MUELLER

2024
BENEFITS GUIDE

Living Life Well

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The information in this Enrollment Guide is intended for illustrative and informational purposes only. The information contained herein was taken from various summary plan descriptions, certificates of coverage, and benefit information. While every effort was taken to accurately report your benefits, discrepancies and errors are always possible. It is not intended to alter or expand rights or liabilities set forth in the official plan documents or contracts. It is not an offer to contract nor are there any expressed or implied guarantees. In case of a discrepancy between this information and the actual plan documents, the actual plan documents will prevail. If you have any questions about this summary, please contact Human Resources. © 2020 Marsh & McLennan Agency. All rights reserved.

WELCOME TO YOUR 2024 BENEFITS!

Paul Mueller Company is pleased to provide you and your family with a wide range of competitive benefits. Your benefits are an important part of your total compensation. You have the flexibility to choose the benefits that are right for you and your family — to keep you physically and financially healthy now and in the future.

This benefits guide provides important information about your benefits and how to use them to your best advantage. Please review this information carefully, ask questions if needed, and make sure to enroll by the deadline.

ELIGIBILITY

If you are regularly scheduled to work at least 30 hours per week, you are eligible for the Paul Mueller Company's benefits program. You may also enroll your eligible dependents for coverage. Eligible dependents include:

- Your legal spouse
- Children under the age of 26, regardless of student, dependency or marital status
- Children past the age of 26 who are fully dependent on you for support due to a mental or physical disability (and are indicated as such on your federal tax return).

All employees are eligible for benefits following a 30-day waiting period!

For details on eligibility and when your benefits begin and end, refer to your summary plan documents.

Benefits End

Your medical, dental and vision benefits end on your date of termination. Your company-sponsored Life and Disability benefits end on your date of termination.

Changing Benefits After Enrollment

During the year, you cannot make changes to your medical, dental, vision, or Health Care or Dependent Care Flexible Spending Accounts unless you experience a Qualified Life Event, such as marriage or the birth of a child. If you experience a Qualified Life Event (examples below), you should contact Human Resources within 30 days of the event, or you will have to wait until the next annual open enrollment period to make changes (unless you experience another Qualified Life Event).

Qualified Life Event	Possible Documentation Needed
Change in marital status	
Marriage	Copy of marriage certificate
Divorce/Legal Separation	Copy of divorce decree
Death	Copy of death certificate
Change in number of dependents	
Birth or adoption	Copy of birth certificate or copy of legal adoption papers
Stepchild	Copy of birth certificate plus a copy of the marriage certificate between employee and spouse
Death	Copy of death certificate
Change in employment	
Change in your eligibility status (i.e., full-time to part-time)	Notification of increase or reduction of hours that changes coverage status
Change in spouse's benefits or employment status	Notification of spouse's employment status that results in a loss or gain of coverage

HOW TO ENROLL

Open enrollment will be October 30 – November 15, 2023.

This will be a **passive enrollment** – you will only have to log into the electronic open enrollment site if you want to make changes to your current elections.

This is an **active** enrollment for the FSA, you must make an FSA election for 2024.

Before You Enroll or Make Changes

- Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverages that are best for you and your family.
- Go to the Paul Mueller benefit microsite at https://paulmueller-benefits.com/ to learn more and access a wealth of information about the benefit package offer to our valued employees.
- Ensure family members meet the eligibility requirements
- Gather the Name, Date of Birth, Gender and Social Security Number of any dependents that you want to cover under the plans.
- Understand the cost of the plans you selected.
- Be sure to have the Name, Relationship and Phone Number for any beneficiaries you will be designating on the Life insurance plans..

Café Enrollment for 2024 Annual Enrollment

Chose one of the following methods from October 30- November 15 to make changes for 2024 and/or make your FSA election:

1. Self-Serve Enrollment website at **https://unum.benselect.com/pm**

   - Login: Username: Employee ID or full SSN
   - Password is a 6-digit PIN consisting of the last 4 digits of your SSN followed by your 2-digit birth year.
   - For example, if your SSN is ###-##-4321 and your DOB is 08/06/1988, you would have a pin of 432188

2. You may also enroll/make changes via the call center 314-442-0052 (open 8am-5pm CT)

On the days of the open enrollment meetings, we will also have benefit counselors on site in Osceola, IA and Springfield, MO to assist employees who do not want to enroll/make changes on their own through the self-serve website or call center.

WELLNESS PROGRAM

Annual Health Risk Assessment

If you and/or your spouse complete the annual health risk assessment you will each receive a $100 credit toward the following year's medical plan annual deductible.

MEDICAL

Paul Mueller Company's medical coverage provides you and your family the protection you need for everyday health issues or unexpected medical expenses. Medical coverage is administered by UMR, utilizing the UnitedHealthcare Choice Plus network.

Spousal Surcharge

Please note, an additional $500 annual premium, spread over 12 months, will be added for employees that enroll a spouse who is eligible for coverage through their employer.

How Medical Coverage Works

When you enroll in medical coverage, you pay a portion of your health care costs when you receive care and the plan pays a portion, as detailed below. Note that preventive care — like physical exams, flu shots and screenings — is always covered 100% when you use in-network providers. The key difference between the plans is the amount of money you'll pay each pay period and when you need care. The plans have different:

- **Deductibles** — the amount you pay each year for eligible in-network and out-of-network charges before the plan begins to pay a portion of the costs.
- **Copays** — a fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.
- **Coinsurances** — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.
- **Out-of-pocket maximums** — the most you will pay each year for eligible in- or out-of-network services. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.
- **Prescriptions** — Once you have met the prescription deductible, you are responsible for the applicable coinsurance or copay.

Before You Enroll

Consider this:

1. Think about the per-pay-period cost and out-of-pocket expenses you will incur and your possible future medical expenses. The option that has the highest per-pay-period cost typically pays more, which results in lower deductibles, coinsurance, and/or copays when you need care.
2. Want to stay with your doctor? Ensure they are in the plan's network by visiting www.uhc.com/find-a-doctor and select the Choice Plus network. If they're out of network, services may not be covered or may be more expensive.
3. Consider the cost of services and prescription drugs you expect to receive during the year.
4. Evaluate how your out-of-pocket expenses may fluctuate and consider adding accident or critical illness insurance to help offset your out-of-pocket medical costs.

PRESCRIPTIONS

Our medical coverage through UMR includes a Prescription Drug Program. You can find in-network pharmacies and a list of covered prescriptions at www.umr.com or www.optumrx.com.

FORMULARY

A formulary is a list of prescribed medications or other pharmacy care products, services or supplies chosen for their safety, cost, and effectiveness. Medications are listed by categories or classes and are placed into cost levels known as tiers. It includes both brand and generic prescription medications. The formulary used by our plan is called The Premium Drug Formulary

GENERIC DRUGS

To get more out of your health care plan, choose Generic drugs when possible. Generic drugs are the chemical equivalent of their more expensive brand name drug counterparts. **Even if your doctor prescribes you a brand name drug, you can always ask for the Generic equivalent.   Note: If your doctor indicates that you can take the generic and you elect to take the brand drug you will pay the cost difference of the brand and generic.**

SPECIALTY DRUGS

Specialty medications are used to treat complex conditions and are generally higher in cost. The OptumRx specialty pharmacy can provide most of your specialty medications along with helpful programs and services. Call **1-855-427-4682** and ask how you can have your prescriptions delivered right to your home or doctor's office.

90 DAY FILLS AT A RETAIL PHARMACY

Members may get a 90 day fill of their maintenance medication at any retail pharmacy.

OPTUMRX HOME DELIVERY

Receive a 90 day supply of maintenance medications and free standard shipping.   Medications are delivered to your mailbox and can be auto-refilled. 24/7 access to pharmacists.   For more information: www.optumrx.com

PRESCRIPTIONS

Prior Authorization

What is Prior Authorization?
Prior Authorization means that you must obtain approval for certain medications to be covered by your plan. OptumRx works with your doctor to make sure coverage is appropriate.

How does a Prior Authorization work?
We work with your doctor to ensure safe and effective use of select prescription medications. Before your copay can be applied at the pharmacy, the medication must be approved by OptumRx, along with help from your doctor. We will contact your doctor to get the information needed to determine coverage for your medication.

Why do some medications require Prior Authorization?
Some medications have a higher possibility of overuse or may be prescribed outside of clinical dosing guidelines. In some cases, there are also specific dosages that should be used based on medical guidelines.

Who decides which medications require Prior Authorization?
A team of independent, licensed doctors, pharmacists and other medical experts review and discuss the latest medical guidelines and research. They decide which medications should be included in the PA Program.

How do I know if my medication requires a Prior Authorization?
Your pharmacist will let you know when you pick up your prescription at the pharmacy. You may also call the Member Services number on your pharmacy card for more information.

What if my Prior Authorization request is not approved?
If your request for a Prior Authorization is denied, you will be responsible for the full cost of your prescription at the pharmacy. You may still fill your prescription, but your copay will not apply.

Step Therapy

How do I know if my medication requires a Prior Authorization?
The pharmacist will let you know when you pick up your prescription at the pharmacy. You may also call the member services phone number on your pharmacy card for more information.

What is a Step Therapy Program?
A Step Therapy Program is an approach to medication therapy that requires you to first try a more cost-effective medication (usually a generic medication) that has proven effective for most people with your condition before you can receive coverage for a similar, more expensive, brand name medication. These are considered “steps” of therapy.

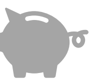
How does a Step Therapy Program work?
If your doctor writes a prescription for a medication that requires a Step Therapy, the requested medication may not be covered until a more cost-effective medication “step” is tried first.

What if I need to skip a step?
Your doctor may contact us to request prior authorization approval. This is a review between your doctor and OptumRx to determine coverage for your medication.

Why do some medications need Step Therapy?
Some medications are extremely costly. If lower-cost, clinically-effective medications exist, it may be prudent to try these first. In some cases, there are also specific dosages and quantities that should be used based on medical guidelines.

Who decides what medications will need Step Therapy?
A team of independent, licensed doctors, pharmacists and other medical experts review and discuss the latest medical guidelines and research, then decide which medications should be included in the Step Therapy Program.

MEDICAL



The table below summarizes the key features of the medical coverage. Please refer to the official plan documents for additional information on coverage and exclusions.

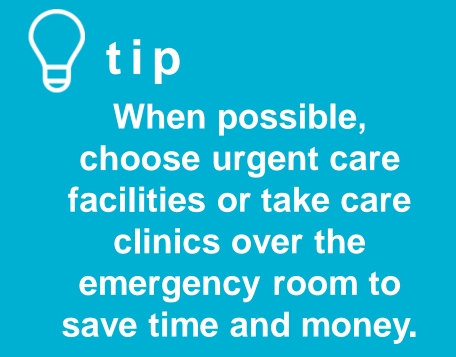
	Base Plan		Buy Up Plan	
	Choice Plus		Choice Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual	$1,000	$2,000	$500	$1,000
Family	$3,000	$6,000	$1,500	$3,000
Calendar Year Out-of-Pocket Maximum (Does Not Include Deductible)				
Individual	$5,000	$10,000	$2,000	$5,000
Family	$10,000	$20,000	$5,000	$10,000
	You pay	You pay	You pay	You pay
Coinsurance*	20%	50%	20%	50%
Preventive Care	$0	$0	$0	$0
Primary Care Physician	20%	50%	20%	50%
Specialist	20%	50%	20%	50%
Urgent Care	20%	50%	20%	50%
Emergency Room	$250 copay then 20%	$250 copay then 20%	$250 copay then 20%	$250 copay then 20%
Lab & X-ray	20%	50%	20%	50%
Hospitalization	20%	$100 copay then 50%	20%	$100 copay then 50%
Diagnostic Imaging (MRI/CT)	20%	50%	20%	50%
Pharmacy				
Rx Deductible	$125		$125	
Retail Non-First Choice, First Choice, and Mail Order (Non-First Choice limited to 30 day supply)				
Generic	30%		30%	
Preferred	30%		30%	
Compound	30%		30%	
Non-Preferred	30%		30%	
Specialty				
Generic/Brand Name	$100		$100	
*After Deductible				

STAYING IN-NETWORK

If you choose to see an out-of-network provider or pharmacy, you will still be able to use insurance, however, your costs will be *substantially* higher and your deductible and out-of-pocket maximums will be higher.

Your medical network is made up of:

- Convenience care (quick) clinics
- Physicians
- Facilities (urgent care, emergency room)
- Nurse practitioners
- Specialists
- Pharmacies



When you see an in-network provider, you will:

- Have lower health care costs for medical services and prescription drugs.
- Not need to obtain pre-authorization before a procedure such as surgery. Your in-network provider will handle this on your behalf.
- Not have to worry about paying for balance-billed charges and charges above the usual, reasonable, and customary.

How to find an in-network provider:

- Visit the UMR website at www.umr.com, click “Find a Provider” from the lower part of the home screen. The network name is UnitedHealthcare Choice Plus
- If easier, you can also call 800-826-9781 or the number on the back of your ID card.
- Remember, always ask “are you an in-network provider with Choice Plus”.

YOUR ID CARD

Every enrolled employee with dependents receives 2 ID Cards. However, if an EE has more than 5 dependents, the 5th dependent's name is printed on an additional card and in that situation, 2 more ID cards are sent.

Once a member has their initial ID card they are able to create a UMR Portal account and view an electronic copy of their ID card as well as order more cards if they would like.

Understanding your new ID card

Have you ever wondered what all that stuff on your ID card really means? Here's a sample of what you might see. Each plan is different.

UMR A UnitedHealthcare Company
YOUR COMPANY NAME HERE
Issuer (80840) 911-39026-02
Customer Logo (If Applicable)
Member ID: 12345685
Group Number: 76-123456
Member: JAMES A SAMPLE 00 MED
Dependents: JOANNE SAMPLE 01 MED, JOHN SAMPLE 02 MED, JOSEPH SAMPLE 03 MED
OPTUMRx
Rx BIN: 610127
Rx PCN: 01960000
Rx GRP: 0196XXXX
CO-PAYS MAY APPLY
UnitedHealthcare Choice Plus Network
Self-funded plan administered by UMR

- The number assigned specifically to you to track all of your benefits and claims information.
- A list of the family members who are covered under your plan.
- The number assigned to identify your group health plan.
- Information about your prescription drug plan. Pharmacists use this to process your claims.
- Your medical provider network, also referred to as your preferred provider organization (PPO). Going to doctors, clinics and hospitals in your network will save you money.

More on the back

Look for important contact information, including the customer service phone number to call for answers to claims or benefit questions. You can also go to **umr.com** to check your benefits, claims status, accumulators and eligibility.

This card must be presented each time services...
Medical: In-Net / Out-of-Net
Ded: / OOPM:
Call UMR CARE at 866-494-4502 for plan required prior authorization.
FAILURE TO CALL FOR PRIOR AUTHORIZATION MAY REDUCE BENEFITS.
For Members: www.umr.com 8XX-XXX-XXXX
Nurseline: 8XX-XXX-XXXX
For Providers: www.umr.com 877-233-1800
Claims: EDI # 39026, UMR, PO Box 30541, Salt Lake City, UT 84130-0541
Pharmacists & Members: 877-559-2955

- Your in-network (In-Net) and out-of-network (Out of Net) medical individual and family deductibles (Ded) and out-of-pocket maximums (OOPM) information.
- Call this number only when you need medical services and your plan requires prior authorization for those services.
- Call this number when you have questions about pharmacy benefits.

UMR.COM

Access your health benefits in two clicks

You don't have time to dig through paperwork or wonder where to go for care when you need it. And your health and financial resources are too valuable for second guesses.

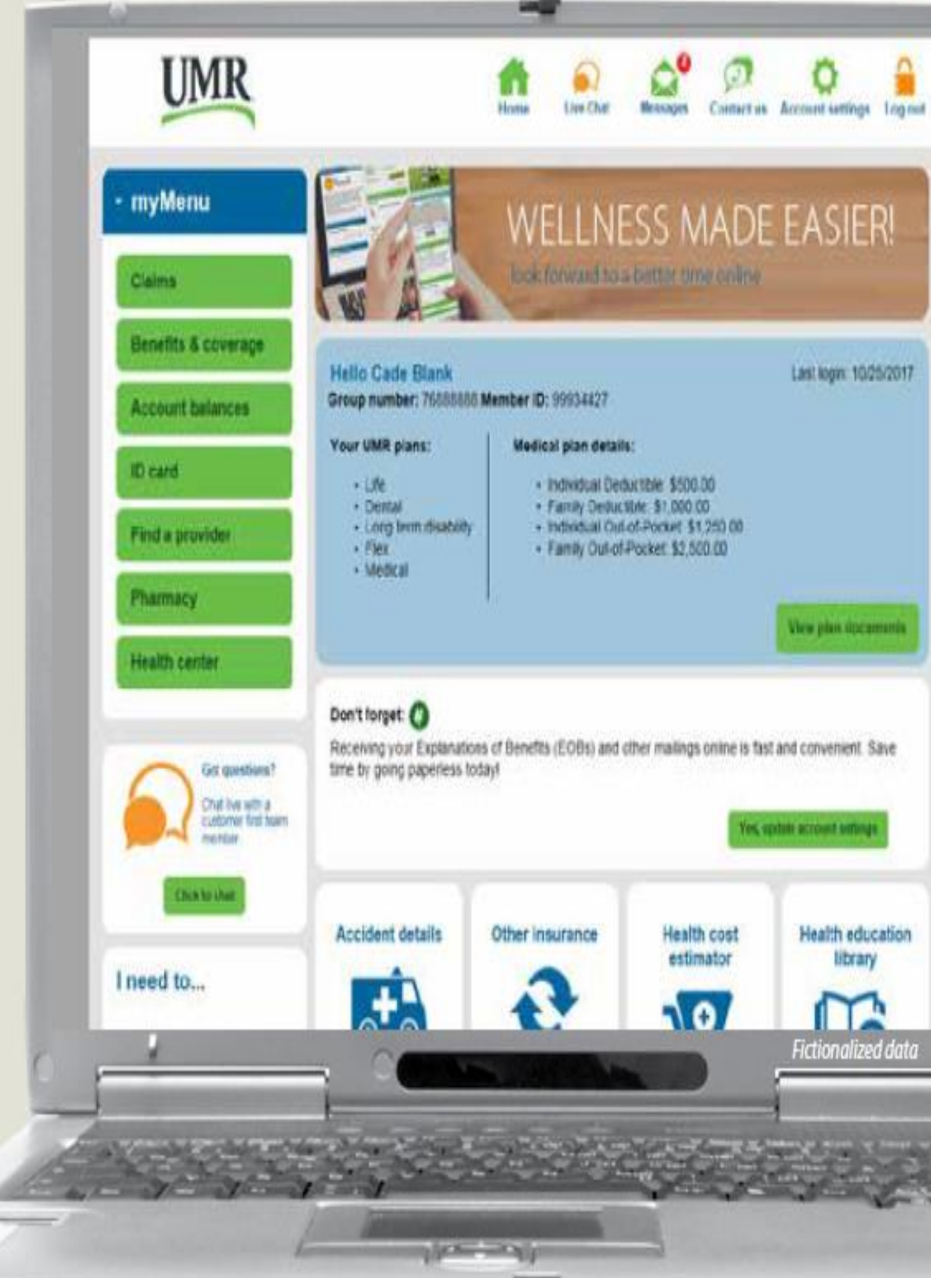
At **umr.com**, there are no hassles and no waiting – just the answers you're looking for, anytime, night or day.

Log in now to:

- Check your benefits and see what's covered
- Look up what you owe and how much you've paid
- Find a doctor in your network
- Learn about medical conditions and treatment options
- Access tools and trusted resources to help you live a healthier life

Getting started

If you already have an account, go to **umr.com** and enter your username and password in the upper-right corner. If it's your first time visiting us, click **New user? Register here** to open an account. Make sure you have your ID card handy and follow the steps to get started.



OPTUMRX.COM

The pharmacy website is fast, safe and secure way to manage your prescription benefits on-line

- Refill and renew mail service prescriptions
- Search for drug pricing and lower cost prescriptions
- View your Rx benefits in real time
- Search for drugs on the formulary list : **Premium Drug Formulary**
- Locate an in-network Pharmacy

From the UMR Home Page:

As a UMR member, you can access your prescription information from the UMR website.

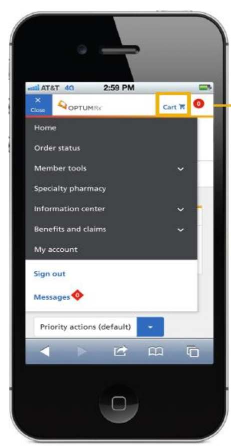
Follow these steps to register:

1. Visit **umr.com**.
2. In the left margin menu, select **Members.**
3. Login by entering your username and password in the top right login section. If you have not yet registered for a member account, select **New user? Register here** shown underneath username field.
4. Once successfully registered and/or logged in, select **Pharmacy** from the menu on the left. The website will redirect you to your online services home page.

Once on the pharmacy home page, you click on OptumRx or the Visit the pharmacy button to enter **optumrx.com** and begin to take advantage of the many tools and features that will help you manage your pharmacy benefit. On your first visit, you will also need to register at **optumrx.com** — just follow the simple instructions.

Mobile website

Use your smartphone to access the mobile website, **m.optumrx.com**. The mobile website lets you manage your prescription benefits from your smartphone. You can order refills, check your order status, set up medication reminders and more — anytime, anywhere. It's perfect for people on the go.



DENTAL

Paul Mueller Company offers dental coverage through MetLife. For information on finding a dental provider using the PDP Plus network, visit www.metlife.com, click Solutions > Enhance Your Health Coverage > Dental. Scroll down to Find a Dentist, and choose the PDP Plus Network. Type in your zip code to search for in-network providers.

Taking care of your oral health is not a luxury; it is necessary for optimal long-term health. With a focus on prevention, early diagnosis and treatment, dental coverage can greatly reduce the cost of restorative and emergency procedures. Preventive services at in-network providers are generally covered at no cost to you and include routine exams and cleanings. You pay a small deductible and coinsurance for basic and major services.

You may enroll yourself and your eligible dependents — or you may waive dental coverage. You do not have to be enrolled in medical coverage to elect a dental plan.

However, if you are enrolled in medical coverage, Paul Mueller Company will pay 100% of the dental base plan premium, equivalent to your medical enrollment tier. For example, if an employee is enrolled in employee only medical coverage and elects family dental, Paul Mueller Company will pay 100% of the dental base plan employee only premium. You would then be responsible for the difference. If an employee is enrolled in medical and elects the buy up plan, Paul Mueller Company will pay the same amount as the base plan premium, and the employee will be responsible for the difference.

Before You Enroll

Consider this:

1. Most in-network preventive cleanings and exams are covered at 100%.
2. You may receive dental care in- or out-of-network. However, when you go out of network, the provider can charge more and the plan will only reimburse up to the reasonable and customary rates.

MetLife does not mail Dental ID cards to members. Should you want a card, you will have to set-up an account via www.metlife.com/dental to print cards. It is not necessary to have an ID card. Members should always provide the Employee's SSN to their dentist office and that office will look them up in our system by the EE SSN.

DENTAL

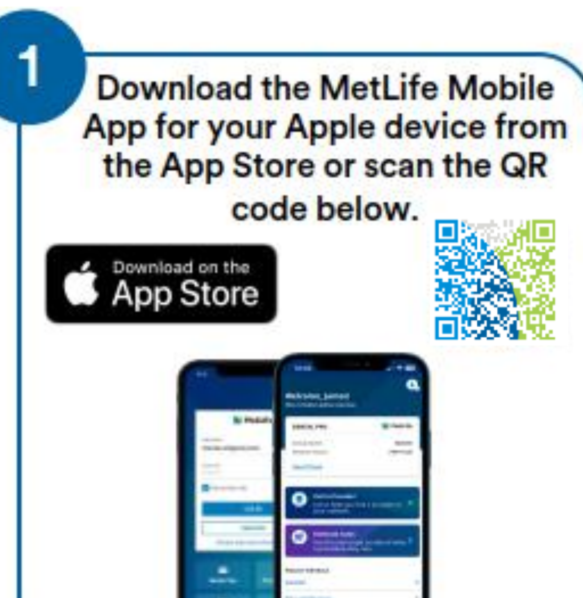
The table below summarizes the key features of the dental plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	Base Plan		Buy-Up Plan	
	PDP Plus		PDP Plus	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Calendar Year Deductible				
Individual	$50	$50	$50	$50
Family	$150	$150	$150	$150
Calendar Year Benefit Maximum				
Per Individual	$1,000		$1,000	
	You pay		You pay	
Preventive Care				
Exams, Cleanings, X-rays, Fluoride Treatments, Space Maintainers, Sealants	0%	0%	0%	0%
Basic Services				
Fillings, Periodontics (maintenance), Emergency Palliative Treatment	20%	20%	20%	20%
Major Services				
Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs, Oral Surgery, Endodontics, Periodontics (surgery), Extractions	Not covered		50%	50%
Orthodontia				
Adults	Not covered		Not Covered	
Children (up to 19th birthday)	Not covered		50% up to a lifetime maximum benefit of $1,000 per individual; deductible waived	

METLIFE MOBILE APP

MetLife

1 Download the MetLife Mobile App for your Apple device from the App Store or scan the QR code below.



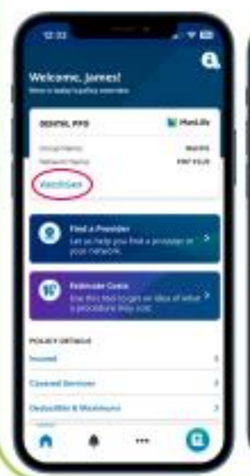
2 Registration & Login

- Register directly within the app in a few short steps.
- Once registered, log in easily with Face or Touch ID recognition.

3 Access and save your Dental ID card to your Apple Wallet

Click on **View ID Card** Click on **Add to Apple Wallet** Click **OK** Click **Add**

Your Dental ID card has been added to your Apple Wallet.



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VOLUNTARY VISION

Paul Mueller Company offers vision coverage through UNUM using the EyeMed Insight Network. For information on finding a vision provider, visit www.EyeMedVisionCare.com/Unum and click on Find an Eye Doctor, and enter your zip code. UNUM will send you send a Vision ID card once enrolled.

Healthy eyes and clear vision are an important part of your overall health and quality of life. You may enroll yourself and your eligible dependents — or you may waive vision coverage. You do not have to be enrolled in medical coverage to elect a vision plan.

The table below summarizes the key features of the vision plan. Please refer to the official plan documents for additional information on coverage and exclusions.

	UNUM Vision Plan	
	In-Network	Out-of-Network
	You pay	Reimbursement
Cost		
Exam	$10	Up to $40
Materials	$25	Variable
Covered Services – Lenses		
Single Lenses	$25	Up to $30
Bifocals	$25	Up to $50
Trifocals	$25	Up to $70
Frames	$175 Retail Allowance	Up to $123
Covered Services – Contacts in lieu of Frames/Lenses		
Contacts – Medically Necessary	Covered in Full	Up to $210
Contacts – Elective	$175 Allowance	Up to $175
Fitting Exam	$40	Not Covered
Benefit Frequency		
Exams	Once every 12 Months	
Lenses	Once every 12 Months	
Frames	Once every 12 Months	
Contacts (in lieu of lenses)	Once every 12 Months	

FLEXIBLE SPENDING ACCOUNTS (FSAs)

Flexible Spending Accounts (FSAs) allow you to pay for eligible health care and dependent care expenses using tax-free dollars. There are two types of FSAs — the Health Care FSA and the Dependent Care FSA:

- **Health Care FSA** – Used to pay for out-of-pocket expenses associated with your medical, dental or vision plan such as copayments, coinsurance deductibles, prescription expenses, lab exams and tests, contact lenses and eyeglasses.
- **Dependent Care FSA** – Used to pay for day care expenses associated with caring for elder or child dependents that are necessary for you or your spouse to work or attend school full-time.

You cannot use your Health Care FSA to pay for dependent care expenses, and you cannot use your dependent care FSA to pay for health care expenses.

Important: The IRS has a "use it or lose it" rule. If you do not spend all of the money in your FSA by the annual deadline, any unused dollars in your account(s) will be forfeited. Paul Mueller Company does allow employees to rollover up to $640 of unused funds in their Health Care FSA.

How the Health Care FSA Works	How the Dependent Care FSA Works
You may contribute up to $3,200 per year, pretax. Minimum election amount is $500 per year.	You may contribute up to $5,000 per year, pretax, or $2,500 if married and filing separate tax returns
You receive a debit card to pay for eligible medical expenses (funds must be available in your account)	You submit claims for reimbursement; no debit cards are provided
Eligible expenses include medical copays, coinsurance, deductibles, eyeglasses and over-the-counter medications prescribed by your doctor	Can be used to pay for eligible dependent care expenses including day care, after-school programs and elder care programs
Submit claims up to March 31 of the following year for expenses from January 1 to December 31	Submit claims up to March 31 of the following year for expenses from January 1 to December 31
Paul Mueller has a rollover maximum $640. Anything over $640 will be forfeited per IRS regulations.	If you do not spend all the money in account unused dollars will be forfeited per IRS regulations

BASIC LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

Life insurance, provided by UNUM, pays a lump-sum benefit to your beneficiaries to help meet expenses in the event you pass away. Accidental death and dismemberment (AD&D) insurance pays a benefit if you die or suffer certain serious injuries as the result of a covered accident. In the case of a covered accidental injury (such as loss of sight or the loss of a limb), the benefit you receive is a percentage of the total AD&D coverage you elected based on the severity of the accidental injury.

Beneficiary Information

Situations often change, resulting in the need to update beneficiary information. You should review and update this information every year, or prior to retirement. Check with Human Resources for more information.

Basic Life Insurance	
Eligible Classes	All full-time U.S. non-union employees, scheduled to work at least 30 hours per week, and whose annual pay is: • Class 1: Less than or equal to $30,000 • Class 2: More than $30,000 but less than $40,000 • Class 3: Greater than or equal to $40,000
Coverage Amount *Basic Annual Earnings (BAE)*	Class 1: 2.5 X BAE up to $100,000 Class 2: 3.5 X BAE up to $150,000 Class 3: 4 X BAE up to $1,000,000
Age Reduction Schedule	Benefits reduce to 65% at age 70, and 50% at age 75

Life / AD&D Insurance (If Enrolled in Medical, In Addition to Basic Life Insurance)	
Eligible Classes	All Full Time Eligible Employees, enrolled in the Medical Plan, working 30 hours per week
Coverage Amount (Employee)	$50,000
Coverage Amount (Spouse)	$2,000
Coverage Amount (Child)	$2,000

Imputed Income

Under current tax laws, imputed income is the value of your basic life insurance that exceeds $50,000 and is subject to federal income, Social Security and state income taxes, if applicable. This imputed income amount will be included in your paycheck and shown on your W-2 statement.

VOLUNTARY LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT

Voluntary life and AD&D insurance, provided by UNUM, allows you to tailor coverage for your individual needs and provide financial protection for your beneficiaries in the event of your death or accidental serious injury. Employees and spouses who elect coverage when they are first eligible can elect up to the Guaranteed Issue (GI) amount without Evidence of Insurability (EOI). Any coverage over the GI amount requires an EOI form for medical underwriting approval. Previously eligible employees who want to elect coverage for the first time during annual enrollment (late entrants) would need to fill out an Evidence of Insurability (EOI) during open enrollment to enroll in Voluntary Life/AD&D Insurance.

Voluntary Life / AD&D Insurance - For You and Your Dependents			
	Employee	Spouse	Child(ren) up to age 26
Coverage Amount	Increments of $10,000 up to $500,000 - not to exceed five times your salary	Increments of $5,000 up to $250,000 – not to exceed 50% of Employee coverage	Increments of $2,000 to a maximum of $10,000; $2,000 for children under 6 months
Guaranteed Issue	$200,000	$50,000	$10,000
Evidence of Insurability	Required for initial eligibility, new elections, and any amounts over your current election	Required for initial eligibility, new elections, and any amounts over your current election	Not required

Before You Enroll

Consider this:

1. Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
2. It’s important to understand any EOI rules that apply. If you enroll when you first become eligible, Voluntary Term Life Insurance for you and your spouse is guaranteed up to the amounts shown in the table. If you initially waive this coverage but want to enroll at a later date, you may need to provide satisfactory EOI before any coverage can take effect.
3. Think about who you want to designate as beneficiaries and make sure to name them as beneficiaries on your policy.

DISABILITY

Disability insurance can help you remain financially stable by providing a portion of your income if you become disabled and are unable to work. These benefits are provided at no cost through UNUM. You are automatically covered as a full-time employee – no enrollment is needed.

Short-Term Disability Benefits at a Glance	
Eligibility	Class 1: Eligible Exempt EEs with Salary Grades 41- 50 working at least 30 hrs/wk Class 2: Eligible Exempt EEs with Salary Grades 31– 40 working at least 30 hrs/wk Class 3: Eligible Full-time, non-exempt, non-contract employees and Mueller Transportation Inc.(MTI) drivers Class 4: Eligible Union EEs working 30 hr/wk enrolled in medical plan
Duration and Weekly Benefit	Class 1: 13 weeks at 100%, then 13 weeks at 60% Class 2: 4 weeks at 100%, then 22 weeks at 60% Class 3: 1 week at 100%, then 25 weeks at 60% Class 4: $370 per week up to 52 weeks
Weekly Maximum	Class 1 - 3: Unlimited Class 4: $370
Elimination Period	Class 1 - 3: 5 days for illness / 0 days for injury, hospitalization or outpatient surgery Class 4: 5 days for illness/0 days for injury, hospitalization or outpatient surgery

Long-Term Disability Benefits at a Glance	
Eligibility	All full-time non-union United States employees, scheduled to work at least 30 hours per week, and whose annual pay is: • Class 1: Greater than $100,000 • Class 2: $40,000 to $100,000 • Class 3: Less than $40,000
Monthly Benefit	66.67%
Monthly Maximum	Class 1: $15,000 Class 2 & 3: $10,000
Benefit Duration	SS ADEA
Pre-Existing Limitation	3/3/12

Pre-Existing Conditions

A pre-existing condition is an injury or illness for which you have received advice or treatment from a doctor within three months of the effective date of your insurance plan.

A qualifying disability is a sickness or injury that causes you to be unable to perform any other work for which you are or could be qualified by education, training or experience.

VOLUNTARY SUPPLEMENTAL BENEFITS

Just like it sounds, supplemental benefits plans such as accident, critical illness and whole life can help you pay for costs you may incur after an accidental injury, illness or hospitalization. These plans are 100% voluntary and are not medical insurance. Coverage is available for your spouse and children with most plans.

Most plans pay benefits regardless of any other insurance and benefits are paid directly to you, unless you specify otherwise. Benefits can help pay for expenses other insurance may not cover, such as out-of-pocket expenses, lost income, childcare, travel to and from treatment, home health care costs or regular household expenses.

Before You Enroll

Consider this:

1. What would happen if you had an accident or became seriously ill and unable to work? Would you be covered financially?
2. These benefits provide a lump-sum payment that can help you cover unexpected medical expenses or make up for missed income.

Accident

Accident coverage, through UNUM, is designed to provide a cash benefit in the event of a covered accident or injury. The plan will pay a set amount based on the injury suffered and treatment received, regardless of any other insurance.

Sample of Eligible Expenses			
	Emergency Room Visits		**Hospital Stays**
	Medical Exams – Including major diagnostic exams		**Physical Therapy**
	Fractures and Dislocations		**Transportation and Lodging** – if you are away from home when the accident happens

Contact Human Resources for a full list of covered accidents.

VOLUNTARY SUPPLEMENTAL BENEFITS

Critical Illness Insurance

Critical Illness coverage, through UNUM, provides a lump-sum cash benefit in the event you are diagnosed with a qualifying illness to help offset the unexpected associated costs. The plan will pay regardless of any other insurance. Critical Illness coverage is not medical insurance.

Benefit Amounts	
Employee	$10,000, $20,000 or $30,000
Spouse	50% of employee coverage amount
Children	50% of employee coverage amount
See Human Resources for a full list of covered illnesses and cost of coverage.	

Be Well Benefit

If you elect the Accident and/or Critical Illness coverage, you and your dependents may be eligible for receive a $50 Be Well incentive if you receive a qualified Be Well screening. These screenings include annual wellness exams, cancer screenings, cardiovascular function screenings, cholesterol and diabetes screenings, and more.

Whole Life Insurance

Whole Life Insurance, through UNUM, enables you to tailor coverage for your individual needs and provides financial security for your family members.

Key Highlights
Provides money to beneficiaries when the insured person passes away
Earns cash value
Spouse and child coverage are available
Premiums and benefits stay the same over the life of the policy
Living benefit is included with all policies at no extra premiums (allows access to death benefit when medical condition limits the life expectancy to 12 months or less)
Guaranteed issue available
See Human Resources for more information.

PLANNING FOR RETIREMENT

What does retirement look like for you? Whatever your vision for retirement is, it's important to plan ahead so you have the income you'll need in the future.

One of the best ways to ensure a secure retirement is to start saving as early as possible. Our 401(k) savings plan, through Transamerica Retirement Solutions, allows you to save for retirement on a pretax basis. You can begin contributing to the plan through pretax payroll deductions as soon as you become eligible.

Increase Your Retirement Savings with a 401(k)

- You are automatically enrolled at 8% contribution, increasing by 1% annually up to 10%, unless you elect otherwise. Visit www.my.trsretire.com for more information.
- Paul Mueller will match employee contributions based on the following formula: 50% of the first 8% of compensation that you contribute to your account. The matching contribution will not exceed 4% of compensation.
- You can contribute using convenient payroll deductions up to the IRS limit of $23,000 per year.
- Are you age 50 or older? You can make an additional "catch-up" contribution of up to $7,500 to save even more.

See the summary plan description for more information, including eligibility requirements.

All employees are eligible for benefits following a 30-day waiting period!

ADDITIONAL BENEFITS

Employee Assistance Program

Paul Mueller Company also provides you access to the Employee Assistance Program (EAP) at no cost. This program, available through UNUM, provides professional, confidential telephonic or face-to-face counseling services to you and your loved ones. Online/phone support is unlimited, and available 24/7. You can also get up to 3 in-person or video counseling visits at no additional cost. The EAP can help you resolve personal issues and problems before they affect your health, relationships and work performance.

This program is available 24 hours a day, 365 days a year for confidential assistance and referral services with items such as:

- Managing stress
- Marital or family problems
- Anxiety and depression
- Substance abuse (alcohol and/or drugs)
- Financial issues
- Childcare issues including identifying schools, daycare, tutors, and more
- Aging parents

It's important to note that all EAP conversations are voluntary and strictly confidential. If you and your counselor determine that additional assistance is needed, you'll be referred to the most appropriate and affordable resource available. Although you're responsible for the cost of referrals, these costs are often covered under your medical plan.

Worldwide Travel Assistance

Worldwide Travel Assistance, offered through UNUM, can assist you in the event of an emergency while you are traveling for business or for leisure. Whenever you travel 100 miles or more from home, Travel Assistance can help you locate hospitals, embassies, and other "unexpected" travel destinations. This service is available 24/7.

One phone call connects you to:

- Multi-lingual, medically certified crisis management processions
- A state-of-the-art global response operations center
- Qualified medical providers around the world

IMPORTANT CONTACTS

Coverage	Administrator	Phone	Website/E-mail
Human Resources	Chris Dickerson	417-575-9474	cdickerson@paulmueller.com
Wellness Program	Chris Dickerson	417-575-9474	cdickerson@paulmueller.com
Medical	UMR	1-800-826-9781	www.umr.com
Dental	MetLife	1-800-GET-MET-8	www.mybenefits.metlife.com
Vision	UNUM	1-866-679-3054	www.EyeMedVisionCar.com/UNUM
Flexible Spending Accounts	FlexFacts	732-640-5951	www.flexfacts.com info@flexfacts.com
Life and AD&D	UNUM	1-800-ASK-UNUM	askunum@unum.com
Disability	UNUM	1-800-ASK-UNUM	askunum@unum.com
Accident Insurance	UNUM	1-800-ASK-UNUM	askunum@unum.com
Critical Illness Insurance	UNUM	1-800-ASK-UNUM	askunum@unum.com
Whole Life Insurance	UNUM	1-800-ASK-UNUM	askunum@unum.com
401(k) Retirement	Transamerica	1-800-755-5801	www.my.trsretire.com
Employee Assistance Program (EAP)	UNUM	1-800-854-1446	www.unum.com/lifebalance
Worldwide Travel Assistance	UNUM	Within US: 1-800-872-1414 Outside US: +609-986-1234	medservices@assistamerica.com

GLOSSARY

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called “eligible expense,” “payment allowance” or “negotiated rate.” If your provider charges more than the allowed amount, you may have to pay the difference (see Balance Billing).

Annual Maximum Benefit: A cap on the benefits your insurance company will pay in a year while you’re enrolled in a particular benefit plan. After an annual limit is reached, you must pay all associated health care costs for the rest of the year.

Balance Billing: When a provider bills you for the difference between the provider’s charge and the allowed amount. For example, if the provider’s charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A provider who balance bills is typically known as an out-of-network provider. An in-network provider cannot balance bill you for covered services.

Coinsurance: The percentage of costs of a covered health care service you pay (20%, for example) after you’ve paid your deductible.

Copayment (copay): A fixed amount ($20, for example) you pay for a covered health care service after you’ve paid your deductible. Copays can vary for different services within the same plan, like drugs, lab tests, and visits to specialists.

Deductible: The amount you pay for covered health care services before your insurance plan starts to pay. With a $2,000 deductible, for example, you pay the first $2,000 of covered services yourself. After you pay your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest. Your deductible starts over each plan year.

Guarantee Issue Amount: The amount of coverage you can be automatically approved for. If you apply for more coverage than the guarantee issue amount you will have to complete an Evidence of Insurability form and be approved for your coverage amount. Usually only available at your first enrollment opportunity.

In-Network: Providers who contract with your insurance carrier. In-network coinsurance and copayments usually cost you less than out-of-network providers.

Out-of-Network: Providers who don’t contract with your insurance carrier. Out-of-network coinsurance and copayments usually costs you more than in-network coinsurance. In addition, you may be responsible for anything above the allowed amount (see Balance Billing).

Out-of-Pocket Maximum: The most you have to pay for covered services in a plan year. After you spend this amount on deductibles, copayments, and coinsurance, your plan pays 100% of the costs of covered benefits. The out-of-pocket limit doesn’t include your monthly premiums. It also doesn’t include anything you may spend for services your plan doesn’t cover.

Prescription Drug Formulary: A list of prescription drugs covered by a prescription drug plan. Also called a drug list.

Prior Authorization: Approval from a health plan that may be required before you get a service or fill a prescription in order for the service or prescription to be covered by your plan.

Preventive Care: Routine health care that includes screenings, check-ups, and patient counseling to prevent illnesses, disease, or other health problems.

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