2024 Employee Benefits Guide

1/1/2024 - 12/31/2024

Hello and welcome to PAM Transport! We are excited to have you as part of our team!

We are always working throughout the year with our benefit partners to ensure that we have the best overall benefit options in place for our employees and their families.

Included in your benefit material, you will find benefit information as well as the cost for coverage available.

Remember, you will only have a limited amount of time to enroll in benefits. To make enrolling as easy as possible, you can enroll over the phone through our call center (as a new hire) or online (open enrollment). Just follow the steps in this packet and if you do have questions or need more information, feel free to contact HR at 800-390-7330 or hrhelp@pamt.com.

WHAT YOU NEED TO KNOW

ELIGIBILITY:

- You become eligible the first day of the month following 60 days of service (must be actively employed on the effective date).
- Weekly payroll deductions made through this pre-tax Cafeteria plan begin the first pay period following your eligibility date.

ENROLLMENT INSTRUCTIONS:

- 🔍 **REVIEW YOUR BENEFITS**—read this guide thoroughly. It will describe plan and product options for the year.
    - Detailed descriptions of each plan offered can be found at www.pamtransportbenefits.com
- ❶ **GETTING READY TO ENROLL**--- Items you'll need:
    - Social security numbers and date of birth for you and your eligible family members
    - Supporting documents for dependents/spouses with different last names—to show relationship. Examples: **Spouse**-Marriage License. **Children**-Birth Certificate
    - Beneficiary designation information, so we can properly identify beneficiaries.
- ☎ **CALL TO ENROLL**—
    - A live person will enroll you over the phone
    - The number to call is 1-877-282-0808 Monday-Friday 07:00am-04:00pm CST
        - This number can also be used to decline benefits.

CHANGING YOUR BENEFIT ELECTIONS:

Please remember that since your premium contributions are deducted on a pre-tax basis, according to the IRS regulations, you are "locked in" to your benefit election for the next year unless you have a change in family status. Changes may NOT be made during the year unless there is a qualifying Life Event such as:

- Marriage or Divorce
- Legal Guardianship
- Birth or Adoption of a child
- Loss of a Dependent
- Court or Administrative Order
- Loss or Gain of Spouse's Employment

You must notify the human resources department about any qualifying Life Events as soon as possible and before 31 days have passed. You also must provide proof of the event (a marriage license, birth certificate, death certificate, etc.). If you wait longer than 31 days, you will not be allowed to make any coverage changes until the next annual open enrollment. This is not due to PAM's requirements but by the IRS regulations.

MEDICAL PLAN OVERVIEW

PAM Transport offers two types of medical plans. Depending on your plan choice, coverage will vary. The plan uses a Preferred Provider Organization (PPO). A provider may be a physician, hospital, lab, rehab, or durable medical equipment supplier.

PLAN CHOICE 1		
Plan Feature	**In-Network**	**Out of Network**
Calendar year deductible	$1,000/individual; $2,000/family	$2,000/single; $4,000/family
Out of pocket max	$5,500/individual; $11,500/family	Unlimited
Coinsurance	80%	50%
Physician Office visit	$35 copay	50% coinsurance
Specialty Office visit	$65.00 copay	50% coinsurance
MDLIVE	$10 copay	50% coinsurance
Urgent Care	$35 copay per visit; Specialist: 20% coinsurance	50% coinsurance
Preventative Care/screening/immunization	Covered at 100%	50% coinsurance
Diagnostic Testing (x-ray, bloodwork)	PCP Office related services: No Charge. All other locations: 20% coinsurance	50% coinsurance
Imaging (CT/PET scans, MRI's)	20% coinsurance	50% coinsurance
Emergency Room care	Medical Emergency: 20% coinsurance Non-Emergency: 50% coinsurance	Medical Emergency: 20% coinsurance Non-Emergency: 50% coinsurance

PHARMACY		
Plan Feature	**Generic/ Name Brand/Non-Preferred** 34-day supply costing less than $400	**Mail Order** 100-day supply-maintenance medications only costing less than $1,200
	Tier 1/ Tier2/ Tier 3	
Calendar year deductible	**<u>$100</u> annual deductible must be met before copay/coinsurance**	
Copay	$18/$45/$75 For a 34-day supply costing over $400, member will pay 20%, not to exceed $200/prescription	$35/$100/$150 For a 100-day supply costing over $1,200, member will pay 20%, not to exceed $600/prescription
Specialty Drugs	Specialty Drugs are limited to a 30-day supply per fill and require prior approval. Specialty Drugs must be purchased through CVS Caremark Specialty Pharmacy. 20% coinsurance with a max of $500 per fill.	

See summary plan description for full list of eligible expenses and plan exclusions!

<u>PLAN CHOICE 1 EMPLOYEE WEEKLY COST:</u>

Employee Only	$35.00
Employee + Spouse	$85.00
Employee + Child(ren)	$65.00
Employee + Family	$115.00

MEDICAL PLAN OVERVIEW
(continued)

PLAN CHOICE 2 (HIGH DEDUCTIBLE)		
Plan Feature	**In-Network**	**Out of Network**
Calendar year deductible	$3,200/individual; $6,000/family	$6,000/single; $12,000/family
Out of pocket max	$8,000/individual; $16,000/family	Unlimited
Coinsurance	70%	50%
Physician Office visit	$35 copay	50% coinsurance
Specialty Office visit	$65 copay	50% coinsurance
MDLIVE	$10 copay	$10 copay
Urgent Care	$50 co-pay	50% coinsurance
Preventative Care/screening/immunization	Covered at 100%	50% coinsurance
Diagnostic Testing (x-ray, bloodwork)	Office related services: No Charge. All other locations: 30% coinsurance	50% coinsurance
Imaging (CT/PET scans, MRI's)	30% coinsurance	50% coinsurance
Emergency Room care	Medical Emergency: $50 copay, then 30% coinsurance Non-Emergency: 50% coinsurance	Medical Emergency: $50 copay, then 30% coinsurance Non-Emergency: 50% coinsurance

PHARMACY		
Plan Feature	**Generic/ Name Brand/Non-Preferred** 34-day supply costing less than $400	**Mail Order** 100-day supply-maintenance medications only
	Tier 1/ Tier2/ Tier 3	
Copay	$25/ 25% coinsurance / 25% coinsurance For a 34-day supply	$50/ 20% coinsurance /20% coinsurance

See summary plan description for full list of eligible expenses and plan exclusions!

PLAN CHOICE 2 (HIGH DEDUCTIBLE) EMPLOYEE WEEKLY COST:

Employee Only	$15.00
Employee + Spouse	$50.00
Employee + Child(ren)	$40.00
Employee + Family	$65.00

My Blueprint Mobile Features

Connect to your health plan from anywhere!

- View electronic member IDs and send via email or fax (where applicable)
- Access "Find Care & Cost" features with cost estimates for procedures, mapping and doctor reviews
- Access claims and policy information
- See your Personal Health Record to help fill out medical forms
- Easily reach customer service by phone or email
- View pharmacy information with prescription history and refill orders (where applicable)
- Pay your bill (where applicable)

DENTAL PLAN OVERVIEW

Plan Feature	In-Network	Out of Network
Annual Maximum Payment	$1,500 per person	
Annual Deductible	$50 per person-max of $100 per family	
Diagnostic and Preventative Services	100% 2 cleanings per year, office visits and x-rays (every 3 years)	
Basic Restorative	80%	
Major Restorative	80%	
Orthodontic Services	12 month waiting period. Children under 19 only. $50 deductible 80% with $1,000 lifetime max	
Prosthodontics	5-year replacement clause	
Note: For Out of Network services, the claim must be submitted by the employee to Delta Dental Directly.		

See summary plan description for full list of eligible expenses and plan exclusions.

EMPLOYEE WEEKLY COST:

Employee Only	$9.25
Employee + Spouse	$10.00
Employee + Child(ren)	$12.00
Employee + Family	$14.50

Delta Dental Mobile Features

Log in to access the full range of tools and resources!

Mobile ID Card

No need for a paper card. View and share your ID card from your phone, and easily save it to your device for quick access, including Apple Passbook and Google Wallet.

My Coverage and My Claims

View information on your plan and coverage details and check the status of claims for you and your family. Easily add your dependents to your account so you can access the whole family's coverage in one spot.

Find a Dentist

It's easy to find a dentist near you. Search and compare dental offices to find one that suits your needs. Save your family's preferred dentists to your account for easy access.

Schedule Dental Appointments*

View and select open appointment times with participating dentists, making scheduling dental appointments more convenient than ever. (Powered by Brighter Schedule)

Dental Care Cost Estimator*

Find out what to expect with our Dental Care Cost Estimator. Our easy-to-use tool provides estimated cost ranges on common dental care needs for dentists in your area, now with the option to select your dentist for tailored cost estimates.

LifeSmile Score

Do you know how your smile scores? Learn more about your personal oral health risk profile by taking our simple risk assessment survey.

Toothbrush Timer

Help your family keep up with their oral health routine by using this handy tool. Our timer counts down for two minutes while reminding you to brush each tooth.

VISION PLAN OVERVIEW

Plan Feature	In-Network	Copay	Frequency
Well Vision Exam	$10 copay	$10	Every calendar year
Prescription Glasses		$25	See frame and Lenses
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance	Included in Prescription Glasses	Every Calendar year
Lenses	• Single vision, lines bifocal and lined trifocal lenses	Included in Prescription Glasses	Every Calendar year
Lens Enhancements	• Progressive lenses • Anti-reflective coating • Polycarbonate lenses • Average savings of 20-25% on other enhancements	$0	Every Calendar year
Contacts (instead of glasses)	• $150 allowance, copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every Calendar year
Primary EyeCare	As a VSP member, you can visit your VSP doctor for medical and urgent eyecare. Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. Ask your VSP doctor for details.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured name brands. Go to vsp.com/offers for details • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam		
	Retinal Screening • No more than $39 copay on a routine retinal screening as an enhancement to a Well Vision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Visit www.vsp.com for full list of eligible expenses and plan exclusions. No internet access, call 800.877.7195.

EMPLOYEE WEEKLY COST:

Employee Only	$1.82
Employee + Spouse	$3.60
Employee + Child(ren)	$3.71
Employee + Family	$5.97

VSP Mobile Features

- **Find a doctor** by name or location and get directions to your appointment.
- Access your **Member Vision Card** and personal benefit information.
- View **Exclusive Member Extras**, like rebates, special offers, and promotions.
- Get **eye care information** on a variety of topics to maintain optimal eye health.

Supplemental Life Insurance Overview

Employee	
Guaranteed coverage amount during initial offering or approved special enrollment period	$250,000
Newly hired employee guaranteed coverage amount	$250,000
Continuing employee guaranteed coverage annual increase amount	Choice of $10,000 or $20,000
Maximum coverage amount	5 times your annual salary ($300,000 maximum in increments of $10,000)
Minimum coverage amount	$10,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen

Spouse	
Guaranteed coverage amount during initial offering or approved special enrollment period	$30,000
Newly hired employee guaranteed coverage amount	$30,000
Continuing employee guaranteed coverage annual increase amount	Choice of $5,000 or $10,000
Maximum coverage amount	50% of the employee coverage amount ($150,000 maximum in increments of $5,000)
Minimum coverage amount	$5,000
Optional AD&D coverage amount	Equal to the life insurance amount chosen

Dependent Children	
6 months to age 19 (to age 25 if unmarried, & a full-time student) guaranteed coverage amount	$10,000
Age 14 days to 6 months guaranteed coverage amount	$500

Group rates for you

The estimated weekly premium for life and AD&D is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium rate.

Please use table below for rates.

Coverage Amount *X* ***Premium Rate***=

$ Weekly Premium

Employee Age Range	Life & AD&D Premium Rate
0-29	0.0000254
30-34	0.0000277
35-39	0.0000323
40-44	0.0000462
45-49	0.0000738
50-54	0.0001200
55-59	0.0001800
60-64	0.0002769
65-69	0.0004223
70-99	0.0004823

Group rates for your Spouse

The estimated weekly premium for life and AD&D is determined by multiplying the desired amount of coverage (in increments of $10,000) by the employee age-range premium rate.

Please use table above for rates.

Coverage Amount *X* ***Premium Rate***=

$ Weekly Premium

Group rates for your dependent children

One affordable weekly premium covers all of your eligible dependent children.

Coverage Amount	Weekly Premium
$10,000	$0.46

Disability Insurance Overview

To supplement your income during extended illness or injury.

Short Term Disability	
Weekly benefit amount	60% of your weekly salary, limited to $2,300/week
Sickness elimination period	7 days
Accident elimination period	7 days
Maximum coverage period	12 weeks

Rate calculation

Weekly salary X ***0.0116***=

$ Weekly Premium

Long Term Disability	
Weekly benefit amount	60% of your weekly salary, limited to $10,000/month
Elimination period	90 days
Coverage period for your occupation	24 months
Maximum coverage period	2 years or up to age 70, whichever comes first

Rate calculation

Monthly salary X ***0.00132***=

$ Weekly Premium

Allstate Policies

Cancer:

MODE	PLAN	Employee only	Employee + Spouse	Employee + Children	Family
WEEKLY	LOW	$3.26	$5.15	$4.61	$6.50
	HIGH	$7.28	$11.46	$10.32	$14.50

Accident

MODE	PLAN	Employee only	Employee + Spouse	Employee + Children	Family
WEEKLY	LOW	$2.61	$4.73	$5.08	$6.08
	HIGH	$4.73	$8.97	$9.66	$11.66

Universal Life: A personalized illustration of coverage and premiums will be provided to the certificate holder at issue.

Detailed descriptions of each plan offered can be found at www.pamtransportbenefits.com