Owner-Driver Overview – Terminal 540

Baltimore, MD

Qualifications:

- CSA violations, driving record and background check will be reviewed upon submitting application for employment
    - Application link: https://intelliapp.driverapponline.com/c/jackcooperoo
- No more than a combination of 3 moving violations/at-fault accidents within 3 years from date of application
- Must have 1 year of high-capacity car haul experience

Equipment:

- No age limit or requirement on equipment. Equipment must be in good visible condition
- You will be required to send in photos of your equipment for approval
- Equipment will be subject to inspection by our maintenance facilities
- Auto haul trailer must have the ability to haul at least 7 units (7 car carrier or larger)

Pay:

- 80% of gross load pay
    - 20% of that 80% will be paid as a driver check on a weekly basis (W2)
    - 80% of that 80% will be paid as a truck check on a monthly basis (1099)
    - **Example: A load pays a total of $2,000. Your cut is $1,600. $1,280 of that will be paid to you in your monthly settlement. The remaining $320 will pay out to you on a weekly basis so a month with 4 weeks would pay you out $80 per week in the driver check.**
- Estimated annual earnings of 350K+
- 100% fuel surcharge paid to owner-driver

- All major deductions come out of the monthly truck check (fuel, CLC, insurance, medical, pension, maintenance etc)
- Union dues come out of weekly settlement

Insurance Requirements:

- Non trucking liability coverage of 1M limit.
    - Driver Owner can source their own non-trucking policy or opt into Company's.
    - Non-Trucking is a flat rate of $38.00 per month. Subject to change.
- Comprehensive auto liability and commercial general liability (ALGL) are provided by the company and charged back to Driver-Owner
    - This is not optional. Will be covered under Company's policy.
    - Cost based on mileage (IFTA) at a rate of .09 cents per mile. Subject to change.
- Physical damage is at the discretion of driver-owner

Lanes:

- Home terminal is based out of Baltimore, MD
    - Inventory at your home terminal is a priority, but there are other opportunities throughout the network
- Product hauled is Stellantis (Chrysler, Dodge & Jeep)
- Lanes in Baltimore run to OH, MI, IN, KY, NC, MD, PA and VA
- Driver-owner can run out of any NAAT or Jack Cooper terminal. Your first dispatch of the week will be seniority based. For backhauls, you must be dispatched within 30 minutes of arrival at the terminal.
    - https://www.jackcoopernews.com/jct-terminal-locations-us
    - https://www.jackcoopernews.com/naat-terminal-locations
- Actual lanes: https://www.jackcoopernews.com/drive-jack-cooper
- 2000-2500 average projected miles per week

General Information:

- You will be operating under North American Auto Transport's authority
- Contract applies to one single driver, and we do not allow the operation of team drivers
- Teamster's Union
- Up to .40 cents per gallon in fuel discounts
    - Company provided fuel card
- Company provided CLC card for hotel discounts
- Access to company discounts for repairs/maintenance

- Flat fee of $175.00 per week for Administrative Fees (this covers 40 hours of sick time, workman comp coverage, cargo losses over $3500 escrow, the use of our systems & maintaining customer contracts)
- Additional 10% broker fee applies to purchased transportation loads only
- Unused sick pay will be cashed out at the end of the contract year.
- Driver-owner **must** opt into pension and health benefits (Copy of medical plan shown below)
    - Benefits are effective on day 1 past your 30 day probationary period. Carrier is Blue Cross Blue Shield
    - Estimated monthly deduction for health and welfare benefits is $2,200 (this is calculated at a rate of $507 per week and is subject to change based on Teamcare cost.
    - Estimated monthly cost for pension is $650 ($30 per working day with a maximum of $150/week)
    - Union dues are roughly between $70-$80 per month, depending on the local union
- An escrow of $3500 will be required. This will be deducted in the amount of $100 per week until the amount of $3500 has been reached
- Licensing will be covered up front by the company and charged back to driver-owner You will be required to go through company licensing and may not provide your own plates
- All deductions for fuel, hotels, maintenance, insurance, health benefits etc. are deducted from the monthly truck check. The only expenses coming out of the weekly driver's check will be taxes and union dues
- Signed lease is good for one year

Truck Drivers and Helpers Local 355 Health and Welfare Fund Plan A -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, contact 1-866-621-7974. 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.healthcare.gov/sbc-glossary.com or call 1-866-621-7974 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$100 Individual / $200 Family**	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 policy, the overall family deductible must be met before the plan begins to pay.
Are there services covered before you meet your deductible?	**Yes**	This plan covers some items and services even if you haven't yet met the deductible amount (i.e. office visits, prescription drugs). For those services a copayment may apply.
Are there other deductibles for specific services?	**$50 Individual / $100 Family for Dental services. There are no other specific deductibles.**	You must pay all of the costs for non-preventive dental services up to the specific deductible amount before the plan begins to pay for dental services.
What is the out-of-pocket limit for this plan?	**Medical** **$2,000 Individual / $4,000 Family** **Rx $4,850 Ind / $9,700 Family**	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members on the policy, the overall family out-of-pocket limit must be met before the plan begins to pay.
What is not included in the out-of-pocket limit?	**Premiums, balance-billing charges 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 a list of preferred providers, visit www.carefirst.com or call **1-800-235-5160.**	This plan uses a preferred provider network. You will pay the most if you use a non-preferred 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 services.
Do you need a referral to see a specialist?	**No.**	You can see the specialist you choose without a referral. You will pay less if you choose a preferred provider specialist.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10	$10 plus balance over allowed amount	Out of Network charges above allowed amount are your responsibility
	Specialist visit	$10	$10 plus balance over allowed amount	Out of Network charges above allowed amount are your responsibility
	Preventive care/screening/ immunization	$0	$10 plus balance over allowed amount	Immunizations as recommended by the Department of Health & Human Services
If you have a test	Diagnostic test (x-ray, blood work)	$0 for first $300/year 20% coinsurance thereafter	$0 for first $300/year 20% coinsurance thereafter	Out of Network charges above allowed amount are your responsibility
	Imaging (CT/PET scans, MRIs)	$0 for first $300/year 20% coinsurance thereafter	$0 for first $300/year 20% coinsurance thereafter	Out of Network charges above allowed amount are your responsibility
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.express-scripts.com	Generic drugs	$10 copayment/month $20 copayment for 90 days through mail order	N/A	You can receive a 3-month supply for single copay through mail order or at Walgreens. Mail order / Walgreens mandatory after 2 fills for maintenance medications. Mandatory generic program.
	Preferred brand drugs	$25 copayment/month $50 copayment for 90 days through mail order	N/A	You can receive a 3-month supply for single copay through mail order or at Walgreens. Mail order / Walgreens mandatory after 2 fills for maintenance medications. . Mandatory generic program.
	Non-preferred brand drugs	$25 copayment/month $50 copayment for 90 days through mail order	N/A	You can receive a 3-month supply for single copay through mail order or at Walgreens. Mail order / Walgreens mandatory after 2 fills for maintenance medications. Mandatory generic program.
	Specialty drugs	Varies	N/A	Contact Accredo at 1-866-759-1557
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	20% coinsurance based on allowed amount	Out of Network charges above allowed amount are your responsibility.
	Physician/surgeon fees	20% coinsurance	20% coinsurance based on allowed amount	Out of Network charges above allowed amount are your responsibility.
If you need immediate medical attention	Emergency room care	$50 copayment if true emergency $150 copayment if non-	$50 copayment if true emergency $150 copayment if non-	Services must be received within 12 hours of onset of accidental injury or life-threatening illness for coverage as true emergency

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
		emergency	emergency	
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care – office visit only	$10	$10 plus balance over allowed amount	Out of Network charges above allowed amount are your responsibility.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	20% coinsurance based on allowed amount	Pre-authorization **required** – call American Health Holdings @ **1-800-641-5566.** Semi-private room rate/up to 365 days per disability.
	Physician/surgeon fees	20% coinsurance	20% coinsurance based on allowed amount	Out of Network charges above allowed amount are your responsibility
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	20% coinsurance based on allowed amount	Out of Network charges above allowed amount are your responsibility
	Inpatient services	20% coinsurance	20% coinsurance based on allowed amount	Pre-authorization **required** – call American Health Holdings @ **1-800-641-5566.** Semi-private room rate/up to 365 days per disability.
If you are pregnant	Office visits	20% coinsurance	20% coinsurance based on allowed amount	Out of Network charges above allowed amount are your responsibility.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance based on allowed amount	Members and spouses only. Out of Network charges above allowed amount are your responsibility.
	Childbirth/delivery facility services	20% coinsurance	20% coinsurance based on allowed amount	Members and spouses only. Out of Network charges above allowed amount are your responsibility.
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance based on allowed amount	
	Rehabilitation services	20% coinsurance	20% coinsurance based on allowed amount	Pre-authorization **required** – call American Health Holdings @ **1-800-641-5566.** Occupational/ Speech/ Physical therapies/ Chiropractic and Acupuncture – combined 75 visit annual limit.
	Habilitation services	Not Covered	Not Covered	
	Skilled nursing care	20% coinsurance	20% coinsurance based on allowed amount	100 days per disability

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Preferred Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	20% coinsurance	20% coinsurance based on allowed amount	Out of Network charges above allowed amount are your responsibility
	Hospice services	$0	$0	Palliative care only – maximum of 6 months. Pre-authorization **required** – call American Health Holdings @ **1-800-641-5566.**
If your child needs dental or eye care	Children's eye exam	Amount above annual allowance	Amount above annual allowance	Plan pays up to $325/person each calendar year for exam/glasses combined. If under age 19, annual maximum does not apply when medically necessary.
	Children's glasses	Amount above annual allowance	Amount above annual allowance	
	Children's dental check-up	$0	Amount above plan allowance	Every 6 months.

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.)

- Cosmetic Surgery
- Dental Care (separate plan)
- Infertility treatment
- Long-term care
- Private duty nursing
- Routine eye care (separate plan)
- Weight loss programs

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

- Acupuncture and chiropractic care (combined with Physical/Speech/Occupational therapy 75 annual visit maximum)
- Bariatric surgery (medically necessary)
- Hearing aids (every 5 years, maximum $5,000)
- Non-emergency care outside U.S.
- Routine foot care

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. For more information on your rights to continue coverage, contact the plan at 1-866-621-7974. You may also contact the Department of Labor Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. 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 the plan at 443-573-3635 or 1-888-805-7996. For more information about your rights, this notice, or assistance, contact the plan at 443-573-3632 or 1-866-621-7974. You may also contact the U.S. Department of Labor, Benefits Security Administration (1-866-444-3272 or www.dol.gov/ebsa) or the U.S. Department of Health and Human Services (1-877-267-2323 X61565 or www.cciio.cms.gov)

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.

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.

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

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	$100
Specialist *[cost sharing]*	$10
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	$10

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	**$12,738**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$100
Copayments	$60
Coinsurance	$2,480
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,700**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	$10
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	$10

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$735
Coinsurance	$372
What isn't covered	
Limits or exclusions	$55
The total Joe would pay is	**$1,263**

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

The plan's overall deductible	$100
Specialist *[cost sharing]*	$10
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	$10

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	**$1,941**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$100
Copayments	$180
Coinsurance	$215
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$495**

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