Hi-Speed Industrial Service

Important Information Regarding your 2022/2023 Employee Benefits

Attached to this cover letter is the 2022/2023 Program Highlights Booklet for your reference. Please keep this booklet and refer to if you have questions regarding:

- **The payroll deductions for each benefit plan**
- **The benefit summaries that explain how the plans work**
- **The benefit Carrier's contact information**

OPEN ENROLLMENT PROCESS FOR 2022/2023

Open enrollment is February 7th through February 11th for any CHANGES you would like to make to your insurance benefits. Those changes, as well as any current enrollment, will be effective beginning March 1st, 2022.

If you are not making "any" changes to your enrollment, no action is required by you.

***If you are making changes or if you are a new employee, that is newly eligible for benefits*, you will need the social security number, date of birth and home zip code for you and your dependents. Please complete the enrollment form in its entirety and print clearly.**

DEADLINE FOR ENROLLING is the end of business day on February 11th.

ALL EMPLOYEES will receive NEW identification cards from HPI (Health Plans Inc.) regardless of whether you are making changes.

Important: You cannot make any enrollment changes after the open-enrollment ends on February 11th unless you have a qualifying life event as defined by the IRS, such as marriage, divorce, birth of a baby, etc. Please visit https://www.healthcare.gov/glossary/qualifying-life-event for the entire list of changes that are allowed by the IRS.

HRA (Health Reimbursement Arrangement) Information: Active employees have 90 days after the end of the plan year (12/31/22) to submit expenses against their prior plan year for dates of service that were incurred during that eligibility period.

Open enrollment is a good time to review your life insurance benefits and beneficiaries if applicable!

DO YOU HAVE ANY QUESTIONS about enrollment, eligibility or claims?

Please call Karen Blount at Collier Insurance at (901) 529-2900.

HI-SPEED
INDUSTRIAL SERVICE

Plan Year 2022/2023

Employee Benefit Program Highlights

March 1, 2022 through February 28, 2023

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HI-Speed Industrial Service

Employee Benefit Guide 2022-2023

This Program is designed exclusively for you and your family members and has been built to provide comprehensive benefits. By participating in this program, you will receive:

Peace of Mind – Know that you are covered in case you need it.
Control – You decide what options to choose.
Information – Statements showing the cost of your elections.
Technology – State of the art tools designed for you to manage your benefits.
Education – Access information about health or financial questions any time.

Major Benefits Areas Offered

The HI-Speed Industrial Service Benefit Guide offers the following benefits to you and your family members:

Major Medical & Rx Drug Plans
Health Reimbursement Arrangement – "HRA"
Basic Life Insurance with AD&D
Voluntary Life Insurance with AD&D
Dental Insurance
Vision Insurance
Long Term Disability Insurance
Accident, Critical Illness and Cancer

Eligibility

*Employee : All full-time employees actively working **30** or more hours weekly
*Dependent: Legal Spouse and dependent children up to age **26**
*New Hires are eligible: **First of the month following 30 days**

**If your spouse has Medical Insurance coverage available through his or her employer, you will not be allowed to cover them on the HI-Speed Medical plan. In those cases, coverage options would be limited to Employee Only or Employee + Child(ren) coverage.

Election changes made throughout the year require a qualifying event.
If you have questions regarding your coverage election, please contact Collier.

Karen Blount
901-529-2900
kblount@collier.com

Carrier Contact Sheet

Benefit	Carrier	Phone/Email
Concierge Service	Pathways	**PLEASE CALL FIRST IF YOU HAVE A MEDICAL QUESTION: 1-(888)-711-6766. They will best assist you on all things medical.**
Major Medical Carrier and Medical Claims Processor	hpi Health Plans Inc	**1-800-532-7575** https://www.hpitpa.com/ They process medical claims for Providers such as hospitals and Doctors offices.
PPO Network**: FIND A DOCTOR**	Cigna	https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001 They are the PPO for "In-Network" benefits. (They do not pay claims)
NO COST Surgery Benefit	KISCard Keep It Simple Surgery	**1-877-438-5479** https://getkisx.com/
Prescription Drug	PROACT	**1-877-635-9545** https://secure.proactrx.com/
Prescription **Specialty** Drugs	PROACT PLUS PROACT	**1-888–242–9798,** Monday thru Friday, 8:00am–6:00pm ET
Cancer Benefit	CancerCARE	**1-877-640-9610** https://cancercareprogram.net/
Telemedicine	dr. on demand	**1-800-997-6196** support@doctorondemand.com
Dental	Sun Life Financial	**1-800-786-5433** https://www.sunlife.com/en/
Vision (VSP Network)	Sun Life Financial	**1-800-786-5433** https://www.vsp.com/eye-doctor
Short and Long Term Disability	Sun Life Financial	**1-800-786-5433** https://www.sunlife.com/en/
Basic Life/AD&D, Voluntary Life/AD&D, Accident, Critical Illness and Cancer	Sun Life Financial	**1-800-786-5433** https://www.sunlife.com/en/

No Changes in Rates or Benefits for 2022!

Medical & Rx Benefits

HRA Plan

hpi Cigna

Medical Benefits	In-Network		
Annual Deductible	$5,000 Individual $10,000 Family		
Annual Out of Pocket Max	$7,150 Individual $14,300 Family		
Coinsurance	70%		
Preventive Exams	Covered at 100%		
Primary Care / Specialist	$30 copay / $50 copay		
Urgent Care	$50 copay		
Emergency Room	Deductible then 30%		
Inpatient / Outpatient Services	Deductible then 30%		
Rx Benefits	**In-Network**		
	Retail/Mail Order Up to 30 day supply	Mail Order 31-60 day supply	Mail Order 61-90 day supply
Generic	$10 copay	$20 copay	$30 copay
Preferred Brand	$35 copay	$70 copay	$105 copay
Non-Preferred Brand	$50 copay	$100 copay	$150 copay
Specialty Drugs	$100 copay	-	-
"Net" Benefits When Coordinated with the HRA			
Annual Net Deductible (per calendar yr)	$1,500 / $3,000		
Annual Net Out of Pocket Maximum (per calendar yr)	$3,500 / $7,500		
The HRA reimburses 100% of eligible medical expenses per claim from the first dollar up to when the HRA allocation is depleted. You are responsible for paying the remaining expenses up to the Out-of-Pocket Max.			

To search for a provider, go to:
https://hcpdirectory.cigna.com
CIGNA is the network and HPI is the Claims Payor

Election	Per Paycheck
Employee Only	$107.26
**Employee + SP	$235.97
Employee + CH	$203.81
Family	$321.77

****If your spouse has Medical Insurance coverage available through his or her employer, you will not be allowed to cover them on the HI-Speed Medical plan. In those cases, coverage options would be limited to Employee Only or Employee + Child(ren) coverage.**

This table is a brief summary of benefits. Consult your Policy and/or the Plan Document for a full description of benefits.

HRA Benefit

Health Reimbursement Arrangement

Single Coverage
After the participant incurs the 1st $1,500 of In-Network Medical Deductible expenses, they may be reimbursed the next $3,650 of In-Network Medical Deductible, Co-Pays & Co-Insurance expenses.

Family Coverage
After the participant incurs the 1st $3,000 of In-Network Medical Deductible expenses, they may be reimbursed the next $7,300 of In-Network Medical Deductible, Co-Pays & Co-Insurance expenses processed as Embedded.

Coverage Election	Plan Year Annual Limit
Employee Only	$3,000.00
Family	$6,000.00

Active employees have 90 days after the end of the plan year (12/31/22) to submit expenses against their prior plan year for dates of service that were incurred during that eligibility period.

Terminated employees have 90 days after their termination date to submit expenses for dates of service that were incurred during their eligibility period.

When a participant terminates, he/she should be offered COBRA to continue their coverage in the Health Reimbursement Arrangement accounts. Expenses will continue to be eligible if incurred during the “period he or she is covered”.

When submitting HRA claims for reimbursements, EOB’s (Explanation of Benefits) from the Health Insurance Provider are required for documentation.

Only those expenses incurred, not merely paid, during the plan year are eligible. Paying off a "balance due" that was not incurred during your plan year will not be reimbursed.

Hi-Speed Industrial Service, Inc.
HRA Non-Debit Card - FACT SHEET

Plan Year: January through December

HRA funds are for services incurred during the "current – active" plan year only.
(For example: An HRA plan year 1/1/2022 – 12/31/2022 can only be used for services incurred from 1/1/2022 – 12/31/2022; meaning you CANNOT claim a service rendered in May of 2021. This would result in the claim being rejected because the service was not rendered between 1/1/2022 – 12/31/2022.)

HRA claims are processed as below:

- **Single Coverage HRA plan**
  - The Employee incurs the 1st $1,500.00 of In-Network Medical Deductible expenses
  - **Then the Employer will reimburse the next $3,650.00 of In-Network Medical Deductible, Medical Co-Pays & Medical Co-Insurance expenses**

- **Family Coverage HRA plan processed as Embedded**
  - The Employee incurs the 1st $3,000.00 of In-Network Medical Deductible expenses
  - **Then the Employer will reimburse the next $7,300.00 of In-Network Medical Deductible, Medical Co-Pays & Medical Co-Insurance expenses**

An EOB (Explanation of Benefit) and/or YTD (Year-to-Date) from the company sponsored health insurance provider must be submitted for documentation along with the applicable claim form.

HRA EMPLOYER RUN-OFF PERIODS:

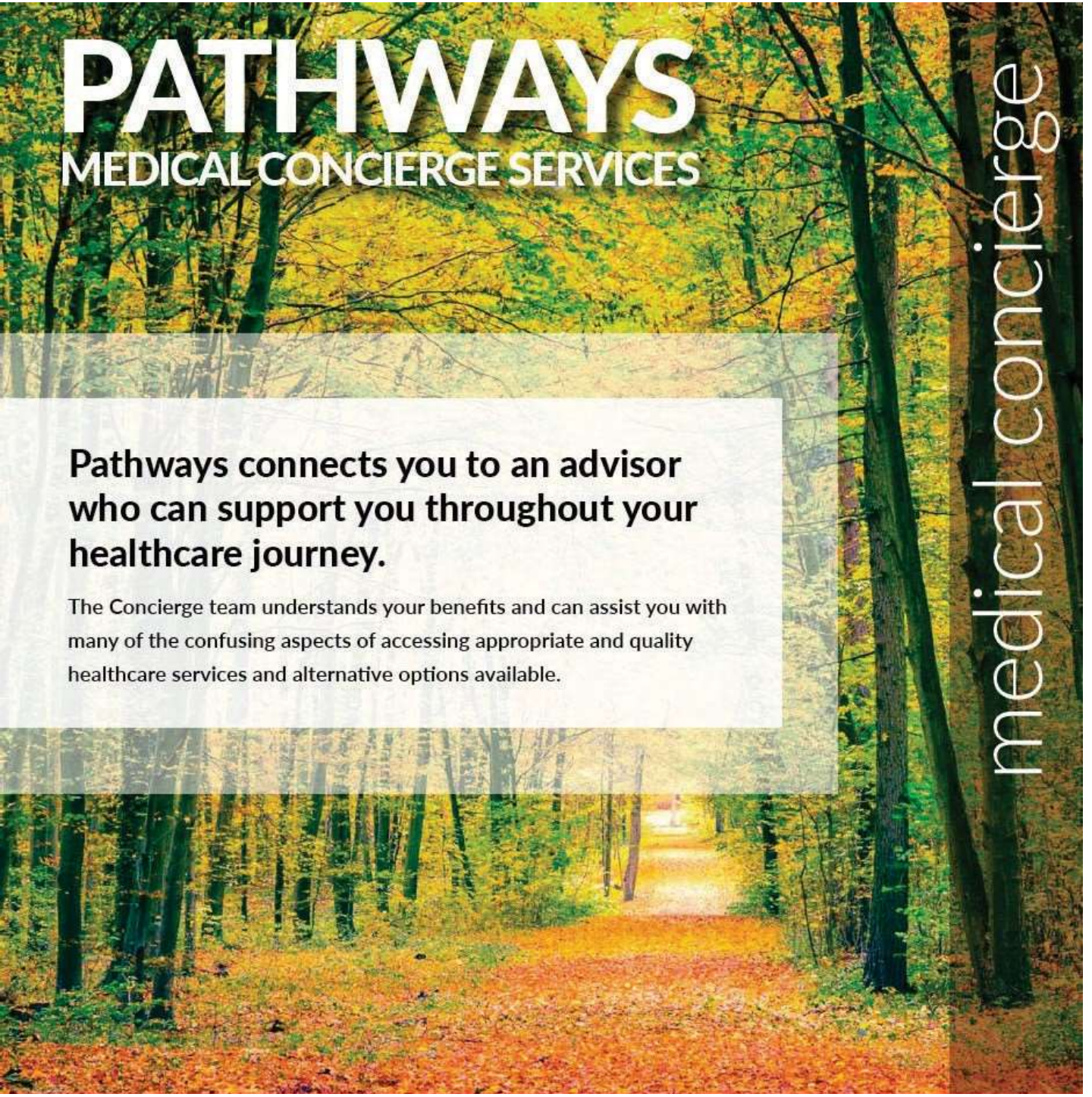
- **Run-off period to file claims** after plan year ends: **105 days**
  (Services must be filed using the manual reimbursement submittal process)
- **Run-off period to file claims after termination date: 105 days**
  (Services must be incurred during dates of eligibility or the claim will be denied)

  - **The HRA Plan year run on a calendar year basis, January through December**
  - **The Medical deductibles, Out-of-Pocket accruals and claims run on a calendar year basis, January through December**

OTHER HELPFUL FACTS:

- **CPN's Customer Service Center Contact Information**
  - Phone: (901) 756-8244 / Toll Free: (800) 737-0125 - Press 1
  - Email: claims@cpnflex.com
  - Monday through Friday, 8:00 am to 4:00 pm, CDT

- **Consumer Portal Information**: Handout materials for setting up the employee's Consumer Portal and adding a dependent can be found on CPN's website, www.cpnflex.com, located under the **Consumer Info** page.



Pathways connects you to an advisor who can support you throughout your healthcare journey.

The Concierge team understands your benefits and can assist you with many of the confusing aspects of accessing appropriate and quality healthcare services and alternative options available.

HOW DO I GET STARTED?

Call Monday-Friday 8am-8pm EST toll free: **(888) 711-6766**

ProAct Member Guide

YOUR PHARMACY BENEFITS MADE EASY

Helping you get and remain healthy.

We're here to ensure that your pharmacy benefits are accessible, with ease, if and when you need them most.

Customer Service

The ProAct Help Desk is available to serve you 24 hours a day, 7 days a week. Our knowledgeable customer service representatives can assist you with: Benefit Overview, Eligibility, Prior Authorization, and *much more*.

Tel: 877-635-9545
Fax: 315-287-7864
Web: www.ProActRx.com

Email: Support@ProActRx.com
Mail: 1230 US Highway 11
Gouverneur, New York 13642

Mail Order Pharmacy

ProAct Pharmacy Services will deliver maintenance prescriptions, in a 90 -day supply, directly to your door for the cost of your mail order pharmacy copay. You will need a new prescription from your doctor to begin using the mail service. Your doctor can e-scribe, call in, or fax your prescription to "ProAct Pharmacy Services" (NCPDP #3335468). You may also mail a prescription along with a completed profile form. To get started, call a Help Desk representative to set up your home delivery profile and method of payment.

Tel: 877-635-9545
Fax: 315-287-3330
Web: www.ProActPharmacyServices.com

Email: Support@ProActRx.com
Mail: 1226 US Highway 11
Gouverneur, New York 13642

Specialty Pharmacy

Noble Health Services is ProAct's specialty pharmacy and is available to dispense medications used to treat complex and chronic conditions. Our experts at Noble strive to support patients in all aspects of therapy and always provide the utmost care, from prescription needs and medication therapy management to financial guidance. Emergency on-call support is available at all times via our toll-free number. Your doctor may mail, fax, call, or e-scribe to "Noble Health Services" (NCPDP #5806457). Packages will ship next day delivery to your home, physician's office, or place of business. Same day delivery is available in some areas of Upstate New York. Local members may pick up specialty medications at our facility in Syracuse, New York.

Tel 888-843-2040
Fax: 888-842-3977
Web: www.NobleHealthServices.com

Email: ContactUs@NobleHealthServices.com
Mail: 6040 Tarbell Road
Syracuse, New York 13206

International Mail Order Pharmacy

Approximately 350 brand name maintenance medications are available through ProAct's international mail order partner, CanaRx. If your drug is available internationally, you are eligible to receive up to a 90 day supply at a $0 copay.

CanaRx
Simple. Safe.

Tel 866-893-6337
Fax: 866-715-6337
Web: www.CanaRxSavingsProgram.com

Email: info@canarx.com
Mail: CanaRx Savings Program,
P.O. Box 44650,
Detroit, Michigan 48244-0650

PROACT PLUS

A new approach to reducing your prescription costs!

ProActPLUS is an additional program, added to your standard pharmacy benefits, that is revolutionizing your prescription drug coverage. Our unique **ProActPLUS** strategy offers a suite of services to drive enhanced benefits and savings for members taking expensive, high-cost medications. Listed below are a few items ProAct wants you to know about your **ProActPLUS** benefit enhancement:

PRESCRIPTION REFILLS

To ease the transition, ProAct recommends that you obtain a refill on your prescription(s) before the plan change occurs. This will eliminate the need to obtain your prescription right after the 1st of the month and gives the pharmacy ample time to realize the change in pharmacy benefits. **If you receive a rejection** at the pharmacy for your first refill after the transition, please **DO NOT LEAVE THE PHARMACY**. Contact ProAct's 24/7/365 Help Desk at 877-635-9545.

SPECIALTY UTILIZERS

If you are prescribed a specialty medication, you will be contacted by a **ProActPLUS** Case Coordinator to assist you with lowering your specialty out-of-pocket costs. Significant savings may be available through manufacturer programs—reducing the cost of specialty drugs for members and the plan by up to 100%.

ENHANCED INTERNATIONAL MAIL ORDER

ProActPLUS offers members access to a full-service retail pharmacy in Canada. As this is a service driven program, **ProActPLUS** monitors your claims file to find opportunities to save using the international pharmacy. We then reach out to you directly. No need to check if your medication is available, we do the work for you ensuring you never miss a chance to save.

COMMUNICATION IS KEY

The most important thing to know about ProAct and **ProActPLUS** is that we are the quickest solution to any issue you may have. If you experience an issue at the pharmacy, please contact ProAct's 24/7/365 Help Desk immediately (877-635-9545). Most issues can be resolved in a matter if moments by a ProAct or **ProActPLUS** representative.

ProActPLUS is a 100% concierge, member-centric program. As a ProAct member, there is no enrollment required. ProAct recommends carefully reviewing all information received during open enrollment, or in your new member packets. The change to ProAct should be as undisruptive as possible, so we recommend always calling us before leaving the pharmacy for any questions about the way your prescription is processing. Our Help Desk is available 24 hours per day, 7 days per week.

PROACT
PHARMACY BENEFIT MANAGEMENT

PROACT PLUS

Attention:
SPECIALTY MEDICATION USERS

Welcome to your new prescription drug benefit plan through:

Your pharmacy benefit includes ProActPLUS. That means you can realize significant savings (up to a $0 co-pay) on the cost of specialty medications.

If you are currently taking a specialty medication, or plan to begin treatment with a specialty medication, ProAct needs to hear from you. This will ensure that you receive the maximum savings and avoid any potential delays in receiving your specialty medication.

Specialty medications are used to treat complex, chronic conditions like cancer, inflammatory conditions, rheumatoid arthritis, and multiple sclerosis. Specialty medications are typically higher-cost and sometimes require special handling and administration such as injection or infusion.

If you are being treated for these, or any other specialty condition, please email us with the following information.

- Name
- Date of Birth
- Phone Number
- Specialty Medication Name(s)

ProActPLUS@proactrx.com

-OR-

Text us @ 888-242-9798

Scan with your smart phone's camera to email ProAct.

For questions specific to the ProActPLUS program, please reach out via text or call to: 1-888-242-9798 Monday – Friday, 8:00am–6:00pm EST

PROACT PHARMACY BENEFIT MANAGEMENT

dr. on demand

It's fast and easy

- Connect virtually with a physician in minutes[1]
- Video visits held online or through the mobile app
- Pay only your office visit/PCP-level cost share
- Referrals are not required
- Paperless prescriptions are sent directly to your pharmacy[2]

Medical Urgent Care Visits

Doctors can diagnose, treat and write prescriptions for many conditions, including:

- Coughs/colds/flu
- Sore/strep throat
- Pediatric issues
- Sinus and allergies
- Nausea/diarrhea
- Rashes and skin issues
- Women's health
- Sports injuries

Behavioral Health Visits[3]

Psychologists support you using talk therapy, while psychiatrists will also look for biological imbalances and can prescribe medicine as part of a treatment plan.[4]

How it works

1. Download the app on your mobile device or access doctorondemand.com/health-plans-inc
2. Create your account and enter insurance (choose Health Plans, Inc.) and pre-consult information.
3. Complete a questionnaire of current symptoms and medical history.
4. Pay cost-share via app or website.
5. Consult with a Doctor On Demand board certified provider.
6. Receive email follow up after the visit to share with your PCP, or request that it be sent directly to your PCP.

The details of your consultation will not be forwarded to your PCP without your consent.

Download on the App Store | GET IT ON Google Play

or web video visits at doctorondemand.com/health-plans-inc

[1] *Availability more limited during overnight hours.*

[2] *Doctor On Demand physicians do not prescribe Schedule I-IV DEA controlled substances, and may elect not to treat or prescribe other medications based on what is clinically appropriate.*

[3] *Doctor On Demand is not meant for crisis or emergency mental health situations. If you are experiencing a crisis or emergency, call 911 or go to your nearest emergency room. Psychology visits are typically available within 48 hours to one week and psychiatry visits are typically available within 2–3 weeks.*

[4] *Doctor on Demand psychiatrists can prescribe medications when necessary for treatment; however, Doctor On Demand does not prescribe any controlled substances. In these cases, alternatives with less potential for abuse and dependence may be offered.*

Have questions about Doctor On Demand? Contact Member Support at 800-997-6196 or support@doctorondemand.com.

For questions about your plan benefits or eligibility, contact HPI Customer Service at the phone number or website on the back of your member ID card.

hpi™

Cigna is the network NOT THE CARRIER, they are the **NETWORK. HPI processes the medical claims**

ID Card Information

Call Pathways Concierge if you need assistance

Pro Act is administers all of your Rx needs.

Pathways

Your Personal ID Number

Your Group ID Number

Those covered on your plan

Your plan's copays will be listed here.

HPI is the carrier.

If your pharmacy has any questions, please have them call this number.

Please make sure your provider(s) knows when verifying medical benefits to call HPI.

Your medical provider will submit claims to Cigna via this info. listed here.

Your Pathways Concierge can:

- ✓ **ADDRESS** benefit questions and coverage (co-pays, deductibles, balance billing, etc.)
- ✓ **LOCATE** providers and facilities
- ✓ **PRE-CERTIFICATION** for facility services
- ✓ **REVIEW** of cost-effective treatment options and available alternatives
- ✓ **PREPARE AND EDUCATE** you for your hospitalization or procedure
- ✓ **ASSIST** with claim and will review your EOB and bills on your behalf

KISxCard
Keep It Simple Surgery

Surgery. Simplified.

Call Us! (877) Get.KISx OR (877) 438-5479

CancerCARE

Right Care. Right Time. Right Place.

Your Cancer Advisor and Advocate

CancerCARE is an additional health benefit, provided by your company that specializes in dealing with cancer. We are experts on all things cancer, and we'll use our knowledge and resources to lead you, or your dependents through a potential cancer diagnosis.

Survivorship is our goal!

Day One Help

We can start helping you the day of a diagnosis. We always have a real person you can talk to. You can use any of the contact methods below.

Personalized Care

We assign a specialized nurse to every patient. We verify that the best treatment is being followed at all steps to promote the best quality of life.

National Resources

We have access to resources beyond your local community. We use top hospitals for second opinions, treatment plans, and treatment.

Expert Medical Team

We have an **expert medical staff with decades of experience** dealing with cancer. They are accessible and involved throughout the care process and afterwards.

+1 877 640 9610

Dental Insurance

Sun Life

COMMONLY COVERED

- Exams and cleanings
- X-rays
- Fillings
- Tooth extractions
- Child braces

PROTECTS YOUR SMILE.
You can feel more confident with dental insurance that encourages routine cleanings and checkups. Dental insurance helps protect your teeth for a lifetime.

PREVENTS OTHER HEALTH ISSUES.
Just annual preventive care alone can help prevent other health issues such as heart disease and diabetes. Many plans cover preventive services at or near 100% to make it easy for you to use your dental benefits.

LOWERS OUT-OF-POCKET EXPENSES.
Seeing an in-network dentist can reduce your fees approximately 30% from their standard fees. Add the benefits of your coinsurance to that and things are looking good for your wallet.

DENTAL FAST FACTS

Periodontal disease can lead to receding gums, bone damage, loss of teeth, and can increase the risk of other health problems such as heart disease and diabetes.[1]

Treatment of gum disease in people with type 2 diabetes can lower blood sugar over time.[2]

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY # 945344

Sun Life Assurance Company of Canada

1831180 DENTA CLT 01/01/2022 14:50:18

800-247-6875 • sunlife.com/us

Dental Insurance

What's covered

Good news! *Your plan covers routine services like cleanings and exams at* ***100%.***

CALENDAR YEAR MAXIMUM	IN-NETWORK	OUT-OF-NETWORK
Type I, II, III (Preventive, Basic and Major Services)	$1,500 per person	$1,500 per person
Type IV Ortho Service	$1,000 lifetime per child	$1,000 lifetime per child

CALENDAR YEAR DEDUCTIBLE

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	N/A	N/A
Type II, III (Basic and Major Services)	$50 individual/$150 family	$50 individual/$150 family
Type IV Ortho Services	N/A	N/A

THE PLAN PAYS THE FOLLOWING PERCENTAGE FOR PROCEDURES

PROCEDURE	IN-NETWORK	OUT-OF-NETWORK
Type I Preventive Services	100%	100%
Type II Basic Services	80%	80%
Type III Major Services	50%	50%
Type IV Ortho Services	50%	50%

SERVICES

Type I Preventive Dental Services, including:

- Oral evaluations – 2 in any calendar year
- Routine dental cleanings – 2 in any calendar year
- Fluoride treatment – 1 in any 6 month period. *Only for children under age 14*
- Sealants – no more than 1 per tooth in any 36 month period, only for permanent molar teeth. *Only for children under age* 14
- Bitewing x-rays – 1 in any 12 month period
- Intraoral complete series x-rays – 1 in any 60 month period
- Genetic test for susceptibility to oral diseases

Type II Basic Dental Services, including:

- New fillings, including posterior composites
- Space maintainers – *only for children under age 19*
- Simple extractions, incision and drainage
- Surgical extractions of erupted teeth, impacted teeth, or exposed root
- Biopsy (including brush biopsy)
- Endodontics (includes root canal therapy) – 1 per tooth in any 24 month period
- General anesthesia/IV sedation – medically required
- Minor gum disease (non-surgical periodontics)
- Scaling and root planing – 1 in any 24 month period per area
- Periodontal maintenance – 2 in any calendar year
- Localized delivery of antimicrobial agents
- Major gum disease (surgical periodontics)

Type III Major Dental Services, including:

- Dentures and bridges – subject to 10 year replacement limit
- Stainless steel crowns– *only for children under age 19*
- Inlay, onlay, and crown restorations – 1 per tooth in any 10 year period

Type IV Ortho Services, including:

- Orthodontic treatment is limited to the dependent children or student age listed above

Waiting Periods

For a complete description of services and waiting periods, please review your certificate of insurance. If you were covered under your employer's prior plan the wait will be waived for any type of service covered under the prior plan and this plan.

- No waiting period for preventive, basic or major services
- No waiting period for orthodontic services

Frequently asked questions

How does a PPO work?
PPO stands for Participating Provider Organization. With a dental PPO plan, dental providers agree to participate in a dental network by offering discounted fees on most dental procedures. When you visit a provider in the network, you could see lower out-of-pocket costs because providers in the network agree to these pre-negotiated discounted fees on eligible claims.

How do I find a dentist?
Simply visit www.sunlife.com/findadentist. Follow the prompts to find a dentist in your area who participates in the PPO network. You do not need to select a dentist in advance. The PPO network for your plan is the Sun Life Dental Network® with 130,000+ unique dentists.

Do I have to choose a dentist in the PPO network?
No. You can visit any licensed dentist for services. However, you could see lower out-of-pockets costs when you visit a dentist in the network.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[3] and dependent children. An eligible child is defined as a child to age 26.[4]

What if I have already started dental work, like a root canal or braces, that requires several visits?
Your coverage with us may handle these procedures differently than your prior plan. To ensure a smooth transition for work in progress, call our dental claims experts before your next visit at 800-442-7742.

Do I have to file the claim?
Many dentists will file claims for you. If a dentist will not file your claim, simply ask your dentist to complete a standard American Dental Association (ADA) claim form and mail it to:

Sun Life
P.O. Box 2940
Clinton, IA 52733

How can I get more information about my coverage or find my dental ID card?
After the effective date of your coverage, you can view benefit information online at your convenience through your Sun Life account. To create an account go to www.sunlife.com/account and register. You can also access this information from our mobile app—*Benefit Tools*, which is available for Apple and Android devices. Or you can call Sun Life's Dental Customer Service at 800-442-7742. You can also call any time, day or night, to access our automated system and get answers to common questions when it's convenient for you.

What value added benefits does my plan include?
Your plan includes our Lifetime of Smiles® program, with benefits many people prefer, such as tooth-colored fillings for back teeth and brush biopsies for the early detection of oral cancer.

CONSIDER A PRE-DETERMINATION OF BENEFITS

They allow us to review your provider's treatment plan to let you know before treatment is started how much of the work should be covered by the plan, and how much you may need to cover. We recommend them for any dental treatment expected to exceed $300.

1. American Academy of Periodontology http://www.perio.org/consumer/love_the_gums_you%27re_with. (accessed on 06/06/19)
2. https://www.cdc.gov/diabetes/ndep/pdfs/150-Healthy-teeth-matter.pdf (accessed 06/06/19)
3. If permitted by the Employer's employee benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
4. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions

Benefit adjustments

Benefits will be coordinated with any other dental coverage. Under the Alternative Treatment provision, benefits will be payable for the most economical services or supplies meeting broadly accepted standards of dental care.

Late entrant

If you or a dependent apply for dental insurance more than 31 days after you become eligible, you or your dependent are a late entrant. The benefits for the first 12 months for late entrants will be limited as follows:

TIME INSURED CONTINUOUSLY UNDER THE POLICY	BENEFITS PROVIDED FOR ONLY THESE SERVICES
Less than 6 months	Preventive Services
At least 6 months but less than 12 months	Preventive Services and fillings under Basic Services
At least 12 months	Preventive, Basic, Major and Ortho Services

We will not pay for treatments subject to the late entrant limitation, and started or completed during the late entrant limitation period.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Dental

We will not pay a benefit for any Dental procedure, which is not listed as a covered dental expense. Any dental service incurred prior to the Effective date or after the termination date is not covered, unless specifically listed in the certificate. A member must be a covered dental member under the Plan to receive dental benefits. The Plan has frequency limitations on certain preventive and diagnostic services, restorations (fillings), periodontal services, endodontic services, and replacement of dentures, bridges and crowns. All services must be necessary and provided according to acceptable dental treatment standards. Treatment performed outside the United States is not covered, except for emergency dental treatment, subject to a maximum benefit. Dental procedures for Orthodontics; TMJ; replacing a tooth missing prior the effective date; implants and implant related services; or occlusal guards for bruxism are not covered unless coverage is elected or mandated by the state.

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This plan does not provide coverage for pediatric oral health services that satisfies the requirements for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act (PPACA).

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-DEN-C-01.

GVBH-EE-8384 SLPC 29579

Rates

Coverage and **bi-weekly** cost for Dental.

Rates are effective as of March 1, 2022.

Coverage	Cost per pay period*
Employee	$6.16
Employee + 1 dependent	$18.43
Employee + 2 or more dependents	$40.59

Vision Insurance

Sun Life

COMMONLY COVERED

- Annual exams
- Lenses
- Frames
- Contact lenses
- Laser vision correction discount

PROTECTS YOUR EYES.

You can help protect your eyesight by visiting an eye doctor regularly. Vision insurance includes an annual comprehensive eye exam with an eye care doctor. Taking care of your eyes today can lead to a better quality of life later.

PREVENTS OTHER HEALTH ISSUES.

Just annual preventive care alone can help detect signs of chronic health conditions such as high blood pressure and diabetes. Early detection can be key before costly symptoms arise.[1]

LOWERS OUT-OF-POCKET EXPENSES.

Seeing an in-network eye care provider can reduce your expenses with savings on frames, lenses, contacts, eye exams and more.

VISION INSURANCE FAST FACTS

Roughly, 90% of diabetes-related blindness can be avoided by getting an annual eye exam.[2]

59% of adults report experiencing symptoms of digital eye strain, such as blurred vision or headaches.[3]

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY # 945344

What's covered

BENEFIT	FREQUENCY	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT
Exam services			
WellVision exam*	1 per 12 months	$10 for exam	Up to $45
Routine retinal screening		No more than a $39 copay	N/A
Laser vision correction discount	Once per eye per lifetime.	Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.	N/A
Lenses			
Single lined	1 per 12 months	$25 (lenses and frame)	Up to $30
Bifocal lined			Up to $50
Trifocal			Up to $60
Lenticular			Up to $100
Necessary contacts			Up to $210
Lens enhancements			
Standard		$55 copay	N/A
Premium progressive		$95-$105 copay	N/A
Custom progressive		$150–$175 copay	N/A
Other		Average savings of 20-25%	N/A
Frames	1 per 24 months	$130 for the frame of your choice and 20% off the amount over your allowance $70 allowance at Costco* and Walmart**	Up to $70
Elective contact lenses *Contact lenses are in place of lenses and frame.*	1 per 12 months	$60 for your contact lens exam (fitting and evaluation) $130 for contact lenses	Up to $105
Additional glasses and sunglasses discount	20% off complete pairs of prescription and non-prescription glasses, including sunglasses. Discounts are unlimited for 12 months following exam.		N/A
Coverage with retail providers	*Coverage with retail providers may be different. Check with Costco for VSP member pricing. Costco and Walmart allowance is equivalent to the allowance at preferred providers and other retail providers.		

This chart outlines services for Plan 3.

Administrative services for the vision insurance plan are provided by Vision Service Plan (VSP).

Frequently asked questions

How do I use my vision benefit?
Once enrolled, simply tell your VSP doctor you're a member and they will handle the rest. If you visit an in-network doctor for services and materials, you don't need an ID card or have forms to complete.

How do I locate an in-network VSP doctor?
You will have access to the largest national network[4] of private-practice eye care doctors in the industry through Vision Service Plan (VSP). There are three ways to find an in-network doctor:
1. Visit vsp.com and select the Choice network.
2. Call VSP at 800-877-7195.
3. Download our mobile app, Benefit Tools, and search for a doctor near you.

What happens if I use an out-of-network doctor?
You will be required to pay the full amount to the doctor at time of service. You can then submit a claim for reimbursement, which is a lesser benefit when compared to visiting a VSP doctor.

When will my coverage become effective?
Your coverage starts on the effective date specified in your group policy, provided you are actively at work on that date. Otherwise, your coverage will become effective on the day you return to full-time duties.

Can I enroll as a late entrant?
If you elect coverage more than 31 days after your eligibility date, your effective date will be delayed to the next plan anniversary date.

Are my dependents eligible for coverage?
Yes. Your plan offers coverage for your spouse[5] and dependent children. An eligible child is defined as a child to age 26.[6]

How can I get more information about my coverage?
After the effective date of your coverage, you can visit www.sunlife.com/account to create a Sun Life account. Once you're logged in, you'll be able to see your plan details and more. Or you can call VSP Customer Service at 800-877-7195.

Can I use my benefits to buy glasses or contacts online?
Absolutely. Just visit www.eyeconic.com. Once you have linked your benefits you will be able to see how your coverage will be applied to different options that you are reviewing. Eyeconic features a virtual try-on tool so you can see how the glasses will look on you before you make your purchase.

1. https://vsp.com/eye-symptoms.html accessed 03/13/19.
2. https://www.vsp.com/diabetes.html accessed 03/13/19.
3. The Vision Council https://www.thevisioncouncil.org/content/digital-eye-strain accessed on 02/21/19.
4. Netminder as of December 2018.
5. If permitted by the Employer's benefit plan and not prohibited by state law, the term "spouse" in this benefit includes any individual who is either recognized as a spouse, a registered domestic partner, or a partner in a civil union, or otherwise accorded the same rights as a spouse.
6. Please see your employer for more specific information.

Read the *Important information* section for more details including limitations and exclusions.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below conditions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Vision

We will not pay a benefit for any vision materials, services or options that are not shown in the Benefit Highlights section of the certificate. Any vision service incurred prior to the Effective date or after the termination date is not covered. A member must be a covered vision member under the Plan to receive vision benefits. In no event will benefits exceed the lesser of the actual cost of the examination or materials or the limits of coverage shown in the Benefit Highlights section of the certificate. The plan is designed to cover visually necessary materials rather than cosmetic materials; the member will be responsible for any additional costs above the basic cost.

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This vision plan does not provide coverage for pediatric vision health services that satisfies the requirement for "minimum essential coverage" as defined by The Patient Protection and Affordable Care Act ("PPACA").

Sun Life companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 15-GP-01 and 16-VIS-C-01.

GVBH-EE-8384 SLPC 29579

Rates

Coverage and **bi-weekly** cost for Vision.

Rates are effective as of March 1, 2022.

Coverage	Cost per pay period*
Employee	$1.48
Employee + Spouse	$2.80
Employee + Child(ren)	$3.29
Employee + Family	$4.61

Short-Term Disability Insurance

Sun Life

PROTECTS YOUR INCOME WHEN YOU CAN'T WORK.

If you're unable to work because of a covered disability, Short-Term Disability insurance replaces a portion of your income in addition to providing other services and benefits that help you return to work.

PROVIDES YOU WITH A WEEKLY CHECK.

After your claim is approved, you will receive a check for your benefits that helps you pay everyday expenses like your mortgage or rent, childcare and groceries.

COMMON CAUSES OF DISABILITY

- Pregnancy
- Injuries
- Joint disorders
- Back disorders
- Digestive disorders

BENEFITS (You can purchase this coverage at a group rate.)	
Weekly benefit after your claim is approved	You will receive a check for your benefits on a weekly basis. It will replace **60%** of your Total Weekly Earnings, up to **$500** each week.
When benefits begin	Benefits begin on the first day of disability if you are unable to work due to an injury and as soon as **8 days** from the date you are unable to work due to an illness.
Benefits may be paid for	Up to **13 weeks**, as long as you are still unable to work due to a covered disability.
Additional plan information	This plan provides a benefit for covered disabilities resulting from illness or injury that are not work-related.

SHORT-TERM DISABILITY FAST FACTS

1 in 4 workers *will miss up to 3 months of work due to disability during their career.*[1]

More than three-quarters *of workers are living paycheck to paycheck.*[2]

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY # 945344

Sun Life Assurance Company of Canada

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800-247-6875 • sunlife.com/us

Short-Term Disability Insurance

Frequently asked questions

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability Application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

How do I file a Short-Term Disability claim?

If you become disabled after the effective date of coverage, check with your employer to make sure you are eligible for benefits. You can file a claim with us by downloading forms from our website. We'll ask you and your doctor to provide information about your medical condition and your expected recovery.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table) and meet the policy's definition of disability. Generally, disability is defined as your inability to perform some or all of your job duties due to your injury, illness or pregnancy and may require that you have also had a certain percentage of earnings loss due to your disability. Please see your Certificate for details.

What if I have a pre-existing condition?

If you become disabled within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Can I work while I'm disabled?

Your plan is designed to encourage and support your return to work. If you are able to work part-time, for example, you may receive part of your benefit while working.

Will income from other sources affect my benefit?

Your benefit may be reduced by Social Security benefits; disability benefits from retirement, government plans or state disability income such as California SDI; state paid family and medical leaves; other group disability plans; no-fault benefits, salary continuance or sick leave; and return-to-work earnings. For more information or to determine if this coverage is appropriate for you, contact your benefits administrator.

How is my benefit taxed?

If you or your employer pays for all or part of the cost of coverage on a pre-tax basis, all or part of your benefit amount will be Form W-2 taxable income. In these situations, FICA tax deductions may reduce the amount we will pay you.

The group disability insurance policies described in this advertisement provide disability income insurance only.

1. Realitycheckup.org, Council for Disability Awareness, 2018

2. "Living Paycheck to Paycheck is a Way of Life for Majority of U.S. Workers," CareerBuilder.com, Aug. 2017.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Short-Term Disability

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; operation of a motorized vehicle while intoxicated. We will not pay a benefit for any accident or sickness covered by Worker's Compensation or similar law; or for any work-related illness or injuries unless otherwise stated previously; or if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.).

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GVBH-EE-8384 SLPC 29579

Rates

Employee - **monthly** rate for Short-Term Disability.

Rates are effective as of March 1, 2022.

Short-Term Disability coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Find your age bracket (as of the effective date of coverage) to see your rate.

Follow the example below to figure out your monthly and pay period costs.

Your age	Rate*
Under 25	$0.181
25 - 29	$0.210
30 - 34	$0.261
35 - 39	$0.284
40 - 44	$0.256
45 - 49	$0.302
50 - 54	$0.341
55 - 59	$0.459
60 - 64	$0.556
65 - 69	$0.510
70+	$0.323

Example weekly benefit (60% of earnings)		Divide by 10		Multiply by rate		Example monthly cost
$350	/	10 = 35	x	0.181	=	$6.34
Your weekly benefit (60% of earnings)		**Divide by 10**		**Multiply by rate**		**Your monthly cost**
$_____	/	10 = _____	x	$_____	=	$_____
Your monthly cost		**Multiply by 12 months**		**Annual cost**		**Divide by your number of pay periods per year (ex: 12,24,26,52,etc.)**
$_____	x	12	=	$_____	/	_____

	Your estimated cost per pay period
=	$_____

*Contact your employer to confirm your part of the cost.

Long-Term Disability Insurance

Sun Life

COMMON CAUSES OF DISABILITY

- Musculoskeletal conditions
- Circulatory conditions
- Cancer
- Nervous system disorders
- Injuries

HELPS YOU KEEP YOUR LIFE ON TRACK.

If you're unable to work because of a covered disability, Long-Term Disability insurances replaces a portion of your income. After your claim is approved, you will receive a monthly check for your benefits that helps you pay everyday expenses like your mortgage or rent, childcare and groceries.

HELPS YOU RETURN TO WORK.

If you are able, Sun Life has benefits and services, including guidance from vocational rehabilitation counselors, to help you return to work.

PART OF YOUR BENEFIT PACKAGE.

This benefit is completely paid for by your employer.

BENEFITS	
Monthly benefit after your claim is approved	You will receive a check for your benefits on a monthly basis. It will replace **60%** of your Total Monthly Earnings, up to **$5,000** each month.
When benefits begin	Benefits begin as soon as **180 days** from the date of your disability.
Benefits may be paid for	Up to your Social Security Normal Retirement Age or longer, depending on your age at disability.
Additional plan information	This plan provides a benefit for covered disabilities resulting from illness or injury that occur on or off the job.

LONG-TERM DISABILITY FAST FACTS

34.6 months

The length of the average long-term disability claim.[1]

You may receive additional benefits if your covered disability begins with a hospital stay of 14 days or more.

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY # 945344

Sun Life Assurance Company of Canada

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Frequently asked questions

How do I file a Long-Term Disability claim?

If you become disabled after the effective date of coverage, check with your employer to make sure you are eligible for benefits. You can file a claim with us by downloading forms from our website. We'll ask you and your doctor to provide information about your medical condition and your expected recovery.

How do I qualify for benefits?

You'll start receiving disability payments if you satisfy the Elimination Period (see "When benefits begin" in the table) and meet the policy's definition of disability. Generally, disability is defined as your inability to perform some or all of your job duties due to your injury, illness or pregnancy and may require that you have also had a certain percentage of earnings loss due to your disability. Please see your Certificate for details.

What if I have a pre-existing condition?

If you become disabled within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 3 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Can I work while I'm disabled?

Your plan is designed to encourage and support your return to work. If you are able to work part-time, for example, you may receive part of your benefit while working.

Will income from other sources affect my benefit?

Your benefit may be reduced by Social Security benefits; disability benefits from retirement, government plans or state disability income; other group disability plans; no-fault benefits, salary continuance or sick leave; and return-to-work earnings. For more information, contact your benefits administrator.

How is my benefit taxed?

If you or your employer pays for all or part of the cost of coverage on a pre-tax basis, all or part of your benefit amount will be Form W-2 taxable income. In these situations, FICA tax deductions may reduce the amount we will pay you.

The group disability insurance policies described in this advertisement provide disability income insurance only.

1. "Chances of disability," Council for Disability Awareness, disabilitycanhappen.org, last accessed April 2019.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Refer to the Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Long-Term Disability

We will not pay a benefit that is caused by, contributed to in any way or resulting from: intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; operation of a motorized vehicle while intoxicated. We will not pay a benefit if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.); or for any Period of disability during which you are incarcerated. Disability benefits may be limited for certain conditions.

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Basic Life Insurance

Sun Life

PROTECTS YOUR LOVED ONES.
Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments and more.

HELPS PAY YOUR FINAL EXPENSES.
Your beneficiaries may use this money to pay for your burial or cremation, and pay any outstanding medical bills.

PART OF YOUR BENEFIT PACKAGE.
This benefit is completely paid for by your employer. Remember to name your beneficiaries if you haven't done so already.

Even among people who have life insurance, about ***1 in 5*** *say they don't have enough.*[1]

BENEFITS	
For you*	**$25,000**. No medical questions asked. Benefits are reduced at age 65 and may reduce again in subsequent years as noted in your Certificate.

***This coverage includes Accidental Death and Dismemberment insurance.**

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY # 945344

Frequently asked questions

What is my AD&D benefit?

We will pay your beneficiaries an Accidental Death insurance amount that matches your Basic Life insurance amount, if you die from a covered accident. Additional benefits are available for accidental injuries (i.e., dismemberment) such as loss of limbs, fingers or sight. Refer to your Certificate for a full list of covered accidental injuries.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Can I access my life insurance if I become terminally ill?

You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is called an "Accelerated Benefit" and there are some important things to know about it, including that it is not long-term-care insurance, it may be taxable and it may affect your eligibility for public assistance programs. It will also reduce the total amount of the life insurance payment we pay to your beneficiary(ies).

What happens if I become Totally Disabled?

If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.

How does my beneficiary file a death claim?

Your beneficiary(ies) and your employer will complete the appropriate claims forms and submit them to us. We will notify your beneficiaries when the decision is made and if we have any questions. If approved, beneficiaries may elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.) If your AD&D claim for an accidental injury is approved, the benefit amount will be paid directly to you.

1. LIMRA, Facts about Life 2018.

Read the *Important information* section for more details including limitations and exclusions.

Important information

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to the Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Life

In some states, your employer's group policy may exclude payment for suicide that occurs within a specific time period after the insurance or increase in insurance becomes effective. Please see your Certificate for details.

Accidental Death and Dismemberment

We will not pay a benefit that is due to or results from: suicide while sane or insane; injuring oneself intentionally; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; bodily or mental infirmity or disease or infection unless due to an accidental injury; riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.

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Voluntary Life Insurance

Sun Life

MORE PROTECTION FOR YOUR LOVED ONES.

The people you love and support could face financial challenges without you. Life insurance provides your loved ones with money they can use for household expenses, tuition, mortgage payments and more.

HELPS YOU CLOSE ANY COVERAGE GAPS.

You may have life insurance today, either on your own or through your employer. Now is a good time to ask yourself if you need more coverage.

BENEFITS (You can purchase this coverage at a group rate.)	
For you*	You can choose from **$10,000 to $500,000**—in increments of $10,000 **not to exceed 5 times** your Basic Annual Earnings. No medical questions asked **up to the Guaranteed Issue amount of $100,000**. Benefits are reduced at age 70 and may reduce again in subsequent years as noted in your Certificate.
For your spouse*	If you elect coverage for yourself, you can choose from **$5,000 to $250,000**—in increments of $5,000. No medical questions asked **up to the Guaranteed Issue amount of $25,000**. The amount you select for your spouse cannot exceed 50% of your coverage amount. Coverage ends when you turn age 70.
For your child(ren)*	If you elect coverage for yourself, you can choose **$1,000 to $10,000**—in $1,000 increments. No medical questions asked. The amount you select for your child(ren) cannot exceed 50% of your coverage amount. Benefits may reduce as noted in your Certificate. Child(ren) must primarily depend on the employee for 50% or more of their support. A full benefit is payable for a dependent child who is 6 months to 26. A reduced benefit of $500 is payable for a child from 14 days to 6 months. (No benefit is payable for a child from birth to 14 days).

This coverage includes Accidental Death and Dismemberment insurance.

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY #: 945344

What is my AD&D benefit?

We will pay your beneficiaries an Accidental Death insurance amount that matches your Voluntary Life, if you die from a covered accident. Additional benefits are available for accidental injuries (i.e., dismemberment) such as loss of limbs, fingers or sight. Refer to your Certificate for a full list of covered accidental injuries. This plan includes AD&D coverage for your dependents.

Do I need to answer any health questions to enroll?

Yes, if you request an amount higher than the Guaranteed Issue amount. You may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Can I access my life insurance if I become terminally ill?

You may apply to receive a portion of your life insurance to help cover medical and living expenses. This is called an "Accelerated Benefit" and there are some important things to know about it, including that it is not long-term-care insurance, it may be taxable and it may affect your eligibility for public assistance programs. It will also reduce the total amount of the life insurance payment we pay to your beneficiary(ies).

What happens if I become Totally Disabled?

If we determine that you are Totally Disabled and cannot work, your life insurance coverage may continue at no cost. You must meet certain requirements, as detailed in the Certificate.

How does my beneficiary file a death claim?

Your beneficiary(ies) and your employer will complete the appropriate claims forms and submit them to us. We will notify your beneficiaries when the decision is made and if we have any questions. If approved, beneficiaries may elect to receive a lump sum payment or to have the benefit paid into an account where the funds accumulate interest and can be withdrawn at any time. (State restrictions apply and options may vary by state.) If your AD&D claim for an accidental injury is approved, the benefit amount will be paid directly to you.

1. LIMRA, Facts about Life 2018.

Read the *Important information* section for more details including limitations and exclusions.

Important information

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to the Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Life

In some states, your employer's group policy may exclude payment for suicide that occurs within a specific time period after the insurance or increase in insurance becomes effective. Please see your Certificate for details.

Accidental Death and Dismemberment

We will not pay a benefit that is due to or results from: suicide while sane or insane; injuring oneself intentionally; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; bodily or mental infirmity or disease or infection unless due to an accidental injury; riding in or driving any motor-driven vehicle in a race, stunt show, or speed test.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GVBH-EE-8384 SLPC 29579

Rates

Employee - Coverage and **monthly** cost for Employee Voluntary Life and AD&D.

Rates are effective as of March 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Coverage amounts	Age and cost													
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85+
$10,000	1.42	1.42	1.42	1.67	2.37	3.37	5.17	8.07	12.17	19.87	40.27	72.37	143.57	264.37
$20,000	2.84	2.84	2.84	3.34	4.74	6.74	10.34	16.14	24.34	39.74	80.54	144.74	287.14	528.74
$30,000	4.26	4.26	4.26	5.01	7.11	10.11	15.51	24.21	36.51	59.61	120.81	217.11	430.71	793.11
$40,000	5.68	5.68	5.68	6.68	9.48	13.48	20.68	32.28	48.68	79.48	161.08	289.48	574.28	1057.48
$50,000	7.10	7.10	7.10	8.35	11.85	16.85	25.85	40.35	60.85	99.35	201.35	361.85	717.85	1321.85
$60,000	8.52	8.52	8.52	10.02	14.22	20.22	31.02	48.42	73.02	119.22	241.62	434.22	861.42	1586.22
$70,000	9.94	9.94	9.94	11.69	16.59	23.59	36.19	56.49	85.19	139.09	281.89	506.59	1004.99	1850.59
$80,000	11.36	11.36	11.36	13.36	18.96	26.96	41.36	64.56	97.36	158.96	322.16	578.96	1148.56	2114.96
$90,000	12.78	12.78	12.78	15.03	21.33	30.33	46.53	72.63	109.53	178.83	362.43	651.33	1292.13	2379.33
$100,000	14.20	14.20	14.20	16.70	23.70	33.70	51.70	80.70	121.70	198.70	402.70	723.70	1435.70	2643.70
$110,000	15.62	15.62	15.62	18.37	26.07	37.07	56.87	88.77	133.87	218.57	442.97	796.07	1579.27	2908.07
$120,000	17.04	17.04	17.04	20.04	28.44	40.44	62.04	96.84	146.04	238.44	483.24	868.44	1722.84	3172.44
$130,000	18.46	18.46	18.46	21.71	30.81	43.81	67.21	104.91	158.21	258.31	523.51	940.81	1866.41	3436.81
$140,000	19.88	19.88	19.88	23.38	33.18	47.18	72.38	112.98	170.38	278.18	563.78	1013.18	2009.98	3701.18
$150,000	21.30	21.30	21.30	25.05	35.55	50.55	77.55	121.05	182.55	298.05	604.05	1085.55	2153.55	3965.55
$160,000	22.72	22.72	22.72	26.72	37.92	53.92	82.72	129.12	194.72	317.92	644.32	1157.92	2297.12	4229.92
$170,000	24.14	24.14	24.14	28.39	40.29	57.29	87.89	137.19	206.89	337.79	684.59	1230.29	2440.69	4494.29
$180,000	25.56	25.56	25.56	30.06	42.66	60.66	93.06	145.26	219.06	357.66	724.86	1302.66	2584.26	4758.66
$190,000	26.98	26.98	26.98	31.73	45.03	64.03	98.23	153.33	231.23	377.53	765.13	1375.03	2727.83	5023.03
$200,000	28.40	28.40	28.40	33.40	47.40	67.40	103.40	161.40	243.40	397.40	805.40	1447.40	2871.40	5287.40
$210,000	29.82	29.82	29.82	35.07	49.77	70.77	108.57	169.47	255.57	417.27	845.67	1519.77	3014.97	5551.77
$220,000	31.24	31.24	31.24	36.74	52.14	74.14	113.74	177.54	267.74	437.14	885.94	1592.14	3158.54	5816.14
$230,000	32.66	32.66	32.66	38.41	54.51	77.51	118.91	185.61	279.91	457.01	926.21	1664.51	3302.11	6080.51
$240,000	34.08	34.08	34.08	40.08	56.88	80.88	124.08	193.68	292.08	476.88	966.48	1736.88	3445.68	6344.88
$250,000	35.50	35.50	35.50	41.75	59.25	84.25	129.25	201.75	304.25	496.75	1006.75	1809.25	3589.25	6609.25
$260,000	36.92	36.92	36.92	43.42	61.62	87.62	134.42	209.82	316.42	516.62	1047.02	1881.62	3732.82	6873.62
$270,000	38.34	38.34	38.34	45.09	63.99	90.99	139.59	217.89	328.59	536.49	1087.29	1953.99	3876.39	7137.99
$280,000	39.76	39.76	39.76	46.76	66.36	94.36	144.76	225.96	340.76	556.36	1127.56	2026.36	4019.96	7402.36
$290,000	41.18	41.18	41.18	48.43	68.73	97.73	149.93	234.03	352.93	576.23	1167.83	2098.73	4163.53	7666.73
$300,000	42.60	42.60	42.60	50.10	71.10	101.10	155.10	242.10	365.10	596.10	1208.10	2171.10	4307.10	7931.10
$310,000	44.02	44.02	44.02	51.77	73.47	104.47	160.27	250.17	377.27	615.97	1248.37	2243.47	4450.67	8195.47
$320,000	45.44	45.44	45.44	53.44	75.84	107.84	165.44	258.24	389.44	635.84	1288.64	2315.84	4594.24	8459.84
$330,000	46.86	46.86	46.86	55.11	78.21	111.21	170.61	266.31	401.61	655.71	1328.91	2388.21	4737.81	8724.21
$340,000	48.28	48.28	48.28	56.78	80.58	114.58	175.78	274.38	413.78	675.58	1369.18	2460.58	4881.38	8988.58
$350,000	49.70	49.70	49.70	58.45	82.95	117.95	180.95	282.45	425.95	695.45	1409.45	2532.95	5024.95	9252.95
$360,000	51.12	51.12	51.12	60.12	85.32	121.32	186.12	290.52	438.12	715.32	1449.72	2605.32	5168.52	9517.32
$370,000	52.54	52.54	52.54	61.79	87.69	124.69	191.29	298.59	450.29	735.19	1489.99	2677.69	5312.09	9781.69
$380,000	53.96	53.96	53.96	63.46	90.06	128.06	196.46	306.66	462.46	755.06	1530.26	2750.06	5455.66	10046.06
$390,000	55.38	55.38	55.38	65.13	92.43	131.43	201.63	314.73	474.63	774.93	1570.53	2822.43	5599.23	10310.43
$400,000	56.80	56.80	56.80	66.80	94.80	134.80	206.80	322.80	486.80	794.80	1610.80	2894.80	5742.80	10574.80
$410,000	58.22	58.22	58.22	68.47	97.17	138.17	211.97	330.87	498.97	814.67	1651.07	2967.17	5886.37	10839.17
$420,000	59.64	59.64	59.64	70.14	99.54	141.54	217.14	338.94	511.14	834.54	1691.34	3039.54	6029.94	11103.54
$430,000	61.06	61.06	61.06	71.81	101.91	144.91	222.31	347.01	523.31	854.41	1731.61	3111.91	6173.51	11367.91
$440,000	62.48	62.48	62.48	73.48	104.28	148.28	227.48	355.08	535.48	874.28	1771.88	3184.28	6317.08	11632.28
$450,000	63.90	63.90	63.90	75.15	106.65	151.65	232.65	363.15	547.65	894.15	1812.15	3256.65	6460.65	11896.65
$460,000	65.32	65.32	65.32	76.82	109.02	155.02	237.82	371.22	559.82	914.02	1852.42	3329.02	6604.22	12161.02
$470,000	66.74	66.74	66.74	78.49	111.39	158.39	242.99	379.29	571.99	933.89	1892.69	3401.39	6747.79	12425.39
$480,000	68.16	68.16	68.16	80.16	113.76	161.76	248.16	387.36	584.16	953.76	1932.96	3473.76	6891.36	12689.76
$490,000	69.58	69.58	69.58	81.83	116.13	165.13	253.33	395.43	596.33	973.63	1973.23	3546.13	7034.93	12954.13
$500,000	71.00	71.00	71.00	83.50	118.50	168.50	258.50	403.50	608.50	993.50	2013.50	3618.50	7178.50	13218.50

Rates

Spouse - Coverage and **monthly** cost for Spouse Voluntary Life and AD&D.

Rates are effective as of March 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Spouse rates are based on the employee's age.

Coverage amounts	Age and cost									
	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$5,000	0.74	0.74	0.74	0.86	1.21	1.71	2.61	4.06	6.11	9.96
$10,000	1.47	1.47	1.47	1.72	2.42	3.42	5.22	8.12	12.22	19.92
$15,000	2.21	2.21	2.21	2.58	3.63	5.13	7.83	12.18	18.33	29.88
$20,000	2.94	2.94	2.94	3.44	4.84	6.84	10.44	16.24	24.44	39.84
$25,000	3.68	3.68	3.68	4.30	6.05	8.55	13.05	20.30	30.55	49.80
$30,000	4.41	4.41	4.41	5.16	7.26	10.26	15.66	24.36	36.66	59.76
$35,000	5.15	5.15	5.15	6.02	8.47	11.97	18.27	28.42	42.77	69.72
$40,000	5.88	5.88	5.88	6.88	9.68	13.68	20.88	32.48	48.88	79.68
$45,000	6.62	6.62	6.62	7.74	10.89	15.39	23.49	36.54	54.99	89.64
$50,000	7.35	7.35	7.35	8.60	12.10	17.10	26.10	40.60	61.10	99.60
$55,000	8.09	8.09	8.09	9.46	13.31	18.81	28.71	44.66	67.21	109.56
$60,000	8.82	8.82	8.82	10.32	14.52	20.52	31.32	48.72	73.32	119.52
$65,000	9.56	9.56	9.56	11.18	15.73	22.23	33.93	52.78	79.43	129.48
$70,000	10.29	10.29	10.29	12.04	16.94	23.94	36.54	56.84	85.54	139.44
$75,000	11.03	11.03	11.03	12.90	18.15	25.65	39.15	60.90	91.65	149.40
$80,000	11.76	11.76	11.76	13.76	19.36	27.36	41.76	64.96	97.76	159.36
$85,000	12.50	12.50	12.50	14.62	20.57	29.07	44.37	69.02	103.87	169.32
$90,000	13.23	13.23	13.23	15.48	21.78	30.78	46.98	73.08	109.98	179.28
$95,000	13.97	13.97	13.97	16.34	22.99	32.49	49.59	77.14	116.09	189.24
$100,000	14.70	14.70	14.70	17.20	24.20	34.20	52.20	81.20	122.20	199.20
$105,000	15.44	15.44	15.44	18.06	25.41	35.91	54.81	85.26	128.31	209.16
$110,000	16.17	16.17	16.17	18.92	26.62	37.62	57.42	89.32	134.42	219.12
$115,000	16.91	16.91	16.91	19.78	27.83	39.33	60.03	93.38	140.53	229.08
$120,000	17.64	17.64	17.64	20.64	29.04	41.04	62.64	97.44	146.64	239.04
$125,000	18.38	18.38	18.38	21.50	30.25	42.75	65.25	101.50	152.75	249.00
$130,000	19.11	19.11	19.11	22.36	31.46	44.46	67.86	105.56	158.86	258.96
$135,000	19.85	19.85	19.85	23.22	32.67	46.17	70.47	109.62	164.97	268.92
$140,000	20.58	20.58	20.58	24.08	33.88	47.88	73.08	113.68	171.08	278.88
$145,000	21.32	21.32	21.32	24.94	35.09	49.59	75.69	117.74	177.19	288.84
$150,000	22.05	22.05	22.05	25.80	36.30	51.30	78.30	121.80	183.30	298.80
$155,000	22.79	22.79	22.79	26.66	37.51	53.01	80.91	125.86	189.41	308.76
$160,000	23.52	23.52	23.52	27.52	38.72	54.72	83.52	129.92	195.52	318.72
$165,000	24.26	24.26	24.26	28.38	39.93	56.43	86.13	133.98	201.63	328.68
$170,000	24.99	24.99	24.99	29.24	41.14	58.14	88.74	138.04	207.74	338.64
$175,000	25.73	25.73	25.73	30.10	42.35	59.85	91.35	142.10	213.85	348.60
$180,000	26.46	26.46	26.46	30.96	43.56	61.56	93.96	146.16	219.96	358.56
$185,000	27.20	27.20	27.20	31.82	44.77	63.27	96.57	150.22	226.07	368.52
$190,000	27.93	27.93	27.93	32.68	45.98	64.98	99.18	154.28	232.18	378.48
$195,000	28.67	28.67	28.67	33.54	47.19	66.69	101.79	158.34	238.29	388.44
$200,000	29.40	29.40	29.40	34.40	48.40	68.40	104.40	162.40	244.40	398.40
$205,000	30.14	30.14	30.14	35.26	49.61	70.11	107.01	166.46	250.51	408.36
$210,000	30.87	30.87	30.87	36.12	50.82	71.82	109.62	170.52	256.62	418.32
$215,000	31.61	31.61	31.61	36.98	52.03	73.53	112.23	174.58	262.73	428.28
$220,000	32.34	32.34	32.34	37.84	53.24	75.24	114.84	178.64	268.84	438.24
$225,000	33.08	33.08	33.08	38.70	54.45	76.95	117.45	182.70	274.95	448.20
$230,000	33.81	33.81	33.81	39.56	55.66	78.66	120.06	186.76	281.06	458.16
$235,000	34.55	34.55	34.55	40.42	56.87	80.37	122.67	190.82	287.17	468.12
$240,000	35.28	35.28	35.28	41.28	58.08	82.08	125.28	194.88	293.28	478.08
$245,000	36.02	36.02	36.02	42.14	59.29	83.79	127.89	198.94	299.39	488.04
$250,000	36.75	36.75	36.75	43.00	60.50	85.50	130.50	203.00	305.50	498.00

Rates

Child - Coverage and **monthly** cost for Child Voluntary Life and AD&D.

Rates are effective as of March 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Coverage amounts	Cost per pay period
$1,000	0.31
$2,000	0.62
$3,000	0.93
$4,000	1.24
$5,000	1.56
$6,000	1.87
$7,000	2.18
$8,000	2.49
$9,000	2.80
$10,000	3.11

Accident Insurance

Sun Life

You can purchase this coverage for you and your family. Child coverage is available to age 26.

HELPS YOUR FINANCES AFTER A MISHAP.

When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs.

HELPS COVER RELATED EXPENSES.

While health plans may cover direct costs associated with an accident, you can use accident benefits to help cover related expenses like lost income, child care, deductibles and co-pays.

PAYS CASH BENEFITS DIRECTLY TO YOU.

Accident Insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. And get this – there are no health questions or pre-existing conditions limitations.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

ACCIDENT FAST FACTS

Falls *are the leading cause of injuries treated in emergency rooms every year, for people of all ages.*[1]

This coverage pays benefits for accidents that occur off the job.

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY # 945344

Sun Life Assurance Company of Canada

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What's covered

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable. The full list of benefits is listed here.

DISLOCATIONS	OPEN (SURGERY)	CLOSED (NO SURGERY)
Hip	$4,000	$2,000
Knee, ankle, or bones of the foot	$2,000	$1,000
Elbow, wrist or Lower jaw	$800	$400
Shoulder	$1,000	$500
Collarbone or bones of the hand	$1,600	$800
Finger(s) or toe(s)	$200	$100
FRACTURES	**OPEN (SURGERY)**	**CLOSED (NO SURGERY)**
Hip or thigh	$4,000	$2,000
Skull-depressed	$6,000	$3,000
Skull-simple	$3,000	$1,500
Vertebral processes, Bones of the face or Nose	$700	$350
Leg	$2,000	$1,000
Vertebrae, Sternum or Pelvis	$1,600	$800
Upper jaw or upper arm	$750	$375
Lower jaw, Collarbone, Shoulder, Forearm, Hand, Wrist, Foot, Ankle, Kneecap, Elbow or Heel	$650	$325
Rib, Finger, Toe or Coccyx	$350	$175
Multiple ribs	$1,000	$500
ADDITIONAL INJURIES		
Eye Injury - surgical repair		$250
Eye Injury - object remove		$250
Gunshot wound		$500
Paralysis—paraplegia		$25,000
Paralysis—quadriplegia		$50,000
Coma		$10,000
Concussion		$100
BURNS	**2ND DEGREE**	**3RD DEGREE**
20-40 square centimeters	$400	$1,000
41-65 square centimeters	$800	$2,000
66-160 square centimeters	$1,200	$6,000
161-225 square centimeters	$1,600	$14,000
More than 225 square centimeters	$2,000	$20,000
Skin graft	50% of the applicable Burn Benefit	
LACERATIONS		
No sutures and treated by doctor		$35
Single laceration under 5 cm with sutures		$65
5-15 cm with sutures (total of all lacerations)		$250
Greater than 15 cm with sutures (total of all lacerations)		$500

MEDICAL SERVICES	
Diagnostic Exam - Arteriogram, Angiogram, CT, CAT, EKG, EEG, or MRI (1 time per benefit year)	$200
Diagnostic Exam - X-ray (1 time per covered accident)	$100
Accident Emergency Treatment, non-emergency room (once per covered accident)	$150
Physician's Follow-up Treatment office visit (per visit, up to 6 times per covered accident)	$100
Physical Therapy (per visit up to 10 visits per covered accident)	$25
Medical Devices	$500
Epidural Pain Management (up to 2 times per covered accident)	$150
Prescription drug	$50
Prosthesis (one)	$500
Prosthesis (two)	$1,000
Blood, Plasma, or Platelet Transfusion	$200
HOSPITAL	
Hospital Admission (once per benefit year)	$2,000
Hospital Confinement (per day up to 365 days per covered accident)	$400
Intensive Care Unit Admission (once per Benefit Year; payable instead of Hospital Admission benefit if Confined immediately to ICU)	$3,000
Intensive Care Unit Confinement (per day up to 14 days, payable in addition to any Hospital Confinement benefit)	$500
Ambulance (Ground)	$400
Ambulance (Air)	$2,000
Emergency Room Admission	$200
Family Lodging (per day up to 30 days per benefit year)	$100
Transportation (100 or more miles up to 3 times per covered accident)	$500
Rehabilitation Unit (per day up to 30 days per covered accident)	$100
SURGERY	
Miscellaneous Surgery requiring general anesthesia (not covered by any other benefit)	$300
Open Surgery	$1,250
Exploratory Surgery or Debridement	$250
Tendon/Ligament/Rotator Cuff Tear	$625
Torn Knee Cartilage	$625
Ruptured/Herniated Disc	$625
EMERGENCY DENTAL	
Emergency Dental extraction	$65
Emergency Dental crown	$200
WELLNESS	
Wellness Screening Benefit (once per benefit year)	$50

LIFE AND DISMEMBERMENT LOSSES*	
Accidental Death	$25,000
Accidental Death Common Carrier (pays an additional benefit if accidental death occurs while traveling as a fare-paying passenger on a public conveyance)	$100,000
Catastrophic Loss: Both arms or both hands, both legs or both feet, one hand and one foot or one arm and one leg, or irrecoverable loss of sight of both eyes	$15,000
Loss of one hand, foot, leg, or arm	$7,500
Loss of sight of one eye or loss of one eye	$7,500
Two or more fingers or toes	$1,500
One finger or one toe	$750

*Benefits displayed for life and dismemberment are for the employee only. Spouse benefits are 100% of the employee benefit amount for death and 100% of the employee benefit amount for dismemberment. Dependent children benefits are 50% of the employee benefit amount for death and 50% of the employee benefit amount for dismemberment.

Frequently asked questions

How do I file an accident claim?
If you have an accident after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about the accident and the treatment provided.

What happens once my claim is approved?
The benefit amount you receive will depend on your injury and/or the treatment provided. Remember, benefits are payable only once for each covered accident, unless noted otherwise in the benefit schedule.

Is there a time period that I need to follow?
Injuries and other related benefits due to a covered accident must be diagnosed or treated within a defined period of time from the date of your accident. This could be as few as three days for certain benefits. Please refer to your Certificate for details.

How do I get the Wellness Screening Benefit?
You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests and cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). Our wellness screening benefit claim form can also be downloaded from our website.

Can I take my insurance with me if I leave my employer?
Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

Is my benefit taxable?
If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Accident insurance is a limited benefit policy. The Certificate has exclusions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of your Certificate.

1. "Health, United States, 2016," US Department of Health and Human Services, Table 75.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Accident

We will not pay a benefit that is due to or results from: suicide while sane or insane; intentionally self-inflicted injuries; committing or attempting to commit an assault, felony or other criminal act; war or an act of war; active participation in a riot, rebellion or insurrection; voluntary use of any controlled substance/illegal drugs; operation of a motorized vehicle while intoxicated; if you do not submit proof of your loss as required by us (this covers medical examination, continuing care, death certificate, medical records, etc.); incarceration; engaging in hang-gliding, bungee jumping, parachuting, sail gliding, parasailing, parakiting or mountaineering; participating in or practicing for any semi-professional or professional competitive athletic contest in which any compensation is received, including coaching or officiating; injuries sustained from commercial air transportation other than riding as a fare paying passenger; work-related illness or injuries unless you are enrolled in 24-hour coverage.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GVBH-EE-8384 SLPC 29579

Rates

Coverage and **monthly** cost for Accident.

Rates are effective as of March 1, 2022.

Accident coverage is contributory. You are responsible for paying for all or a part of the cost through payroll deduction.

Coverage	Cost per pay period*
Employee	$13.54
Employee + Spouse	$21.88
Employee + Child(ren)	$25.34
Employee + Family	$33.68

*Contact your employer to confirm your part of the cost.

Cancer insurance

Mock Inc. DBA HI-Speed Industrial Service | All Eligible Employees | 945344

Protect your savings against the costs of cancer

A cancer diagnosis may have crossed your mind over the years. Or you may have a family history. Recovering from cancer would be your main focus. Cancer also has a financial impact that can be hard to recover from. Cancer insurance pays you cash benefits for a variety of the ways your cancer is treated.

How it works.

Your employer is offering you and your coworkers this coverage as a group, at a group rate. You are responsible for paying a portion or all of the cost.

The benefit schedule on the following pages lists what the plan pays for covered cancer treatments.

Benefits

Coverage is provided for	A covered person who is diagnosed with cancer after the effective date of insurance. Coverage is available for you and your family. An eligible child is defined as your child from birth to age 26.
Additional plan features	Benefits are payable directly to you, the employee This plan pays benefits in addition to any other coverage you may have.

Sun Life Financial®

What did cancer insurance mean for Beth?

Beth was diagnosed with breast cancer in her mid-50s. She was concerned about her health, and about her finances.

Beth filed claims with Sun Life as she received treatments.

We reviewed her medical information and details from her physician. We approved her claims.

She received cash benefits for hospital stays, radiation and chemotherapy treatments.

These benefits helped her pay her medical deductible and copays, and travel expenses for medical appointments

Did you know? A recent study shows that cancer patients spend 11% of their household income on expenses related to their cancer treatments. This may prompt you to consider cancer insurance.*

Sun Life Assurance Company of Canada
sunlife.com
800-249-6875

Benefit schedule

Once your coverage goes into effect, you can file a claim for covered cancer treatments for cancer diagnoses that occur after your insurance's effective date. Unless otherwise specified, benefits are payable only once. The full list of benefits is listed here. Choose the plan (Level 1 or Level 2) that best meet your needs and your budget.

Covered service	Level 1	Level 2
Second Surgical Opinion	$200	$200
Surgery and General Anesthesia Benefits vary based on the procedure performed. Combined maximum for any one surgery is $2,000 for Level 1 and $7,500 for Level 2. Surgery for skin cancer and reconstruction is not covered under this benefit.	Anesthesia $50 to $1,815 Surgical $150 to $5,500	Anesthesia $50 to $1,815 Surgical $150 to $5,500
Hospital Confinement (limited to 90 days per period of confinement)	$200 Daily	$400 Daily
In-hospital and Outpatient Blood and Plasma	$50 Daily	$50 Daily
Ambulance (limited to 2 one-way trips per period of confinement per person)	$250	$250 Ground $2,000 Air
Cancer Screening Includes colonoscopy, CA 125 test, chest x-ray, flexible sigmoidoscopy, pap smear, biopsy, PSA, CT scans or MRI scans, BRCA testing, or Hemocult stool specimen. This benefit is limited to once per benefit year.	$50	$75
Mammography Benefit Covers a baseline mammogram for breast cancer screening for women age 35-39. For women age 40-49 covers mammograms every two years or more frequently based on a physician's recommendation. Covers a mammogram every year for women age 50 and older	$50	$75
In-hospital Doctor Visits Limited to a maximum of 75 visits.	$25 Daily	$25 Daily
Prosthesis Lifetime maximum for surgically implanted prosthesis is $4,000 for Level 1 and $6,000 for Level 2. Lifetime maximum for other devices is $400 for Level 1 and $600 for Level 2.	Surgically implanted $2,000 Other $200	Surgically implanted $3,000 Other $300
Skin Cancer		
Biopsy Only	$100	$100
Reconstructive surgery following previous excision of skin cancer	$250	$250
Excision of skin cancer without flap or graft	$375	$375
Excision of skin cancer with flap or graft	$600	$600
Radiation and Chemotherapy		
Injected Cytotoxic Medications	$300 Weekly	$1,000 Weekly
Pump Dispensed Cytotoxic Medications	$300 First Prescription and Per Refill	$1,000 First Prescription and Per Refill
Oral Cytotoxic Medications	$150 Per Prescription	$500 Per Prescription
Cytotoxic Medications Administration by Any Other Method	$300 Weekly	$1,000 Weekly
External Radiation Therapy	$400 Weekly	$600 Weekly

Covered service	Level 1	Level 2
Insertion of Interstitial or Intracavity Administration of Radioisotopes or Radium	$450 Weekly	$750 Weekly
Oral or IV Radiation This benefit is not payable for the same day the Experimental Treatment benefit is payable. These benefits are not payable for treatment planning, therapeutic devices, immunotherapy, laboratory tests, diagnostic x-rays, dosimetry or simulation associated with these procedures. Maximums apply: Oral Cytotoxic Medications are subject to a monthly maximum of $450 for Level 1 and $1,500 for Level 2, other listed treatments are subject to a yearly maximum of $4,000 for Level 1 and $12,000 for Level 2.	$400 Weekly	$600 Weekly
Extended-care Facility This benefit is payable if the extended care confinement occurs within 30 days of a period of hospital confinement due to internal cancer and you have received a Hospital Confinement benefit. Limited to a maximum of 90 days per benefit year per covered person. This benefit is not payable for any day the Hospital Confinement benefit is payable.	$200 Daily	$200 Daily
Hospice Limited to a maximum of 100 days during the covered person's lifetime. This benefit is not payable for any day the Extended-Care Facility benefit, the Home Health Care benefit or the Hospital Confinement benefit is payable.	$100 Daily	$100 Daily

Additional benefits available if you enroll in Level 2

Covered service	Benefit amount
First Occurrence Payable if diagnosed with Internal Cancer for the first time. This benefit is only payable once per lifetime.	$5,000
National Cancer Institute Evaluation/Consultation This benefit is not payable for the same day the Second Surgical Opinion benefit is payable. This benefit is limited and only payable once per lifetime.	$500
Medical Imaging When a follow-up evaluation is performed using any imaging test as directed by a doctor after an initial diagnosis of internal cancer, (except breast mammography and breast ultrasound) this benefit is payable. You may receive this benefit twice per benefit year provided you or your covered dependent are charged for these procedures and they are performed on an outpatient basis.	$100
Home Health Care The service must begin within 7 days of the date you or your covered dependent are released from hospital confinement. This benefit is not payable for any day the Hospice benefit is payable. Caregivers must be licensed or certified. Limited to a maximum of 10 visits per period of hospital confinement; up to 30 visits per benefit year.	$50 Per Visit
Outpatient Hospital Surgical This benefit is not payable for surgery performed in a doctor's office or if you or your covered dependent are hospital confined on the same day. Limited to a maximum of 3 days per procedure.	$250 Daily
Transportation The hospital or clinic must be more than 100 miles away from your or your covered dependent's residence. Limited to 3 round trips per benefit year, per covered person.	$500
Lodging The hospital or clinic must be more than 100 miles away from your or your covered dependent's residence. Limited to 1 benefit per day up to 90 days per benefit year, per covered person.	$100 Daily
Bone Marrow or Stem Cell Transplant A benefit is paid for either a bone marrow transplant or a stem cell transplant, not both. Payable once per lifetime, per covered person.	Bone Marrow $10,000 Donor ($1,500)

Covered service	Benefit amount
	Stem Cell $2,500
Nursing Services Care must be provided by a licensed registered graduate nurse or vocational nurse, but not by a family member. Limited to 30 days per benefit year per covered person.	$125 Daily
Immunotherapy We will not pay benefits under this provision for the same treatment under either the Radiation and Chemotherapy Benefit or the Experimental Treatment Benefit. Lifetime maximum of $3,500 applies, per covered person.	$450 Monthly
Reconstructive Surgery In addition, 30% of the surgery amounts listed is paid for general anesthesia used during these procedures.	
Breast Symmetry (modification of the non-cancerous breast performed within 5 years of reconstructing the cancerous breast)	$350
Breast Reconstruction	$700
Facial Reconstruction	$700
Breast Transverse Rectus Abdominis Myocutaneous (TRAM) Flap	$2,500
Alternative Care Pays the amount shown per visit to an accredited practitioner for you or your covered dependent upon the diagnosis of internal cancer for Palliative care (acupuncture, massage therapy, bio- feedback and hypnosis), and Lifestyle training (smoking cessation, Yoga, meditation, relaxation techniques, Tai Chi and nutritional counseling). Limited to 20 visits per benefit year under either category, per covered person and lifetime maximum of 2 benefit years. There is also a one- time benefit ($150) for Integrative Assessment and Education when performed by an accredited practitioner following the diagnosis of internal cancer.	$50 Per Visit
Experimental Treatment Treatment must be administered by medical personnel in a doctor's office, clinic, or hospital; maximum monthly benefit is $1,050. We will not pay benefits under this provision for laboratory tests, immunotherapy, diagnostic x-rays and therapeutic device or other procedures related to these treatments. This benefit is not payable for any day the Radiation or Chemotherapy benefit is payable.	$150 Daily
Anti-nausea drugs	$100 Monthly
Post-hospital Doctor Visits This benefit is payable per doctor visit once every 6 months. Benefits payable up to 5 years after the diagnosis of internal cancer for the purpose of ongoing cancer evaluation.	$50 Per Visit

Cancer insurance FAQs

How do I file a claim?

We will ask for information from you and your doctor about your medical condition. You can download forms from our website. Please complete and sign all forms. Missing information or signatures can delay your claim.

Can I receive benefits for more than one cancer diagnosis?

Regardless of types of Cancer or number of diagnoses, you may receive benefits for covered Cancer treatments from your inforce policy. If you have Level 2 coverage, the First Occurrence Benefit provides a one-time payment for your initial Cancer diagnosis in addition to your covered treatment benefits.

Is my benefit taxable?

If you pay for your coverage all post-tax, your benefit will not be taxable income or tax reported by us to the IRS. If you pay for your coverage all pre-tax, if you pay for part of your coverage post-tax and your employer pays for the rest, or if your employer pays the entire premium, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please consult with a tax advisor or your employer if you have any questions.

What if I have a pre-existing condition?

If you submit a claim within 12 months of your insurance taking effect, or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought or received treatment for in the 12 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue group coverage when your employment terminates. Your employer can advise you about your options.

"Cancer insurance" is a limited benefit policy. The certificate has exclusions and limitations that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate.

Read the important plan provisions section for more information including limitations and exclusions.

* Even Insured Patients Are Overwhelmed By The Cost Of Cancer Care," Duke University study, www.forbes.com, August 2017

Important plan provisions

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage") and do not satisfy the requirement for Minimum Essential Coverage under the Affordable Care Act. They do NOT provide basic hospital, basic medical, or major medical insurance as defined by the New York State Department of Financial Services.

To become insured, all persons must be actively at work and performing their regular duties at their usual place of business on the proposed effective date or their date of coverage will be deferred until they return to active work. Refer to the Certificate for details and similar requirements for dependent coverage.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see the Certificate or ask your benefits administrator for details.

Cancer

We will not pay a benefit that is due to or results from: services or Treatment not included in the Covered Cancer Benefits; war or an act of war; active military duty; intentionally self-inflicted injuries while sane or insane; services or Treatment for which the Insured is not charged, unless there is no charge because the facility is a United States government facility; services or Treatment provided by a Family Member; services or Treatment for premalignant conditions; services or Treatment for conditions with malignant potential; services or Treatment for non-cancer illnesses; elective plastic or cosmetic surgery.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of the insurance. The cost is included in the total amount billed. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

This Overview is preliminary to the issuance of the Policy. Refer to your Certificate for details. Receipt of this Overview does not constitute approval of coverage under the Policy. In the event of a discrepancy between this Overview, the Certificate and the Policy, the terms of the Policy will govern. Product offerings may not be available in all states and may vary depending on state laws and regulations.

Sun Life Financial companies include Sun Life and Health Insurance Company (U.S.) and Sun Life Assurance Company of Canada (collectively, "Sun Life Financial" or "Sun Life").

Group insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 93P-LH, 98P-ADD, 12-GP-01, 13-ADD-C-01, 15-GP-01, 15-LF-C-01, 15-ADD-C-01, 12-DI-C-01, 16-DI-C-01, TDBPOLICY-2006, TDI-POLICY, 12-AC-C-01, 16-AC-C-01, 12-SD-C-01, 16-SD-C-01, and 16-CAN-C-01.

GVBH-EE-6701

SLPC 29219 08/18 (exp 08/20)

Sun Life Financial®

Rate Sheet

Coverage and **monthly** rate for Cancer Insurance.

Cancer coverage is contributory, meaning that you are responsible for paying for all or a portion of the cost through payroll deduction.

Level 1

	monthly Cost*			
Employee Age	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Thru 49	12.53	21.30	13.76	22.53
50-59	15.44	26.25	16.67	27.48
60-64	24.63	41.86	25.86	43.09
65+	32.98	56.05	34.21	57.28

Level 2

	monthly Cost*			
Employee Age	**Employee**	**Employee + Spouse**	**Employee + Child(ren)**	**Employee + Family**
Thru 49	29.43	50.03	32.37	52.97
50-59	36.29	61.69	39.23	64.63
60-64	57.87	98.37	60.81	101.31
65+	77.49	131.72	80.43	134.66

*The rate is in effect for March 1, 2022. Contact your employer to confirm the portion of the cost for which you will be responsible.

Critical Illness Insurance

Sun Life

HELPS PROTECT YOUR FINANCES FROM AN ILLNESS.

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan.

HELPS COVER RELATED EXPENSES.

While health plans may cover direct costs associated with a critical illness, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and co-pays.

PAYS A CASH BENEFIT DIRECTLY TO YOU.

Critical Illness insurance can be used however you want, and it pays in addition to any other coverage you may already have.

What's more, all family members on your plan are eligible for a wellness-screening benefit, also paid directly to you once each year per covered person.

With Critical Illness Insurance, you also get access to health care support services. You can talk with medical and claims experts about your medical coverage, benefits, diagnosis and treatment options.

BENEFITS *(You can purchase this coverage at a group rate.)*	
For you	You can choose between **$5,000** and **$20,000** of coverage, in increments of $5,000. No medical questions asked.
For your spouse	If you elect coverage for yourself, you can choose between **$5,000** and **$20,000** of coverage, in increments of $5,000. No medical questions asked. Not to exceed 100% of your coverage amount.
For your child(ren)	If you elect coverage for yourself, you can choose between **$2,500** and **$10,000** of coverage, in increments of $2,500. No medical questions asked. Not to exceed 50% of your coverage amount. An eligible child is defined as your child from birth to age 26.

MOCK INC. DBA HI-SPEED INDUSTRIAL SERVICE

All Eligible Employees

POLICY #: 945344

What's covered

Once your coverage goes into effect, you can file a claim for covered conditions diagnosed after your insurance plan's effective date. Below is the full list of conditions.

COVERED CONDITIONS – *The plan pays 100% of the benefit amount unless stated otherwise.*		
Core Conditions	Heart Attack[R] End-Stage Kidney Disease[R] Occupational HIV/Hepatitis B, C, or D Major Organ Failure[R]	Stroke[R] Coronary Artery Bypass Graft[R] (Pays 25%) Angioplasty[R] (Pays 5%)
Cancer Conditions	Invasive Cancer[R] Noninvasive Cancer[R] (Pays 25%) Skin Cancer[R] (Pays 5%)	
Other Conditions	Complete Blindness Complete Loss of Hearing Loss of Speech Benign Brain Tumor Coma	Severe Burns Advanced ALS/Lou Gehrig's Disease Advanced Parkinson's Disease (Pays 25%) Advanced Alzheimer's Disease (Pays 25%) Paralysis
Childhood Conditions *Applies to dependent children only*	Down Syndrome Cystic Fibrosis Type 1 Diabetes Mellitus Complex Congenital Heart Disease	Cerebral Palsy Cleft Lip/Palate Muscular Dystrophy Spina Bifida
Wellness Screening Benefit	Payable to any covered person on your plan one time each year, once you provide proof of an eligible health screening.	Employee $50 Spouse $50 Child $50

[R] = *Recurrence Benefit available*

When would I need the Recurrence Benefit?

Sometimes people are diagnosed with the same condition twice. If this happens to you, and 12 consecutive months have passed between the first and second diagnoses, we'll pay you an additional benefit (the amount of which is noted in your Certificate). Only the conditions marked (R) in the table above are eligible for the Recurrence Benefit. Once a Recurrence Benefit has been paid, no additional benefit will be paid for that critical illness.

Frequently asked questions

Do I need to answer any health questions to enroll?

If you contribute to the cost of your insurance, you may need to complete health questions if you don't elect coverage when it's first available to you and you want to elect at a later date, or if you want to increase coverage. To answer health questions, please fill out our Evidence of Insurability application. Health questions must be approved by Sun Life before coverage takes effect. Please see your Certificate for details.

What if I have a pre-existing condition?

If you are diagnosed with a covered critical illness within 12 months of your insurance taking effect or 12 months following any increase in your amount of insurance, we will not pay any benefit for any pre-existing condition. A pre-existing condition includes anything you have sought treatment for in the 12 months prior to your insurance becoming effective. Treatment can include consultation, advice, care, services or a prescription for drugs or medicine.

How do I file a critical illness claim?

If you have a diagnosis after the effective date of coverage, you can file a claim with us by downloading forms from our website. We'll ask that you and your doctor provide information about your medical condition.

How do I get the Wellness Screening Benefit?

You may be paid the benefit when you or a covered family member submit proof of a covered screening each year, like specific blood tests, cancer screenings, cardiac stress tests, immunizations, school sports exams and more (may vary by state). The claim form can also be downloaded from our website.

Can I receive benefits for more than one critical illness?

Yes. In order to receive benefits for more than one critical illness, there must be at least 1 month between each diagnosis date. You can only claim benefits once for each covered condition unless a recurrence benefit is payable.

How is my benefit taxed?

If you or your employer pay for all or part of the cost of coverage on a pre-tax basis, some or all of your benefit amount will be tax reported on a Form 1099 as taxable income. Please reach out to a tax advisor or your employer if you have any questions.

Can I take my insurance with me if I leave my employer?

Depending upon state variations and your employer's plan, you may have an option to continue coverage when your employment terminates. Your employer can advise you about your options.

CRITICAL ILLNESS FAST FACT

*Most heart attack victims are middle-aged or older; the risk of a heart attack climbs for men after age 45 and for women after age 55.***

**"What Are Your Odds of a Heart Attack?" health.com, June 2018.

Critical Illness insurance is a limited benefit policy. The certificate has exclusions, limitations and benefit waiting periods for certain conditions that may affect any benefits payable. Benefits payable are subject to all terms and conditions of the certificate.

Read the *Important information* section for more details including limitations and exclusions.

Important information

The following coverage(s) do not constitute comprehensive health insurance (often referred to as "major medical coverage"). They do NOT provide basic hospital, basic medical, or major medical insurance.

To become insured, you must meet the eligibility requirements set forth by your employer. Your coverage effective date will be determined by the Policy and may be delayed if you are not actively at work on the date your coverage would otherwise go into effect. Similarly, dependent coverage, if offered, may be delayed if your dependents are in the hospital (except for newborns) on the date coverage would otherwise become effective. Refer to your Certificate for details.

Limitations and exclusions

The below exclusions and limitations may vary by state law and regulations. This list may not be comprehensive. Please see your Certificate or ask your benefits administrator for details.

Critical Illness

We will not pay a benefit that is due to or results from services, treatment or complications not included in the Benefit Highlights; provided by an immediate family member; or unrelated to a Critical Illness/Specified Disease. These include an autologous bone marrow transplant, suicide, attempted suicide or intentionally self inflicted injuries, elective plastic or cosmetic surgery, active military duty, war, any act of war, or your active duty in any armed service during a time of war (excluding during acts of terrorism); your active participation in a riot, rebellion or insurrection; committing or attempting to commit an assault, felony or other criminal act; engaging in dangerous conduct or hazardous activity where there is a likelihood of death or serious injury; being incarcerated in a penal institution of any kind; being legally intoxicated or under the influence of any narcotic, unless taken on the advice of a physician and taken as prescribed.

Covered conditions have specific diagnostic criteria that must be met (along with supporting documentation) for a benefit to be paid. For additional information regarding covered conditions, please request an outline of coverage.

This product is inappropriate for individuals who are eligible for Medicaid coverage.

Information about services offered

Value-added services are not insurance, are offered only on specific lines of coverage and carry a separate charge, which is added to the cost of insurance. The cost is included in the total amount billed. HealthChampion℠(a health care support service) is not insurance and is provided by ComPsych®. ComPsych® is a registered trademark of ComPsych Corporation. The entities that provide the value-added services are not subcontractors of Sun Life and Sun Life is not responsible or liable for the care, services, or advice provided by them. Sun Life reserves the right to discontinue any of the Services at any time.

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GVBH-EE-8384

SLPC 29579

Rates

Rates are effective as of March 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Employee Critical Illness - Choice 1 Non-tobacco rates | Age and cost - pay period (monthly) premium

Coverage amounts	<25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75+
$5,000	4.10	4.40	5.30	6.80	9.10	12.25	16.45	20.50	24.45	30.05	39.95	54.15
$10,000	6.95	7.55	9.35	12.35	16.95	23.25	31.65	39.75	47.65	58.85	78.65	107.05
$15,000	9.80	10.70	13.40	17.90	24.80	34.25	46.85	59.00	70.85	87.65	117.35	159.95
$20,000	12.65	13.85	17.45	23.45	32.65	45.25	62.05	78.25	94.05	116.45	156.05	212.85

Employee Critical Illness - Choice 1 Tobacco rates | Age and cost - pay period (monthly) premium

Coverage amounts	<25	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75+
$5,000	4.15	4.65	5.95	8.35	12.45	18.50	27.00	35.95	45.10	57.60	74.10	90.55
$10,000	7.05	8.05	10.65	15.45	23.65	35.75	52.75	70.65	88.95	113.95	146.95	179.85
$15,000	9.95	11.45	15.35	22.55	34.85	53.00	78.50	105.35	132.80	170.30	219.80	269.15
$20,000	12.85	14.85	20.05	29.65	46.05	70.25	104.25	140.05	176.65	226.65	292.65	358.45

Rates

Rates are effective as of March 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Find your age bracket (as of the effective date of coverage) to see the cost for the coverage amount you choose.

Spouse rates are based on the employee's age.

Spouse Critical Illness - Choice 1 Non-tobacco rates | Age and cost - pay period (monthly) premium

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	4.10	4.40	5.30	6.80	9.10	12.25	16.45	20.50	24.45	30.05	39.95	54.15
$10,000	6.95	7.55	9.35	12.35	16.95	23.25	31.65	39.75	47.65	58.85	78.65	107.05
$15,000	9.80	10.70	13.40	17.90	24.80	34.25	46.85	59.00	70.85	87.65	117.35	159.95
$20,000	12.65	13.85	17.45	23.45	32.65	45.25	62.05	78.25	94.05	116.45	156.05	212.85

Spouse Critical Illness - Choice 1 Tobacco rates | Age and cost - pay period (monthly) premium

Coverage amounts	<25	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75+
$5,000	4.15	4.65	5.95	8.35	12.45	18.50	27.00	35.95	45.10	57.60	74.10	90.55
$10,000	7.05	8.05	10.65	15.45	23.65	35.75	52.75	70.65	88.95	113.95	146.95	179.85
$15,000	9.95	11.45	15.35	22.55	34.85	53.00	78.50	105.35	132.80	170.30	219.80	269.15
$20,000	12.85	14.85	20.05	29.65	46.05	70.25	104.25	140.05	176.65	226.65	292.65	358.45

Rates are effective as of March 1, 2022.

The chart below shows possible coverage amounts and their **monthly** costs.

Child(ren) Critical Illness - Choice 1

Coverage amounts	Cost - pay period (monthly) premium
$2,500	0.33
$5,000	0.65
$7,500	0.98
$10,000	1.30

General Information About the Plan

Plan Name: Mock Inc. DBA HI-Speed Industrial Service Employee Benefits Program (the "Plan")
Contact: Mock Inc. DBA HI-Speed Industrial Service
7030 Ryburn Dr., Millington, TN 38053
901-873-5300

The Plan Administrator has the sole discretionary authority and responsibility to control and administer the Plan in accordance with its terms and has, without limitation, the discretionary authority to interpret the Plan or its terms. The Plan Administrator's powers include making and enforcing rules it deems necessary or proper for the efficient administration of the Plan, allocating its responsibilities under the Plan to other persons, and deciding all questions concerning the Plan, including determining eligibility for benefits under the Plan.

With respect to the coverage described in this Summary Plan Description (SPD), the Plan Administrator has delegated to Health Plans Inc. (HPI) the discretionary authority related to medical and prescription drug coverage to make determinations on eligibility and claims for benefits under the Plan, and, as such, Health Plans Inc. (HPI) is a claims review fiduciary of the Plan. The Plan Administrator has delegated to Sun Life Financial the discretionary authority related to dental, vision, disability, accident, critical illness, cancer and life coverage to make determinations on eligibility and claims for benefits under the Plan, and, as such, Sun Life Financial is a claims review fiduciary of the Plan.

Group/Policy Number:	YB3
Claims Administrator:	Health Plans Inc. (HPI)
Medical & Prescription Drug Coverage:	www.hpitpa.com
Group/Policy Number:	945344
Claims Administrator:	Sun Life Financial
Dental, Vision, DI & Life Coverage:	www.sunlife.com

The Plan Administrator keeps the records for the Plan and will also answer any questions you may have about the Plan. If you have general questions about the Plan, you may contact Human Resources, which acts on behalf of the Plan Administrator with respect to day-to-day matters, and whose contact information is provided immediately below.

Plan Contact/Sponsor Information:	Mock Inc. DBA HI-Speed Industrial Service Attn: *Human Resources* 7030 Ryburn Dr., Millington, TN 38053 901-873-5300
Plan Sponsor's Employer ID Number (EIN):	62-1026043
ERISA Plan Number:	501

Agent for Service of Legal Process: Mock Inc. DBA HI-Speed Industrial Service
7030 Ryburn Dr., Millington, TN 38053
901-873-5300

MARCH 1, 2022 the Plan is operated on as follows:
MARCH 1, 2022 through FEBRUARY 28, 2023 referred to as the "Plan Year"

The Plan is an employee welfare benefit plan, and includes the medical, prescription, drug, dental, vision, disability, and life coverage described in this SPD.

Type of Funding/Administration: Medical & Prescription Drug Coverage
The medical and prescription drug portion of the Plan described in this SPD is self insured and is administered in accordance with the provisions of the administrative services agreement with the Claims Administrator named above. Plan benefits are funded through the employer's general assets. No amounts are held in trust or are otherwise segregated from the general assets of the Employer.

Participants are required to contribute to the cost of the coverage

Type of Funding/Administration: Dental, Vision, Disability & Life Coverage
The dental, vision, disability, life coverage is insured and is administered in accordance with the provisions of the insurance policy issued by the Insurer named above. Plan benefits are provided pursuant to an insurance policy, the premiums for which are paid from the employer's general assets. The Insurer(s), not the group, is responsible for paying claims under the Plan. Participants are required to contribute to the cost of coverage.

Amendment or Termination of the Plan
The Plan may, at any time, in the Plan Sponsor's sole discretion, be amended or terminated, without advance notice to any person (except as may be required by law). Any amendment or termination of the Plan (or any coverage(s) under the Plan) will not affect any proper entitlement to benefits incurred prior to the effective date of such amendment or termination. No person shall have any vested right to continue benefits under the Plan.

Effect of the Plan Document
This SPD provides a summary of the terms, conditions, and benefits under the Plan for eligible employees and their eligible dependents. It does not give the details on all the terms of the official Plan documents (including the insurance policy). If there is any conflict between the information in this SPD and the provisions of the Plan documents, the Plan documents control.

Your Rights Under ERISA and Other Applicable Law
This statement of ERISA rights is required by federal law and regulation.

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

Receive Information About Your Plan and Benefits

• Examine, without charge, at the office of the Plan Administrator and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the Plan (if applicable) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

• Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series), if applicable, and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

• Receive a summary of the Plan's annual financial report (if applicable). If applicable, the Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

COBRA – General Notice and Qualifying Event Notice

• 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 or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

• Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the group health plan (if applicable), if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when: (i) you lose coverage under the Plan; (ii) you become entitled to elect COBRA continuation coverage; (iii) your COBRA continuation coverage ceases; or (iv) you request a certificate of creditable coverage before losing coverage, or within 24 months after losing coverage.

• Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U. S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Availability of Summary Health Information—Summary of Benefits and Coverage (SBC)

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Choosing a health coverage option is an important decision. To help you make an informed choice, the Plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options.

Your 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*.

Also, a special enrollment period for group health plan coverage may be available if (i) you or your dependent child(ren) lose coverage under a Medicaid or CHIP plan, if that coverage is terminated due to loss of eligibility; or (ii) you or your dependent child(ren) become eligible for financial assistance under Medicaid or CHIP with respect to coverage under the Plan. However, *you must request enrollment within 60 days of the occurrence of one of these events*.

You may be required to provide supporting documentation when requesting special enrollment. To request special enrollment or obtain more information, contact Human Resources.

Procedures for Requesting a Certificate of Creditable Coverage (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires a Certificate of Creditable Coverage be issued to individuals losing health coverage. A Certificate of Creditable Coverage will be issued automatically when you or your dependent's applicable group health plan coverage (including continuation coverage) under the Plan terminates. You may also request a Certificate of Creditable Coverage, free of charge, at any time while covered and up to 24 months after the date coverage terminates. A third party whom you designate in writing may also obtain a copy of the certificate on your behalf. All requests for a Certificate of Creditable Coverage should include your full name, home address, and, if the certificate is to be delivered to a third party other than yourself, the name and address of that party. Requests for a certificate should be in writing, mailed to the Plan Administrator at the following address:

Mock Inc. DBA HI-Speed Industrial Service
7030 Ryburn Dr.
Millington, TN 38053
Phone: 901-873-5300

If you designate a plan or issuer of health insurance (such as that offered by a subsequent employer) to receive the certificate on your behalf and the plan or issuer agrees to accept the information contained in the certificate by non-written means (for example, by telephone), the Plan may provide the information exclusively in that manner.

Patient Protection Notices Required by the Affordable Care Act

The plan generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in your network and who is available to accept you or your family members.

For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your provider.

Statement of Rights Under the Newborns' and Mothers' Health Protection Act

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 normal 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 as applicable). The laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. For more information, refer to the SPD.

Privacy of Protected Health Information—Availability of Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices

The Plan maintains a HIPAA Notice of Privacy Practices that provides information to individuals whose protected health information (PHI) will be used or maintained by the Plan. If you would like a copy of the Plan's HIPAA Notice of Privacy Practices, please contact the number located on the back of your member ID card.

Women's Health and Cancer Rights Act of 1998

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. For more information, refer to the SPD or contact the Plan Administrator (contact information is provided under "General Information About the Plan" above).

MEDICARE PART D CREDITABLE COVERAGE NOTICE
Important Notice About Your Prescription Drug Coverage and Medicare

Please read this notice carefully for information about your current prescription drug coverage and 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 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) which offers prescription drug coverage. 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. The plan has determined the prescription drug coverage offered by the medical plan options is "creditable." In other words, the plan has determined that the prescription drug coverage offered by the medical plan options under the plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays (and, therefore, is considered to be "creditable" coverage). Because your existing coverage is creditable coverage, you can keep this coverage and not pay a higher premium (a penalty) if you decide to later 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 15 through December 7. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two-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 coverage will be affected. Coverage between the plan and Medicare Part D may be coordinated. If you do decide to join a Medicare drug plan and drop your current coverage, be aware you and your dependents may not be able to get this coverage back until open enrollment.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?
You should also know if you drop or lose your current coverage 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 percent of the Medicare base beneficiary premium per month for every month in which you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19 percent 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 Human Resources office for further information or call the phone number on the back of your medical insurance ID card. Please note you will get this notice each year. You will also get it before the next period you can join a Medicare drug plan, as well as if this coverage changes. You also may request a copy of this notice at any time.

Qualified Medical Child Support Orders (QMCSOs)

The Plan will comply with the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or a judgment from a court or administrative body (including a National Medical Support Notice) directing the Plan to cover a child of a participant under the group health plan coverage provided through the Plan. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a QMCSO. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the Plan's procedures for determining if the order is valid. Coverage under the applicable coverage(s) of the Plan pursuant to a QMCSO will not become effective until the Plan Administrator determines that the order is a QMCSO.

If you have any questions or would like to receive, without charge, a copy of the Plan's written procedure for determining whether an order is a QMCSO, contact your carrier.

Newborns & Mothers Health Protection Act (NMHPA)

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), signed into law on September 26, 1996, requires plans that offer maternity coverage to pay for at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section). This law was effective for group health plans for plan years beginning on or after January 1, 1998.

On October 27, 1998, the Department of Labor, in conjunction with the Departments of the Treasury and Health and Human Services, published interim regulations clarifying issues arising under the Newborns' Act. The changes made by the regulations are effective for group health plans for plan years beginning on or after January 1, 1999.

The Newborns' Act and its regulations provide that health plans and insurance issuers may not restrict a mother's or newborn's benefits for a hospital length of stay that is connected to childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. However, the attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier.

The Newborns' Act, and its regulations, prohibit incentives (either positive or negative) that could encourage less than the minimum protections under the Act as described above.

A mother cannot be encouraged to accept less than the minimum protections available to her under the Newborns' Act and an attending provider cannot be induced to discharge a mother or newborn earlier than 48 or 96 hours after delivery.

The type of coverage provided by the plan (insured or self-insured) and state law will determine whether the Newborns' Act applies to a mother's or newborn's coverage.

The Newborns' Act provisions always apply to coverage that is self-insured. If the plan provides benefits for hospital stays in connection with childbirth and is insured, whether the plan is subject to the Newborns' Act depends on State law. Based on a recent preliminary review of State laws, if the coverage is in Wisconsin and several U.S. territories, it appears that the Federal Newborns' Act applies to the plan. If the coverage is in any other state or the District of Columbia, it appears that State law applies in lieu of the Federal Newborns' Act.

All group health plans that provide maternity or newborn infant coverage must include a statement in their summary plan description (SPD) advising 'Act requirements.

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 January 31, 2020. Contact your State for more information on eligibility –

See next page for chart.

To see if any other states have added a premium assistance program since January 31, 2020, or for more information on special enrollment rights, 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 Service
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.

ALABAMA – Medicaid

http://myalhipp.com/ Ph: 1-855-692-5447

ALASKA – Medicaid

http://myakhipp.com/
http://dhss.Alaska.gov/dpa/pages/Medicaid/default.aspx Ph: 1-866-251-4861

ARKANSAS – Medicaid

http://myarhipp.com/ Ph: 1-855-692-7447

GEORGIA – Medicaid

https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Ph: 678-564-1162 x 2131

COLORADO – Medicaid

https://www.healthfirstcolorado.com/ Ph: 1-800-221-3943

https://colorado.gov/HCPF/Child-health-plan-plus Ph: 1-800-359-1991

IOWA – Medicaid and CHIP (Hawki)

http://dhs.iowa.gov/ime/members Ph: 1-800-338-8366

http://dhs.iowa.gov/Hawki Ph: 1-800-257-8563

FLORIDA – Medicaid

http://flmedicaidtplrecovery.com/hipp/ Ph: 1-877-357-3268

KENTUCKY – Medicaid

https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Ph: 1-855-459-6328

https://kidshealth.ky.gov/Pages/index.aspx Ph: 1-877-524-4718

INDIANA – Medicaid

For Low-income adults 19-64

http://www.in.gov/fssa/hip/
Phone 1-877-438-4479

All other Medicaid

http://www.indianamedicaid.com
Ph: 1-800-403-0864

MAINE – Medicaid

http://www.maine.gov/dhhs/ofi/public-assistance/index.htm Ph: 1-800-442-6003

KANSAS – Medicaid

http://www.kdheks.gov/hcf/default.htm Ph: 1-800-792-4884

MINNESOTA – Medicaid

https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Ph: 1-800-657-3739

LOUISIANA – Medicaid

www.medicaid.la.gov Ph: 1-888-342-6207

www.ldh.la.gov/lahipp Ph: 1-855-618-5488

MONTANA – Medicaid

http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Ph: 1-800-694-3084

NEVADA – Medicaid

http://dhcfp.nv.gov Ph: 1-800-992-0900

MASSACHUSETTS – Medicaid and CHIP

http://www.mass.gov/eohhs/gov/departments/masshealth/ Ph: 1-800-861-4840

NEW JERSEY – Medicaid and CHIP

http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Ph: 1-609-631-2392

http://www.njfamilycare.org/index.html Ph: 1-800-701-0710

MISSOURI – Medicaid

http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Ph: 573-751-2005

NEBRASKA – Medicaid

http://www.accessNebraska.ne.gov Ph: 855-632-7633

NORTH CAROLINA – Medicaid

http://dma.ncdhhs.gov/ Ph: 919-855-4100

NEW HAMPSHIRE – Medicaid

http://www.dhhs.nh.gov/oii/nhhpp/ Ph: 603-271-5218
Hotline: 1-800-852-3345 x5218

OKLAHOMA – Medicaid and CHIP

http://www.insureoklahoma.org Ph: 1-888-365-3742

NEW YORK – Medicaid

https://www.health.ny.gov/health_care/medicaid/ Ph: 1-800-541-2831

PENNSYLVANIA – Medicaid

https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Ph: 1-800-692-7462

NORTH DAKOTA – Medicaid

http://www.nd.gov/dhs/services/medicalserv/medicaid/ Ph: 1-844-854-4825

RHODE ISLAND – Medicaid

http://www.eohhs.ri.gov/ Ph: 1-855-697-4347

OREGON – Medicaid

http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html

Ph: 1-800-699-9075

SOUTH DAKOTA - Medicaid

http://dss.sd.gov Ph: 1-888-828-0059

UTAH – Medicaid and CHIP

Medicaid: http://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip Ph: 1-877-543-7669

SOUTH CAROLINA – Medicaid

http://www.scdhhs.gov Ph: 1-888-549-0820

WASHINGTON – Medicaid

https://www.hca.wa.gov/ Ph: 1-888-828-0059

TEXAS – Medicaid

http://gethipptexas.com/ Ph: 1-800-440-0493

WEST VIRGINIA – Medicaid

http://mywvhipp/.com Ph: 1-855-699-8447

VERMONT– Medicaid

http://www.greenmountaincare.org/ Ph: 1-800-250-8427

WISCONSIN – Medicaid and CHIP

https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Ph: 1-800-362-3002

VIRGINIA – Medicaid and CHIP

Medicaid Ph: 1-800-432-5924 CHIP Ph: 1-855-242-8282

https://www.coverva.org/hipp/

WYOMING – Medicaid

https://wyequalitycare.acs-inc.com/ Ph: 307-777-7531