Employee Benefits Information

Quality Driver Solutions, Inc.

"Your Translogistics Staffing Source"

Drivers

Plan Effective: June 1, 2017 - May 31, 2018

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Welcome Valued and Trusted Employee

Quality Driver Solutions, Inc. provides comprehensive employee benefits as part of our total compensation program.

Options in cost and plan design are intended to provide you with the opportunity to customize your benefit plan to meet your lifestyle and personal choices, while offering protection, flexibility and security to you and your family.

The decisions you make regarding your enrollment in benefits deserves your careful consideration. Your choices will be in effect for the plan year. You will be able to make changes during the plan year only in the event of an IRS qualified Family Status Change. There are many resources available to assist you in making your benefit choices and remember that there are no right or wrong selections; your primary consideration in this decision is what works best for you.

Keep in mind that this summary provides only a general overview of the benefits available to you. It does not include details of all covered expenses or exclusions and limitations. Please refer to each plan's Evidence of Coverage (EOC) booklet for the terms and conditions of coverage.

Employer Contribution

Quality Driver Solutions, Inc. contributes towards the employee only cost for medical benefits. Your share of costs for medical coverage will equate to 9.5% of your salary.

Eligibility

Full-time employees working a minimum of **30 hours** per week are eligible for benefits on **the first day of the month following 60 days** of employment**.**

Eligible Dependents

Your legal spouse or domestic partner are eligible for medical, dental and vision benefits. Children are eligible for medical, dental and vision benefits up to age 26 regardless of their marital, financial, or student status.

When Can You Enroll?

You can sign up for benefits at any of the following times:

- After completing initial eligibility period (new-hire or transfer to benefit eligible category)
- During the annual open enrollment period, for a **June 1st** effective date
- Within 30 days of a qualified family -status change

If you do not enroll at the above times, you must wait for the next annual open enrollment period.

How to Enroll

Complete the appropriate enrollment forms for the plans in which you are enrolling. Make a copy for your records and submit them to your Benefits Administrator within the specified timeframe provided. Failure to do so will result in a forfeiture of coverage. Forms can be found on your Ease Central benefits portal at **QDSD-BDR.easecentral.com.**

Making Changes

You can make changes to certain benefit elections during the year only if you experience a qualifying life event. You can request changes that are consistent with your life event by making changes to your benefit elections within 30 days after the date of the event. Depending upon the life event, you may be required to submit documentation of the event (document must state the effective date of the event). If you do not make the changes timely, you will not be able to change your benefits until the next annual enrollment opportunity. Any new election due to a life event must be on account of and correspond with the change in status event that affects eligibility for coverage. This means that there must be a logical relationship between the event that occurs and the election change you are requesting (i.e., if you divorce, it would not be logical to increase your Healthcare FSA election). Contact the Benefits Administrator for assistance in making timely changes. Such change in status events include but not limited to:

- Your marriage, divorce, or legal separation
- Birth or adoption of an eligible child
- Death of your spouse or covered child
- Change in your spouse's work status that affects his or her benefits
- Change in your work status that affects your benefits
- Change in residence or work site that affects your eligibility for coverage
- Change in your child's eligibility for benefits
- Receiving Qualified Medical Child Support Order (QMCSO)

Terminating Benefits

If you or a dependent no longer meet the plan's eligibility requirements, coverage ends on the last day of the month in which you or your dependents' status changed. You must notify the Benefits Administrator within 30 days if any of your dependents cease to be eligible for benefits.

Medical Benefits

CaliforniaChoice® Your Health. Your Choice.®	Kaiser Silver HMO B (In California)	Anthem Blue Cross Silver PPO B (Outside of California)
Benefit Overview	**In-Network**	**In-Network***
Network	HMO	PPO
Calendar Year Deductible	$1,000 Individual $2,000 Family	$1,500 Individual $3,000 Family
Calendar Year Out-of-Pocket Limit	$6,500 Individual $13,000 Family	$7,150 Individual $14,300 Family
Outpatient Services		
Physician/Specialist Office Visits	$45	$35 first 3 visits then 70%
Preventive Care/ Screening/Immunization	No Charge	No Charge
Diagnostic Test (X-ray, blood work)	$50 / $45	Deductible then 70%
Imaging (CT/PET Scans, MRI)	Deductible then $250	Deductible then 70%
Outpatient Surgery (Facility fee)	Deductible then 30%	Deductible then $300 Copay
Urgent Care	$45	Deductible then 70%
Pediatric Dental See Summary	Included	Included
Hospital Benefits		
Emergency Room Services	Deductible then 30%	Deductible then $300 Copay
Hospital Stay (Facility Fee)	Deductible then 30%	Deductible then $750
Prescription Drugs		
Rx Deductible	$150 Individual $300 Family	$250 Individual $500 Family
Generic	$25	$5
Brand Name	Deductible then $60	Deductible then $40
Non-Formulary	Deductible then $60	Deductible then $80
Specialty Drugs	Deductible then 20%	Deductible then 70%

*See Summary of Benefits & Coverage for details on Out-of-network coverage

Medical Plan Premiums

Premiums are based on the age of each family member. Refer to page 3 to see what your employer contributes toward your plans.

		Premium Per Pay Period (52) - Before Employer Contribution	
Rate Per Family Member		**Kaiser Silver HMO B**	**Anthem Blue Cross Silver PPO B**
Age as of Date of Enrollment		$1,000 / $2,000 Deductible $45 Office Visit $6,500 / $13,000 OOP	$1,500 / $3,000 Deductible $35 then 30% Office Visits $6,350 / $12,700 OOP
Age	0-18	$38.97	$49.45
Age	19-20	$35.75	$49.45
Age	21-24	$56.29	$77.88
Age	25	$56.52	$78.19
Age	26	$57.64	$79.75
Age	27	$58.99	$81.62
Age	28	$61.19	$84.65
Age	29	$62.99	$87.15
Age	30	$63.89	$88.39
Age	31	$65.24	$90.26
Age	32	$66.59	$92.13
Age	33	$67.44	$93.30
Age	34	$68.34	$94.54
Age	35	$68.79	$95.17
Age	36	$69.24	$95.79
Age	37	$69.69	$96.41
Age	38	$70.14	$97.04
Age	39	$71.04	$98.28
Age	40	$71.94	$99.53
Age	41	$73.29	$101.40
Age	42	$74.59	$103.19
Age	43	$76.39	$105.68
Age	44	$78.64	$108.80
Age	45	$81.29	$112.46
Age	46	$84.44	$116.82
Age	47	$87.99	$121.72
Age	48	$92.04	$127.33
Age	49	$96.03	$132.86
Age	50	$100.54	$139.09
Age	51	$104.98	$145.24
Age	52	$109.88	$152.02
Age	53	$114.84	$158.87
Age	54	$120.18	$166.27
Age	55	$125.53	$173.67
Age	56	$131.33	$181.69
Age	57	$137.18	$189.79
Age	58	$143.43	$198.43
Age	59	$146.53	$202.71
Age	60	$152.78	$211.36
Age	61	$158.18	$218.84
Age	62	$161.73	$223.74
Age	63	$166.17	$229.89
Age	64+	$168.87	$233.63

Health Plan Resources

KAISER PERMANENTE®

24-Hour Advice Nurse

Kaiser is there for it's members, night and day.

A registered nurse is available by phone about any health concern 24/7 and has access to your health information.

If you have an illness or injury and you're not sure what kind of care you need, Kaiser's advice nurses can help. With access to your health information, they can assess your problem and help you decide what to do.*

Call **(866) 454-8855** (from U.S. only) 24 hours a day, 7 days a week.

*Advice nurses can't give specific medical advice during an emergency. If you think you're having a medical emergency, call 911 or go to the nearest hospital.

Your 24-Hour Online Access

· Access to medical record
· Email your Doctor
· Schedule an appointment
· Find estimated costs of services
· Refill a prescription

Visit www.kp.org to access these features and more!

Know Your Health Plan

Health Maintenance Organization (HMO): An HMO provides medical services through contracted physicians and hospitals. All healthcare services are managed in-network through your Primary Care Physician (PCP). First select a PCP. Referrals to hospitals and specialists are managed by your PCP.

Out-of-Pocket: The amount you have to pay out of your pocket for health care services during a particular period of time, generally, calendar year.

Out-of-Pocket Maximum: Also called a "stop-loss" or "coinsurance maximum", is a provision that limits the amount you have to pay during a particular period of time.

Coinsurance: A co-sharing agreement between you and your health plan in which you pay a set percentage of the covered costs after the deductible has been paid.

Deductible: The amount you are required to pay before your benefits become payable. Deductibles are usually an annual fixed fee. Based on your benefit plan, a deductible may apply to all services obtained or to only a portion of your benefits.

Embedded Deductible: An embedded deductible means each member in the family must meet the Individual amount or the family must meet the Family amount before benefits will apply for that member.

Aggregate Deductible: An aggregate deductible means the family amount must be met before benefits will apply for any member of the family.

CalPerks

All California Choice medical members and their dependents are eligible for immediate savings through the following programs:

Employee Discounts

Cal Perks Discount Program offers discounts on movies, theme parks, hotels, and more.

EPIC Hearing

EPIC Hearing provides all members with a free hearing plan that provides discouts of up to 50% on all hearing –related products, test, and more.

Prescription Discounts

The California Rx Card Program offers discounts of up to 75% on prescriptions at most major pharmacies including CVS/pharmacy, Walgreens, and Rite-Aid.

Vision Discount Eyecare Program

Discount Vision available through **EyeMed Vision Care Program** offers all members discounts on frames, lenses, and eye examinations at many locations including Sears and Target optical centers.

Dental Solutions

Dentegra Smile Club is included at no additional cost and offers services at reduced fees and a network of over 12,000 dentists.

You may also enroll in the **SmileSaver Plan 3000** voluntary dental coverage at a discounted rate for you and your dependents. **The per pay period rates for this plan are below.** Please see plan summary for details.

Employee Only: $2.70
Employee + 1: $5.39
Employee + 2 or more: $7.76

Choosing a Dental Provider

You may obtain care from any licensed provider. However, our dental plan provides you with access to richer benefits through Preferred (PPO) dentists. Services obtained from network dentists will not be subject to "balance billing".

If you visit a Non-Participating dentist, you may be responsible for balance billed costs if the provider's charges exceed the plan's maximum allowable amounts for non-participating dentists. For a directory of in-network contracted providers visit the carrier website.

Voluntary Dental Benefits

PREMIER ACCESS

Benefit Overview	Premier Choice Network (PCN)	In-Network (PPO)	Out-of-Network
Calendar Year Deductible (Waived for preventive)	None	None	$50 *3 max per family*
Calendar Year Maximum		$1,500	
Preventive and Diagnostic Care Routine exams, cleanings, x-rays	100%	100%	100%*
Basic Services Fillings, root canal, periodontics, endodontics, composite fillings	100%	90%	Deductible then 80%*
Major Services Crowns, dentures, bridges	70%	60%	Deductible then 50%*

Note: For detailed plan information, please review the individual plan summaries.

*Out-of-network services are paid based on the 90th percentile Usual, Customary, and Reasonable (UCR) amount for the geographic region.

Employee Contributions

Employee Cost Per Pay Period (52)	
Employee	$10.37
Employee & Spouse	$23.44
Employee & Child(ren)	$16.29
Employee & Family	$29.55

Voluntary Vision Benefits

Benefit Overview	In-Network	Out-of-Network Reimbursements
Plan Copay (exam / materials)	$20	
Exam *Covered every 12 months*	Covered in full after $20 copay	Up to $45
Frames *Covered every 24 months*	$150 allowance	Up to $70
Standard Lenses *Covered every 12 months* *Single Vision* *Bifocal* *Trifocal*	Covered in full after $20 copay	Up to: $30 $50 $65
Contacts lenses in lieu of glasses *Covered every 12 months*	$150 allowance	Up to $105

Note: For detailed plan information, please review the individual plan summaries.

Choosing a Vision Provider

You may choose any provider you wish for your vision care, but you receive the highest level of coverage when you choose a provider in network for your services.

When you visit an out-of-network provider, you will typically pay more out-of-pocket. For a directory of in-network contracted providers visit the carrier website.

Employee Contributions

Employee Cost Per Pay Period (52)	
Employee	$2.17
Employee & Spouse	$3.32
Employee & Child(ren)	$5.63

TransAmerica Supplemental Benefits

Accidents and injuries can happen at any place at any time. A reduction of stress can lead to a speedier recovery. With health plans having deductibles of $1,000 or higher, this insurance can help offset the medical deductible. Accident insurance can help you pay for medical bills and other out-of-pocket expenses that often arise after an unexpected injury.

See the plan summary for in-depth information about what benefits are paid for specific injuries or procedures and rates.

Get benefits to spend on what you need

Accidents can have a dramatic impact on finances while you receive treatment for recovery. Benefits are paid directly to the member, allowing you to use the funds how and where you need them most without dipping into your family savings or using credit cards.

Get benefits that fit your needs

Special allowances to cover the cost of the services that you need based on your accident. For example: Funds to cover emergency costs and care during the first 96 hours after your accident and funds for follow-up visits and physical therapy if needed.

Protect yourself and your family

Enjoy extra peace of mind by adding your spouse and children to this policy. Dependent children can be covered through age 25.

Hassle-free online claims

Update your information, keep track of your policies, and submit claims from any internet enabled mobile device or PC.

Section 125 Information

Your contributions towards the elected Health & Welfare Benefits are pre-tax deductions in accordance with Section 125 of the Internal Revenue Code; this will reduce your taxable income. These elections are binding and cannot be modified until the next enrollment period, unless you have a Family Status Change or Special Enrollment Event (Qualifying Event). The tax-free exemption is not available for your Domestic Partner (DP) unless she/he is an eligible "tax dependent" as defined in IRS Code §152. Premiums for dependents that fall outside of the IRS definitions must be paid post-tax.

Sample Section 125 Salary Reduction Plan			
Without Pretax Deduction		**With Pretax Deduction**	
Taxable Gross	$1,000.00	Gross	$1,000.00
15% Federal Tax	-$150.00	Medical & Dental	-$100.00
7.65% Social Security Tax	-$76.50	**Taxable Gross**	$900.00
4% CA Tax	-$40.00	15% Federal Tax	-$135.00
Take Home	$733.50	7.65% Social Security Tax	-$68.85
Medical & Dental	-$100.00	4% CA Tax	-$36.00
Take Home	**$633.50**	**Take Home**	**$660.15**

Important Federal Notices

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 your plan.

Newborns' Act Disclosure

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

Special Enrollment Notice

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. To request special enrollment or obtain more information, contact your plan administrator.

Michelle's Law

A group health plan or issuer shall not terminate coverage of a dependent child due to a medically necessary leave of absence that causes the child to lose student status before the date that is the earlier of:

- the date that is one year after the first day of the medically necessary leave of absence; or
- the date on which such coverage would otherwise terminate under the terms of the plan or health insurance coverage. *See ERISA section 714(b).*

Important Federal Notices

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**

Notice of Patients Protections (For non-grandfathered plans)

Some California Choice HMO Plans generally allow the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, your chosen plan may designate one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the plan administrator.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from your chosen plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the benefit administrator.

Mental Health Parity Provisions

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires group health plans and health insurance issuers to ensure that financial requirements (such as copays, deductibles) and treatment limitations (such as visit limits) applicable to mental health or substance use disorder (MH/SUD) benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits.

For more information, please visit: www.cms.gov or http://www.dol.gov/ebsa/newsroom/fsmhpaea.html

Important Federal Notices Continued...

Quality Driver Solutions, Inc.
"Your Translogistics Staffing Source"

Notes:

Important Reference Information

CONTACT	CONTACT TYPE	WEBSITE/EMAIL	PHONE NUMBER
Quality Driver Solutions **Gaby Cousineau**	Benefits Administrator	gaby@qualitydriversolutions.com	916-920-9999
Benefits Done Right **Marilu Montero**	Benefits Advisor Account Manager	 mmontero@benefitsdoneright.com	800-482-1817 800-482-1817 ext. 220

CARRIER (In alphabetical order)	PLAN	WEBSITE/EMAIL	PHONE NUMBER
California Choice **Group No. 23746**	Medical	www.calchoice.com	800-558-8003
Premier Access **Group No. 17053**	Dental	www.premierlife.com	888-634-6074
Transamerica Life Insurance Co. **Group No. G00036530**	Accident Plan	www.transamericaemployeebenefits.com	888-763-7474
Vision Service Plan **Group No. SSN**	Vision	www.vsp.com	800-877-7195
Ease Central **Employee Benefits Portal**	**Self-Service Resource**	**QDSD-BDR.easecentral.com** **Documents Library** **Password: Benefits 1**	**Benefit Summaries, SBCs, SPD, Creditable Coverage Notice, Forms**

Benefits Done Right INSURANCE AGENCY

forward focus

The information in this Benefits Summary is presented for illustrative purposes. The text contained in this summary was taken from various summary plan descriptions and benefit information. While every effort was made to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact the benefits Administrator.

Employee Benefits · Made Simple · Done Right

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