The Company has established a variety of employee benefit programs designed to assist you and your eligible dependents in meeting the financial burdens that can result from illness and disability. This Summary contains a very general description of the benefits to which you may be entitled as a team member with the Company.

Please understand that this is general explanation is not intended to and does not provide you with all the details of these plans. This Benefit Summary does not change or otherwise interpret the terms of the official plan documents. Your rights can be determined only by referring to the full text of the official plan documents, which are available for your examination from the Personnel Department. To the extent that any of the information contained in this Summary is inconsistent with the official plan documents, the provisions of the official documents will govern in all cases.

BENEFITS AVAILABLE AFTER 90 DAYS

(TO ALL REGULAR, FULL-TIME TEAM MEMBERS)

HOLIDAYS

It is the policy of Brothers Express, Inc. to provide eight (8) paid holidays each year for all regular full-time hourly paid team members. Brothers Express will observe the eight (8) holidays listed below: **NOTE**: (**Brothers *Superior Services*** Team Members are afforded six (6) paid holidays each year; contact your supervisor for the days that are observed.)

NEW YEARS DAY	January 1
MEMORIAL DAY	4th Monday of May
INDEPENDENCE DAY	July 4
LABOR DAY	1st Monday of September
THANKSGIVING DAY (plus one day)	4th Thursday of November and the day before or the day after
CHRISTMAS DAY (plus one day)	December 25 and the day before or the day after

ANY ADDITIONAL HOLIDAY DATES will be SPECIFIED

To qualify for holiday pay a team member must:
a) Be a regular full-time status team member with ninety (90) plus days of service (includes salaried team members) and
b) Be at work the normal scheduled work day before and after the holiday,

If a paid holiday falls on a Sunday; Monday will usually be the paid holiday. If a paid holiday would fall on a Saturday; Friday will usually be the paid holiday. If a holiday should fall during your vacation; the vacation may be extended for the appropriate time upon mutual agreement between yourself and your supervisor, or you will receive the holiday pay in addition to your vacation pay.

JURY DUTY

We recognize that jury duty is the obligation of all citizens and encourages you to fulfill this obligation. If you are called for jury duty, you will be granted time away from work. You are expected, however, to return to your duties any time you are not needed in the courtroom. If you are called for jury duty, advise your supervisor and show the supervisor your summons as soon as possible after you learn you must serve.
The company will pay up to five (5) jury days per calendar year for regular team members. Jury pay will be compensated at 50% of the team member's normal straight time pay.

INSURANCE BENEFITS

Group Medical Insurance

Medical insurance is offered to all full-time team members with affordable rates through a payroll deduction. Upon the satisfactory completion of a ninety (90)-day introductory period, a team member will become eligible to participate in this plan as a regular team member.

The medical plan at Brothers Express is a self-funded group health plan with the administration provided through Core Benefits, Inc., our third party administrator (TPA). Questions regarding claims and coverage options should be handled through contacting Core Benefits (contact information included on the last page of this Summary).

There are three plan options, A, B and C.

To find out if a service provider is in network, check out the following website:

For Brothers Express: Lutheran/Three Rivers Preferred www.medpartnersonline.com
For Brothers Superior: Sagamore www.sagamorehn.com

Team members can select from a variety of plan options and levels of coverage which can include dependents. Premiums are shared by the team member and the company. The premium amount is determined by the actual options elected and deducted on a pre-tax basis through a weekly payroll deduction.

PRESCRIPTION DRUG BENEFIT SCHEDULE

PRESCRIPTION DRUG BENEFIT		
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR		
	NETWORK	**NON-NETWORK**
Pharmacy Option (30 Day Supply)		
Generic Drugs	20% copayment, minimum $10	Prescriptions are only covered at participating pharmacies
Brand Name Drugs	30% copayment, minimum $20	Prescriptions are only covered at participating pharmacies
Mail Order Option (90 Day Supply)		
Generic Drugs	$25.00 copayment	Not Applicable
Brand Name Drugs	$50.00 copayment	Not Applicable
Refer to the Prescription Drug Section for details on the Prescription Drug benefit.		

PLAN A

	PPO NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. The deductibles and out of pocket amounts accumulate separately for each benefit tier.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$1,500	$4,500
Per Family Unit	$3,000	$9,000
The Calendar Year deductible is waived for the following Covered Charges: - In Network Preventive Care		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible) The out-of-pocket maximum for Network Providers applies only to those charges. The out-of-pocket maximum for non-Network Providers applies only to those charges.		
Per Covered Person	$3,500	Unlimited
Per Family Unit	$7,000	Unlimited
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR FOR PRESCRIPTION DRUGS (SEPARATE FROM MEDICAL OUT OF POCKET LISTED ABOVE)		
Per Covered Person	$3,350	
Per Family Unit	$6,700	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over Usual and Reasonable Charges		
COVERED CHARGES	**PPO NETWORK PROVIDERS**	**NON-NETWORK PROVIDERS**
Hospital Services		
Room and Board	80% after deductible the semiprivate room rate	40% after deductible the semiprivate room rate
Intensive Care Unit	80% after deductible Hospital's ICU Charge	40% after deductible Hospital's ICU Charge
Emergency Room Visit		
Medical Emergency	80% after deductible	80% after deductible
Non Emergent Services	80% after deductible	40% after deductible
Skilled Nursing Facility	80% after deductible the facility's semiprivate room rate	40% after deductible the facility's semiprivate room rate
Physician Services		
Inpatient visits	80% after deductible	40% after deductible
Office visits	80% after deductible	40% after deductible
Urgent Care visits	80% after deductible	40% after deductible
Surgery	80% after deductible	40% after deductible
Allergy testing	80% after deductible	40% after deductible
Allergy serum and injections	80% after deductible	40% after deductible
Diagnostic Testing (X-ray & Lab)	80% after deductible	40% after deductible
Home Health Care	80% after deductible	40% after deductible
Hospice Care	80% after deductible	40% after deductible
Ambulance Service	80% after deductible	80% after deductible

Jaw Joint/TMJ	80% after deductible $2,000 Lifetime maximum	40% after deductible $2,000 Lifetime maximum
Occupational Therapy	80% after deductible	40% after deductible
Speech Therapy	80% after deductible	40% after deductible
Physical Therapy	80% after deductible	40% after deductible
Durable Medical Equipment	80% after deductible	40% after deductible
Prosthetics	80% after deductible	40% after deductible
Custom Molded Foot Orthotics	80% after deductible $200 Lifetime maximum	40% after deductible $200 Lifetime maximum
Spinal Manipulation Chiropractic	80% after deductible $500 Calendar Year maximum	40% after deductible $500 Calendar Year maximum
Mental Disorders		
Inpatient	80% after deductible	40% after deductible
Outpatient	80% after deductible	40% after deductible
Substance Abuse		
Inpatient	80% after deductible	40% after deductible
Outpatient	80% after deductible	40% after deductible
Preventive Care		
Routine Well Adult Care	100%	40% after deductible
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, immunizations/flu shots, tobacco cessation aids, colonoscopies, bone density scans and fecal occult blood tests and EKGs.		
Frequency limits for mammogram Ages 40 and over . . . . . annually		
Routine Well Newborn Care	80% after deductible	40% after deductible
Routine Well Child Care	100%	40% after deductible $500 Calendar Year maximum
Includes: office visits, routine physical examination, laboratory tests, x-rays, immunizations and other preventive care and services required by applicable law if provided by a Participating Provider.		
Organ Transplants	80% after deductible $10,000 Donor Lifetime maximum	40% after deductible $10,000 Donor Lifetime maximum
Obesity/Weight Loss Program	50% after deductible $1,500 Lifetime maximum	40% after deductible $1,500 Lifetime maximum
Surgical procedures are excluded. Must be Physician supervised program. Diagnosis of Morbid Obesity required.		
Pregnancy	80% after deductible	40% after deductible
Dependent daughters not covered.		
Prescription Drug Benefit – Calendar Year deductible must be satisfied before pharmacy copayments are honored. Pharmacy charges will be applied to the Calendar Year deductible.		

PLAN B

	PPO NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. The deductibles and out of pocket amounts accumulate separately for each benefit tier.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$2,500	$5,000
Per Family Unit	$5,000	$10,000
The Calendar Year deductible is waived for the following Covered Charges: - In Network Preventive Care		
COPAYMENTS		
Physician visits	$25.00	N/A
Urgent Care visits	$50.00	N/A
Emergency room	$250.00 – 1st Visit $500.00 – 2nd Visit $750.00 – 3rd Visit $1,000 – Additional Visits	$250.00 – 1st Visit $500.00 – 2nd Visit $750.00 – 3rd Visit $1,000 – Additional Visits
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible) The out-of-pocket maximum for Network Providers applies only to those charges. The out-of-pocket maximum for non-Network Providers applies only to those charges.		
Per Covered Person	$5,000	Unlimited
Per Family Unit	$10,000	Unlimited
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR FOR PRESCRIPTION DRUGS (SEPARATE FROM MEDICAL OUT OF POCKET LISTED ABOVE)		
Per Covered Person	$1,850	
Per Family Unit	$3,700	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over Usual and Reasonable Charges		
COVERED CHARGES		
Supplementary Accident Charge Benefit		
Maximum benefit per accident.....first $300, payable at 100% deductible waived		
Hospital Services		
Room and Board	75% after deductible the semiprivate room rate	40% after deductible the semiprivate room rate
Intensive Care Unit	75% after deductible Hospital's ICU Charge	40% after deductible Hospital's ICU Charge
Emergency Room Visit		
Medical Emergency	75% after deductible and copayment	75% after deductible and copayment
Non Emergent Services	75% after deductible and copayment	40% after deductible and copayment

COVERED CHARGES	PPO NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Skilled Nursing Facility	75% after deductible the facility's semiprivate room rate	40% after deductible the facility's semiprivate room rate
Physician Services		
Inpatient visits	75% after deductible	40% after deductible
Office visits	100% after copayment	40% after deductible
Urgent Care visits	100% after copayment	40% after deductible
Surgery	75% after deductible	40% after deductible
Allergy testing	75% after deductible	40% after deductible
Allergy serum and injections	75% after deductible	40% after deductible
Diagnostic Testing (X-ray & Lab) **Deductible waived if services provided through One Call Care**	75% after deductible	40% after deductible
Home Health Care	75% after deductible	40% after deductible
Hospice Care	75% after deductible	40% after deductible
Ambulance Service	75% after deductible	75% after deductible
Jaw Joint/TMJ	75% after deductible $2,000 Lifetime maximum	40% after deductible $2,000 Lifetime maximum
Occupational Therapy	75% after deductible	40% after deductible
Speech Therapy	75% after deductible	40% after deductible
Physical Therapy	75% after deductible	40% after deductible
Durable Medical Equipment	75% after deductible	40% after deductible
Prosthetics	75% after deductible	40% after deductible
Custom Molded Foot Orthotics	75% after deductible $200 Lifetime maximum	40% after deductible $200 Lifetime maximum
Spinal Manipulation Chiropractic	75% after deductible $500 Calendar Year maximum	40% after deductible $500 Calendar Year maximum
Mental Disorders		
Inpatient	75% after deductible	40% after deductible
Outpatient	75% after deductible	40% after deductible
Substance Abuse		
Inpatient	75% after deductible	40% after deductible
Outpatient	75% after deductible	40% after deductible
Preventive Care		
Routine Well Adult Care	100%	40% after deductible
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, immunizations/flu shots, tobacco cessation aids, colonoscopies, bone density scans and fecal occult blood tests and EKGs.		
Frequency limits for mammogram Ages 40 and over . . . . . annually		
Routine Well Newborn Care	75% after deductible	40% after deductible
Routine Well Child Care	100%	40% after deductible $500 Calendar Year maximum
Includes: office visits, routine physical examination, laboratory tests, x-rays, immunizations and other preventive care and services required by applicable law if provided by a Participating Provider.		

Organ Transplants	75% after deductible $10,000 Donor Lifetime maximum	40% after deductible $10,000 Donor Lifetime maximum
Obesity/Weight Loss Program	50% after deductible $1,500 Lifetime maximum	40% after deductible $1,500 Lifetime maximum
Surgical procedures are excluded. Must be Physician supervised program. Diagnosis of Morbid Obesity required.		
Pregnancy	75% after deductible	40% after deductible
Dependent daughters not covered.		

PLAN C

	PPO NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Note: The maximums listed below are the total for Network and Non-Network expenses. The deductibles and out of pocket amounts accumulate separately for each benefit tier.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	$5,000	$10,000
Per Family Unit	$10,000	$20,000
The Calendar Year deductible is waived for the following Covered Charges: - In Network Preventive Care		
COPAYMENTS		
Physician visits	$25.00	N/A
Urgent Care visits	$50.00	N/A
Emergency room	$250.00 – 1st Visit $500.00 – 2nd Visit $750.00 – 3rd Visit $1,000 – Additional Visits	$250.00 – 1st Visit $500.00 – 2nd Visit $750.00 – 3rd Visit $1,000 – Additional Visits
The Emergency room copayment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, must be notified within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR (includes deductible) The out-of-pocket maximum for Network Providers applies only to those charges. The out-of-pocket maximum for non-Network Providers applies only to those charges.		
Per Covered Person	$6,000	Unlimited
Per Family Unit	$12,000	Unlimited
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR FOR PRESCRIPTION DRUGS (SEPARATE FROM MEDICAL OUT OF POCKET LISTED ABOVE)		
Per Covered Person	$850	
Per Family Unit	$1,700	
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%. Cost containment penalties Amounts over Usual and Reasonable Charges		
COVERED CHARGES		
Supplementary Accident Charge Benefit		
Maximum benefit per accident.....first $300, payable at 100% deductible waived		
Hospital Services		
Room and Board	60% after deductible the semiprivate room rate	30% after deductible the semiprivate room rate
Intensive Care Unit	60% after deductible Hospital's ICU Charge	30% after deductible Hospital's ICU Charge
Emergency Room Visit		
Medical Emergency	60% after deductible and copayment	60% after deductible and copayment
Non Emergent Services	60% after deductible and copayment	30% after deductible and copayment

COVERED CHARGES	PPO NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Skilled Nursing Facility	60% after deductible the facility's semiprivate room rate	30% after deductible the facility's semiprivate room rate
Physician Services		
Inpatient visits	60% after deductible	30% after deductible
Office visits	100% after copayment	30% after deductible
Urgent Care visits	100% after copayment	30% after deductible
Surgery	60% after deductible	30% after deductible
Allergy testing	60% after deductible	30% after deductible
Allergy serum and injections	60% after deductible	30% after deductible
Diagnostic Testing (X-ray & Lab) **Deductible waived if services provided through One Call Care**	60% after deductible	30% after deductible
Home Health Care	60% after deductible	30% after deductible
Hospice Care	60% after deductible	30% after deductible
Ambulance Service	60% after deductible	60% after deductible
Jaw Joint/TMJ	60% after deductible $2,000 Lifetime maximum	30% after deductible $2,000 Lifetime maximum
Occupational Therapy	60% after deductible	30% after deductible
Speech Therapy	60% after deductible	30% after deductible
Physical Therapy	60% after deductible	30% after deductible
Durable Medical Equipment	60% after deductible	30% after deductible
Prosthetics	60% after deductible	30% after deductible
Custom Molded Foot Orthotics	60% after deductible $200 Lifetime maximum	30% after deductible $200 Lifetime maximum
Spinal Manipulation Chiropractic	60% after deductible $500 Calendar Year maximum	30% after deductible $500 Calendar Year maximum
Mental Disorders		
Inpatient	60% after deductible	30% after deductible
Outpatient	60% after deductible	30% after deductible
Substance Abuse		
Inpatient	60% after deductible	30% after deductible
Outpatient	60% after deductible	30% after deductible
Preventive Care		
Routine Well Adult Care	100%	30% after deductible
Includes: office visits, pap smear, mammogram, prostate screening, gynecological exam, routine physical examination, x-rays, laboratory tests, immunizations/flu shots, tobacco cessation aids, colonoscopies, bone density scans and fecal occult blood tests and EKGs.		
Frequency limits for mammogram Ages 40 and over . . . . . annually		
Routine Well Newborn Care	60% after deductible	30% after deductible
Routine Well Child Care	100%	30% after deductible $500 Calendar Year maximum
Includes: office visits, routine physical examination, laboratory tests, x-rays, immunizations and other preventive care and services required by applicable law if provided by a Participating Provider.		

Organ Transplants	60% after deductible $10,000 Donor Lifetime maximum	30% after deductible $10,000 Donor Lifetime maximum
Obesity/Weight Loss Program	50% after deductible $1,500 Lifetime maximum	30% after deductible $1,500 Lifetime maximum
Surgical procedures are excluded. Must be Physician supervised program. Diagnosis of Morbid Obesity required.		
Pregnancy	60% after deductible	30% after deductible
Dependent daughters not covered.		

Any spouse that is employed and eligible to participate in their own Employer Group Health Plan must accept those benefits and are NOT eligible for coverage under the Brother's Group Plan.

Plan annual open enrollment is in June with changes effective for July 1 and December with changes effective for January 1.

******For an entire copy of the Plan Document and Summary Plan Description, Visit www.brothersexpress.com/ep and use the password BXI to enter******

Group Dental Insurance

The dental plan is also self-funded through our health plan. Basic care, preventive care, major care and orthodontia are also available for both team members and dependents.

Premiums are paid by the team member and deducted on a pre-tax basis through our weekly payroll.

Plan annual open enrollment is in June with changes effective for July 1 and in December with changes effective for January 1.

Annual Deductible	
Individual	$50
Family	$100
MAXIMUM BENEFIT AMOUNT	
Class A – Preventative Class B – Basic Class C – Major Services	$1000 per person/per year
Class D – Orthodontia	$250/per person/per year
Lifetime maximum per Individual (for Class D services)	$1000
DENTAL PERCENTAGE PAYABLE	
Class A – Preventative	100%
Class B – Basic	80%
Class C – Major Services	50%
Class D – Orthodontia	50%

Class A (Preventative)
Oral exams and cleanings – 2 per person/year
One bitewing x-ray/year
One full mouth x-ray/5 years
One fluoride treatment/year

Class B (Basic)
Periodontics (gum treatments)
Endodontics (root canals)
Extractions (includes local anesthesia)
Recementing bridges, crowns or inlays
Fillings
Antibiotic drugs
Impacted teeth

Class C (Major)
Installation of crowns
Gold restorations
Repair of crowns, bridgework and removable dentures

No benefits are payable for Class B, C and D Services in the first six months of the covered person's coverage under the Plan.

Group Vision Insurance

Team members have the option of purchasing vision insurance for themselves and dependents.

Premiums are paid by team members on a pre-tax basis through weekly payroll deductions.

Plan annual open enrollment is in December with changes effective January 1.

Eye Exams (every 12 months)	
Co-Payment	$10
Out-of-Network	Reimbursed up to $40
Eyeglasses (every 24 months)	
Co-Payment	$25
Out-of-Network	Reimbursed up to $40 for frames
Eyeglass Lenses (every 12 months)	
Co-Payment	$25
Out-of Network	Reimbursed up to $80
Contact Lenses (every 12 months)	
Co-Payment	$25
Out-of-Network	Reimbursed up to $105 if elective Reimbursed up to $225 if medically necessary

Discounts are available up to 25% off Laser Vision Correction Services with participating providers.

Discounted fixed fees for frame/lens options, such as premier frames, scratch-resistant coating, polarized lenses, etc.

Short Term Disability

Short Term Disability insurance is available for those wishing to carry coverage. Coverage provides approximately 60% of your pre-disability income after a 14-day waiting period for circumstances due to injury or sickness. This disability insurance is not company funded.

Premiums are paid by team members on an after-tax basis through weekly payroll deductions.

Life Insurance

Life insurance coverage in the amount of $15,000 is paid for by the company at no cost to team members. Coverage is provided through Standard Insurance Company, with reduced coverage beginning at age 65. Upon the end of employment, team members have the option of maintaining their life insurance coverage. Team members are responsible to contact Security Life Insurance after termination to maintain coverage and make payment arrangements.

Accidental Death and Dismemberment Insurance

Accidental Death Life Insurance coverage in the amount of $15,000 is paid for by the company at no cost to team members. Coverage is provided through Standard Insurance Company, with reduced coverage beginning at age 65. Upon the event of the loss of a finger, hand, toe, foot, arm, leg, sight, etc., you are also eligible for a lump sum payment up to $15,000 per the schedule of benefits. Upon the end of employment, team members have the option of maintaining their coverage. Team members are responsible to contact Security Life Insurance after termination to maintain coverage and make payment arrangements.

Health Savings Account (HSA)

Brothers Express provides team members the opportunity to save for out-of-pocket medical expenses such as deductibles and co-pays through a Health Savings Account program. If you elected Plan A, you may elect to withhold earnings from your pay on a pre-tax basis. These funds can be used for prescription co-

pays, non-insurance covered medical items, deductibles, durable medical goods and other expenses for dental or vision.

You control how your HSA money is spent. Any unused funds stay in your account and can be used for future medical expenses.

Corporate Chaplain

As a company, we have contracted a Corporate Chaplain to help our team members who may be in need. A Corporate Chaplain is available to you by phone at all times (24/7) by calling Chuck Koenemann at (877) 322-2427 ext. 4227 or on his cell phone at (317) 263-4838.

Corporate Chaplains has created and collected vast resources for help, comfort and direction during times of crisis. Their chaplains regularly care for those struggling with divorce, financial ruin and despair. They bring the love of Christ to bear in every situation, offering their time, support and training to help team members and your loved ones cope with difficulty and loss. This benefit is at no cost to you.

In the event of a death in the family, illness, divorce, marriage or any other life changing event, our Chaplain will contact you to offer you help, support and assistance. In such case, we will release your name and personal phone number to the Chaplain so they may contact you directly. In the event of a hospitalization, the Chaplain will want to visit you in the hospital.

If you would like to opt out of this program, you may do so. Information to opt out with be provided to you with your benefit packet upon the completion of your 90 days.

Verizon Wireless Discount Program

All Brothers Express and Brothers Superior Services team members qualify for up to 18% off monthly account access fees through Verizon Wireless. Stop in to your local Verizon Wireless store with your paystub and ask for your employee discount. Team members also receive 25% off most accessories.

Travel Assistance Program

Assistance is available when you travel more than 100 miles from home or internationally for up to 180 days for business or pleasure. It offers aid before and during your trip, including; passport, visa, weather and currency exchange information, emergency airline tickets, credit card and passport replacement, funds transfer and missing baggage assistance, 24/7 phone access to registered nurses for health and medication information, emergency evacuation to the nearest adequate medical facility, connection to a local attorney, or bail bond services, arrangements for ground transportation, housing and/or evacuation in the event of political unrest and social instability, and many more travel related services.

BENEFITS AVAILABLE AFTER 1 YEAR

VACATION

Vacation benefits are defined under this plan to all regular team members. Paid vacation time is earned on the number of years of service as follows:

Years of Service	Vacation Weeks Awarded
1 and 2	1
3 through 9	2
10 through 19	3
20 or more	4

A "year of service" is defined as each 12-month period commencing with the team member's introductory employment date and each subsequent anniversary date thereafter wherein the regular team member is credited with a minimum of 1840 hours or 46 weeks worked.

Weekly vacation pay rates are computed as follows:

Road drivers: Prior annual earnings divided by 365, then multiplied by 6 days
Hourly paid drivers: Hourly rate multiplied by 45 hours
Hourly paid office team members: Hourly rate multiplied by 40 hours
All Salaried team members: Current weekly rate (daily pay calculated by dividing the weekly salary by five (5) days)

*Brothers Superior Services Hourly paid team members: Hourly rate multiplied by 40 hours

Vacation request forms are available from your supervisor. Please file at least fourteen (14) days in advance of requested dates for scheduling considerations. Vacations must be taken in full week increments. Single days or partial weeks are not allowed.

All vacations must be taken within twelve (12) months of the date earned, and any vacation time earned that was not taken will be paid at that time. (No yearly carry over.)

During January of each year, we will honor vacation requests by seniority. After January 31st, we will schedule vacations on a first request basis. Partial days of vacation time will not be allowed (No half days - only full days).

The payroll department has the responsibility of recording and tracking all vacation times earned and taken for each team member. If for some reason you are unsure of your available earned vacation time, please contact the payroll department for all verifications.

A part-time team member who gains "regular status" will begin accruing vacation allowance on the date their ninety (90) day introductory status begins.

If a designated holiday is observed during a team member's vacation period, the team member may elect to extend his/her vacation by the same number of days as allowed for that holiday and the request is approved in advance by their immediate supervisor.

If any advance pay for vacation is desired by a team member, the request for advance pay must be noted on the vacation request form. Advance pay will only be allowed if the team member is taking a week or more of vacation.

If a team member has available paid time off under this policy at the time he or she requests a leave under the Family Medical Leave Act of 1993 ("FMLA"), the team member will receive paid time off under this policy at the same time as FMLA leave. In that event, the team member's available time off under this policy, as well as the team member's FMLA leave entitlement, will be reduced by the period of the leave. After a team member requests an FMLA leave, the Company will notify the team member that paid time off under this policy will be provided during the team member's FMLA leave.

CONTACT INFORMATION

Internal Questions:
Personnel Department — (260) 410-9927
www.brothersexpress.com

Medical and Dental Insurance:
Core Benefits, Inc. — (260) 492-7451
www.corebenefitsinc.com

Vision Insurance:
CS Group Benefits
(Citizens Security Life Insurance Co.) — (800) 843-7752
www.citizensgroup.com

Short Term Disability:
The Standard Insurance Company — (888) 937-4783

Corporate Chaplain: — (877) 322-2427

Travel Assistance Protection:
The Standard Insurance Company — (800) 527-0218
(Available 24/7)

Life Insurance/Accidental Death:
The Standard Insurance Company — (888) 937-4783