THE TRANSPORTATION SOLUTION™

CRST® INTERNATIONAL

# 2014 Summary of Benefits

## DRIVERS

CRST International • CRST Dedicated Services • CRST Expedited
CRST Lincoln Sales • CRST Logistics • CRST Malone
CRST Specialized Transportation • North American Driver Training Academy

## *A message to our valued CRST employees:*

At a time when health care costs continue to rise nationwide, we are pleased once again to offer a comprehensive benefits package to our employees and their families.

**Enrollment Process for New Hires**

This booklet provides a high-level overview of the benefits offered by CRST. It is your responsibility to review the Summary Plan Documents (found on your CHIP Employee Homepage) and complete your enrollment online. Attached to this package, you will find a Rate Sheet that outlines the employee premium rates for all health, dental and vision plans. In addition, during orientation, you will be provided with a CRST Benefits Enrollment Guide that outlines the steps to complete your online enrollment.

To access your CHIP Employee Homepage:

- If you are at a CRST Terminal, click on the CHIP icon located on the desktop.
- If you are outside a CRST Terminal, double-click the Internet Explorer icon on your computer (Internet Explorer 7 recommended).
- Go to https://chip.crst.com/wfc/logon.
- Follow the Benefits Enrollment Guide to create an account and complete benefits enrollment.

If you have any questions regarding the information contained in this booklet or any of the benefits offered at CRST, please contact the HR Benefits Department at 866-934-4895 or via email at benefits@crst.com.

Here's to a healthy and prosperous 2014!

Angie Stastny
Director – Human Resources
CRST International, Inc.

Brooke Willey
Vice President – Human Resources
CRST International, Inc.

***CRST offers two medical benefit options to our employees:***

**1. Indemnity (GAP) Plan:** For new hires who are in need of medical coverage prior to their eligibility for major medical benefits (pages 1-2).

**2. Major Medical Plan:** Upon reaching your eligibility date, employees are eligible to select this coverage (pages 3-4).

## MEDICAL BENEFITS: INDEMNITY (GAP) PLAN

***Transamerica – Administered by Web TPA***
P.O. Box 310
Grapevine, TX 76099-0076
866-441-3433
www.multiplan.com

Group Plan #TWM-TWM 0097

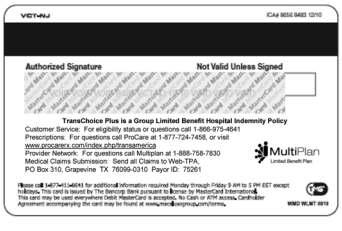
### Gap Medical Plan – TransChoice Plus

*Effective: Monday following your first payroll deduction through the 1st of the month following 60 days of employment*

| GAP PLAN BASICS | PLAN PAYS |
|---|---|
| **Daily In-Hospital Indemnity Benefit**<br>Per day over 23 hours (max of 30 days per confinement) | $200 |
| **Surgical and Anesthesia Indemnity Benefit**<br>Pays benefit shown in Surgical Schedule up to max amount; Pays additional 20% for Anesthesia | $1,500<br>Schedule |
| **Outpatient Physician Office Visit Indemnity Benefit**<br>Per visit up to 6 visits per calendar year per covered person | $50 |
| **Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit**<br>Up to 3 days of testing per calendar year, per covered person | $100 |
| **Off-the-Job Accidental Injury Benefit**<br>Pays actual charges of expenses up to a maximum per covered accident (5 covered accidents per calendar year) | $200 |
| **Wellness Indemnity Benefit** *(services described in Summary of Plan Description)*<br>1 visit per calendar year per insured over 2 years of age;<br>4 visits per year for children 0-12 months and 2 visits per year for children 12-24 months | $100 |
| **Emergency Room Sickness Benefit**<br>**Per visit; 4 visits per calendar year per covered person** | $100 |
| **Intensive Care Indemnity Benefit**<br>Per day (Annual maximum of 30 days) | $200 |
| **Ambulance Indemnity Benefit**<br>Per trip in an ambulance, 3 trips per calendar year per covered person; lifetime maximum of 6 trips | $200 |
| **Prescription Drug Indemnity Benefit**<br>Per prescription for up to 12 prescriptions per calendar year per covered person | $25 |
| **Group Term Life Insurance Policy with**<br>**Accidental Death and Dismemberment Rider (AD&D)**<br>AD&D not available to dependent children | Employee: $5,000<br>Spouse: $2,500<br>Child(ren): $2,500 |

For a complete version of the TransChoice Plus plan, refer to the Summary Plan Description on your CHIP employee homepage.

The Transamerica card outlined below serves two purposes:
1. Proof of insurance
2. Prescription/Rx Card, which must presented at time of filling a prescription. In addition, see details below regarding how this card can suffice as a debit card.


**Prescription Drug Indemnity Benefit**
Your prescription drug indemnity benefit amount will be paid for each prescription you fill, subject to the limitations stated in your certificate. When the discounted cost of your prescription is greater than your indemnity benefit, you will pay the difference at the pharmacy. When the discounted cost of your prescription is less than your indemnity benefit, Transamerica will pay the excess benefit directly to you.

In addition to negotiating deeper discounts on prescriptions with Walmart, Transamerica has also set up a way to be able to quickly pay any excess amounts owed to you when you use a Walmart pharmacy. Whenever you fill a prescription using your TransChoice Plus ID/Debit card at a Walmart, Neighborhood Market or Sam's Club pharmacy, any excess amount owed to you will be credited to your Debit card within minutes of picking up your prescription and can be spent anywhere MasterCard® is accepted, including Walmart. If you go to any other pharmacy, Transamerica will mail you a check for any excess benefit owed.

## INDEMNITY (GAP) MEDICAL PLAN: FREQUENTLY ASKED QUESTIONS

**What is an indemnity benefit?**
It means that the insurance company will pay a set amount each time the insured receives a covered service. The same amount is paid regardless of the fees charged by the provider.

**How are premium payments made?**
Premiums will be taken through payroll deduction. If you miss a payroll deduction as a result of absence or lack of work, no benefits will be extended for the following period. However, if a claim is incurred during a period of time when premiums were missed, the missed premium will be subtracted from the pending claim, maintaining a continuity of coverage. If a claim is not incurred during the missed premium timeframe, missed premium does not need to be made up. However, if you miss 5 deductions of premium, coverage will be terminated and you will not be eligible to re-enroll until the next open enrollment period unless you experience a qualifying event.

**When does coverage begin?**
Coverage for you and your eligible dependents begins on the Monday following your first payroll deduction.

**When will my coverage end?**
Your coverage will end when you no longer qualify under the plan or when your premium payments are 5 deductions behind, whichever comes first. Coverage on dependants ends on either the date they no longer meet the definition of a dependant or, the date your coverage terminates, whichever comes first.

**Can I sign up for coverage at any time?**
No. You must sign up for coverage in the first 30 days of your date of hire. Your coverage will begin the Monday following your first payroll deduction. If you do not elect coverage in the first 30 days, you will not be able to enroll until the next open enrollment period unless you experience a qualifying event.

**Can I cancel coverage at any time?**
Premiums are paid with pre-tax dollars through payroll deductions as part of a Section 125 Savings Plan. You will not be able to change these elections, unless you have a Qualifying Event.

**How do I get reimbursement if I have to pay out-of-pocket for insured services?**
Claim filing information is provided for your convenience so that you may receive reimbursement from the insurance carrier. You will still receive the plan benefits; however, you will pay for treatment/services up front and then file a claim for reimbursement. Please contact the appropriate Customer Numbers listed below for claim filing instructions.

**What if I need to use my benefits PRIOR to my cards arriving?**
Give the provider the Customer Service Contact information below:

**How do I find a doctor in my area?**
Call 1-866-680-7427 or visit www.multiplan.com.

**Hospital Indemnity/Customer Service**

| | |
|---|---|
| WEB-TPA | 1-866-441-3433 |
| Member ID | Employee's Social Security Number |
| Claims | WebTPA<br>P.O. Box 310<br>Grapevine, TX 76099-0076 |

## MEDICAL BENEFITS

***Federal Health Insurance Marketplace (i.e. "The Federal Exchange")***

*The Federal Exchange will be available for all U.S. citizens effective January 1, 2014. This government-generated program allows you and/or members of your family to elect benefits from the Exchange versus your Employer. The primary purpose of this program is to provide all Americans additional options for affordable health care coverage. More information on the Federal Exchange Program can be found at www.HealthCare.gov. We encourage all employees to view the Exchange as it may offer you a more affordable option that best suits your family and financial needs.*

### *Wellmark BlueCross & BlueShield of Iowa*

636 Grande Avenue
Des Moines, IA 50309
800-600-4149
www.wellmark.com

Plan #77017

### Major Medical Insurance

*Eligible: All regular full-time employees and part-time employees who work more than 30 hrs/week*

*Effective: 1st of the month following 60 days of employment*

***Spouse Coverage** – If your spouse works and is eligible for health care coverage with their own employer, he/she is not able to participate in the CRST Major Medical Insurance Plan. For spouses who do NOT have coverage options elsewhere, they have the opportunity to enroll in the CRST Major Medical Plan.*

***Spouse Affidavit** – If you are enrolling a spouse in the CRST Major Medical Plan, a Spouse Affidavit must be completed and signed prior to benefit eligibility. You may either complete the form online via CHIP Self Service during the benefit enrollment process or fill out the form on page 13 and fax it to 319-731-6366.*

*Your **Alliance Select (PPO)** medical plan allows you to receive care from any medical care provider you choose. Your cost is lower, however, when you choose a medical care provider who participates in the Alliance Select network and is classified as a primary care practitioner (PCP) for office services. To find an in-network medical care provider, refer to the Alliance Select provider directory on www.wellmark.com. The deductible/coinsurance is waived for in-network preventive care.*

| MEDICAL PLAN BASICS | ALLIANCE SELECT (PPO) | |
|---|---|---|
| | IN-NETWORK BENEFIT | OUT-OF-NETWORK BENEFIT |
| **Benefit Period Deductible**<br>Dollar amount you pay during the plan year before insurance carrier starts to make payments for covered medical services. | $1,500 Single<br>$3,000 Family | |
| **Coinsurance**<br>Percentage of medical expenses you pay after the deductible is met, until you reach your out-of-pocket maximum. | 20% | 30% |
| **Office Visit Copayment**<br>Amount you pay at the time you receive certain office-based services *(includes mental health).* | $30 (primary care practitioner)<br>$45 (non-primary care practitioner) | 30% after deductible |
| **Emergency Room Copayment***<br>Amount you pay for emergency room and related facility and practitioner services.<br>* waived if admitted to in-patient service | $400 | $400 |
| **Out-of-Network Emergency Services** | Covered emergency services for medical conditions that a prudent layperson expects would otherwise result in death, permanent disability or severe pain will be reimbursed as though services were received from a participating provider. You are responsible for any excess of the provider's billed charge over our settlement amount. | |
| **Out-of-Pocket Maximum (OPM)**<br>Maximum amount you pay for covered services each calendar year. Deductible and coinsurance apply to OPM. Once your OPM is satisfied, most services are covered in-full through the end of the calendar year. | $3,250 Single<br>$6,500 Family | |
| **Pre-existing Condition Waiting Period** | Waiting period applies for the first 12 months of coverage for all enrollees over 19 years of age. The length of the waiting period may be reduced by a credible coverage you have from prior health plans. | |

MEDICAL BENEFITS (CONTINUED)

| COVERED BENEFITS | ALLIANCE SELECT (PPO) | |
|---|---|---|
| | IN-NETWORK BENEFIT | OUT-OF-NETWORK BENEFIT |
| **Preventive Care Services**<br>• Physical exam *(one per benefit period; includes gynecological exam)*<br>• Immunizations<br>• X-ray/labs<br>• Mammogram *(one per benefit period)*<br>• Pap smears<br>• Prostate screening<br>• Well-child care to age 7 *(deductible waived)*<br>• Smoking cessation counseling<br>• Obesity counseling/screening<br>• Child hearing and vision screening<br>• Colonoscopy | Covered in full | 30% coinsurance after deductible |
| **Ambulance** | 30% coinsurance after deductible | 30% coinsurance after deductible |
| **Chiropractic Care Office Services** | $45 copayment | 30% coinsurance after deductible |
| **Facility Services**<br>• Outpatient hospital<br>• Nursing facility<br>*(includes mental health)* | 20% coinsurance after deductible | 30% coinsurance after deductible |
| **Facility Services**<br>• Inpatient hospital *(includes mental health and maternity)* | $400 copayment followed by 20% coinsurance after deductible | 30% coinsurance after deductible |
| **Home/Durable Medical Equipment** | 20% coinsurance after deductible | 30% coinsurance after deductible |
| **Home Health Care** | 20% coinsurance after deductible | 30% coinsurance after deductible |
| **Hospice Services** | 20% coinsurance after deductible | 30% coinsurance after deductible |
| **Independent Lab Services** | 20% coinsurance (coinsurance waived for MHCD Services) | 30% coinsurance after deductible |
| **Maternity Care – Inpatient/Outpatient**<br>• Physician services | 20% coinsurance after deductible | 30% coinsurance after deductible |
| **Physician Services**<br>• Inpatient facility care<br>• Outpatient facility care | 20% coinsurance after deductible | 30% coinsurance after deductible |

## PHARMACY BENEFITS

| ANNUAL DEDUCTIBLE | TIER 1 GENERIC DRUGS | TIER 2 PREFERRED BRANDS | TIER 3 NON-PREFERRED BRANDS | TIER 4 SELECTED NON-PREFERRED BRANDS | SELF-ADMINISTERED SPECIALTY DRUGS |
|---|---|---|---|---|---|
| $100 single<br>$200 family | $15<br>(deductible waived) | $35 | $60 | 100% of allowed amount | $100 |

If you purchase a Tier 2, Tier 3, or Tier 4 drug when an A-rated generic drug is available, you are responsible for your deductible, copayment or coinsurance amount plus any difference in price between the maximum allowable fee for the generic drug and the maximum allowable fee for the brand-name drug. You are responsible for this difference even if your provider has specified that you must take the brand-name drug.

Drug Quantities

- Mail order maintenance prescriptions: 90-day supply for two copayments. Forms available on the CHIP Employee Page.
- All other prescriptions: 30-day supply for one copayment.

## DENTAL BENEFITS

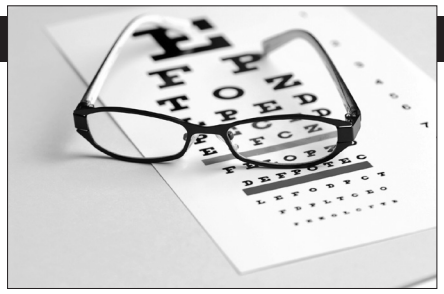
*Delta Dental of Iowa (Delta Premier)*
P.O. Box 9000 Plan #90372
Johnson, IA 50131-9000
800-544-0718
www.deltadentalia.com

*Effective: 1st of the month following 60 days of employment*

The table below summarizes the dental benefits:

| | DEDUCTIBLE | COINSURANCE | BENEFIT PERIOD MAX |
|---|---|---|---|
| **Benefit Categories** | $25 per person | | $750 |
| **Check-Ups and Teeth Cleaning**<br>(Diagnostic & Preventative Services)<br>1. Dental Cleaning<br>2. Oral Evaluation<br>3. Fluoride Applications<br>4. X-rays | No | 20% | Yes |
| **Cavity Repair & Tooth Extractions**<br>(Routine and Restorative Services)<br>1. Contour of Bone<br>2. Emergency Treatment<br>3. General Anesthesia/Sedation<br>4. Restoration of Decayed or Fractured Teeth<br>5. Limited Occlusal Adjustment<br>6. Routing Oral Surgery<br>7. Sealant Applications (within age restrictions)<br>*($120 Lifetime Maximum)*<br>8. Space Maintainers | Yes | 20% | Yes |
| **Root Canals** (Endodontic Services)<br>1. Apicoectomy<br>2. Direct Pulp Cap / Pulpotomy<br>3. Retrograde Fillings<br>4. Root Canal Therapy | Yes | 50% | Yes |
| **Gum & Bone Diseases**<br>(Periodontal Services)<br>1. Conservative Procedures<br>2. Complex Procedures<br>3. Maintenance Therapy | Yes | 50% | Yes |
| **High Cost Restorations**<br>1. Cast Restorations<br>a. Crowns<br>b. Inlays / Onlays<br>c. Posts and Cores | Yes | 50% | Yes |
| **Dentures & Bridges** (Prosthetics)<br>1. Dentures<br>2. Bridges | Yes | 50% | Yes |

## VISION BENEFITS



***Avesis Incorporated***
3724 North 3rd Street, Suite 300
Phoenix, AZ 85012
800-828-9341
www.avesis.com

Plan #60790

*Effective: 1st of the month following 60 days of employment*

Participants may choose either contact lenses or spectacle lenses as their 12-month eyewear benefit. Once enrolled, you must remain on the plan for 12 months. The table below summarizes the vision benefits:

| AVESIS INCORPORATED | EYE EXAM | EYEWEAR BENEFIT – LENSES* | EYEWEAR BENEFIT – FRAMES* |
|---|---|---|---|
| **Benefit Period** | **12 months** | **12 months** | **24 months** |
| **Copay** | **$10** | **$15** | **$15** |

**Responsible for any amount over $150 for lenses and frames*
**Responsible for any amount over $130 for contact lenses*

## 401(k) PLAN

***MassMutual Financial Group***
1295 State Street
Springfield, MA 01111
800-743-5274
www.massmutual.com/retire

Plan #51621-1-1

*Eligible: All regular full-time employees and part-time employees who work more than 1,000 hrs./annually*
*Effective: 1st of the month following 90 days of employment*

The CRST Profit Sharing 401(k) Plan is designed to help the employee accumulate the assets he or she will need for retirement. Contributions are voluntary and can be made either pre-tax (Traditional), post-tax (Roth), or a combination of the two. If an employee elects pre-tax (Traditional) contributions, current taxable income will be reduced and contributions and earnings will be taxed at the time of withdrawal. If an employee elects post-tax (Roth) contributions, current taxable income will remain unchanged and contributions and earnings will be tax-free at the time of withdrawal.

In order for the employee's account to grow, CRST offers a contribution match of 50% of the first 6% of the employee's salary in the Traditional 401(k) plan. Company contributions begin the first of the month following twelve months of employment. All company contributions are made on a pre-tax basis and will be taxable at the time of withdrawal. Employees may contribute up to $17,000 of an employee's pre-tax income annually. Participating employees who are fifty years of age or older can put an additional $5,500 in their account. All employee contributions are immediately 100% vested and employer contributions are subject to a six-year vesting schedule. There is a choice of numerous investment accounts for employee elective deferrals and company contributions. Refer to plan enrollment materials and the summary plan description for more details.

| VESTING SCHEDULE | | | | | | |
|---|---|---|---|---|---|---|
| YEAR | 1 | 2 | 3 | 4 | 5 | 6 |
| VESTING % | 0% | 20% | 40% | 60% | 80% | 100% |

To enroll in this plan, go to www.retiresmart.com or call Mass Mutual at 800-743-5274 for assistance.

Advisors for our MassMutual 401(k) plan are Joel Drake and Scott Dewhurst of Diversified Financial Group, a comprehensive financial services firm that is committed to helping clients improve their long-term financial success. You can reach Joel at joel@dfginv.com, Scott at sdewhurst@dfginv.com or either of them at 515-457-2930 (toll free: 800-308-2198).

## LIFE INSURANCE – COMPANY PAID

*Reliance Standard*
7300 West 110th Street, Suite 500
Overland Park, KS 66210
800-351-7500
www.rsli.com

*Effective: 1st of the month following 6 months of employment*

CRST provides basic term life insurance equal to $20,000 at no cost to eligible employees; this includes AD&D (Accidental Death and Dismemberment). Dependent life coverage is also provided by CRST at no cost to the employee with a spouse benefit of $2,000 and dependent children benefit of $2,000 after six months of age.

For insureds age 65 and over, the amount of Basic Life and Accidental Death and Dismemberment insurance is subject to automatic reduction. Upon the insured's attainment of the specified age below, the Basic Life and Accidental Death and Dismemberment insurance will be reduced to the applicable percentage. This reduction also applies to insureds who are 65 or over on their individual effective date.

| AGE | PERCENTAGE OF AVAILABLE OR IN FORCE AT AGE 65: |
|---|---|
| 65-69 | 67% |
| 70+ | 45% |

## VOLUNTARY LIFE INSURANCE BUY-UP

*Reliance Standard*
7300 West 110th Street, Suite 500
Overland Park, KS 66210
800-351-7500
www.rsli.com

*Effective: 1st of the month following 6 months of employment*

In addition to the company-paid life insurance outlined above, voluntary life coverage is available to all eligible employees and for eligible dependents, including a spouse and children to age 26 if a full-time student.

| COVERAGE | INCREMENTS | MINIMUM | MAXIMUM |
|---|---|---|---|
| **Employee** | $10,000 | $10,000 | $500,000 |
| **Spouse** | $10,000 | $10,000 | $250,000 |
| **Children** | $10,000 | | |

During the initial eligibility period, all employees are able to elect up to $100,000 guarantee issue, $50,000 guarantee issue for spouse and up to $10,000 for children. Any employee electing voluntary coverage over $100,000 or any amount outside of their initial eligible period must complete the "Evidence of Insurability for Term Life Insurance" form, available on the CHIP Employee Page under "Forms."

| EMPLOYEE / SPOUSE RATES (per $10,000 of benefit) PER MONTH | |
|---|---|
| **0 – 29** | $0.83 |
| **30 – 34** | $0.97 |
| **35 – 39** | $1.25 |
| **40 – 44** | $2.09 |
| **45 – 49** | $3.59 |
| **50 – 54** | $5.93 |
| **55 – 59** | $8.96 |
| **60 – 64** | $13.94 |
| **65 – 69** | $22.18 |
| **70 and over** | $36.84 |

| CHILDREN RATES | |
|---|---|
| $10,000 | $1.80 |

One rate for all eligible children in a family, regardless of number or age. Employee and/or spouse must be enrolled to receive child coverage.

The amount of insurance in effect on the insured employee is subject to automatic reduction beginning at age 75 as shown in the following table. The reduction applies equally to those eligible employees initiating insurance coverage at age 75 or over.

| AT AGE: | FACE AMOUNT REDUCES TO: |
|---|---|
| **75-79** | 60% of available or in force amount at age 74 |
| **80-84** | 35% of available or in force amount at age 74 |
| **85-89** | 27.5% of available or in force amount at age 74 |
| **90-94** | 20% of available or in force amount at age 74 |
| **95-99** | 7.5% of available or in force amount at age 74 |
| **100+** | 5% of available or in force amount at age 74 |

## EMPLOYEE ASSISTANCE PROGRAM (EAP)

*Mercy Employee Assistance Program*
1340 Blairs Ferry Road, Suite A
Hiawatha, IA 52233
800-383-6694
www.mercycare.org/EAP

CRST has adopted this program as a confidential aid to those employees who voluntarily wish to use the program as means of resolving problems such as marriage, family issues, financial problems, stress, life adjustments, etc. All employees are eligible for three free sessions per calendar year.

## SHORT-TERM DISABILITY

*Reliance Standard*
7300 West 110th Street, Suite 500
Overland Park, KS 66210
800-351-7500
www.rsli.com

*Effective: 1st of the month following 6 months of employment*

CRST provides short-term disability (STD) coverage at no cost. Provisions of the short-term disability plan are outlined below, and additional details are included in your Summary Plan Document (which will be mailed to your home address upon request). Employees are responsible for notifying and submitting in a timely manner all required documentation of a disability to Human Resources and the Plan Administrator. STD benefits run concurrent with FMLA (Family Medical Leave Act) guidelines. For further information regarding FMLA, refer to your driver handbook.

STD benefits begin on the 8th day after 5 consecutive business days of continuous disability. The benefit payable is $200 a week. Claims must be reviewed and approved by the Plan Administrator. The total time from a claimant's last day worked to the end of STD coverage cannot exceed 26 weeks. CRST reserves the right to replace an employee out on STD for more than 26 weeks (within state and federal laws).

Company contributions will continue to be made to the Group Insurance plan for eligible employees absent due to sickness based upon the employee's length of service as shown in the following table:

| LENGTH OF EMPLOYMENT | COMPANY CONTRIBUTIONS TERMINATE |
|---|---|
| **0 - 12 mos.** | First of the month after 1 month of continuous absence |
| **12 - 24 mos.** | First of the month after 3 months of continuous absence |
| **24 + months** | First of the month after 6 months of continuous absence |

## VACATION

Eligibility is dependent on employee status and period of service to the company. Vacation is earned by completing an anniversary year.

| LENGTH OF SERVICE | EARNED VACATION |
|---|---|
| **First Anniversary** | 1 week ($300) |
| **Second through Ninth Anniversary** | 2 weeks<br>(1/52nd of pay, min. $300) |
| **Tenth + Anniversary** | 3 weeks<br>(1/52nd of pay, min. $300) |

## EMPLOYEE DISCOUNTS

| | |
|---|---|
| **AT&T** | 8% discount on monthly service charges<br>www.att.com/wireless/crst or 314-972-2371 |
| **CDW** | Reduced prices on PCs, peripherals and software<br>www.cdw.com/epp – EPP Access #: B9011355 |
| **HP** | Up to 8% off starting prices on consumer products, plus other sales and promotions<br>www.hpdirect.com/employee/crst – Company Code: EP15836 or 866-433-2018 |
| **Lenscrafters** | 20% discount on regular price products and 10% discount on contact lenses and eye examinations<br>Contact Human Resources at 319-390-2772 |
| **Mitsubishi** | Customer cash and/or financing incentives<br>www.mitsubishipartners.com – Password: MITSU362 |
| **National Car Rental** | Various discounts available<br>800-227-7368 – Member ID: 5700237 |
| **Sprint PCS** | 12% discount on monthly service charges<br>New customers: 877-297-4258; Existing customers: 800-927-2199 |
| **Tires Plus** | 15% discount on Bridgestone and Firestone tires, maintenance and repair<br>Contact Human Resources at 319-390-2772 |
| **Verizon** | Up to 18% discount on monthly service charges<br>www.verizonwireless.com/discounts – Customer ID: 2551706 |
| **Working Advantage** | Up to 60% discount on selected items<br>www.workingadvantage.com – Member ID: 604305909 |

## LEGAL DEFINITIONS

**Purpose**

This booklet is not intended to be an all-inclusive review of each employee's benefits. For further detail, please refer to the summary plan documents located on the CHIP Employee Homepage. CRST reserves the right to make changes to this overview at any time without notice.

**Dependent Coverage Information**

Dependent coverage is a key part of your benefits package. One way to ensure we effectively spend our benefit dollars and can continue to offer affordable coverage to our employee is to verify the eligibility of all dependents covered under our benefit plans. In fairness to all employees, it is important that only eligible dependents are provided coverage under our benefits program. All employees who wish to carry dependent coverage will be required to provide supporting documents to verify dependent eligibility. In accordance with the Patient Protection and Affordability Care Act, CRST recently modified the definition of "dependent" to allow medical plan coverage for eligible children up to age 26 (see below).

**Definition of Eligible Dependent**

***Eligible dependents under medical are: your spouse, children or disabled dependent.***

***Spouse:*** is the person to whom you are legally married under applicable state law through the obtainment of a marriage license and the participation in a marriage ceremony and who is treated as your spouse for federal income tax purposes under the Internal Revenue Code.

***Child Dependent (up to age 26):*** a natural born child or stepchild of you or your legal spouse, a child legally adopted by you or your legal spouse.

***Disabled Dependent:*** coverage will continue for a child dependent beyond the age of 19 for those dependents that are incapable of self-sustaining employment by reason of mental retardation or physical handicap.

***Eligible dependents under dental, vision, and voluntary life insurance buy-up are: your spouse, children, student dependent or disabled dependent.***

***Spouse:*** is the person to whom you are legally married under applicable state law through the obtainment of a marriage license and the participation in a marriage ceremony and who is treated as your spouse for federal income tax purposes under the Internal Revenue Code.

***Child Dependent (up to age 19):*** a natural born child or stepchild of you or your legal spouse, a child legally adopted by you or your legal spouse.

***Student Dependent:*** your unmarried child dependents between the ages of 19 and up to 26, who are full-time (FT) students at an accredited institution of higher education.

***Disabled Dependent:*** coverage will continue for a child dependent beyond the age of 19 for those dependents that are incapable of self-sustaining employment by reason of mental retardation or physical handicap.

**Definition of Ineligible Dependents**

Some dependents are not eligible for coverage, regardless of whether you provide 50% of their support or could claim them on your federal income taxes. This includes: foster children, dependent parents, and former spouses (regardless of whether or not the divorce decree stipulated you must carry medical, vision or dental coverage).

REQUIRED DOCUMENTATION – You MUST provide one of the following for each dependent within your first 30 days of employment:

| SPOUSE | CHILD | STUDENT (Dental, Vision and Voluntary Life Insurance only) |
|---|---|---|
| Marriage certification | Adoption certificate | Adoption certificate & proof of FT student status |
| Current or previous year tax return | Birth certificate | Birth certification & proof of FT student status |
| Official court documentation | Official court documentation | Current or previous year tax return & proof of FT student status |
| | Qualified medical support order | Qualified medical support order & proof of FT student status |
| | Current or previous year tax return | Current or previous year tax return & proof of FT student status |

**Qualifying Events**

The following events allow you and any eligible dependent to enroll in or terminate coverage:

- **A)** Birth
- **B)** Adoption
- **C)** Marriage
- **D)** Divorce
- **E)** Spouse or dependent loses eligibility for credible coverage
- **F)** Exhaustion of COBRA coverage
- **G)** Termination or commencement of employment
- **H)** Dependent ceases to satisfy eligibility requirements

Request must be submitted in writing within 30 days of the qualifying event. Submit request to CRST Benefits department.

**Benefit Continuation - COBRA**
Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), an employee terminating employment with the company is entitled to continue participating in the company's group health plan for a prescribed period of time, usually 18 months, provided they were enrolled in the plan prior to termination. (In certain circumstances, such as an employee's divorce or death, the length of coverage period may be longer for qualified dependents). COBRA coverage is not offered to employees terminated for gross misconduct. If a former employee chooses to continue group benefits under COBRA, he/she must pay the total applicable premium plus a 2% administrative fee. Coverage will cease if the former employee fails to make premium payments as scheduled, becomes covered by another group plan that does not exclude pre-existing conditions, or becomes eligible for Medicare. COBRA information and election materials are mailed to the employee following termination.

## FREQUENTLY ASKED QUESTIONS

***1. When will I receive my insurance cards?***
The insurance companies mail cards to your home address 7-10 days from the time that you are entered into their data base(s). Cards do not have to be in-hand for care to be received. Service providers may contact the insurance company directly to verify coverage.

***2. Why aren't my dependents covered? I know I wrote them on the forms I completed at orientation.***
In order for dependents to be covered, you need to provide documentation verifying dependent eligibility (see chart on page 11). These documents can be faxed to 319-731-6366.

***3. How does Short-term Disability work?***
If you have an injury or illness that prevents you from working for more than 7 days, you may qualify for Short-term Disability (STD). If you are hospitalized for an injury or illness, you may qualify immediately for STD. Drivers who have been employed full-time would qualify if disability takes place after the first of the month following 6 months of service. Contact a Benefits Specialist (HR) for further information at 866-934-4895.

***4. How do I cancel my benefits (medical/dental/vision)?***
To cancel any coverage, you must have a qualifying event and submit a written request to Human Resources. You need to specifically state what type of coverage you want cancelled (i.e Gap, Major Medical, etc.) Request must be signed, dated and include driver ID. This can be faxed to 319-731-6366 or emailed to benefits@crst.com.

**5. How can I get a new insurance card (s) if I never received mine or need a replacement?**
New cards may be requested directly from the insurance company or by contacting Human Resources. It is important to report any change of address to ensure the cards are received. It takes approximately 7-10 days to receive the cards.

***6. Who do I contact to update my address?***
Address changes should be submitted to Human Resources by calling 800-366-8460. Changes may also be faxed to 319-731-6366; sign, date, and include driver ID number.

***7. What happens if my dependent or I need health care prior to receiving my cards?***
Contact a Benefits Specialist (HR) for the insurance policy information to give your health provider. Benefits Hotline is 866-934-4895.

***8. When am I eligible to begin major medical, dental, and vision benefits?***
Drivers are eligible the first of the month following 60 days of full-time employment if actively working. 401(k) enrollment is available the first of the month following 90 days of employment for all employees.

***9. Do I need to do anything to be transferred over to the benefits I signed up for at orientation after I've completed the introductory period?***
No, as long as you completed the necessary online enrollment at the time of orientation and provided the necessary documentation, enrollment is automatic. If you have had any dependent, marital status or address changes since hired, please notify a Benefits Specialist (HR) by calling 866-934-4895.

***10. Why aren't my dependents' names listed on the health cards I received?***
The employee's name is the only name listed on insurance cards. Dependents use the cards showing the employee's name.

***11. How are premium deductions handled when I am not actively driving/receiving pay?***
Missed premium payments must be sent to Human Resources Attn: Benefits Specialist, each week of non-driving in order to avoid loss of coverage.

***12. If I separate employment, when do my benefits end?***
Benefits end at midnight on your last day worked (last day on the truck).

# CRST International Spouse Enrollment Certification

All CRST International employees who wish to enroll a spouse in the Major Medical Insurance Plan must complete the following certification. This form must be returned to CRST Human Resources prior to your major medical benefit eligibility.

**By signing this certification, I represent that I understand that false information or omissions on this form may result in the following: 1) cancellation of benefit coverage and/or 2) disciplinary action up to and including termination.**

## VERIFICATION OF SPOUSE ELIGIBILITY

In order to confirm that your spouse is eligible to be covered as a dependent on the CRST International medical plan, please complete the following questions.

| | | | |
|---|---|---|---|
| Is your spouse employed either full-time or part-time? | Full-time ❑ | Part-time ❑ | N / A ❑ |
| Does your spouse's employer offer medical benefits to your spouse? | Yes ❑ | No ❑ | N / A ❑ |

I hereby certify and understand that if my spouse has medical coverage available through his/her own employer, they are not eligible to participate in the CRST International Major Medical Insurance Plan.

If your spouse is not currently on his/her employer's plan, they should notify their Human Resources department of this coverage change. This will qualify as a "Life Event" and could give them the opportunity to enroll in their employer's plan, regardless of the open enrollment period.

_____

Print Name

_____ _____

Employee signature Date signed

*Return completed form to:*

CRST Human Resources Department via email: benefits@crst.com or Fax: 319-731-6366

If you have questions, feel free to contact CRST Human Resources at 1-866-934-4895 or via email at benefits@crst.com.

## LEGAL NOTICES

The following pages consist of legal notices that CRST is required to present to all employees who are eligible to participate in our benefit plans:

- **COBRA Continuation Coverage**
- **Women's Health and Cancer Rights Act**
- **Prescription Drug Coverage and Medicare**
- **Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)**
- **Wellmark Alliance Select℠ Summary of Benefits and Coverage: What This Plan Covers & What It Costs**
- **Wellmark Alliance Select℠ GA Alt Network Summary of Benefits and Coverage: What This Plan Covers & What It Costs**
- **New Health Insurance Marketplace Coverage Options and Your Health Coverage**
- **Notice of Pre-Existing Condition Limitation**
- **Notice of Privacy Practices**
- **Wellness Program – Notice of Reasonable Alternatives**
- **Notice of Special Enrollment Rights**

## NOTICE REGARDING WELLMARK ALLIANCE SELECT BENEFIT PLAN

To help you easily understand your health plan benefits, attached is a Summary of Benefits and Coverage (SBC) for your current health plan. Together, this letter and the SBC on pages 26-33 contain a full description of your health plan and benefits. They are designed to be read in conjunction to provide simple and consistent information using terminology and a format that has been standardized among all health insurance companies.

The SBC summarizes the key features of your policy such as a description of the coverage, deductible amounts, cost-sharing obligations and coverage limitations and exceptions.

**Does This Coverage Provide Minimum Essential Coverage?**
The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage."
**This plan or policy does provide minimum essential coverage.**

**Does This Coverage Meet the Minimum Value Standard?**
The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value).
**This health coverage does meet the minimum value standard for the benefits it provides.**

If you should have any questions, please contact CRST Human Resources Department at 866-934-4895 or via email at Benefits@crst.com.

## CRST INTERNATIONAL, INC. GROUP HEALTH PLAN INITIAL NOTICE AND CONTINUATION OF HEALTH COVERAGE NOTICE

For those who elect major medical benefits, the following notice is in regards to your COBRA continuation coverage under CRST International's Group Health Plan administered by Wellmark Blue Cross and Blue Shield. This COBRA notice contains important information about your right to continue coverage, which is a temporary extension of coverage under the Plan (unless termination is related to misconduct). This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

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 when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

For additional information about your rights and obligations under the Plan and under federal law, review the Plan's Summary Plan Description (found on the ADP website) or contact the Plan Administrator (Wellmark).

**Keep Your Plan Informed of Address Changes**
In order to protect your family's rights, keep the Plan Administrator informed of any changes in the addresses of you or your family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**Plan Contact Information**
If you questions regarding this notice, please contact one of the following:

- Wellmark Blue Cross and Blue Shield of Iowa
  Customer Service: 1-800-600-4149

- CRST Human Resources Department
  260-429-1819

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that your group health plan (the Plan) allow qualified persons (as defined below) to continue group health coverage after it would otherwise end. COBRA applies to group health plans maintained by an employer for medical, dental, vision, prescription, medical reimbursement, and certain employee assistance programs. COBRA does not apply to life insurance or disability benefits.

Please review this Notice carefully and keep with your records. If you are married, please have your Spouse review these materials also. If any individual who is covered under the Plan(s) for which you are being offered continuation coverage does not live with you, you must advise the Plan Administrator (employer) immediately so a Notice and an Election Form can be forwarded to him or her. COBRA Notices will always be sent to the last known address of a covered employee or Qualified Beneficiary.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan. Each Qualified Beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights, if applicable.

**I. Qualifying Events/Qualified Beneficiaries.** Those individuals eligible for COBRA continuation coverage as Qualified Beneficiaries are as follows:

A. An employee, Spouse, and any Dependent Child(ren) whose coverage ends due to termination of the employee's employment for a reason other than gross misconduct (18 months).

B. An employee, Spouse, and any Dependent Child(ren) whose coverage ends due to a reduction in the employee's work hours/layoff (18 months).

C. An employee's former Spouse and any Dependent Child(ren whose coverage ends due to the employee's divorce or legal separation (36 months). Also, if an employee eliminates coverage for his/her Spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, the later divorce or legal separation would be considered a Qualifying Event even though the ex-Spouse lost coverage earlier. If the ex-Spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier, in anticipation of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.

D. An employee's Spouse and/or any Dependent Child(ren) whose coverage ends due to the employee's election to drop out of the Plan upon entitlement to Medicare (36 months). If an employee enrolls under Medicare Part A or B before experiencing a Qualifying Event based on terminating employment or a reduction of hours, the maximum coverage for the employee's Spouse and/or any Dependent Child(ren) will be the longer of 36 months beginning with the employee's enrollment under Medicare and 18 months (29 months with a disability extension) beginning with the date the employee would have had a Qualifying Event based on terminating employment or a reduction in hours/layoff.

E. An employee's surviving Spouse and/or any Dependent Child(ren) whose coverage ends due to the employee's death (36 months).

F. An employee's child whose coverage ends because the child ceases to be a Dependent Child under the terms of the Plan (36 months).

G. An employee's newborn child or child placed for adoption during a period of continuation coverage. You (or a guardian) have the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable Plan eligibility requirements (18 or 36 months from the date of Qualifying Event).

H. A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during the covered employee's period of employment with the Plan Administrator is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee upon occurrence of a Qualifying Event.

I. The original 18-month period of coverage available to a Qualified Beneficiary may be extended for an additional 18 months if a secondary event occurs during the initial 18-month continuation period. A secondary event is a termination or reduction of hours/layoff followed by 1) Death of the (former) employee; 2) Medicare enrollment of the (former) employee; 3) Divorce or legal separation of the (former) employee; or 4) Dependent Child of the (former) employee ceasing to be a dependent. In secondary events, the 36 months of coverage extends from the date of the original Qualifying Event.

J. If a bankruptcy proceeding under Title 11 of the United States Code results in the loss of coverage of a retired employee under the Plan, the retired employee is a Qualified Beneficiary and is entitled for coverage as long as he/she lives. This also applies to the retiree's Spouse and any Dependent Child(ren). If the retiree dies, the maximum coverage for any surviving Spouse and Dependent Child(ren) is 36 months after the retiree's death.

**II. Notification of Qualifying Events.** Under the law, the employer is responsible for knowing when any of the following Qualifying Events occurs: 1) Voluntary termination; 2) Involuntary termination; 3) Reduction of hours/layoff; 4) Death of employee; 5) Medicare enrollment of employee; and 6) Employer's bankruptcy under Title 11 of the U. S. Code. The employee or a family member has the responsibility to inform the Plan Administrator (employer) of a divorce, legal separation, or a Dependent Child losing dependent status under the Plan, within 60 days of the date of the event or the date on which coverage would end under the Plan because of the event, whichever is later. In addition, you must notify Wellmark Blue Cross and Blue Shield if a disabled employee or family member is determined to no longer be disabled. The notice must be given in writing. Notice will be deemed given when delivered to the appropriate address by hand or by nationally recognized overnight courier service (costs prepaid), sent by facsimile with confirmation of transmission by the transmitting equipment, or received, or rejected, by the addressee if sent by certified mail, return receipt requested.

To enroll a newborn child onto COBRA during a period of continuation coverage or to enroll a child placed for adoption, you or a family member must notify Wellmark of the birth or placement within the same time limits that pertain to enrollment of like dependents acquired by active employees.

**III. Election of Coverage.** Each Qualified Beneficiary has the right to independently elect coverage for himself/herself. Any or all Qualified Beneficiaries may elect to continue coverage without regard to the elections made by the other Qualified Beneficiaries. Parents may elect to continue coverage on behalf of their Dependent Child(ren) only. If your employer maintains three separate employer Plans (such as a medical, dental and vision plan), you have the right to pick only the Plans that you want. However, if the employer maintains only one consolidated group health plan (which may include medical, dental and vision) you must, in this case, elect or decline COBRA coverage as a whole.

To continue coverage, complete the enclosed Election Form and return it to the address or fax number indicated on the Form. The Election Form must be completed and returned within 60 days after the Date of Notification reflected on the Election Form or within 60 days after the coverage would otherwise end, whichever is later. If the Election Form is not returned within the 60-day period, the continuation option expires. A Qualified Beneficiary may change a prior rejection of the continuation coverage any time until the end of the applicable 60-day period.

Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Coverage: Special COBRA rights apply to certain employees who are eligible for the health coverage tax credit. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an employee becomes eligible for the health coverage tax credit, but only if the election is made within the six months immediately after the eligible employee's Plan coverage ended. If you qualify or may qualify for the health coverage tax credit, contact your (former) employer for additional information. YOU MUST CONTACT YOUR (FORMER) EMPLOYER PROMPTLY AFTER QUALIFYING FOR THE HEALTH COVERAGE TAX CREDIT OR YOU WILL LOSE YOUR SPECIAL COBRA RIGHTS.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you will lose the right to avoid having pre-existing condition exclusion periods applied to you (this does not apply to dependents under age 19) by other group health plans if you have more than a 63-day gap in health coverage; election of continuation coverage may help you to avoid or reduce a gap in coverage. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusion periods if you do not elect and exhaust the continuation coverage available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed in Section I. You will also have the same special enrollment right at the end of continuation coverage if you elect and exhaust the continuation coverage available to you.

**IV. COBRA Premiums.** You must pay the entire premium amount shown on the enclosed Election Form for your COBRA coverage. Your COBRA premium is calculated by adding 2% to the applicable premium to cover administrative expenses. If your COBRA coverage is extended to 29 months due to the disability provision explained in Section VI. Item C, COBRA regulations allow premiums to be increased to 150% of the otherwise applicable premium for the 19th through 29th months of COBRA coverage.

If you choose, you may submit your initial payment with the COBRA Election Form. If you do not submit your initial payment with the Election Form, or the payment is insufficient, your first invoiced contribution(s) will be due on or before the 45th day after electing COBRA coverage. If you do not make your first payment(s) for continuation coverage within 45 days, you will lose all continuation rights under the Plan(s).

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan(s) would have otherwise terminated through the end of the current month being invoiced. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. It is important to note that, if you have chosen automatic account withdrawal as your payment option, the initial withdrawal from your designated checking or savings account may be more than one month in order to pay your account through Wellmark's current billing period. If you have any questions regarding continuation coverage or payments, please feel free to call the 800 number listed on your ID card. If you do not have your ID card, please call 800-524-9242 to speak with a Customer Service Representative. Payment(s) made at the time of election should be submitted and mailed with the Election Form.

After the initial payment, your monthly premium payment is due on the first day of each month for that month's COBRA coverage (for automatic account withdrawal, Wellmark allows a payment due date of the 1st or the 5th of the month). There is a grace period which expires on the 30th day after the first of the month. If a monthly payment is not submitted or cannot be pulled from the designated account (for automatic account withdrawal) for any reason, it is your responsibility to ensure that payment is remitted by the end of the grace period for the month for which premium is being paid, in order for coverage to continue. If you do not make the premium payment within the 30-day grace period, COBRA coverage will be cancelled retroactively to the first of the month.

If you have chosen automatic account withdrawal, premiums will be withdrawn from your designated checking or savings account on the designated day (1st or 5th) of each month. If submitting payments, your subsequent payments, beyond those payment(s) submitted with the Election Form, should be submitted with your Wellmark ID number to the following address:

Wellmark Blue Cross and Blue Shield
P.O. Box 1313
Des Moines, IA 50306-1313

There are specific times within the determination period when the Plan(s) may increase a Qualified Beneficiary's COBRA premium:

1) The Plan has charged less than the maximum amount allowed.

2) The permitted increase during the disability extension period.

3) A Qualified Beneficiary chooses to become covered under a more expensive Plan, when offered, or adds a new benefit, when offered.

4) A Qualified Beneficiary adds a family member, as allowed by the Plan that would cause the applicable premium to be higher for that family unit size.

Health Coverage Tax Credit: The Trade Act of 2002 created a new coverage tax credit for certain individuals who become eligible for trade adjustment assistance (eligible individuals) and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the Trade Act provisions, eligible individuals can either take a tax credit or get advance payment (a portion of premiums paid for qualified health insurance, including continuation coverage). If you have questions about these tax provisions, including details on the premium credit or payment amount eligible to qualifying beneficiaries for continuation coverage, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act, including an online application, is also available at www. doleta.gov/tradeact.

## V. COBRA Provisions.

A. Any qualified person may elect coverage for a dependent (Spouse, newborn child, adopted child, etc.) acquired during a period of continuation. Qualified persons must apply to Wellmark for coverage of acquired dependents within the same time limits that pertain to enrollment of like dependents acquired by active employees. Please refer to your Booklet for provisions regarding dependent eligibility and effective dates. Elections that are not made on a timely basis will be declined.

B. Your continued coverage(s) will be subject to the same benefit and rate changes, when applicable, as the Plan. You will be notified of any changes in benefits or premium rates.

C. During open enrollment, you will have the same options under COBRA coverage as active employees covered under the Plan. In addition, HIPAA's (Health Insurance Portability and Accountability Act of 1996) special enrollment rights will apply to those who have elected COBRA.

D. If a Qualified Beneficiary moves outside the service area of a region-specific benefit package, the coverage will be changed to the same coverage available to an active employee moving to the same area.

E. A complete description of the Plan provisions and benefits is outlined in your Coverage Manual.

## VI. Duration of COBRA Coverage.

A. If the Qualifying Event is termination of the covered employee's employment or a reduction in hours/layoff, COBRA coverage continues for up to 18 months from the date on which coverage would otherwise end.

B. If the Qualifying Event is a divorce or legal separation, the death of the covered employee, the covered employee's enrollment in Medicare, or the loss of Dependent Child status under the terms of the Plan, coverage continues for up to 36 months from the date on which coverage would otherwise terminate.

C. If a Qualified Beneficiary or family member is disabled, an 18-month continuation coverage period may be extended to a maximum of 29 months for all Qualified Beneficiaries enrolled under the covered employee's contract if the following conditions are met: 1) the Social Security Administration determines that the Qualified Beneficiary or family member is disabled at any time during or prior to the first 60 days of continuation coverage, and 2) the Qualified Beneficiary provides Wellmark with a copy of the determination documentation within the 18-month coverage period and not later than 60 days after a) the date the determination is made by the Social Security Administration, b) the date of the qualifying event, or c) the date on which the Qualified Beneficiary loses coverage under the Plan due to the qualifying event, using the delivery procedures specified in Section II. COBRA regulations allow the premium for COBRA coverage to be increased to 150% of the otherwise applicable premium, after the 18 months of coverage, when COBRA coverage is extended due to disability. The non-disabled family members may also be charged up to 150% of the applicable premium if the disabled individual is included in the coverage.

D. Coverage for a Qualified Beneficiary who is a Spouse or Dependent Child of the covered (former) employee can increase to a maximum of 36 months if any of the following events occurs during the initial 18-month continuation period: 1) the covered (former) employee dies; 2) the covered (former) employee and Spouse are divorced or legally separated; 3) (for the Dependent Child only) the Dependent Child loses status as a Dependent Child under the Plan; or 4) the covered (former) employee enrolls in Medicare. Requests for such extended continuation coverage must be sent to Wellmark within 60 day after occurrence of any qualifying event. The request must be in writing using the delivery procedures specified in Section II.

E. COBRA coverage will terminate (before the end of the maximum coverage periods described in paragraphs A through D) on the earliest of the following dates:

1. Retroactive to the first of the month for which the Qualified Beneficiary's monthly premium is not timely paid;

2. On the date the employer ceases to maintain any Plan for its employees;

3. On the date a Qualified Beneficiary enrolls in Medicare (applies only to the person enrolling in Medicare);

4. Retroactive to the first of the month or on the date a Qualified Beneficiary becomes covered by another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition of the beneficiary other than an exclusion or limitation which does not apply or has been satisfied under HIPAA. COBRA coverage will terminate after the exclusion or limitation no longer applies. This rule applies only to the Qualified Beneficiary who becomes covered by another group health plan, and includes all COBRA coverages, such as dental, etc.

5. For a Qualified Beneficiary entitled to 29 months of COBRA coverage due to his/her disability or the disability of a Qualified Beneficiary or family member under the same qualifying event, coverage will terminate during the 11-month extension if the Social Security Administration later determines that the formerly-disabled Qualified Beneficiary or family member is no longer disabled. The individuals affected must notify Wellmark within 30 days of any final determination that the Qualified Beneficiary or family member is no longer disabled. Coverage will terminate the first of the month following 30 days after the date of the final determination that the Qualified Beneficiary or family member is no longer disabled. If a Qualified Beneficiary or family member is deemed no longer disabled, COBRA coverage for all Qualified Beneficiaries who were entitled to the disability extension will also terminate.

**VII. Individual Purchase (Conversion).** Does not apply to residents outside of Iowa or South Dakota. When continuation coverage ends, conversion coverage may be available from Wellmark for you and/or your Spouse and Dependent Child(ren). An application for conversion coverage and payment of the required premium must be made within 31 days after the COBRA continuation coverage ends. Prescription drug, dental and vision coverage are not available as conversion coverages.

Please note the benefits provided by Wellmark individual plans and the Wellmark conversion policies will not be identical to the coverage provided under the Plan and will be subject to different premium rates. If you wish to receive information about the benefits available under the individual plans or conversion policies and the associated premium rates, contact Wellmark's Direct Marketing Department at 1-800-722-1795, and they will provide outlines of coverage and copies of the individual plans and conversion policies on request.

**VIII. For More Information.** This Notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan may be available in your Coverage Manual or from your employer. You may request a copy of your Coverage Manual from your employer.

For more information about your rights under ERISA (Employee Retirement Income Security Act), including COBRA, HIPAA, and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa.

**IX. Keep Your Plan Informed of Address Changes.** In order to protect your family's rights, you should keep your employer or the COBRA Administrator (if you have COBRA coverage) informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to your employer or the COBRA Administrator.

**X. Questions.** If you have any questions regarding continuation coverage or payments, please feel free to call the 800 number listed on your ID card. If you do not have your ID card, please call 1-800-524-9242 to speak with a Customer Service Representative. or:

Wellmark Blue Cross and Blue Shield
P.O. Box 9232
Des Moines, IA 50306-9232

## WOMEN'S HEALTH AND CANCER RIGHTS ACT

Special Rights Following Mastectomy. A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of mastectomy.

Our Plan complies with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. Our Plan neither imposes penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

## CRST INTERNATIONAL, INC. PRESCRIPTION DRUG COVERAGE AND MEDICARE

**Important Notice from CRST International, Inc. About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with CRST International, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. CRST International, Inc. has determined that the prescription drug coverage offered by the CRST Health Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

**What happens to your current coverage if you decide to join a medicare drug plan?**
If you decide to join a Medicare drug plan, your current CRST International, Inc. coverage will not be affected. You can keep this coverage if you elect part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current CRST International, Inc. coverage, be aware that you and your dependents will be able to get this coverage back.

**When will you pay a higher premium (penalty) to join a Medicare drug plan?**
You should also know that if you drop or lose your current coverage with CRST International, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

**For more information about this notice or your current prescription drug coverage**
Contact the person listed below for further information:
CRST Benefits Department at 866-934-4895

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through CRST International, Inc changes. You also may request a copy of this notice at any time.

**For more information about your options under Medicare prescription drug coverage**
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

**For more information about Medicare prescription drug coverage**

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

| | |
|---|---|
| Date: | October 1, 2012 |
| Name of Entity/Sender: | CRST International, Inc. |
| Contact--Position/Office: | CRST Human Resources |
| Address: | 3930 16th Ave SW<br>Cedar Rapids, IA 52404 |
| Phone Number: | 866-934-4895 |

## 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 listed below, 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 at 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility:

| | |
|---|---|
| **ALABAMA – Medicaid**<br>Website: http://www.medicaid.alabama.gov<br>Phone: 1-855-692-5447 | **COLORADO – Medicaid**<br>Medicaid Website: http://www.colorado.gov/<br>Medicaid Phone (In state): 1-800-866-3513<br>Medicaid Phone (Out of state): 1-800-221-3943 |
| **ALASKA – Medicaid**<br>Website: http://health.hss.state.ak.us/dpa/programs/medicaid/<br>Phone (Outside of Anchorage): 1-888-318-8890<br>Phone (Anchorage): 907-269-6529 | **FLORIDA – Medicaid**<br>Website: https://www.flmedicaidtplrecovery.com/<br>Phone: 1-877-357-3268 |
| **ARIZONA – CHIP**<br>Website: http://www.azahcccs.gov/applicants<br>Phone (Outside of Maricopa County): 1-877-764-5437<br>Phone (Maricopa County): 602-417-5437 | **GEORGIA – Medicaid**<br>Website: http://dch.georgia.gov/<br>Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)<br>Phone: 1-800-869-1150 |
| **IDAHO – Medicaid and CHIP**<br>Medicaid Website: www.accesstohealthinsurance.idaho.gov<br>Medicaid Phone: 1-800-926-2588<br>CHIP Website: www.medicaid.idaho.gov<br>CHIP Phone: 1-800-926-2588 | **MONTANA – Medicaid**<br>Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml<br>Phone: 1-800-694-3084 |
| **INDIANA – Medicaid**<br>Website: http://www.in.gov/fssa<br>Phone: 1-800-889-9949 | **NEBRASKA – Medicaid**<br>Website: www.ACCESSNebraska.ne.gov<br>Phone: 1-800-383-4278 |
| **IOWA – Medicaid**<br>Website: www.dhs.state.ia.us/hipp/<br>Phone: 1-888-346-9562 | **NEVADA – Medicaid**<br>Medicaid Website: http://dwss.nv.gov/<br>Medicaid Phone: 1-800-992-0900 |
| **KANSAS – Medicaid**<br>Website: http://www.kdheks.gov/hcf/<br>Phone: 1-800-792-4884 | **NEW HAMPSHIRE – Medicaid**<br>Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf<br>Phone: 603-271-5218 |
| **KENTUCKY – Medicaid**<br>Website: http://chfs.ky.gov/dms/default.htm<br>Phone: 1-800-635-2570 | **NEW JERSEY – Medicaid and CHIP**<br>Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 1-800-356-1561<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |

| | |
|---|---|
| **LOUISIANA – Medicaid**<br>Website: http://www.lahipp.dhh.louisiana.gov<br>Phone: 1-888-695-2447 | **NEW YORK – Medicaid**<br>Website: http://www.nyhealth.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MAINE – Medicaid**<br>Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html<br>Phone: 1-800-977-6740<br>TTY 1-800-977-6741 | **NORTH CAROLINA – Medicaid**<br>Website: http://www.ncdhhs.gov/dma<br>Phone: 919-855-4100 |
| **MASSACHUSETTS – Medicaid and CHIP**<br>Website: http://www.mass.gov/MassHealth<br>Phone: 1-800-462-1120 | **NORTH DAKOTA – Medicaid**<br>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-800-755-2604 |
| **MINNESOTA – Medicaid**<br>Website: http://www.dhs.state.mn.us/<br>Click on Health Care, then Medical Assistance<br>Phone: 1-800-657-3629 | **OKLAHOMA – Medicaid and CHIP**<br>Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 |
| **MISSOURI – Medicaid**<br>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | **OREGON – Medicaid and CHIP**<br>Website: http://www.oregonhealthykids.gov<br>http://www.hijossaludablesoregon.gov<br>Phone: 1-877-314-5678 |
| **PENNSYLVANIA – Medicaid**<br>Website: http://www.dpw.state.pa.us/hipp<br>Phone: 1-800-692-7462 | **VERMONT– Medicaid**<br>Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **RHODE ISLAND – Medicaid**<br>Website: www.ohhs.ri.gov<br>Phone: 401-462-5300 | **VIRGINIA – Medicaid and CHIP**<br>Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm<br>Medicaid Phone: 1-800-432-5924<br>CHIP Website: http://www.famis.org/<br>CHIP Phone: 1-866-873-2647 |
| **SOUTH CAROLINA – Medicaid**<br>Website: http://www.scdhhs.gov<br>Phone: 1-888-549-0820 | **WASHINGTON – Medicaid**<br>Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm<br>Phone: 1-800-562-3022 ext. 15473 |
| **SOUTH DAKOTA - Medicaid**<br>Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | **WEST VIRGINIA – Medicaid**<br>Website: www.dhhr.wv.gov/bms/<br>Phone: 1-877-598-5820, HMS Third Party Liability |
| **TEXAS – Medicaid**<br>Website: https://www.gethipptexas.com/<br>Phone: 1-800-440-0493 | **WISCONSIN – Medicaid**<br>Website: http://www.badgercareplus.org/pubs/p-10095.htm<br>Phone: 1-800-362-3002 |
| **UTAH – Medicaid and CHIP**<br>Website: http://health.utah.gov/upp<br>Phone: 1-866-435-7414 | **WYOMING – Medicaid**<br>Website: http://health.wyo.gov/healthcarefin/equalitycare<br>Phone: 307-777-7531 |

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

## Wellmark Alliance Select℠

**Summary of Benefits and Coverage: What This Plan Covers & What It Costs**

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: Single & Family | Plan Type: PPO

*This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wellmark.com or by calling 1-800-524-9242. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-524-9242 to request a copy.*

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall **deductible?** | **$1,500** person/**$3,000** family per calendar year<br><br>Does not apply to in-network preventive care, well-child care, in-network office services and in-network independent labs. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart on the following pages for how much you pay for covered services after you meet the **deductible.** |
| Are there other **deductibles** for specific services? | Yes. **$100** person/**$200** family per calendar year for drug card, which does not apply to generics. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| Is there an **out–of–pocket limit** on my expenses? | Yes. **$3,250** person/$**6,500** family per calendar year | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the **out–of–pocket** limit? | Premiums, pre-service review penalties, your drug card costs, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| Is there an overall annual limit on what the plan pays? | No. | See the Common Medical Event chart on the following pages which describes any limits on what the plan will pay for specific covered services, such as office visits. |
| Does this plan use a **network of providers?** | Yes. See www.wellmark.com for a list of in-network providers. | If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their network. See the Common Medical Event chart on the following pages for how this plan pays different kinds of **providers.** |
| Do I need a referral to see a **specialist?** | No. You do not need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes | Some of the services this plan doesn't cover are listed in this summary. See your policy or plan document for additional information about **excluded services.** |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount,** you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, copayments,** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network (IN) Provider | Out-of-Network (OON) Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay | 30% coinsurance | Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, and PAs. |
| | Specialist visit | $45 copay | 30% coinsurance | Applies to Non-PCP providers. |
| | Other practitioner office visit | $30 PCP/$45 Non-PCP for chiropractors | 30% coinsurance for chiropractors | None |
| | Preventive care/screening/ immunization | No charge | 30% coinsurance | One preventive exam and one gynecological exam with pap smear per calendar year. School, sport, employment or other administrative physical exams are covered in addition to a preventive physical exam. One mammogram per calendar year. Well-child care covered to age 7. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | For a test in a providers office or clinic, your cost is included in the cost share listed above. Waive coinsurance for in-network independent labs for mental health and substance abuse. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Imaging (CT /PET scans, MRIs) | 20% coinsurance | 30% coinsurance | For a test in a provider's office or clinic, your cost is included in the cost share listed above. Failure to obtain prior approval for imaging services listed on Wellmark.com will result in denial. |
| **If you need drugs to treat your illness or condition**<br><br>**More information about prescription drug coverage is available at www.wellmark.com.** | Generic drugs | $15 copay | $15 copay | Drugs listed on Wellmark's Drug List are covered. Drugs not on the Drug List are not covered. For OON, you may be balance billed.<br><br>3 copays or coinsurance for 90-day supply (Retail maintenance).<br><br>2 copays or coinsurance for 90-day supply (Mail order maintenance).<br><br>Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights. |
| | Preferred brand drugs | $35 copay | $35 copay | |
| | Non-preferred brand drugs | $60 copay | $60 copay | |
| | Select non-preferred brand drugs | 100% coinsurance | 100% coinsurance | |
| | Specialty drugs | $100 copay | $100 copay | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Physician / surgeon fees | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| **If you need immediate medical attention** | Emergency room services | $400 copay | $400 copay | For emergency medical conditions treated OON, you may be balance billed. Dental treatment for accidental injury is covered if initiated within 72 hours and completed within 30 days of the injury. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | $30 PCP/$45 Non-PCP copay | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Physician / surgeon fee | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office: $30 PCP/$45 Non-PCP copay; Facility: 20% coinsurance | 30% coinsurance | None |
| | Mental/Behavioral health inpatient services | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Substance use disorder outpatient services | Office: $30 PCP/$45 Non-PCP copay; Facility: 20% coinsurance | 30% coinsurance | None |
| | Substance use disorder inpatient services | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |

| Common Medical Event | Services You May Need | Your Cost If You Use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network (IN) Provider | Out-of-Network (OON) Provider | |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 30% coinsurance | None |
| | Delivery and all inpatient services | $400 copay and 20% coinsurance | 30% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Rehabilitation services | Office: $30 PCP/$45 Non-PCP copay; Outpatient: 20% coinsurance; Inpatient: $400 copay and 20% coin. | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Habilitative services | Office: $30 PCP/$45 Non-PCP copay; Outpatient: 20% coinsurance; Inpatient: $400 copay and 20% coin. | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Skilled nursing care | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Hospice service | 20% coinsurance | 30% coinsurance | Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | None |
| | Glasses | Not covered | Not covered | None |
| | Dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

| | | | |
|---|---|---|---|
| Acupuncture | Cosmetic surgery | Dental care - Adult | Dental check-up |
| Eye exam | Glasses | Hearing aids | Long-term care |
| Routine eye care - Adult | Routine foot care | Weight loss programs | |

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

| | | |
|---|---|---|
| Bariatric surgery | Chiropractic care | Infertility treatment (excludes some services) |
| Most coverage provided outside the U.S. | Private-duty nursing | |

**Your Rights to Continue Coverage:**
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your employer or group sponsor. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**Your Grievance and Appeals Rights:**
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242 or Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

**About These Coverage Examples:**
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**Having a baby**
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $4,400
- Patient pays: $3,140

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,500 |
| Copays | $560 |
| Coinsurance | $930 |
| Limits or exclusions | $150 |
| **Total** | **$3,140** |

**Managing type 2 diabetes**
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $3,370
- Patient pays: $2,030

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $120 |
| Copays | $1,590 |
| Coinsurance | $0 |
| Limits or exclusions | $320 |
| **Total** | **$2,030** |

***This is not a cost estimator.*** *Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different. See the next page for important information about these examples.*

**What are some of the assumptions behind the Coverage Examples?**
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

**What does a Coverage Example show?**
For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

**Does the Coverage Example predict my own care needs?**
No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**
No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

**Can I use Coverage Examples to compare plans?**
Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**
Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

*This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.*

## Wellmark Alliance Select℠ GA Alt Network

**Summary of Benefits and Coverage: What This Plan Covers & What It Costs**

Coverage Period: 01/01/2014 – 12/31/2014
Coverage for: Single & Family | Plan Type: PPO

*This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.wellmark.com or by calling 1-800-524-9242. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-524-9242 to request a copy.*

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| What is the overall **deductible?** | **$1,500** person/**$3,000** family per calendar year<br><br>Does not apply to in-network preventive care, well-child care, in-network office services and in-network independent labs. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the Common Medical Event chart on the following pages for how much you pay for covered services after you meet the **deductible.** |
| Are there other **deductibles** for specific services? | Yes. **$100** person/**$200** family per calendar year for drug card, which does not apply to generics. There are no other specific deductibles. | You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services. |
| Is there an **out–of–pocket limit** on my expenses? | Yes. **$3,250** person/$**6,500** family per calendar year | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| What is not included in the **out–of–pocket** limit? | Premiums, pre-service review penalties, your drug card costs, balance-billed charges, and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| Is there an overall annual limit on what the plan pays? | No. | See the Common Medical Event chart on the following pages which describes any limits on what the plan will pay for specific covered services, such as office visits. |
| Does this plan use a **network of providers?** | Yes. See www.wellmark.com for a list of in-network providers. | If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their network. See the Common Medical Event chart on the following pages for how this plan pays different kinds of **providers.** |
| Do I need a referral to see a **specialist?** | No. You do not need a referral to see a specialist. | You can see the **specialist** you choose without permission from this plan. |
| Are there services this plan doesn't cover? | Yes | Some of the services this plan doesn't cover are listed in this summary. See your policy or plan document for additional information about **excluded services.** |

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is your share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible.**
- The amount the plan pays for covered services is based on the **allowed amount.** If an out-of-network **provider** charges more than the **allowed amount,** you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing.**)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles, copayments,** and **coinsurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network (IN) Provider | Out-of-Network (OON) Provider | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $30 copay | 30% coinsurance | Primary Care Practitioners (PCP) are defined as General and Family Practice, Internal Medicine, OB/GYN, Pediatricians, Nurse Practitioners, and PAs. |
| | Specialist visit | $45 copay | 30% coinsurance | Applies to Non-PCP providers. |
| | Other practitioner office visit | $30 PCP/$45 Non-PCP for chiropractors | 30% coinsurance for chiropractors | None |
| | Preventive care/screening/ immunization | No charge | 30% coinsurance | One preventive exam and one gynecological exam with pap smear per calendar year. School, sport, employment or other administrative physical exams are covered in addition to a preventive physical exam. One mammogram per calendar year. Well-child care covered to age 7. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 30% coinsurance | For a test in a providers office or clinic, your cost is included in the cost share listed above. Waive coinsurance for in-network independent labs for mental health and substance abuse. Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Imaging (CT /PET scans, MRIs) | 20% coinsurance | 30% coinsurance | For a test in a provider's office or clinic, your cost is included in the cost share listed above. Failure to obtain prior approval for imaging services listed on Wellmark.com will result in denial. |
| **If you need drugs to treat your illness or condition**<br><br>**More information about prescription drug coverage is available at www.wellmark.com.** | Generic drugs | $15 copay | $15 copay | Drugs listed on Wellmark's Drug List are covered. Drugs not on the Drug List are not covered. For OON, you may be balance billed.<br><br>3 copays or coinsurance for 90-day supply (Retail maintenance).<br><br>2 copays or coinsurance for 90-day supply (Mail order maintenance).<br><br>Failure to obtain prior authorization or prior approval for drugs listed on Wellmark.com will result in denial with review rights. |
| | Preferred brand drugs | $35 copay | $35 copay | |
| | Non-preferred brand drugs | $60 copay | $60 copay | |
| | Select non-preferred brand drugs | 100% coinsurance | 100% coinsurance | |
| | Specialty drugs | $100 copay | $100 copay | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Physician / surgeon fees | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| **If you need immediate medical attention** | Emergency room services | $400 copay | $400 copay | For emergency medical conditions treated OON, you may be balance billed. Dental treatment for accidental injury is covered if initiated within 72 hours and completed within 30 days of the injury. |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | None |
| | Urgent care | $30 PCP/$45 Non-PCP copay | 30% coinsurance | None |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Physician / surgeon fee | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | Office: $30 PCP/$45 Non-PCP copay; Facility: 20% coinsurance | 30% coinsurance | None |
| | Mental/Behavioral health inpatient services | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Substance use disorder outpatient services | Office: $30 PCP/$45 Non-PCP copay; Facility: 20% coinsurance | 30% coinsurance | None |
| | Substance use disorder inpatient services | $400 copay and 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |

| Common Medical Event | Services You May Need | Your Cost If You Use an | | Limitations & Exceptions |
|---|---|---|---|---|
| | | In-Network (IN) Provider | Out-of-Network (OON) Provider | |
| **If you are pregnant** | Prenatal and postnatal care | 20% coinsurance | 30% coinsurance | None |
| | Delivery and all inpatient services | Facility: $400 copay and 20% coinsurance; Practitioner: 20% coinsur. | 30% coinsurance | Copay applies to the out-of-pocket maximum. |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. |
| | Rehabilitation services | Office: $30 PCP/$45 Non-PCP copay; Inpatient: $400 copay and 20% coin.; Other services: 20% coin. | 30% coinsurance | Copay applies to the out-of-pocket maximum. Reduction for failure to precertify is 50%. |
| | Habilitation services | Office: $30 PCP/ $45 Non-PCP copay; Inpatient: $400 copay and 20% coin.; Other services: 20% coin. | 30% coinsurance | Copay applies to the out-of-pocket maximum. Reduction for failure to precertify is 50%. |
| | Skilled nursing care | Facility: $400 copay and 20% coin.; Practitioner: 20% coinsurance | 30% coinsurance | Reduction for failure to precertify is 50%. Copay applies to the out-of-pocket maximum. |
| | Durable medical equipment | 20% coinsurance | 30% coinsurance | Failure to obtain prior approval for services listed on Wellmark.com will result in denial with review rights. |
| | Hospice service | 20% coinsurance | 30% coinsurance | Hospice respite care is limited to 15 inpatient and 15 outpatient days per lifetime. |
| **If your child needs dental or eye care** | Eye exam | Not covered | Not covered | None |
| | Glasses | Not covered | Not covered | None |
| | Dental check-up | Not covered | Not covered | None |

## Excluded Services & Other Covered Services

**Services Your Plan Does NOT Cover** (This isn't a complete list. Check your policy or plan document for other excluded services.)

| | | | |
|---|---|---|---|
| Acupuncture | Cosmetic surgery | Dental care - Adult | Dental check-up |
| Eye exam | Glasses | Hearing aids | Long-term care |
| Routine eye care - Adult | Routine foot care | Weight loss programs | |

**Other Covered Services** (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

| | | |
|---|---|---|
| Bariatric surgery | Chiropractic care | Infertility treatment ($15,000 LTM) |
| Most coverage provided outside the U.S. | Private-duty nursing | |

**Your Rights to Continue Coverage:**
If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a premium, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact your employer or group sponsor. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

**Your Grievance and Appeals Rights:**
If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Wellmark at 1-800-524-9242 or Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

*Wellmark Blue Cross and Blue Shield of Iowa is an Independent Licensee of the Blue Cross and Blue Shield Association.*

*Questions: Call 1-800-524-9242 or visit us at www.wellmark.com. If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-524-9242 to request a copy.*

**About These Coverage Examples:**
These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**Having a baby**
(normal delivery)

- Amount owed to providers: $7,540
- Plan pays: $4,560
- Patient pays: $2,980

**Sample care costs:**

| | |
|---|---|
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $1,500 |
| Copays | $560 |
| Coinsurance | $770 |
| Limits or exclusions | $150 |
| **Total** | **$2,980** |

**Managing type 2 diabetes**
(routine maintenance of a well-controlled condition)

- Amount owed to providers: $5,400
- Plan pays: $3,380
- Patient pays: $2,020

**Sample care costs:**

| | |
|---|---|
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | **$5,400** |

**Patient pays:**

| | |
|---|---|
| Deductibles | $120 |
| Copays | $1,580 |
| Coinsurance | $0 |
| Limits or exclusions | $320 |
| **Total** | **$2,020** |

***This is not a cost estimator.*** *Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different. See the next page for important information about these examples.*

**What are some of the assumptions behind the Coverage Examples?**
- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

**What does a Coverage Example show?**
For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

**Does the Coverage Example predict my own care needs?**
No. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

**Does the Coverage Example predict my future expenses?**
No. Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

**Can I use Coverage Examples to compare plans?**
Yes. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

**Are there other costs I should consider when comparing plans?**
Yes. An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

*This contains only a partial description of the benefits, limitations, exclusions and other provisions of the health care plan. It is not a contract or policy. It is a general overview only. It does not provide all the details of coverage, including benefits, exclusions, and policy limitations. In the event there are discrepancies between this document and the Coverage Manual, Certificate, or Policy, the terms and conditions of the Coverage Manual, Certificate, or Policy will govern.*

## PART A: General Information

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

**What is the Health Insurance Marketplace?**

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

**Can I Save Money on My Health Insurance Premiums in the Marketplace?**

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

**Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?**

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

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

**How Can I Get More Information?**

For more information about your coverage offered by your employer, please check your summary plan description or contact the CRST Human Resources Department at 866-934-4895 or via email at benefits@crst.com.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

[1] An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs.

## PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

| | | |
|---|---|---|
| 3. Employer name<br>*See Below* | 4. Employer Identification Number (EIN)<br>*See Below* | |
| 5. Employer address<br>*See Below* | 6. Employer phone number<br>866-934-4895 | |
| 7. City<br>*See Below* | 8. State<br>*See Below* | 9. ZIP code<br>*See Below* |
| 10. Who can we contact about employee health coverage at this job?<br>CRST Human Resources Department | | |
| 11. Phone number (if different from above) | 12. Email address<br>Benefits@crst.com | |

| Employer Information | | | | | |
|---|---|---|---|---|---|
| **Name** | **EIN** | **Address** | **City** | **State** | **ZIP Code** |
| CRST International, Inc. | 421118724 | 3930 16th Avenue SW | Cedar Rapids | IA | 52406 |
| CRST Expedited, Inc. | 420750182 | 3930 16th Avenue SW | Cedar Rapids | IA | 52406 |
| CRST Malone, Inc. | 630722855 | 1901 Floyd Bradford Rd. | Trussville | AL | 35173 |
| CRST Lincoln Sales, Inc. | 203641963 | 3930 16th Avenue SW | Cedar Rapids | IA | 52406 |
| Specialized Transportation Agent Group, Inc. | 770638095 | 5001 US Hwy 30 West | Fort Wayne | IN | 46818 |
| Spectran Transportation Management Group, Inc. | 201135589 | 5001 US Hwy 30 West | Fort Wayne | IN | 46818 |
| CRST Dedicated Services, Inc. | 421166029 | 3930 16th Avenue SW | Cedar Rapids | IA | 52406 |
| CRST Logistics, Inc. | 421374316 | 3930 16th Avenue SW | Cedar Rapids | IA | 52406 |
| North American Driver Training Academy | 462888193 | 3930 16th Avenue SW | Cedar Rapids | IA | 52406 |

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

- As your employer, we offer a health plan to:

  ❑ All employees.

  X Some employees. Eligible employees are:
  All regular Full-time and Part-time employees who work more than 30 hours per week.

- With respect to dependents:
  X We do offer coverage. Eligible dependents are:
  Spouses and dependents up to the Age of 26

  ❑ We do not offer coverage.

  X If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

  ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. Enter the employer information listed above when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

## NOTICE OF PRE-EXISTING CONDITION LIMITATION

As of the first day of the 2014 plan year, the plan does not impose limitations on coverage for pre-existing conditions.

## NOTICE OF PRIVACY PRACTICES

THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices (the "Notice") describes the legal obligations of the Plan and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law. HIPAA requires us to provide this Notice of Privacy Practices to you.

The HIPAA Privacy Rule protects certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health plan, or your employer on behalf of a group health plan, which relates to:

- your past, present or future physical or mental health or condition;
- providing health care to you; or
- making past, present or future payments for providing health care to you.

If you have any questions about this Notice or about our privacy practices, please contact the CRST International, Inc. Privacy Officer, Angie Stastny: Director – Human Resources.

**Effective Date**

This Notice is effective September 20, 2013.

**Our Responsibilities**

We are required by law to:

- maintain the privacy of your protected health information;
- notify you of any breach of unsecured protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

**How We May Use and Disclose Your Protected Health Information**

We may use or disclose your protected health information in certain situations without your permission. The main reasons for which we may use and may disclose your Protected Health Insurance are to evaluate and process any requests for coverage and claims for benefits. Your Protected Health Information (PHI) may be used:

**For Payment.** We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may share your protected health information with health care providers in connection with the payment of health claims or to another health plan to coordinate benefit payments.

**For Health Care Operations.** We may use and disclose your protected health information for plan operations. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. If medical information is used for underwriting, genetic information may not and will not be used or disclosed for this purpose.

**To Business Associates.** We may contract with individuals or entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with us to follow appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation, but only after the Business Associate enters into a Business Associate contract with us.

**To Plan Sponsors.** We may disclose protected health information to certain employees of the Employer so that they can administer the plan. Those employees will only use or disclose protected health information as needed to perform plan administration functions or as otherwise required by HIPAA, unless you have specifically authorized other disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

**As Required by Law.** We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

**Health Oversight Activities.** We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

**Special Situations**

Although unlikely, it is also possible that we may use and disclose your protected health information in these situations:

**For Treatment.** We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you.

**Organ and Tissue Donation.** If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

**Workers' Compensation.** We may release your protected health information for workers' compensation or similar programs.

**Public Health Risks.** We may disclose your protected health information for public health actions. These actions generally would be:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

**Law Enforcement.** We may disclose your protected health information if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, we are unable to obtain the victim's agreement;
- about a death that we believe may be the result of criminal conduct; and
- about criminal conduct.

**Coroners, Medical Examiners and Funeral Directors.** We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

**National Security and Intelligence Activities.** We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

**Research.** We may disclose your protected health information to researchers when:
- the individual identifiers have been removed; or
- when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

**Required Disclosures**
We are required to make disclosures of your protected health information in these situations:

**Government Audits.** We must disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA privacy rule.

**Disclosures to You.** If you request, we must disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. If you request, we also must provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or health care operations, and if the protected health information was not disclosed due to your specific authorization.

**Other Disclosures**
**Personal Representatives.** We will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., if you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:
- you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
- treating such person as your personal representative could endanger you; and
- in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

**Spouses and Other Family Members.** With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if we have agreed to the request, we will send mail as provided by the request for Restrictions or Confidential Communications.

**Authorizations.** Other uses or disclosures of your protected health information, including but not limited to psychotherapy notes, most marketing purposes, and any disclosures that constitute a sale of PHI, will only be made with your written authorization. You may revoke written authorization at any time, but the revocation must be in writing. Once we receive your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that may have been used or disclosed based on the written authorization you provided before we received the revocation.

**Your Rights**
You have the following rights with respect to your protected health information:

**Right to Inspect and Copy.** You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to the CRST Human Resources Department. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the Plan Administrator.

**Right to Amend.** If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Administrator. You must provide a reason why and in what respect you believe your record is incorrect.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us, and any future disclosures of the disputed information will include your statement.

**Right to an Accounting of Disclosures.** You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the Plan Administrator. Your request must state a time period of no more than six years.

Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

To request restrictions, you must make your request in writing to the Plan Administrator. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply—for example, disclosures to your spouse.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Plan Administrator. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

**Right to Be Notified of a Breach.** You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

**Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. Effective January 1, 2014, you may obtain a copy of this notice in the Summary of Benefits Book located on your CHIP Employee Homepage. To obtain a paper copy of this notice, you can also contact the Plan Administrator.

**Complaints**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact the Privacy Officer shown on page 1 of this notice packet. All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.

We may change the terms of this Notice and make new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make any significant change to this Notice, we will provide you with a copy of our revised Notice of Privacy Practices by mail within 60 days after the change.

## WELLNESS PROGRAM – NOTICE OF REASONABLE ALTERNATIVES

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact us at 866-934-4895, and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status."

## NOTICE OF SPECIAL ENROLLMENT RIGHTS

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or 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 or 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, 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, birth, adoption, or placement for adoption.

If you are declined enrollment for yourself or your dependents (including your spouse) while coverage under Medicaid or a state Children's Health Insurance Program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' Medicaid or CHIP coverage ends. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or a CHIP program with respect to coverage under this plan, you may be able to enroll yourself and your dependents (including your spouse) in this plan. However, you must request enrollment within 60 days after you or your dependents become eligible for the premium assistance.

To request special enrollment or obtain more information, contact the CRST Human Resources Department.

## ADMINISTRATIVE DIRECTORY

**General Benefits Questions**
***CRST Benefits Department***
866-934-4895
benefits@crst.com

**Indemnity (Gap) Medical Plan**
***Transamerica – Administered by Web TPA***
866-441-3433
www.multiplan.com

**Major Medical Insurance**
***Wellmark BlueCross & BlueShield of Iowa***
800-600-4149
www.wellmark.com

**Dental Benefits**
***Delta Dental of Iowa (Delta Premier)***
800-544-0718
www.deltadentalia.com

**Vision Benefits**
***Avesis Incorporated***
800-828-9341
www.avesis.com

**401(k) Plan**
***MassMutual Financial Group***
800-743-5274
www.massmutual.com/retire

**Employee Life Insurance/Voluntary Life Insurance Buy-Up and Short-Term Disability**
***Reliance Standard***
800-351-7500
www.rsli.com

**Long-Term Disability**
***Reliance Standard***
800-351-7500
www.rsli.com

**Employee Assistance Program**
***Mercy Employee Assistance Program***
800-383-6694
www.mercycare.org/EAP


CRST International • CRST Dedicated Services • CRST Expedited
CRST Lincoln Sales • CRST Logistics • CRST Malone
CRST Specialized Transportation • North American Driver Training Academy