



Qualifying Event Benefits Notes

Star benefit options: Gold health plan, Dental, Life insurance, and free vision with Gold plan election. Changes made to your insurance will be retroactive so they will start on the date of your event.

***** Any form you return must be completed in full. For example if you are adding someone to your benefits and you already have people on it make sure you put them on the form also. This change form will replace any older forms on file!*****

You must include proof of your event. For example:
marriage – send marriage certificate
loss of coverage – send proof from old coverage that shows when it started and when it ended
birth – send birth certificate
send copies of proof in with the change forms.

Since you have thirty days from your event date to make changes please remember there will be retro premiums coming out of your check along with your new weekly premium amount.



Once you send in your change request it may take a little while to process it through all of the steps and departments here and at the insurance company

Benefit Pricing is included in this change of coverage Packet

*****Medical, Dental, Vision Plan Complete Plan**

Book: www.startransportation.com click on Driver's then on Benefits***

Star uses a PPO network for doctors and hospitals. This is a network of providers that give us a discounted rate. Using providers from this list will help you to keep costs lower.

The PPO network can be accessed at www.multiplan.com . You may also call 1-800-877-4761.

***Ask First - For Mississippi residents use www.mpcn-ms.com or 1-800-931-8533.

*** The PPO network is not for vision, or dental care. You may go to any dentist or vision care professional you choose.

*****Star does not have a yearly open enrollment option. You may downgrade your choices, or drop people from the plans you have chosen, you cannot upgrade or add dependents unless you meet the criteria below.**



Qualifying events:

Qualifying events (Marriage, Divorce, Birth, Death, Adoption, Loss of credible coverage at no fault of the plan member, Spouse coverage changes, Etc.) These events allow you to change your insurance options and add dependents. You only have thirty days from the date of change to notify us, fill out the forms, and provide the documentation required for the change.

If you can not turn in these forms and the proof of change in person, there are four other options available. Mail them to:

Star Transportation
Attn: Brooke Ford
1116 Polk Ave.
Nashville, TN 37210

Fax to Attn: Brook Ford at 615-255-8674

E-mail them to bford@startransportation.com

Put them in a trip pack envelope with Attn: Brooke on the front

Please let me know if you have any questions or need help with the forms.

Thank you,
Brooke Ford
Employee Benefits Specialist
Star Transportation, Inc.
Phone # 615-324-5492
Fax# 615-255-8674

IMPORTANT: This facsimile transmission contains confidential information, some or all of which may be protected health information as defined by the federal Health Insurance Portability & Accountability Act (HIPAA) Privacy Rule. This transmission is intended for the exclusive use of the individual or entity to whom it is addressed and may contain information that is proprietary, privileged, confidential and/or exempt from disclosure under applicable law. If you are not the intended recipient (or an employee or agent responsible for delivering this facsimile transmission to the intended recipient), you are hereby notified that any disclosure, dissemination, distribution or copying of this information is strictly prohibited and may be subject to legal restriction or sanction. Please notify the sender above to arrange the return or destruction of the information and all copies.

STAR TRANSPORTATION, INC EMPLOYEE ENROLLMENT FORM FOR NORTH AMERICA ADMINISTRATORS, L.P. T.P.A.

Change of Benefit: OTR Hire Date: _____ Date of Change: _____ What Changed: _____

EMPLOYEE NAME: LAST _____ FIRST _____ M.I. _____ SS# _____ DATE OF BIRTH _____ SINGLE MALE
 MARRIED FEMALE

EMPLOYEE MAILING ADDRESS _____ City _____ ST _____ Zip Code _____ EMPLOYEE PHONE # _____

Medical coverage (Gold Plan including vision):
 Yes I want medical coverage. Do you smoke: _____ ? No I do not want medical coverage.

Dental coverage
 Yes I want Dental coverage. No I do not want dental coverage.

***If you answered no to both coverage questions skip to the bottom of this form - Sign and date it.**

****Fill in below only if you want to cover a spouse (legal marriage only) or child(ren) on medical or dental.**

*****Eligible children are natural, step, foster, adopted, assigned custody, and forever dependents.**
******Eligible children are natural, step, foster, adopted, assigned custody, and forever dependents no age limit.**

SPOUSE NAME (Provide a marriage certificate if your last names are different.) SS# _____ Date of Birth MM/DD/YY _____ SEX M F Smoker Yes No Medical Yes No Dental Yes No

Child's Name _____ SS# _____ Date of Birth MM/DD/YY _____ SEX M F Smoker Yes No Medical Yes No Dental Yes No

Circle One: Natural Step Foster Adopted Assigned Custody Forever Dependent
 Child's Name _____ SS# _____ Date of Birth MM/DD/YY _____ SEX M F Smoker Yes No Medical Yes No Dental Yes No

Circle One: Natural Step Foster Adopted Assigned Custody Forever Dependent
 Child's Name _____ SS# _____ Date of Birth MM/DD/YY _____ SEX M F Smoker Yes No Medical Yes No Dental Yes No

Circle One: Natural Step Foster Adopted Assigned Custody Forever Dependent
 Child's Name _____ SS# _____ Date of Birth MM/DD/YY _____ SEX M F Smoker Yes No Medical Yes No Dental Yes No

Are you, your spouse, your children, step children, or other dependents covered by any other medical or dental insurance? Yes _____ No _____

I authorize deductions from my earnings of the required contributions, if any, toward the cost of the coverage by my employer. I acknowledge that I have been given the opportunity to elect coverage under the group benefit plan. I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to furnish North America Admins- trators, L.P. with full information regarding medical treatment (including copies of their records). I also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish North America Adminis- trators, L.P. with information regarding benefits to which I/We may be entitled. A copy or photocopy of this authorization shall be considered as effective and valid as the original.

EMPLOYEE SIGNATURE _____ DATE _____

STAR TRANSPORTATION, INC

Statement of Health Plan Understanding

Please read the information below. You are to read and sign that you understand. This does not say that you have one of these right now. It is explaining what they are and what they mean to your insurance options.

I understand that once plan options are elected, I must make changes during my grace period (hire date through effective date of insurance plus 30 day trial period), or within 30 days of qualifying events (see examples below).

1. Marriage.

2. Divorce

3. Death

4. Birth of a child.

5. Adoption of a child

6. Loss of Coverage at "no fault" of mine or my spouse's.

(This does NOT include reduction of benefits or increase in employee contributions/premiums by this sponsored health plan or that of my spouse).

7. Any other US Department of Labor defined qualifying events.

I also understand Star Transportation does not have yearly open enrollment to make plan changes.

SIGNATURE

DATE

Star Transportation, Inc. * N O T I C E * of Privacy Practices

Your name and signature on this sheet indicate that you have received a copy of Star Transportation, Inc.'s Notice of Privacy Practices on the date indicated. If you have any questions regarding the information set forth in the Notice of Privacy Practices, please do not hesitate to contact Bill Harris, Vice President of Risk Management and Privacy Officer at 800-333-3060.

Name: (Please Print): _____

Signature: _____ Date: _____

STAR TRANSPORTATION, INC EMPLOYEE ENROLLMENT FORM FOR THE HARTFORD GL-675090

Change of Benefit: OTR Hire Date: _____ Date of Change: _____ What Changed: _____

Employee Name: Last _____ First _____ M.I. SS# _____ D.O.B. _____ Phone# _____ Male Female

Mailing Address: _____ City _____ ST _____ Zip Code _____ Single Married Did you elect Medical coverage? _____

Yes I elected medical coverage and I have \$15,000 in company paid life insurance on myself. I would like my beneficiary of this basic policy to be: Name _____ This person is my (Mother, Wife, Brother, Etc.) _____

***If you did not elect medical coverage ***You must purchase supplemental life to have life insurance coverage through Star.

Supplemental Life Insurance coverage: *****If you do not want to purchase life insurance coverage for yourself skip to the bottom of this form and sign and date it.

Yes I want to purchase life insurance coverage for myself in the amount of \$10,000 \$20,000 \$30,000 \$40,000 \$50,000 \$60,000 \$70,000 \$80,000 \$90,000 \$100,000. Or you may purchase up to 5X your yearly salary with additional paperwork, if you would like to do this check here

***Fill in below only if you want to elect life insurance coverage for a spouse (legal marriage only), child(ren) under 25 years of age, or forever dependents: I want to purchase life insurance coverage for my spouse in the amount of: \$10,000 \$20,000 \$30,000 Spouse's name _____ Date of Birth _____ Male _____ or Female _____

Yes I want to purchase life insurance coverage for my child(ren) in the amount of \$ 10,000.00 per child.

Child: Last	First	MI	Date of Birth	Sex: M F	Child: Last	First	MI	Date of Birth	Sex: M F
Child: Last	First	MI	Date of Birth	Sex: M F	Child: Last	First	MI	Date of Birth	Sex: M F

**Please be aware that you are the beneficiary of any spousal or child life insurance elected above and your life insurance should be paid out using the following instructions in the event of your death: One Beneficiary 100%, more than one Beneficiary split up the 100%

Primary Beneficiary's Name _____ Relationship: _____ D.O.B. _____ SS# _____

Address: _____ Benefit Percent: _____ %

Primary Beneficiary's Name _____ Relationship: _____ D.O.B. _____ SS# _____

Address: _____ Benefit Percent: _____ %

*OPTIONAL * You may elect Contingent Beneficiary (s) to inherit in the place of your Primary Beneficiary (s) if they have passed away. One Beneficiary 100%, more than one Beneficiary split up the 100%.

Contingent Beneficiary's Name _____ Relationship: _____ D.O.B. _____

SS# _____ Address: _____ Benefit Percent: _____ %

Contingent Beneficiary's Name _____ Relationship: _____ Date of Birth _____ SS# _____

Address: _____ Benefit Percent: _____ %

I hereby apply for the coverage's I have indicated above on behalf of myself and all dependents listed, and I authorize my employer to make the appropriate deductions, if any, from my wages to pay for my share of the cost. I understand that the coverage's available to me are in accordance with the provisions of the contract between Hartford Life and my Group Plan.

I hereby decline the coverage's offered to me. I understand that if I desire to apply for any coverage's at a later date, I will be required to furnish, at my own expense, medical evidence in support of insurability, that is satisfactory to Hartford Life, before my coverage will become effective. SIGNATURE _____ DATE _____

***** A-GOLD *****

Comprehensive Medical and Vision Insurance:

Employee (non-smoker)	\$23.00 per week	
Employee (smoker)	\$33.00 per week	Example
Spouse (non-smoker)	\$39.00 per week	Employee \$33.00
Spouse (smoker)	\$49.00 per week	+ \$4.04 per week
Each Dependent (non-smoker)	\$24.00 per week	1 Daughter + \$7.79 per week
Each Dependent (smoker)	\$34.00 per week	+ \$1.95 per week
		1 Son \$24.00
		Weekly Medical Total \$81.00

Dental Insurance:

Single Coverage	\$4.04 per week
Single plus One	\$7.79 per week
Family Coverage	\$11.95 per week

WEEKLY LIFE

Age	\$ 10,000.00	\$ 20,000.00	\$ 30,000.00	\$ 40,000.00	\$ 50,000.00	\$ 60,000.00	\$ 70,000.00	\$ 80,000.00	\$ 90,000.00	\$ 100,000.00
< 30	\$ 0.21	\$ 0.42	\$ 0.62	\$ 0.83	\$ 1.04	\$ 1.25	\$ 1.45	\$ 1.66	\$ 1.87	\$ 2.08
30 - 34	\$ 0.28	\$ 0.55	\$ 0.83	\$ 1.11	\$ 1.38	\$ 1.66	\$ 1.94	\$ 2.22	\$ 2.49	\$ 2.77
35 - 39	\$ 0.35	\$ 0.69	\$ 1.04	\$ 1.38	\$ 1.73	\$ 2.08	\$ 2.42	\$ 2.77	\$ 3.12	\$ 3.46
40 - 44	\$ 0.42	\$ 0.83	\$ 1.25	\$ 1.66	\$ 2.08	\$ 2.49	\$ 2.91	\$ 3.32	\$ 3.74	\$ 4.15
45 - 49	\$ 0.86	\$ 1.72	\$ 2.58	\$ 3.44	\$ 4.30	\$ 5.16	\$ 6.02	\$ 6.88	\$ 7.74	\$ 8.60
50 - 54	\$ 1.48	\$ 2.96	\$ 4.44	\$ 5.92	\$ 7.40	\$ 8.88	\$ 10.36	\$ 11.84	\$ 13.32	\$ 14.80
55 - 59	\$ 2.38	\$ 4.76	\$ 7.14	\$ 9.52	\$ 11.90	\$ 14.28	\$ 16.66	\$ 19.04	\$ 21.42	\$ 23.80
60 - 64	\$ 3.13	\$ 6.26	\$ 9.39	\$ 12.52	\$ 15.65	\$ 18.78	\$ 21.91	\$ 25.04	\$ 28.17	\$ 31.30
65 - 69	\$ 4.61	\$ 9.22	\$ 13.83	\$ 18.44	\$ 23.05	\$ 27.66	\$ 32.27	\$ 36.88	\$ 41.49	\$ 46.10
70 - 74	\$ 14.43	\$ 28.86	\$ 43.29	\$ 57.72	\$ 72.15	\$ 86.58	\$ 101.01	\$ 115.44	\$ 129.87	\$ 144.30
75 - 99	\$ 14.43	\$ 28.86	\$ 43.29	\$ 57.72	\$ 72.15	\$ 86.58	\$ 101.01	\$ 115.44	\$ 129.87	\$ 144.30

Guaranteed amount of coverage

Employee \$100,000

Maximum amount of coverage

Spouse \$30,000

To calculate your weekly deductions:

Maximum amount of coverage for Child(ren) is \$10,000 and the price is \$0.42 a week

The maximum per family weekly deduction is \$140.00 (medical only)

Add your weekly medical total to your weekly dental cost, then add any life insurance you elected for yourself, plus any election for your spouse, and if you are covering children add \$0.42 per week.

INSURANCE

You and your family are offered a wide choice of insurance benefits with our company.

Eligibility is dependent upon several factors and is effective the **1st of the month following 60 consecutive days of employment.**

There is much more to this plan and some restrictions apply, attached you will find a Schedule of Benefits.

COMPREHENSIVE MEDICAL INSURANCE

Medical benefit premiums; deductibles and co-payments are dependent on a number of factors. One of the most important of these is YOU! Premium discounts are provided for non-smokers. Lower deductibles are offered if you and /or your dependents use physicians and hospitals within our PPO network.

Gold Medical Plan includes the following:

LIFE INSURANCE

- 1. Basic Life Insurance Benefit \$15,000.00
- 2. Accidental Death & Dismemberment Benefit \$15,000.00

VISION BENEFITS

- % Payable Gold 80%
- Maximum Annual Bene \$225.00

LAB ONE BENEFIT

- Outpatient laboratory charges billed by LabOne 100%

This is a summary for information purposes only. If there are any discrepancies between this summary and the plan document, the plan document will prevail.

Pharmacy Deductible	\$50.00 per person
Pharmacy Co-Pay (30 day supply maximum)	
Generic	\$15.00 or 20% whichever is greater
Formulary Brand	\$35.00 or 30% whichever is greater
Non-Formulary Brand	\$50.00 or 35% whichever is greater
Mail Order (90 day supply maximum)	
Generic	\$35.00 or 20% whichever is greater
Formulary Brand	\$65.00 or 30% whichever is greater
Non-Formulary Brand	\$95.00 or 35% whichever is greater

DENTAL BENEFITS ARE AVAILABLE (IF ELECTED)

|Calendar year deductible - Class B & C only.	
Per Individual	\$50.00
Per Family	\$150.00

|Calendar year deductible - Class D only.	
Per Individual	\$100.00

|% Payable	
Class A - Preventive	100%
Class B - Basic	80%
Class C - Major	70%
Class D - Orthodontia	50%

|Maximum Benefits Payable:	
Annual Maximum Benefit (Class A, B, and C combined)	\$1,250.00
Lifetime Maximum Benefit (Class D)	\$1,000.00

GOLD PLAN - A

Schedule of Benefits

COMPREHENSIVE MEDICAL BENEFITS

Lifetime Maximum Benefit (All conditions - Other internal limits may apply)	.....	\$1,000,000.00
Lifetime Maximum - Transplant	.....	\$150,000.00
Lifetime Maximum - TMJ	.....	\$1,000.00
Annual Maximum - Prescription Benefit	.....	\$10,000.00
Annual Maximum - Podiatry	.....	\$500.00

Deductible:

	<u>PPO Benefits</u>	<u>NON-PPO Benefits</u>
Individual	\$1,250	\$2,000
Family	\$2,000	\$3,000
Out-of-Pocket Maximum: (excludes deductibles)		
Individual	\$3,500	\$25,000
Family	\$7,000	\$50,000

After the Individual (or Family) Out-Of-Pocket Maximum has been reached for the calendar year, the Plan will pay 100% of subsequent covered expenses incurred by the individual (or family) during the remainder of that calendar year. Except where there is other secondary coverage for the same illness or injury, the Plan will continue to pay at the applicable 80%, 70%, or 50% co-insurance percentage.

Benefits will be paid at the PPO level for Covered Expenses incurred for radiology, anesthesiology, pathology, and laboratory, provided services are performed in a PPO Network facility or when services are upon referral by a PPO Physician.

If services are not offered by a Preferred Provider or if a Covered Person is traveling outside of the geographical area (more than 50 miles) of the Preferred Provider Organization, benefits will be paid as if the provider was in the Preferred Provider Organization.

Inpatient:

	<u>Subject to Deductible</u>	<u>Subject to Deductible</u>
Room, Board & Ancillaries	80%	50%
Surgery (Physician Charges)	80%	50%
Physician Visits in Hospital	80%	50%
Skilled Nursing Facility	80%	50%
Outpatient		
Diagnostic X-Ray & Lab	80%	50%
-refer to Lab One Benefit		
Surgery-Short Stay Unit or	80%	50%
Outpatient Department		
Home Health Care/Hospice	80%	50%
All other eligible charges	80%	50%
Physician Office	Not subject to Deductible: 100% after \$25 per visit co-payment up to a maximum payment of \$100 balance at 80%	Subject to Deductible: 50%

	<u>PPO Benefits</u>	<u>NON-PPO Benefits</u>
Allergy Injections	80%	50%
Emergency Room Charges	not subject to deductible 80%	50%
Routine Diagnostic	\$250	\$250
Mammogram Benefit	co-pay per visit	co-pay per visit
Routine Pap Smear Benefit	100% up to the maximum per schedule	70%
Annual Physical	100% after \$25 per visit up to max of \$100	70% up to max \$100
Exam Benefit	100% after \$25 per visit co-pay up to max \$350	70% up to max \$350
Routine Well Child Care	100% after \$25 per visit co-pay up to a max \$350	70% up to max \$350

Well Child Care-Expenses for routine health supervision, examinations and immunizations, are covered for children 0-6.



HOMework

For your benefits to work properly you will need to provide me (before your enrollment date) or the insurance company (after your enrollment date) with a little information:

Please send in a copy of your certificate of prior coverage. That is a letter from your previous insurance company listing who was covered and the dates they were covered for.

If you do not have prior insurance coverage you will need to write a letter. Please put your name and social security number at the top. List everyone that you are putting medical coverage on including yourself. Then list every doctor and every prescription for the last six months for each person starting from your hire date going backwards. If there have been no doctor visits or prescriptions write that down.

Mailing Addresses:

North America Administrators P.O. Box 1984 Nashville, TN 37202

Or

Star Transportation Attn: Brooke Ford P.O. Box 100925
Nashville, TN 37224

Thank you,
Brooke Ford Employee Benefit Specialist 615-324-5492

NOTICE OF PRIVACY PRACTICES

PLAN NAME: STAR Group Benefits

Effective Date: April 14, 2004

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

1. Introduction

What is this Notice? This Notice of Privacy Practices ("Notice") describes the Plan's privacy practices, its legal duties, and your rights concerning your protected health information ("PHI"), including how your PHI may be lawfully used and disclosed by the Plan and how you can get access to it. Please review this Notice carefully. Any Questions? Should you have any questions about the contents of this Notice, please contact the Plan's Privacy Official. Please see the end of this Notice for contact information.

2. General Information

What will the Plan do with my health information? The Plan will make sure that your PHI remains private and confidential according to the requirements of the law; and will follow the privacy practices detailed in this Notice while it is in effect.

The Plan reserves the right to change its privacy practices. The Plan reserves the right to change its privacy practices and the terms of this Notice at any time; and to change its privacy practices for the use and disclosure of PHI that the Plan maintains, including PHI the Plan created or received before it made the changes. Before the Plan makes a significant change in its privacy practices, the Plan will revise this Notice and provide you with a new updated Notice.

You may request a copy of our Notice at any time. For more information about the Plan's privacy practices, or for copies of this Notice, please contact the Plan's Privacy Official.

3. Uses And Disclosures Of Health Information

To the Covered Individual. The Plan may disclose your PHI to you or your personal representative for any purpose. The Plan must disclose your PHI to you or your personal representative upon request. **For Treatment, Payment, and Health Care Operations:** The Plan may use and disclose your PHI for purposes of treatment, payment, and health care operation, as those terms are defined in the law. For example:

Treatment: The Plan may disclose your PHI to your doctor or other health care provider to allow for your treatment.

Payment: The Plan may use and disclose the minimum necessary PHI to pay claims for services provided to you by a physician, hospital, or other provider, or to determine your eligibility for benefits under the Plan.

Health Care Operation: The Plan may use and disclose the minimum necessary PHI to conduct quality assessment and improvement activities, to engage in care coordination or case management, to manage the administration of the Plan, and for similar operational purposes.

Organized Health Care Arrangements. The Plan may also disclose the minimum necessary PHI to any insurance companies or health maintenance organizations that provide benefits under the Plan or with other group health plans maintained by the same employer to carry out the Plan's health care operation activities.

To Family and Friends. The Plan may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your care or payment for health care if you agree or, if you are unavailable to agree, the Plan determines that a medical emergency or other situation indicates that disclosure would be in your best interest.

To the Employer. The Plan may disclose the minimum necessary PHI to your employer to permit the employer, in its capacity as Plan administrator, to perform Plan administration functions.

To Business Associates of the Plan. The Plan may disclose the minimum necessary PHI to service providers, known as business associates who perform various functions on behalf of the Plan. The Plan will take appropriate steps to ensure that the business associates will safeguard your PHI.

To Create De-Identified Information. The Plan may use the minimum necessary PHI or disclose the minimum necessary PHI to a business associate to create "de-identified information" by removing sufficient data that the health information is no longer individually identifiable.

As Required by Law. The Plan may use or disclose PHI when the Plan is required to do so by law.

For Public Health Activities. The Plan may disclose the minimum necessary PHI to public health authorities authorized to receive the information for purposes of preventing or controlling disease, injury or disability, or to the appropriate authorities to report child abuse or neglect.

To Report Victims of Abuse, Neglect or Domestic Violence. In certain circumstances, the Plan may disclose your PHI to appropriate authorities, if it reasonably believes you are a victim of abuse, neglect, or domestic violence.

For Health Oversight Activities. The Plan may disclose the minimum necessary PHI to health oversight agencies authorized to oversee the health care system or entities subject to government regulatory programs.

In Response to Judicial and Administrative Proceedings. The Plan may disclose the minimum necessary PHI in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

To Law Enforcement Officials. Under certain conditions, the Plan may disclose limited PHI to a law enforcement official for certain law enforcement activities.

In the Event of Death. The Plan may disclose your PHI to a medical examiner or coroner (and if legally authorized, a funeral director) for identification, to determine cause of death or to carry out other legally authorized duties.

For Cadaveric Organ, Eye or Tissue Donation. The Plan may disclose the minimum necessary PHI to facilitate organ, eye or tissue donation and transplantation.

To Prevent Serious Threat To Health or Safety. The Plan may disclose the minimum necessary PHI to appropriate authorities, if it believes disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

For Military and National Security Purposes. The Plan may disclose to military authorities the minimum necessary PHI of Armed Forces personnel under certain circumstances. The Plan may disclose the minimum necessary PHI to authorized federal officials for lawful intelligence, counterintelligence, and other national security activities.

For Workers' Compensation. The Plan may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs.

To The U.S. Department of Health and Human Services. The Plan must disclose PHI upon request to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with federal privacy laws.

By Written Authorization. Except as described above, the Plan may use or disclose your PHI only if it has received a written authorization from you or your authorized personal representative. You or your personal representative may revoke the authorization in writing at any time, but that revocation will not affect any permitted use or disclosure while the authorization was in effect.

4. Your Individual Rights

You have the following rights with respect to the ways in which the Plan maintains, uses, or discloses your health information:

Right to Inspect and Copy. You have the right to view and receive copies of your PHI kept in the Plan's designated record set for you (with some limited exceptions). The Plan will provide the information to you in the format you request unless the Plan determines that the request is unreasonable.

You must make a request in writing to obtain access to or get copies of your PHI. You may obtain a request form by contacting the Plan's Privacy Official. The request form contains additional information about procedures and charges for obtaining your records.

Right to Obtain List of Certain Disclosures. You have the right to receive a list of all instances in which the Plan disclosed your PHI for purposes OTHER THAN treatment, payment, health care operations and certain other activities. The Plan will provide you with the date of the disclosure, the name of the person or entity to whom the Plan disclosed your information, a description of the information the Plan disclosed, the reason for the disclosure, and certain other information. You may obtain a request form from the Plan's Privacy Official. The request form contains additional information and procedures.

Right to Request Restrictions on Use or Disclosures. You have the right to request restrictions on the use or disclosure of your PHI. The Plan is not required to agree to these additional restrictions, but if the Plan does agree, the Plan will abide by the agreement (except in an emergency). The Plan will not be bound unless the agreement is in writing and signed by the Privacy Official.

Right to Request Confidential Communication. You have the right to request that the Plan communicate with you about your PHI by means other than the phone numbers or address contained in the Plan's records. You must inform the Plan that communication by other means or at other locations is required to avoid endangering you. You must make your request in writing. The Plan will accommodate your request if it is reasonable, if it specifies the other means or location, and provides a satisfactory explanation of how payments for services will be handled.

Right to Amend. You have the right to request that the Plan amend your PHI. Your request must be in writing, and it must explain why the information should be amended. The Plan may deny your request under certain circumstances. Please contact the Privacy Official for more information and procedures for amending your health information.

Right to Have Written Notice of this Form. If you receive this Notice on our web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon request.

5. Questions And Complaints

Who should I contact if I have questions about the Plan's privacy practices? If you want more information about these privacy practices or have questions or concerns about this Notice, please contact the Plan's Privacy Official.

What if I have a complaint about the Plan's privacy practices? If you are concerned that the Plan may have violated your privacy rights, or you disagree with a decision the Plan makes about access to your PHI, an accounting of disclosures, a request to amend, or a request to restrict the use or disclosure of your PHI, you may file a complaint with our Privacy Official. You also may submit a written complaint to the U. S. Department of Health and Human Services.

Will I be penalized if I file a complaint? You will not be penalized if you choose to file a complaint with the Plan or with the U. S. Department of Health and Human Services.

6. Contact Information

Privacy Official: Mark Hopper

Address: Star Transportation, Inc., 1116 Polk Ave, Nashville, TN 37210 Office Telephone: 615-324-5456

Fax: 615-255-3674 E-mail: mhopper@startransportation.com



Example of welcome letter included with you insurance cards to be mailed to your home before your insurance starts.

To see the MEDICAL plan book for your coverage:

Please go to www.startransportation.com click on Drivers, then, click on the Benefits tab. Scroll down and click on the Medical/Dental icon, finally click on all the postings to learn about the plan you chose and any additional benefit programs that come with your choices.

To see the DENTAL plan book for your coverage:

The dental plan is included in ALL three medical plan books. The dental coverage is the same for All PLANS, so pick any plan book for the dental coverage info.

To see the LIFE plan book for your coverage:

Please go to www.startransportation.com click on Drivers, then, click on the Benefits tab. Scroll down and click on the Medical/Dental icon, finally click on all the postings to learn about the plan you chose and any additional benefit programs that come with your choices. Follow the same steps to print the Group Life Insurance information. You can use this to answer questions or you can print what you need.

For coverage questions and claim questions you have a self service option in addition to the phone number on your card:

***The website for Claims Status, Coverage Questions, and Verification of benefits is <https://lin.naa-lp.com>.

To see the NETWORK OF MEDICAL DOCTORS AND HOSPITALS:

***The website for finding a PPO Network doctor or hospital is www.multiplan.com . OR you can use the phone number on your card.



To see a DENTIST:

You may go to any dentist or dental facility in the country.

VISION:

You may get your eyes examined or go to any vision facility in the country.

This is a PPO Plan, implemented to control increasing health costs. We cannot stress enough the importance of familiarizing yourself and your family with the enclosed information, because it lists explicitly the guidelines concerning your health benefits.

The most important thing to remember about the plan is that it is, for all intents and purposes, self-funded. We have obtained catastrophic insurance to protect our company against extreme dollar losses. With this in mind, quite obviously, it is up to each of us to help contain health costs whenever possible.

The following are very important instructions concerning your coverage:

- 1) Use only those hospitals in your preferred provider network "Remember; emergency diagnosis are always paid at in network benefit levels". You will save money this way. If you have questions concerning network hospitals or physicians, please call (800) 877-4761 or you can utilize the network website www.multiplan.com
- 2) When selecting a physician, make sure he/she is in the network. If you already have a physician and he/she is not in the network, you may want to change doctors, or ask your doctor to join our network. Remember that when using an out of network doctor you will be responsible for more of the charges.
- 3) There is a \$25 CO-pay for every doctor's office visit. The plan will pay up to \$100 of any in-office visit after your co-pay. Any amount above \$100 coded for in-office visit will be paid by the patient and applied toward your deductible. This is to keep doctors from doing hundreds of dollars in services and only using the office visit code.
- 4) If you need surgery, either as in-patient or out-patient, make sure you get the surgery pre-certified by having your doctor call 800-356-7126 or 615-256-3644. Failure to pre-certify could result in decreased or denied benefits.



- 5) **LAB WORK:** If you use Lab Card services to have your lab work done the company will pay 100% of your lab costs. You may reach them at 1-800-646-7788 or www.labcard.com
- 6) **PRESCRIPTIONS:** For network pharmacy locations, to get a price quote, or to find out about 90 supplies of medicine call 1-800-711-4550.

7) **If your doctor is not going to submit your expenses to the insurance for you: Send your claim with proper documentation of your medical bills showing procedures and diagnosis codes to "North America Administrators" for processing. Furthermore, make sure the claim is filed within 180 days. Any claims not filed after 180 days of the illness or accident will not be paid. This policy is strictly enforced.**

If your claims are sent to any address other than North America, there is a possibility that the claim will not be paid and you will be responsible for the charges. So make sure your health care providers send all claims to: **North America Administrators**

**P.O. Box 1984
Nashville, TN 37202
ATTN: GROUP 0385**

Please read the plan book that matches your benefit choices!

Please pay special attention to the "Limitations and Exclusions" section of your booklet. This section details those items or conditions that are simply not covered by our program. Things like cosmetic surgery, treatment for accidents while under the influence of drugs or alcohol, or charges for treatment by members of your family are excluded from coverage. Also be aware that our plan does not coordinate benefits with any other plan in excess of the normal coverage afforded by our plan.



Star Transportation, Inc. strives to provide a quality health care program at an affordable price. Each of us must do our part in helping us maintain this coverage. The easiest way for you to control health costs is through a healthy lifestyle that includes proper diet and fitness.

Should you have questions regarding the plan, please contact North America Administrators, 800-411-3650, or 615-256-3561.

If you would like to request a paper copy of your medical of life insurance plan book send an e-mail to: bford@startransportation.com please give me the employees name and the book you are requesting (gold, silver, or bronze) and the address that you want it mailed to.

Or

You can mail your request to:

Employee Benefits
Star Transportation
P.O. Box 100925
Nashville, TN 37224

If you have questions or concerns please let me know.

Thank you,
Brooke Ford
Employee Benefits Specialist
Star Transportation
(800) 333-3060 X 5492
FAX 615-255-8674
bford@startransportation.com