provides any Employee a benefit that would be treated as an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. Welfare Program also means any plan established pursuant to Section 125 of the Code, if incorporated herein.

19) *"Welfare Program Document"* means a written arrangement, including any contract between an Employer and an insurance company, health maintenance organization ("HMO"), administrative service organization ("ASO") or other similar organization to provide benefits, a plan document or other instrument under which a Welfare Program is established and operated.

18. ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Pension and Welfare Benefits Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.