DATE: January 6, 2023

TO: RFP Recipients

FROM: Roni Hattrup, Executive Director of Mountain View Transportation Management Association

SUBJECT: ADDENDUM #1 to RFP for Shuttle Operations

This correspondence constitutes official record of the first alteration of the Mountain View Transportation Management Association's RFP for Shuttle Operation Services, issued on November 22, 2022.

This Addendum includes the following alterations:

1. Proposal Submission Deadline is extended to January 19, 2023 at 3:00PM.
2. Deadline for questions has been extended to January 9, 2023 at 5:00PM.
3. Should interviews be needed, they will be conducted the week of January 30th – February 3rd. There are no changes to the estimated contract award date.
4. Attachment A – Scope of Services, Section E2: The MVCS fleet will be comprised of the following fleet of vehicles as of July 1, 2023. Upon the end of the lease for 2015 vehicles, the MVCS fleet will be comprised of only the 6 remaining vehicles:

Year	Make/Model	Type	Estimated Vehicle Delivery Date	Lease End Date
2015	AmeriTrans E450	Gas	In Current Fleet	12/31/2023
2015	AmeriTrans E450	Gas	In Current Fleet	12/31/2023
2015	AmeriTrans E450	Gas	In Current Fleet	12/31/2023
2023	TurtleTop Terra Transit E450	Gas	In Current Fleet	12/31/2025
2023	TurtleTop Terra Transit E450	Gas	In Current Fleet	12/31/2025
2022	Vicinity Lightening EV	Electric	April 2023	March 2029 (estimated)
2022	Vicinity Lightening EV	Electric	April 2023	March 2029 (estimated)
2022	Vicinity Lightening EV	Electric	April 2023	March 2029 (estimated)
2022	Vicinity Lightening EV	Electric	April 2023	March 2029 (estimated)

5. Attachment F – Current Contractor Wages & Benefits
   Please refer to the modified Attachment F, attached.

ATTACHMENT F – REVISED 1/6/23 CURRENT
CONTRACTOR WAGES & BENEFITS

MVGo Shuttle Program

Contractor: MV Transportation, Inc.

Union Status: Non-Union

Position	Date of Hire	Exempt	Wage
Driver	3/14/2022	N	$ 25.05
Driver	11/8/2021	N	$ 26.85
Driver	4/4/2022	N	$ 25.05
Driver	10/21/2019	N	$ 25.05
Driver	6/23/2021	N	$ 25.05
Driver	7/20/2021	N	$ 25.05
Driver	11/22/2021	N	$ 25.05
Driver	10/31/2022	N	$ 22.00
Driver	11/21/2022	N	$ 25.05
Operations Supvr	8/26/2019	N	$ 29.02

**Wages reflected above are base wages. Wage of $22 is for training period only. Wage increases to $25.05 upon completion of training.*

Number of Drivers: 9 (Regular Full-Time)

Maintenance Worker Wage: $34.65

401K: Company matches 20% of employee contributions up to 6% of compensation.

Benefits: Medical, dental and vision plans are available with employee contributions. See plan information attached. Below is a monthly cost summary for those who participate in the benefit plans.

Benefits Cost Summary				
Medical	**Employee Count**	**Employee Cost**	**Employer Cost**	**Total Cost**
Employee Only	1	$ 87.26	$ 425.87	$ 513.13
Employee + Spouse	2	$ 388.84	$ 740.04	$ 1,128.88
Employee + Children	1	$ 204.26	$ 719.37	$ 923.63
Employee + Family	0	$ 421.96	$ 1,117.42	$ 1,539.38
Dental	**Employee Count**	**Employee Cost**	**Employer Cost**	**Total Cost**
Employee Only	1	$ 31.73	$ -	$ 31.73
Employee + Spouse	2	$ 68.30	$ -	$ 68.30
Employee + Children	1	$ 65.26	$ -	$ 65.26
Employee + Family	0	$ 113.26	$ -	$ 113.26
Vision	**Employee Count**	**Employee Cost**	**Employer Cost**	**Total Cost**
Employee Only	1	$ 5.60	$ -	$ 5.60
Employee + Spouse	2	$ 11.22	$ -	$ 11.22
Employee + Children	1	$ 11.99	$ -	$ 11.99
Employee + Family	0	$ 19.17	$ -	$ 19.17

ATTACHMENT F – REVISED 1/5/23
CURRENT CONTRACTOR WAGES & BENEFITS

Mountain View Community Shuttle Program

Contractor: We Drive U

Union Status: Non-Union

Operations Supervisor Wage: $75,055 annually

Number of Drivers: 10 (non-exempt shuttle driver class)

Job Title	Worker Category	Seniority Date	Regular Pay Rate	FLSA
Driver - Coach Operator	Full-Time	04/16/2015	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	02/02/2016	$29.00	Non-exempt
Driver - Coach Operator	Full-Time	09/18/2022	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	05/14/2018	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	07/23/2018	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	07/01/2019	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	08/01/2019	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	10/28/2019	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	10/05/2021	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	11/16/2021	$28.00	Non-exempt
Driver - Coach Operator	Full-Time	01/24/2022	$28.00	Non-exempt

Benefits: Medical, dental & 401K plans are available. See plan information attached. For 401K, company matches up to 4% of compensation.

MVCS	Medical Coverage	Employee Cost	Employer Cost	Dental Coverage	Employee Cost	Employer Cost	Vision Coverage	Employee Cost	Employer Cost
Driver - Coach Operator	Employee	138.1	552.42	Employee	24.89	30.82	Employee	.66	5.98
Driver - Coach Operator	Employee	138.1	552.42	Employee	3.63	30.82	Employee	.66	5.98
Driver - Coach Operator	Employee	192.96	771.84	Employee	24.89	30.82	Employee	.66	5.98
Driver - Coach Operator	Employee + Children	276.21	1104.83	Employee + Children	47.64	49.93	Employee + Family	3.09	13.27
Driver - Coach Operator	Employee	138.1	552.42	Employee	3.63	30.82	Employee	.66	5.98
Driver - Coach Operator	Employee + Spouse	303.83	1215.31	Employee + Spouse	52.88	54.19			
Driver - Coach Operator	Employee + Family	414.31	1657.25	Employee + Family	83.46	79.78	Employee + Family	3.09	13.27
Driver - Coach Operator	Employee	138.1	552.42	Employee	24.89	30.82			
Driver - Coach Operator				Employee	24.89	30.82			
Driver - Coach Operator	Employee	138.1	552.42	Employee	24.89	30.82	Employee	.66	5.98
Driver - Coach Operator									

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, call Imagine360 at 1-800-827-7223. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 972-391-4600 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$2,000** person/**$4,000** family Level I & Level II PPO & Non-PPO	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	**Yes.** Copayments, prescriptions & PPO preventive services do not apply towards the deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	**No.**	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$4,000** person/**$8,000** family Level I & Level II PPO & Non-PPO	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums; balance-billed charges; any noncompliance penalties; and health care this plan doesn't cover	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	**Yes**, for Level II Providers. See page 2 for an explanation of Level I & Level II Providers. Visit www.multiplan.com/mpipracanc or call 1- 888-671-7427 for a list of participating Multiplan Level II providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get

[* For more information about limitations and exceptions, see the plan or policy document at www.imagine360.com.]

		services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.
Level I Providers include but are not limited to: Hospitals (Inpatient and Outpatient treatment); Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice); Inpatient and Outpatient Facilities of Mental Disorders, Chemical Dependency, Drug and Substance Abuse; Ambulatory Surgery Centers and Dialysis Clinics
Level II Providers are Physicians and all other Providers of service not defined as a Level I Provider.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level I Provider	Level II PPO Provider	Level II Non-PPO Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	N/A	$25 copay/visit; 0% coinsurance; deductible waived	$25 copay/visit; 0% coinsurance; deductible waived	Family/General Practitioners, Pediatricians, Internists & Obstetrician/Gynecologists are considered Primary Care Providers (PCP). PCP copay applies to mental/behavioral & substance abuse office visits. There is no charge for UCM Digital Health consultations. female office sterilization & all FDA approved contraceptive methods. 20% coinsurance (deductible applies) applies to office x-ray, blood work. Non-PPO charges are based on Allowable Claims Limits.
	Specialist visit	N/A	$50 copay/visit; 0% coinsurance; deductible waived	$50 copay/visit; 0% coinsurance; deductible waived	
	Preventive care/screening/ immunization	No Charge	No Charge	No Charge	See your plan document for additional benefit information & limitations. Level I & Non-PPO charges are based on Allowable Claims Limits. You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required or $250 non-compliance penalty applies (not required for KIS Imaging). No Charge applies to MRIs, CTs & PET Scans billed by KIS Imaging.

[* For more information about limitations and exceptions, see the plan or policy document at www.imagine360.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level I Provider	Level II PPO Provider	Level II Non-PPO Provider	
					Level I & Non-PPO charges are based on Allowable Claims Limits.
	Imaging (CT/PET scans, MRIs)	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required or $250 non-compliance penalty applies (not required for KIS Imaging). No Charge applies to MRIs, CTs & PET Scans billed by KIS Imaging. Level I & Non-PPO charges are based on Allowable Claims Limits.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.caremark.com.	Generic drugs	Copays: Retail $10 (30-day supply)/$30 (90-day supply) Mail Order $15 (90-day supply)			Covers a 30-90 day supply for Retail/90-day supply for Mail Order/30-day supply for Specialty. See your plan document for information about drugs that require prior authorization and drugs that are excluded.
	Preferred brand drugs	Copays: Retail $30 (30-day supply)/$90 (90-day supply) Mail Order $45 (90-day supply)			
	Non-preferred brand drugs	Copays: Retail $60 (30-day supply)/$180 (90-day supply) Mail Order $90 (90-day supply)			
	Specialty drugs	Copay: 20% to $500 maximum per prescription			
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance; deductible applies	N/A	N/A	UR notification required or $250 non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Physician/surgeon fees	N/A	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you need immediate medical attention	Emergency room care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	UR notification required if admitted inpatient or $250 non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits
	Emergency medical transportation	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Level I & Non-PPO charges are based on Allowable Claims Limits.
	Urgent care	$75 copay/visit; 0% coinsurance; deductible waived	$75 copay/visit; 0% coinsurance; deductible waived	$75 copay/visit; 0% coinsurance; deductible waived	Level I & Non-PPO charges are based on Allowable Claims Limits.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance; deductible applies	N/A	N/A	UR notification required or $250 non-compliance penalty applies. Level I & Non-

[* For more information about limitations and exceptions, see the plan or policy document at www.imagine360.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level I Provider	Level II PPO Provider	Level II Non-PPO Provider	
	Physician/surgeon fees	N/A	20% coinsurance; deductible applies	20% coinsurance; deductible applies	PPO charges are based on Allowable Claims Limits.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance; deductible applies	$25 copay/visit; 0% coinsurance; deductible waived	$25 copay/visit; 0% coinsurance; deductible waived	See '**If you visit a health care provider's office or clinic**' for the office visit benefit. UR notification required for Inpatient admissions and day treatment or $250 non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Inpatient services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
If you are pregnant	Office visits	N/A	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Office visit copayment applies to the initial visit only. Contact UR for coordination of prenatal care. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Childbirth/delivery professional services	N/A	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Childbirth/delivery facility services	20% coinsurance; deductible applies	N/A	N/A	
If you need help recovering or have other special health needs	Home health care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	Services are limited per calendar year to 120 visits for Home Health, 36 visits for Cardiac Rehabilitation, 60 visits combined for Physical/Occupational Therapy, 60 visits for Speech & 120 days for Skilled Nursing Facilities. $50 copay/visit (0% coinsurance; deductible waived) applies to Cardiac Rehabilitation & Physical/ Occupational/Speech Therapy. Treatment of developmental delays may not be covered. See your plan document for additional information. UR notification required for Home Health, Outpatient Hospice, DME & inpatient admission or $250 non-compliance penalty applies. Level I & Non-PPO charges are based on Allowable Claims Limits.
	Rehabilitation services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Habilitation services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Skilled nursing care	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Durable medical equipment	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	
	Hospice services	20% coinsurance; deductible applies	20% coinsurance; deductible applies	20% coinsurance; deductible applies	

[* For more information about limitations and exceptions, see the plan or policy document at www.imagine360.com.]

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Level I Provider	Level II PPO Provider	Level II Non-PPO Provider	
If your child needs dental or eye care	Children's eye exam	No Charge	No Charge	No Charge	Benefit applies to routine vision screenings for children & annual routine vision exam for all ages limited to 1 exam every 24 months. Non-PPO charges are based on Allowable Claims Limits.
	Children's glasses	Not Covered			Not Covered
	Children's dental check-up	Not Covered			Not Covered

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental Care (Adult)
- Infertility Treatment
- Long Term Care
- Non-emergency care when traveling outside the U.S.
- Routine eye care (Adult)
- Routine foot care
- Weight Loss Programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery (Morbid Obesity **only**)
- Chiropractic Care
- Hearing Aids
- Private Duty Nursing

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: 800-827-7223 or the Department of Labor, Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.].

Does this plan provide Minimum Essential Coverage? **Yes**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

[* For more information about limitations and exceptions, see the plan or policy document at www.imagine360.com.]

Does this plan meet the Minimum Value Standards? **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:

Español: Para obtener asistencia en Español, llame al 800-827-7223.

Tagalog: Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 800-827-7223.

中文: 如果需要中文的帮助， 请拨打这个号码 800-827-7223.

Dine: Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-827-7223.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is **0938-1146**. The time required to complete this information collection is estimated to average **0.08** hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

[* For more information about limitations and exceptions, see the plan or policy document at www.imagine360.com.]

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost-sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$2000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$2,000
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$4,060**

Managing Joe's Type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	**$2000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$900
Copayments	$780
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,700**

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

The plan's overall deductible	**$2000**
Specialist copayment	**$50**
Hospital (facility) coinsurance	**20%**
Other coinsurance	**20%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test (*x-ray*)
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,000
Copayments	$300
Coinsurance	$10
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,310**

The plan would be responsible for the other costs of these EXAMPLE covered services.

DELTA DENTAL

Keep Smiling

Delta Dental PPO™

Save with PPO

Visit a dentist in the PPO[1] network to maximize your savings.[2] These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill.[3] Find a PPO dentist at **deltadentalins.com**.

Set up an online account

Get information about your plan anytime, anywhere by signing up for an online account at **deltadentalins.com**. This free service, available once your coverage kicks in, lets you check benefits and eligibility information, find a network dentist and more.

Check in without an ID card

You don't need a Delta Dental ID card when you visit the dentist. Just provide your name, birth date and enrollee ID or social security number. If your family members are covered under your plan, they will need your information. Prefer to take a paper or electronic ID card with you? Simply log in to your account, where you can view or print your card with the click of a button.

Coordinate dual coverage

If you're covered under two plans, ask your dental office to include information about both plans with your claim, and we'll handle the rest.

Understand transition of care

Did you start on a dental treatment plan before your PPO coverage kicked in? Generally, multi-stage procedures are only covered under your current plan if treatment began after your plan's effective date of coverage.[4] You can find this date by logging in to your online account.

Newly covered?

Visit **deltadentalins.com/welcome**.

Save with a PPO dentist

PPO

NON-PPO

[1] In Texas, Delta Dental Insurance Company provides a dental provider organization (DPO) plan.

[2] You can still visit any licensed dentist, but your out-of-pocket costs may be higher if you choose a non-PPO dentist. Network dentists are paid contracted fees.

[3] You are responsible for any applicable deductibles, coinsurance, amounts over annual or lifetime maximums and charges for non-covered services. Out-of-network dentists may bill the difference between their usual fee and Delta Dental's maximum contract allowance.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier is responsible for any costs. Group- and state-specific exceptions may apply. If you are currently undergoing active orthodontic treatment, you may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

LEGAL NOTICES: Access federal and state legal notices related to your plan at deltadentalins.com/about/legal/index-enrollee.html.

HL_PPO #112725A (rev. 4/18)

Plan Benefit Highlights for: MV Transportation, Inc.
(High Plan)

Group No: 19855 **Effective Date:** 01/01/2019

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) and eligible dependent children to the end of the month dependent turns age 26			
Deductibles	$50 per person / $150 per family each calendar year			
Deductibles waived for Diagnostic & Preventive (D & P) and Orthodontics?	Yes			
Maximums	$1,500 per person each calendar year			
D & P counts toward maximum?	Yes			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental DPO & Premier dentists**	Non-Delta Dental DPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings, x-rays and sealants	100 %	100 %
Basic Services Fillings	80 %	80 %
Endodontics (root canals) Covered Under Basic Services	80 %	80 %
Periodontics (gum treatment) Covered Under Basic Services	80 %	80 %
Oral Surgery Covered Under Basic Services	80 %	80 %
Major Services Crowns, inlays, onlays and cast restorations	50 %	50 %
Prosthodontics Bridges, dentures and implants	50 %	50 %
Orthodontic Benefits Adults and dependent children	50 %	50 %
Orthodontic Maximums	$1,000 Lifetime	$1,000 Lifetime

* Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

** Reimbursement is based on DPO contracted fees for DPO dentists, Premier contracted fees for Premier dentists and Premier contracted fees for non-Delta Dental dentists.

Delta Dental Insurance Company
1130 Sanctuary Parkway, Suite 600
Alpharetta, GA 30009

Customer Service
800-521-2651

Claims Address
P.O. Box 1809
Alpharetta, GA 30023-1809

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

VSP Vision Plan Design

Employees can get vision care where and when they want it.

VSP Preferred Providers
Nearly 95% of members choose a VSP Preferred Provider to maximize their benefit. A list of VSP Choice Preferred Providers can be found on the VSP website,www.vsp.com or by calling customer service at 800-877-7195.

Retail Chain Affiliates
VSP has an exclusive national agreement with Costco® Optical. VSP also has an arrangement with VisionWorks® and other quality retail chains where members receive a covered-in-full benefit experience.

Other Providers
With VSP Open Access, you can choose any provider, including local or national chains. Providers contact VSP directly to check eligibility and submit claims. VSP also has a direct-pay arrangement with Walmart Vision Center and Sam's Club Optical Center to make using the benefit easy.

Benefit Frequency:

Exam	Every 12 months
Lenses	Every 12 months
Frames	Every 24 months

Benefits through a VSP Choice Preferred Provider			
Exam Services	Comprehensive WellVision Exam® covered-in-full		
	Contact lens exam – fitting and evaluation (when choosing contacts): **Standard** and **Premium** fit: Covered in full with a copay. Member receives 15% off of contact lens exam services; member's copay will never exceed $60.		
Lenses	Glass or plastic:	Single vision Lined bifocal Lined trifocal Lenticular Tints & Photochromics	Covered-in-full Covered-in-full Covered-in-full Covered-in-full Covered in full following a $15 Copay
Lens Options	The most popular lens options are covered-in-full with a copay, saving our members an average of 20%-25%. Maximum copay on standard lens enhancements[1]:		
	Patient Option Anti-reflective coating Polycarbonate for children Polycarbonate for adults Progressive Scratch-resistant coating	*Single Vision* $43 No copay $33 N/A $17	*Multifocal* $43 No copay $37 $55 $17
Frame	• Frames covered-in-full up to the retail allowance**:** $150. Costco® Optical allowance of $80 is equivalent to the frame allowance at preferred providers and other affiliate locations. • Frame allowances backed by a wholesale allowance guarantee, ensuring more than 16,000 frames are covered-in-full (depending on plan chosen) • 20% off any amount above the retail allowance • Members can choose from virtually any frame on the market		
Elective Contact Lenses	• Prescription contact lens materials covered-in-full up to the retail allowance**:** $150 (in lieu of frame and lenses) • VSP members get exclusive mail-in rebate savings[2] • Members can choose from any available prescription contact lens materials		
Necessary Contact Lenses	Covered-in-full for members who have specific conditions.		

Additional Pairs of Glasses	20% off unlimited additional pairs of prescription glasses and/or nonprescription sunglasses[3]	
Laser VisionCare Program	Discounts average 15-20% off or 5% off a promotional offer for laser surgery, including PRK, LASIK, Custom LASIK, and IntraLase[4]	
Exclusions	Two pairs of glasses instead of bifocals; replacement of lenses, frames, or contacts; medical or surgical treatment; orthoptics; vision training or supplemental testing. For contact lenses: insurance policies or service agreements; artistically painted or nonprescription lenses; additional office visits for contact lens pathology; contact lens modification; polishing or cleaning	
Open Access Schedule (Non VSP Choice Providers)	VSP offers a generous reimbursement schedule for services from other providers	
	Exam	$45
	Lenses:	
	Single vision lenses	$30
	Bifocal lenses	$50
	Trifocal lenses	$65
	Frame	$70
	Elective contact lenses (in lieu of lenses & frame)	$105

[1] Lens enhancements outlined are standard and based on applicable laws, benefits may vary by doctor location.

[2] Rebates subject to change

[3] 20% off unlimited additional pairs of glasses valid through any VSP Preferred Provider within 12 months of the last covered eye exam.

[4] Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. LaserVision Care discounts are only available from VSP-contracted facilities.

BENEFIT COSTS 2023

Standard Class

Your bi-weekly payroll contributions for medical, dental and vision benefits are shown here.

Medical	Anthem BlueCross $1,000 PPO	Anthem BlueCross $3,500 PPO	Anthem BlueCross $6,000 PPO	Kaiser HMO (California)
Employee Only	$140.33	$89.06	$36.42	$63.74
Employee + Spouse/DP	$308.72	$195.93	$80.13	$140.23
Employee + Child(ren)	$252.59	$160.31	$65.56	$127.48
Family	$435.02	$276.08	$112.92	$191.22

Dental	MetLife Base Plan	MetLife High Plan
Employee Only	$1.67	$11.49
Employee + Spouse/DP	$5.53	$24.40
Employee + Child(ren)	$4.82	$21.99
Family	$9.74	$38.52

Vision	VSP Plan
Employee Only	$0.31
Employee + 1	$0.73
Employee + 2 or more	$1.43

Voluntary Life / AD&D	Employee (Monthly Rate per $10,000 of benefit)	Spouse/DP (Monthly Rate per $5,000 of benefit)
Age		
< 25	$0.594	$0.336
25 – 29	$0.649	$0.363
30 – 34	$0.880	$0.490
35 – 39	$1.309	$0.699
40 – 44	$1.991	$1.051
45 – 49	$3.102	$1.639
50 – 54	$4.565	$2.437
55 – 59	$6.545	$3.592
60 – 64	$8.415	$4.978
65 – 69	$11.968	$7.095
70 – 74	$22.649	$13.420
75 +	$70.004	$41.476
Child Life Monthly Rate	$0.921 per $2,000 of benefit	
AD&D Monthly Rate	**Employee:** $0.387 per $10,000 of benefit **Spouse/DP:** $0.204 per $5,000 of benefit **Child(ren)**: $0.066 per $2,000 of benefit	

Calculating Your Voluntary Life / AD&D Bi-weekly Premium	
Employee Voluntary Life or AD&D Amount	$_____
Divide by $10,000	$_____
Multiply by appropriate age-banded rate	$_____
Multiply by 12, then divide by 26	**Your bi-weekly cost** $_____
Spouse/DP Voluntary Life or AD&D Amount	$_____
Divide by $5,000	$_____
Multiply by appropriate age-banded rate	$_____
Multiply by 12, then divide by 26	**Your bi-weekly cost** $_____
Child Voluntary Life or AD&D Amount	$_____
Divide by $2,000	$_____
Multiply by listed rate	$_____
Multiply by 12, then divide by 26	**Your bi-weekly cost** $_____