AccuFleet INTERNATIONAL

2024 Employee Benefits Guide

February 1, 2024 - January 31, 2025

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Welcome

At AccuFleet International, Inc. we recognize our ultimate success depends on our talented and dedicated workforce. We understand the contribution each employee makes to our accomplishments and so our goal is to provide a comprehensive program of competitive benefits to attract and retain the best employees available. Through our benefits programs we strive to support the needs of our employees and their dependents by providing a benefits package that is easy to understand, easy to access and affordable for all employees. This brochure will help you choose the type of plan and level of coverage that is right for you.

You can also view overviews of our benefit plans by accessing your UltiPro self-service portal, https://nw11.ultipro.com. Or via Brainshark by accessing the link or QR code below.

https://www.brainshark.com/usi/vu?pi=zHJzjvWc4zdHN4z0

Sincerely,

Human Resources
Toni Logsdon
toni.earle@accufleet.com
(281) 999-8800 ext. 1142

Call the Benefit Resource Center ("BRC")
We're Here To Help!

We speak insurance.

Our Benefits Specialists can help you choose the right plan for you and your family, translate confusing jargon, answer questions about which benefits are on your plan and which aren't, work directly with insurance carriers to resolve tricky issues regarding claims and denials of service—and more!

Benefit Resource Center

BRCSouthwest@usi.com | Toll Free: 855-874-0110

Eligibility

Eligible Employees:

You may enroll in the AccuFleet Employee Benefits Program if you are an active Full-Time employee working at least 30 hours per week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse*, and children up to age 26.

How to Enroll:

All employees must complete the benefit enrollment online through the employee self-service portal (UltiPro) https://nw11.ultipro.com to be enrolled in the 2024-2025 benefit plans. New hires must complete the online enrollment within 14 days from their start date.

COMPLETE YOUR BENEFITS ENROLLMENT

During open enrollment period: Click on "Myself", then click on "Open Enrollment" to complete the form.

To make changes to benefits for a qualifying life event: Click on "Myself", then click on "Life Events" to complete the form.

When Coverage Begins:

The effective date for your benefits is February 1, 2024. Newly hired employees and dependents will be effective in AccuFleet' s benefits programs on the first of the month following 30 days of active employment. All elections are in effect for the entire plan year and can only be changed during your annual enrollment period or if you experience a Qualified Life Event.

Qualified Life Events:

A Qualified Life Event is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some Qualified Life Events include:

- Change of legal marital status (i.e. marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e. birth, adoption, death of dependent, ineligibility due to child(ren) reaching age 26)
- Change in employment or job status (spouse loses job, etc.)

If you experience a Qualified Life Event, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact Human Resources to make these changes.

Medical

AccuFleet offers medical coverage options through UnitedHealthcare. The following charts are a brief outline of what is offered. Amounts indicated on the tables refer to the portion you will be responsible for. Please refer to the summary plan description for complete plan details. You can locate these on your UltiPro self-service employee portal.

Preventive Care

Preventive care is regular medical care you receive when you are healthy, to help avoid getting sick. Preventive care can also help diagnose illnesses early, before you begin to experience symptoms. This can help shorten the severity of certain conditions or help you recover more quickly. It can also save you money, since, in many cases, it's less expensive to treat a problem in its early stages.

Preventive care services are provided by your medical plan at no cost to you. These services include:

- Yearly physicals (including Well-woman exams)
- Immunizations
- Health screenings

Please note, these services are only free when you receive them at an in-network doctor. If you discuss existing symptoms or issues during your preventive visit, the physician might file the claim as diagnostic services resulting in you having out-of-pocket costs.

Glossary of Terms

Annual deductible: the amount you pay for covered expenses before the health plan pays. There are separate deductibles for in-network and out-of-network services and certain prescription drugs.

Individual deductible: the amount paid for services for one person covered by the plan before the plan pays benefits.

Family deductible: (two or more people): the combined amount that must be paid for services for at least two family members covered by the plan before the health plan pays.

Coinsurance: the percent the plan pays for eligible expenses after you meet your deductible.

In-Network provider: a member of the plan's predefined network who agrees to provide services at a discounted rate. You pay less when you use a network provider.

Out-of-Network provider: a provider who is not a member of the plan's predefined network. You pay more for out-of-network services because the price is not discounted, and you pay a higher deductible, and/or coinsurance.

Out-of-Pocket maximum: the maximum amount you will pay for covered health care during the calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% for eligible expenses for the rest of the year. There are separate limits for in-network and out-of-network services provided.

Preventive Care: routine checkups and screenings such as well baby and childcare including immunizations, adult annual physicals, and age appropriate screenings such as mammograms, colonoscopy, etc. Preventive care following certain criteria with an in-network provider is covered at 100%.

Medical Plan A

The table below is a brief outline of one of the medical plans. Please refer to the summary plan description for complete plan details. You can locate these on your UltiPro self-service employee portal.

Medical Plan A – BC1V (Value EPO) Rx 52

Network Name: Choice

Eligible Employees: All Eligible Employees except in Arizona

	Medical Plan A BC1V (Value EPO) Rx 52 Schedule of Benefits
Annual Deductible	
Individual	$5,000
Family	$10,000
Coinsurance	0%
Maximum Out-of-Pocket[1]	
Individual	$6,350
Family	$12,700
Physician Visit	
Preventative Care	$0
Telemedicine	$0
Primary Care[2]	$45 copay
Specialty Care[2]	$45 copay / $90 copay
Diagnostic Services	
Inpatient/Outpatient Facility Charges	0% after deductible (Inpatient $250 copay per occurrence)
X-ray and Lab Tests	$0
Complex Radiology (CT Scan, MRI, etc.)	$400 copay per service
Urgent Care Facility	$100 copay
Emergency Room	$400 copay
Retail Pharmacy (30 Day Supply)	
Generic (Tier 1) / Specialty	$15 / $15
Preferred (Tier 2) / Specialty	$40 / $100
Non-Preferred (Tier 3) / Specialty	$75 / $300
Mail Order Pharmacy (90 Day Supply)	
Generic (Tier 1)	$37.50
Preferred (Tier 2)	$100
Non-Preferred (Tier 3)	$187.50

PLAN HIGHLIGHTS

- This plan has no out-of-network benefits. True life-threatening emergencies may be covered at an out-of-network ER.
- Table displays your cost share
- Mail order Pharmacy not available for Specialty Rx

[1]Maximum Out-of-Pocket refers to the maximum amount you will pay for covered health care during the calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% for eligible expenses for the rest of the year. There are separate limits for in-network and out-of-network services provided.

[2]Chart denotes the benefit level in the "Designated Network" "Designated Network" & "Network": You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network.

You will pay the most if you use an out-of-Network provider, and you might receive a bill from a provider for the Difference between the provider's charge and what your plan pays (balance billing). Be aware, your Network provider might use an out-of-Network provider for some Services (such as lab work). Check with your provider before you get services.

Medical Plan A Contributions

Medical Plan A – BC1V (Value EPO) Rx 52

Eligible Employees: All Eligible Employees except in Arizona

PLAN A – Contribution Details				
Tier	**Per Pay Period**	**Total Monthly Cost**	**Employee Monthly Cost**	**Employer Monthly Cost**
Employee	$142.04	$769.37	$307.75	$461.62
Employee & Spouse	$508.61	$1,836.63	$1,101.98	$734.65
Employee & Child(ren)	$556.35	$1,607.24	$1,205.43	$401.81
Employee & Family	$896.56	$2,590.07	$1,942.55	$647.52

Medical Plan B

The table below is a brief outline of one of the medical plans. Please refer to the summary plan description for complete plan details. You can locate these on your UltiPro self-service employee portal.

Medical Plan B – CZWZ (EPO Proformance) Rx G58Y

Network Name: Choice

Eligible Employees: All Eligible Employees except in Arizona

	Medical Plan B CZWZ (EPO Proformance) Rx G58Y
	Schedule of Benefits
Annual Deductible	
Individual	$3,000
Family	$6,000
Coinsurance	20%
Maximum Out-of-Pocket[1]	
Individual	$7,150
Family	$14,300
Physician Visit	
Preventative Care	$0
Telemedicine	$0
Primary Care[2]	$10 copay
Specialty Care[2]	$40 copay / $80 copay
Diagnostic Services	
Inpatient/Outpatient Facility Charges	20% after deductible
X-ray and Lab Tests	$40 copay
Complex Radiology (CT Scan, MRI, etc.)	$500 copay
Urgent Care Facility	$25 copay
Emergency Room	$300 copay + 20% after deductible
Retail Pharmacy (up to 31 Day Supply)	
Generic (Tier 1) / Specialty	$10 / $10
Preferred (Tier 2) / Specialty	$45 / $150
Non-Preferred (Tier 3) / Specialty	$80 / $500
Mail Order Pharmacy (90 Day Supply)	
Generic (Tier 1)	$25
Preferred (Tier 2)	$112.50
Non-Preferred (Tier 3)	$200

PLAN HIGHLIGHTS

- This plan has no out-of-network benefits. True life-threatening emergencies may be covered at an out-of-network ER.
- Table displays your cost share
- Mail order Pharmacy not available for Specialty Rx

[1]Maximum Out-of-Pocket refers to the maximum amount you will pay for covered health care during the calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% for eligible expenses for the rest of the year. There are separate limits for in-network and out-of-network services provided.

[2]Chart denotes the benefit level in the "Designated Network" "Designated Network" & "Network": You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network.

You will pay the most if you use an out-of-Network provider, and you might receive a bill from a provider for the Difference between the provider's charge and what your plan pays (balance billing). Be aware, your Network provider might use an out-of-Network provider for some Services (such as lab work). Check with your provider before you get services.

****Walgreens required for Specialty & 90-day retail; CVS is out of network.**

Medical Plan B

Medical Plan B – CZWZ (EPO Proformance) Rx G58Y

Eligible Employees: All Eligible Employees except in Arizona

PLAN B – Contribution Details				
Tier	**Per Pay Period**	**Total Monthly Cost**	**Employee Monthly Cost**	**Employer Monthly Cost**
Employee	$159.60	$768.43	$345.79	$422.64
Employee & Spouse	$395.38	$1,834.39	$856.66	$977.73
Employee & Child(ren)	$325.26	$1,605.28	$704.72	$900.56
Employee & Family	$595.78	$2,586.89	$1,290.86	$1,296.03

Medical Plan C

The table below is a brief outline of one of the medical plans. Please refer to the summary plan description for complete plan details. You can locate these on your UltiPro self-service employee portal.

Medical Plan C – BCYH (Premier) Rx 0I0Y

Network Name: Choice Plus

Eligible Employees: All Eligible Employees.

	Medical Plan C BCYH (Premier) Rx 0I0Y	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$3,000	$5,000
Family	$6,000	$10,000
Coinsurance	20%	50%
Maximum Out-of-Pocket[1]		
Individual	$6,000	$10,000
Family	$12,000	$20,000
Physician Visit		
Preventative Care	$0	50% after deductible
Telemedicine	$0	50% after deductible
Primary Care[2]	$30 copay	50% after deductible
Specialty Care[2]	$30 copay / $60 copay	50% after deductible
Diagnostic Services		
Inpatient/Outpatient Facility Charges	20% after deductible	50% after deductible[3]
X-ray and Lab Tests	$0	50% after deductible
Complex Radiology (CT Scan, MRI, etc.)	20% after deductible	50% after deductible
Urgent Care Facility	$75 copay	50% after deductible
Emergency Room	$250 copay + 20% after deductible	$250 copay + 20% after deductible
Retail Pharmacy (up to 31 Day Supply)		
Generic (Tier 1) / Specialty	$10 / $10	$10 / $10
Preferred (Tier 2) / Specialty	$35 / $150	$35 / $150
Non-Preferred (Tier 3) / Specialty	$70 / $500	$70 / $500
Mail Order Pharmacy (90 Day Supply)		
Generic (Tier 1)	$25	Not Covered
Preferred (Tier 2)	$75	Not Covered
Non-Preferred (Tier 3)	$125	Not Covered

PLAN HIGHLIGHTS

- This plan offers in- and out-of-network benefits.
- Table displays your cost share
- Mail order Pharmacy not available for Specialty Rx

[1]Maximum Out-of-Pocket refers to the maximum amount you will pay for covered health care during the calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% for eligible expenses for the rest of the year. There are separate limits for in-network and out-of-network services provided.

[2]Chart denotes the benefit level in the "Designated Network"
"Designated Network" & "Network": You pay the least if you use a provider in the Designated Network. You pay more if you use a provider in the Network.

You will pay the most if you use an out-of-Network provider, and you might receive a bill from a provider for the Difference between the provider's charge and what your plan pays (balance billing). Be aware, your Network provider might use an out-of-Network provider for some Services (such as lab work). Check with your provider before you get services.

[3]Preauthorization required for out-of-Network or benefit reduces to the lesser of 50% or $500.

****Walgreens required for Specialty & 90-day retail; CVS is out of network.**

Medical Plan C Contributions

Medical Plan C – BCYH (Premier) Rx 0I0Y

Eligible Employees: All Eligible Employees

PLAN C – Contribution Details				
Tier	**Per Pay Period**	**Total Monthly Cost**	**Employee Monthly Cost**	**Employer Month**
Employee	$163.39	$885.04	$354.02	$531.02
Employee & Spouse	$435.88	$2,112.75	$944.40	$1,168.35
Employee & Child(ren)	$353.28	$1,848.88	$765.44	$1,083.44
Employee & Family	$661.44	$2,979.48	$1,433.13	$1,546.36

Medical Plan D

The table below is a brief outline of one of the medical plans. Please refer to the summary plan description for complete plan details. You can locate these on your UltiPro self-service employee portal.

Medical Plan D – HDHP DDYM – 0I0Y

Network Name: Choice Plus

Eligible Employees: All Eligible Employees

	Medical Plan D HDHP DDYM (Choice Plus) Rx 0I0Y	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$3,500	$5,000
Family	$7,000	$10,000
Coinsurance	20%	50%
Maximum Out-of-Pocket[1]		
Individual	$6,350	$10,000
Family	$12,700	$20,000
Physician Visit		
Preventative Care	$0	50% after deductible
Telemedicine	$50	50% after deductible
Primary Care[2]	20% after deductible	50% after deductible
Specialty Care[2]	20% after deductible	50% after deductible
Diagnostic Services		
Inpatient/Outpatient Facility Charges	20% after deductible	50% after deductible[3]
X-ray and Lab Tests	20% after deductible	50% after deductible
Complex Radiology (CT Scan, MRI, etc.)	20% after deductible	50% after deductible
Urgent Care Facility	20% after deductible	50% after deductible
Emergency Room	20% after deductible	20% after deductible
Retail Pharmacy (up to 31 Day Supply)		
Generic (Tier 1) / Specialty	20% after deductible	50% after deductible
Preferred (Tier 2) / Specialty	20% after deductible	50% after deductible
Non-Preferred (Tier 3) / Specialty	20% after deductible	50% after deductible
Mail Order Pharmacy (90 Day Supply)		
Generic Tier 1 / Specialty	20% after deductible	Not Covered
Preferred Tier 2 / Specialty	20% after deductible	Not Covered
Non-Preferred Tier 3 / Specialty	20% after deductible	Not Covered

PLAN HIGHLIGHTS

- This plan offers in- and out-of-network benefits.
- This is a Qualified High Deductible Health Plan. Payments by the insurance will not apply prior to the deductible being met.
- Table displays your cost share
- Mail order Pharmacy not available for Specialty Rx.

[1]Maximum Out-of-Pocket refers to the maximum amount you will pay for covered health care during the calendar year. Once you reach the out-of-pocket maximum, the plan pays 100% for eligible expenses for the rest of the year. There are separate limits for in-network and out-of-network services provided.

You will pay the most if you use an out-of-Network provider, and you might receive a bill from a provider for the Difference between the provider's charge and what your plan pays (balance billing). Be aware, your Network provider might use an out-of-Network provider for some Services (such as lab work). Check with your provider before you get services.

****Walgreens required for Specialty & 90-day retail; CVS is out of network.**

Medical Plan D Contributions

Medical Plan D – DDYM – 0I0Y

Eligible Employees: All Eligible Employees

PLAN D – Contribution Details				
Tier	**Per Pay Period**	**Total Monthly Cost**	**Employee Monthly Cost**	**Employer Month**
Employee	$88.44	$684.35	$191.62	$492.73
Employee & Spouse	$416.21	$1,633.67	$901.79	$731.88
Employee & Child(ren)	$368.84	$1,429.62	$799.16	$630.46
Employee & Family	$531.66	$2,303.86	$1,151.93	$1,151.93

Health Savings Account

If you elect to participate in the Plan D medical option, you may also be eligible to participate in a Health Savings Account (HSA).

Your HSA belongs to you and is not sponsored by AccuFleet. If you have any questions about your ability to participate in an HSA or other tax implications of your HSA coverage, you are advised to contact your personal tax advisor.

In accordance with IRS guidelines, 2024 HSA contributions are limited to a maximum of $4,100 for employee only coverage, and $8,300 for family coverage.

This is an optional account. If you establish your HSA will be administered by Wex Discovery Benefits.

Payments from your HSA count toward your deductible and out-of-pocket maximum. You can use your HSA money to pay for qualified expenses for you, your spouse, and your federal tax dependents.

** Please note, you must have a physical address to set up the HSA Account with Wex Discovery Benefits. P.O. boxes will not be accepted.*

Here's How an HSA Works:

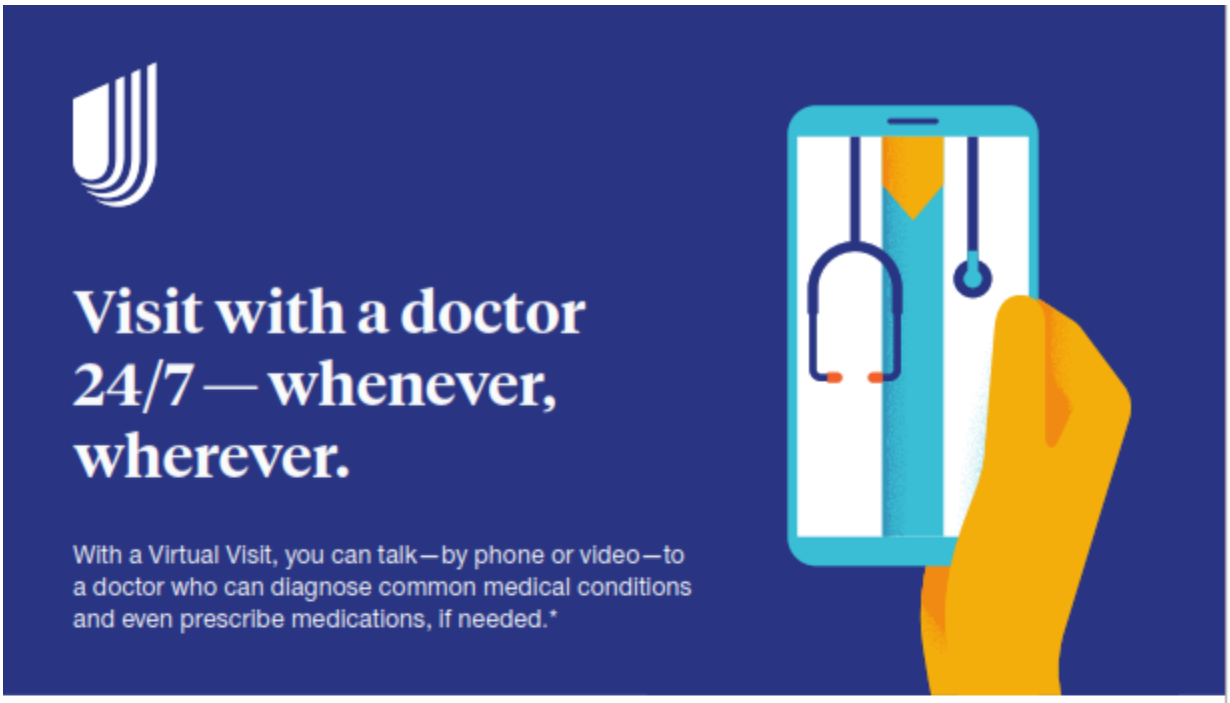
START IT	BUILD IT	USE IT	GROW IT	KEEP IT
After you enroll in the Plan D, you are eligible to set up your HSA account through Wex (Discovery Benefits).	Your contributions to your HSA are pre-tax through payroll contributions (limits apply).	You can use the money in your HSA to pay for covered health care.	Unused money in your account will roll over to the next year. Once you have accrued a certain amount you may choose to invest the money for future growth.	You always own the money in your HSA account including any interest and other investment earnings. Even if you are no longer employed by AccuFleet.

2024 IRS HSA Contribution Limits	
Employee Only	$4,100
Employee & Spouse	$8,300
Employee & Child(ren)	$8,300
Employee & Family	$8,300

If you have been enrolled in Medicare, Tricare or a Veteran's Administration plan in the past 3 months you are not eligible for an HSA.

Note: If you are age 55 or older, you may contribute an additional $1,000 annually.

A Health Savings Account (HSA) is a savings account that allows you to set aside pre-tax money to use on IRS- qualified medical expenses (including your deductible). HSAs are only available to those individuals enrolled in a Qualified High Deductible Health Plan (QHDHP). You can take your HSA with you even if you leave the company and you may invest the funds as you would an IRA or 401(k).



Virtual Visits may make it easier than ever to get treated by a doctor.

Whether using **myuhc.com®** or the UnitedHealthcare® app, Virtual Visits let you video chat with a doctor 24/7—without setting up additional accounts or apps. But, if you'd rather just speak with a doctor, you can simply do a Virtual Visit over the phone.

With a UnitedHealthcare plan, your cost for a Virtual Visit is $0.**

Use a Virtual Visit for these common conditions:

- Allergies
- Bronchitis
- Eye infections
- Flu
- Headaches/migraines
- Rashes
- Sore throats
- Stomachaches
- And more

$0 cost

An estimated 25% of ER visits could be treated with a Virtual Visit—bringing a potential $2,100*** cost down to $0.

Get started.

Sign in at **myuhc.com/virtualvisits** | Download the UnitedHealthcare app | Call **1-855-615-8335**

United Healthcare®

*Certain prescriptions may not be available, and other restrictions may apply.

**The Designated Virtual Visit Provider's reduced rate for a virtual visit is subject to change at any time.

***UnitedHealthcare data: based on analysis of 2016 UnitedHealthcare ER claim volumes, where ER visits are low acuity and could be treated in a Virtual Visit, primary care physician or urgent/convenient care setting.

The UnitedHealthcare® app is available for download for iPhone® or Android™. iPhone is a registered trademark of Apple, Inc. Android is a trademark of Google LLC.

Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

Insurance coverage provided by or through UnitedHealthcare Insurance Company and its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates. Health Plan coverage provided by or through a UnitedHealthcare company.

Dental

AccuFleet offers two dental plan options through United HealthCare. To find an in-network provider, visit www.myuhc.com. The chart below is a brief outline of the plans. Please refer to the summary plan description or consult the fee schedule for complete plan details. Located on your UltiPro self-service employee portal.

Who is Eligible?

- **Passive PPO:** Eligible Employees & Dependents
- **DHMO:** Only TX Eligible Employees & Dependents

Controlling Your Dental Care Costs

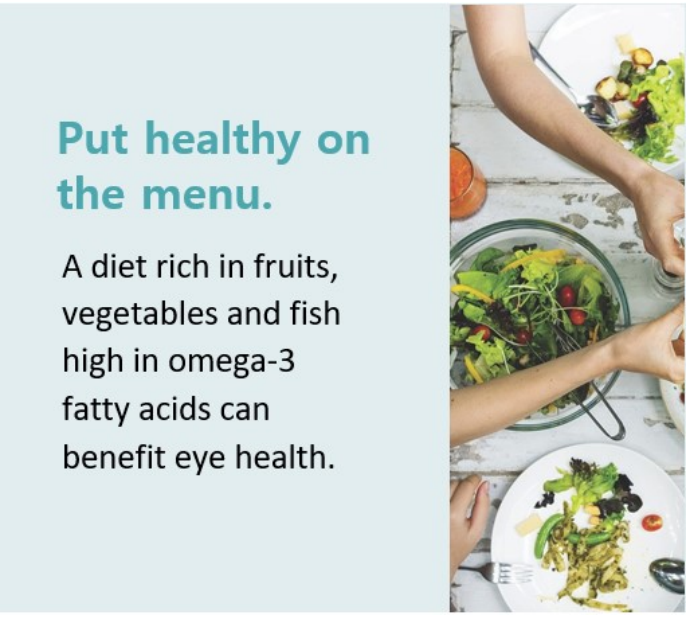
- **Please Note:** It is recommended that when a course of treatment is expected to cost $300 or more, and is of a non-emergency nature, your dentist should submit a treatment plan before he/she begins. This enables you to see what your out-of-pocket expenses will be.
- **Plan benefits for in-network:** Services are based on the percentage of the negotiated fee – the fee that in-network dentists have agreed to accept as payment in full for covered services, subject to any co-payments, deductibles, cost sharing and benefit maximums.
- **Passive PPO Plan Only:** Benefits for out-of-network (OON) services are based on a percentage of the Reasonable and Customary (R&C) charge. If you choose a dentist who does not participate in the network, your OON expenses may be higher, since you will be responsible for paying any difference between the dentist's fee and your plan's payment for the approved service. DHMO plan does not have OON benefits.

	Passive PPO Plan		DHMO Plan (TX Only)	
	In- and Out-of-Network Options PPO 30 Network		Schedule of Benefits National Pacific Dental Network	
Annual Deductible				
Individual	$50		N/A	
Family	$150		N/A	
Annual Maximum				
Per Person / Family	$1,000		N/A	
Preventive	$0		$0*	
Basic (Amalgams, etc.)	20% after deductible		$5 office visit fee + consult fee schedule ($20-$125)	
Major (Periodontal, endodontics, etc.)	50% after deductible		$5 office visit fee + consult fee schedule ($20-$225)	
Orthodontia				
Benefit (Child(ren) up to age 19)	50%		$5 office visit fee + consult fee schedule ($150-$1,895)	
Lifetime Maximum (per individual)	$1,000		N/A	
Employee Contributions	**Passive PPO Plan**		**DHMO Plan**	
	Monthly	Bi-Weekly	Monthly	Bi-Weekly
Employee	$33.70	$15.56	$15.47	$7.14
Employee & Spouse	$67.41	$31.11	$29.98	$13.84
Employee & Child(ren)	$83.95	$38.75	$32.44	$14.97
Employee & Family	$124.36	$57.40	$46.95	$21.67

**Office visit fee and additional fees may apply for complex preventative services.*

Vision

AccuFleet provides Vision Insurance through United Healthcare. Please refer to the summary plan description located in your UltiPro self-service employee portal.



Who is Eligible?

- All Eligible Employees & Dependents

Sight, it's a beautiful thing and not to be taken for granted. Whether you want to be incognito and wear contact lenses or stand out in the crowd with the latest stylish frames, this vision plan has you covered. Go anywhere in the network for an exam, but we suggest you use a major retail chain when getting your frames and lenses.

You may visit a doctor within the United Healthcare Spectra network. You can take advantage of higher benefits coverage when you stay in-network or visit an out-of-network provider of your choice for a reduced benefit. If you use an out-of-network provider, you pay for services and then submit a claim for reimbursement. To locate in-network providers (private practice and retail centers) visit www.myuhcvision.com.

	Vision Plan Spectra Network		
	In-Network	**Out-of-Network**	**Benefit Frequency**
Routine Exam	$10 copay	Up to $40	Covered 1x every 12 months
Lenses	Covered 100% after $25 material copay	Single $40 Bifocal $60 Trifocal $80	Covered every 12 months
Frames	Covered at $130 allowance, +30% discount on balance	Up to $45	Covered every 24 months
Elective Contacts	Covered at $125 allowance, $40 fitting & evaluation fee	Up to $100	Covered every 12 months. (Contacts covered in lieu of frames)
Medically Necessary Contacts	Covered at 100%	Up to $210	

Employee Contributions

	Vision Plan	
	Monthly	Bi-Weekly
Employee	$6.17	$2.85
Employee & Spouse	$11.71	$5.40
Employee & Child(ren)	$13.74	$6.34
Employee & Family	$19.34	$8.93

Flexible Spending Account

Dependent Care FSA

AccuFleet offers you the option to open a Dependent Care FSA (***this is not associated with medical***) through Wex Discovery Benefits. The Dependent Care FSA allows for you to put aside pre-tax dollars to pay for eligible dependent daycare expenses. You may contribute up to $5,000 per year per household. Please contact Human Resources for the Discovery Benefits enrollment materials.

Who is Eligible?	• All eligible employees. Enrollment under another offered benefit is not required.
Why Use It?	• You (and your spouse, if married) work outside the home and require dependent care of an eligible dependent to allow you to work full-time. • You claim the dependent on your income tax return. • Contributions are pre-tax, so it increases your non-taxable take-home pay.
Eligible Expenses	• Pays for daycare for eligible dependents your child or children under age 13, your disabled spouse, an elderly parent or other dependent who is physically or mentally incapable of self-care. • Eligible expenses must be incurred within the same plan year (February 1-January 31) • A complete listing of eligible and ineligible flexible spending account expenses can be found at www.irs.gov. Search Publication 503—Child and Dependent Care Expenses.
Maximum Contribution	• $5,000 per plan year ($2,500 if married and filing separately) • NOTE: This is also a "use-it-or-lose-it" account, so estimate your needs conservatively. The account is NOT pre-funded, meaning that after you file a claim, you may only receive reimbursement for amounts that are currently in the account.
Grace Period Extension	• You have a 2.5-month grace period following the current plan year to use your funds and to submit receipts. Thereafter, the funds will be lost.
Account Administration	• Each new participant will receive a debit card that can be used to pay for eligible expenses. A second card can be ordered online at www.discoverybenefits.com. • Log on to Discovery Benefits portal or mobile app to register. You will be able to easily upload your claim documentation (receipts) for reimbursement and check their status. • Please consult a tax advisor for more information on tax implications of an FSA.

Basic Life and AD&D

AccuFleet provides Basic Life and Accidental Death & Dismemberment (AD&D) benefits to eligible employees through MetLife**.** Please see the summary plan description and certificate of coverage for complete plan details, located on your UltiPro self-service employee portal.
This benefit is 100% paid by AccuFleet.

Who is Eligible?

- All Eligible Employees

The Life insurance benefit will be paid to your designated beneficiary in the event of death while covered under the plan. The AD&D benefit will be paid in the event of a loss of life or limb by accident while covered under the plan.

Beneficiary Designation

You **must** make your beneficiary designations. You can name the person(s) or entity to receive benefits in the event of your death. Failure to do so will void the automatic enrollment.

As a reminder, you can update your life insurance beneficiary at any time throughout the year, and as many times as needed. Contact Human Resources to update your beneficiary information.

Additional Plan Highlights

- Life Insurance benefits begin to decrease at age 65. See plan summary for full reduction details.
- Dependent Life Benefit provides a $5,000 benefit for a dependent. (Dependents are spouse and/or children.)

Basic Life and AD&D	
Benefit Amount *(AD&D amount equal to your Basic Life)*	
Hourly	$20,000
Salaried	2x basic annual earnings (Rounded to next $1,000)
Guaranteed Issue	
Hourly	$20,000
Salaried	$250,000
Dependent Life Benefit *(spouse and/or child)*	
Hourly	N/A
Salaried	$5,000

Beneficiary Designations

You must complete your benefit enrollment process and make your beneficiary designations. Failure to do so will void the automatic enrollment of this free benefit.

Voluntary Life and AD&D

In addition to the employer paid Basic Life and Death & Dismemberment (AD&D) coverage, you have the option to purchase additional voluntary life insurance to cover any gaps in your existing coverage that may be a result of age reduction schedules, cost of living, existing financial obligations, etc.

Voluntary Life and AD&D *(AD&D benefit amount equal to your Voluntary Life)*	
You	
Benefit Minimum	$10,000
Benefit Maximum	Lesser of; $250,000 or 3x basic annual earnings
Benefit Increments	$10,000
Guaranteed Issue	$100,000
Your Spouse	
Benefit Minimum	$5,000
Benefit Maximum	$50,000; not to exceed 50% of employee's elected amount
Benefit Increments	$5,000
Guaranteed Issue	$20,000
Your Child *(benefit per child)*	
Benefit Amount	$10,000

Who is Eligible?

- All Eligible Employees & Dependents

This benefit is 100% paid by you. Contributions will depend on your age and the benefit amount you select. See table below to determine your contribution amount. Use the same table to calculate spouse coverage. You will only pay one child rate regardless of the number of children covered.

Beneficiary Designation

You can update your voluntary Life and AD&D insurance beneficiary at any time throughout the year, and as many times as needed. Contact Human Resources to update your beneficiary information.

Additional Plan Highlights

- Guaranteed Issue only applies to new hires/newly eligible employees.
- If you do not enroll when first eligible or are increasing current elections, you will be subject to Evidence of Insurability (EOI) and must complete a medical questionnaire, meaning your application will be reviewed by the carrier and they may decline coverage.
- $10,000 child benefit is offered to children from 6 months to 26 years of age. Child benefits for children under 6 months old are limited. ***You will only pay one premium regardless of the number of children covered.***

Voluntary Life and AD&D Monthly Premiums *(Spouse premium based on Employee age)*							
Employee Age	$1,000	$10,000	$20,000	$40,000	$50,000	$100,000	Child $10,000
Under 30	$0.06	$0.64	$1.28	$2.56	$3.20	$6.40	$2.31
30-34	$0.08	$0.85	$1.70	$3.40	$4.25	$8.50	
35-39	$0.10	$0.95	$1.90	$3.80	$4.75	$9.50	
40-44	$0.11	$1.06	$2.12	$4.24	$5.30	$10.60	
45-49	$0.16	$1.59	$3.18	$6.36	$7.95	$15.90	
50-54	$0.24	$2.44	$4.88	$9.76	$12.20	$24.40	Note: Table calculations may vary slightly due to rounding.
55-59	$0.46	$4.56	$9.12	$18.24	$22.80	$45.60	
60-64	$0.70	$6.99	$13.98	$27.96	$34.95	$69.90	
65-69	$1.34	$13.45	$26.90	$53.80	$67.25	$134.50	
70+	$2.18	$21.82	$43.64	$87.28	$109.10	$218.20	

Long-Term Disability Insurance

AccuFleet offers long-term income protection through MetLife Inc in the event you become unable to work due to a non-work-related illness or injury. This benefit covers 66.67% of your monthly base salary up to $5,000. Benefit payments begin after 90 days. **This benefit is 100% paid by AccuFleet**.

Please see the summary plan description and certificate of coverage for complete plan details, including maximum duration of benefits. These are in your UltiPro self-service employee portal.

Long-Term Disability	
Benefit Amount	66.67% of monthly based salary
Maximum Monthly Benefit	$5,000
Elimination Period	90 Days
Pre-Existing Conditions	3/12
Maximum Duration	SSNRA or based on reduced duration schedule

Who is Eligible?

- Salaried Eligible Employees

Pre-Existing Condition Limitations

This plan has a 3/12 pre-existing condition limitation. Meaning, the LTD plan does not cover pre-existing conditions for which you received medical treatment, consultation, care or services (including diagnostic measures) or took prescribed drugs or medicines in the 3 months just prior to your effective date of coverage, and the disability begins in the first 12 months after your effective date of coverage.

Additional Highlights

- The 90-day elimination period refers to the period between the disability start date and the day benefits start.
- Maximum Duration: If you become disabled prior to age 60, benefits are payable to age 65, your Social Security Normal Retirement Age (SSNRA). At age 60 (and older), the benefit period will be based on a reduced duration schedule.

Worksite Benefits

AccuFleet is pleased to offer worksite benefit(s) through United HealthCare to all eligible employees: Critical Illness and Accident Insurance. There is no requirement to enroll in a medical plan to participate in worksite benefits. Please see plan summaries for full details to determine which, if any, best fit your family's needs.

Who is Eligible?

- All Eligible Employees & Dependents

Accident Insurance

No one plans to have an accident, but it can happen at any moment, throughout the day, whether at work or at play. Most major medical insurance plans only pay a portion of the bills. Accident insurance can help pick up where other insurance leaves off and provide cash to cover the expenses. It offers peace of mind when an accidental injury occurs.

Accident plan pays a benefit lump-sum benefit directly to the member after a covered injury (fractures, dislocations, etc.). This table shows only some of the covered injuries, please see the plan summary for a full list.

Accident Insurance Monthly Premiums	
Employee Only	$10.15
Employee & Spouse	$16.20
Employee & Child(ren)	$22.30
Employee & Family	$33.77

Accident Insurance	
	Benefit Amounts
Ground Ambulance	$300
Air Ambulance	$1,800
Hospital Admission	$1,000
Hospital Confinement	$250
Coma	$15,000
Concussion	$200
Fractures (Open Reduction)	
Hip, Thigh (femur)	$4,000
Ankle	$2,000
Dislocations (Open Reduction)	
Hip	$3,200
Ankle	$640

Critical Illness Insurance

Critical Illness Insurance is designed to protect your income and personal assets when your out-of-pocket expenses increase as a result of an illness. Health insurance is not always enough to cover all the unforeseen expenses associated with a serious medical condition, like a heart attack, stroke, cancer, loss of sight, paralysis or coma, among others.

Critical Illness Benefit Amounts	
Employee	$10,000
Spouse	$5,000
Child(ren)	$2,500

Critical Illness plan pays a benefit lump-sum benefit directly to the member upon the diagnosis of a covered critical illness help pay for unanticipated expenses or loss of income. This plan includes a Wellness Rider which provides you a $50 benefit for your, and your spouse's, annual exam. See next page for Critical Illness monthly premiums.

Worksite Benefits

Critical Illness Insurance (cont.)

Please see plan summaries for full details. Rates listed below reflect monthly premiums respective to the available benefit amounts: Employee $10,000 | Spouse $5,000 | Child $2,500

Critical Illness Monthly Premium *(Premium are based on employee age and tobacco usage)*								
	Employee Only		Employee + Spouse		Employee + Child(ren)		Employee + Family	
Age Range	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**	**Non-Tobacco**	**Tobacco**
Under 25	$2.90	$3.10	$4.40	$4.70	$3.50	$3.70	$5.00	$5.30
25-29	$4.10	$4.60	$6.15	$6.90	$4.70	$5.20	$6.75	$7.50
30-34	$5.20	$6.20	$7.90	$9.30	$5.80	$6.80	$8.50	$9.90
35-39	$7.30	$9.20	$10.90	$13.80	$7.90	$9.80	$11.50	$14.40
40-44	$11.10	$15.00	$16.50	$23.05	$11.70	$15.60	$17.10	$23.65
45-49	$17.20	$28.70	$25.40	$41.05	$17.80	$29.30	$26.00	$41.65
50-54	$20.40	$31.20	$33.65	$55.90	$21.00	$31.80	$34.25	$56.50
55-59	$30.80	$55.70	$46.85	$85.15	$31.40	$56.30	$47.45	$85.75
60-64	$50.20	$98.20	$71.05	$137.50	$50.80	$98.80	$71.65	$138.10
65-69	$50.60	$95.50	$89.60	$177.90	$51.20	$96.10	$90.20	$178.50
***70-74**	$46.45	$91.35	$67.48	$132.98	$47.05	$91.95	$68.08	$133.58
***75+**	$60.60	$108.75	$88.90	$159.48	$61.20	$109.35	$89.50	$160.08

**Critical Illness plan has a 50% benefit reduction at age 70 for employee and spouse. Premiums are calculated based on the reduced respective benefit amounts: Employee $5,000 | Spouse $2,500 | Child $2,500*

Retirement 401(k) Plan

The AccuFleet 401(k) Plan is a plan designed to help eligible employees save for retirement.

Who is Eligible?

Employees must meet all three eligibility requirements;

- Be at least 21 years of age
- One-year of employment
- Worked at least 1,000 hours

Company Match	
Company Match Calculation	**Meaning, you receive**
100% of the first 3%	$1.00 for every $1.00
50% of the next 2%	$0.50 for every $1.00
To receive the full company match, it is necessary to self-contribute at 5% for a 4% company match	

Employee Contribution and Limits

Through payroll deductions, you may contribute any whole percentage of your salary up to 75 percent.

Federal law limits the amount of your pay that may be contributed to your 401(k). The projected limit for 2024 is $23,000. If you will be at least 50 years of age as of December 31, 2024, you are eligible to participate in a "catch-up" plan which allows you to contribute an additional $7,500 each year.

Company Match

When you contribute to the plan, you will receive a matching contribution based on your self-contribution. To receive the full company match, it is necessary to self-contribute at 5% for a 4% company match.

Vesting

You are always 100 percent vested in your self-contributions to the plan. You will be 100 percent vested in AccuFleet' s matching contributions after five years of service (see Vesting Schedule).

Vesting Schedule	
Years of Service	**Percentage Vested**
0 Years	0%
1 Year	33%
2 Years	66%
3 Years or More	100%

Reasons to invest in your 401(k)

1. **Preparing for retirement through a tax-deferred plan:** AccuFleet 401(k) Plan offers an array of investment options geared for the long term.

2. **Free Money:** When you contribute a percentage of your earnings into your 401(k), you also get contributions added to your account each pay period through the company match (See Vesting Schedule). That is free money!

3. **Tax Benefit:** Any contribution you make lowers your taxable income; thus, your taxes are reduced.

4. **Payroll Savings:** The 401(k) plan provides an automatic savings device allowing you to put aside money first, before you begin paying your normal living expenses and is, therefore, a good-disciplined way to save.

Withdrawals and Distributions

Withdrawals and Distribution options are available under your 401(k) account under certain circumstances. For Example:

Termination of Employment | **Hardship Withdrawals** | **Age 59 1/2** | **Loans** | **Death**

For more information, call Vanguard at 1- 866-794-2145or go to https://my.vanguardplan.com.

Important Legal Notices Affecting Your Health Plan Coverage

THE WOMEN'S HEALTH CANCER RIGHTS ACT OF 1998 (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

NEWBORNS ACT DISCLOSURE - FEDERAL

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- coverage is lost under Medicaid or a State CHIP program; or
- you or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact the person listed at the end of this summary.

STATEMENT OF ERISA RIGHTS

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 per day, until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

CONTACT INFORMATION

CONTACT INFORMATION

Questions regarding any of this information can be directed to:

Toni Logsdon
1404 N. Sam Houston Pkwy E, Suite 100
Houston, Texas United States 77032
281-999-8800 x 1142
toni.earle@accufleet.com

If you are receiving this electronically, you are responsible for providing a copy of this notice to any Medicare Part D-eligible dependents who are covered under the group health plan.

Important Notice from Accufleet 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 Accufleet 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. **Accufleet International, Inc. has determined that the prescription drug coverage offered by United Healthcare 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 Accufleet International, Inc. coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current Accufleet 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 Accufleet 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. **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 Accufleet 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:	02/01/2024
Name of Entity/Sender:	Accufleet International, Inc.
Contact--Position/Office:	Human Resources Department
Address:	1404 N. Sam Houston Pkwy. E., Ste. 100, Houston, TX 77032
Phone Number:	281.999.8800 ext. 1142

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

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

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

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

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

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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**KANSAS – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/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, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMBNo.1210-0149
(expires 6-30-2024)

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 Employee Call Center at 877.503.4372, visit www.IES–co.com/employeeinfo.. Or contact the employer listed in Part B.

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 percent 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		4. Employer Identification Number (EIN)
Accufleet International, Inc.		76-0368466
5. Employer address		6. Employer phone number
1404 N. Sam Houston Pkwy. E., Ste. 100		281.999.8800 ext. 1142
7. City	8. State	9. ZIP code
Houston	TX	77032
10. Who can we contact about employee health coverage at this job?		
Human Resources		
11. Phone number (if different from above)	12. Email address	
	toni.earle@accufleet.com	

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

- As your employer, we offer a health plan to:
  - [x] All employees. Eligible employees are:

    As defined in the contract

  - [ ] Some employees. Eligible employees are:
- With respect to dependents:
  - [x] We do offer coverage. Eligible dependents are:

    As defined in the contract

  - [ ] 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. Here's the employer information you'll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

2024 BENEFITS GUIDE