2024

Employee Benefits Overview

This Benefits Overview summarizes your available benefits. Please take time to review and select the coverage options that best align to meet you and your family's healthcare needs.

Hello Team,

I hope this message finds you well. As we gear up for our annual benefit enrollment period, I want to share some important updates and changes to our offerings. Your safety and well-being are our priority, and we believe these adjustments will enhance your overall benefits package.

This year, benefit enrollment is mandatory for all eligible employees. Whether you currently have benefits with the company or have waived them in the past, you must either enroll or waive benefits for the upcoming year. Our enrollment period starts Tuesday, November 14th and ends Thursday, November 30th.

Please also take this opportunity to review and update your beneficiaries or add them if you haven't done so in the past.

Updates to our benefits are as follows:

- High Deductible Health Plan (HDHP) Changes:
  To address rising costs of our health care plans, we made some adjustments to our High Deductible Health Plan to mitigate premium increases. While the premiums remain the same, the deductible and out-of-pocket amounts have increased, and a prescription copay has been added once the deductible has been met. We encourage you to review the updated plan details during the enrollment period.

- Copay Health Plan:
  Again, due to rising costs and our claims experience, we received an increase of 15-17% on the Copay Health plan. There are no plan design changes this year.

- Increased Company-Paid Life Insurance:
  We are excited to announce the company paid life insurance coverage for full time employees is increasing from $20,000 to $50,000. This enhancement aims to provide greater financial security for you and your family.

- Short Term Disability:
  We are introducing a new short term disability policy through Principal Financial. This new policy offers improved benefits at lower premiums. Participants who enroll in this plan are eligible for their current coverage for Trustmark. No Evidence of Insurability is required during this enrollment for coverage up to the guaranteed issue amount.

- New Vendor for Flex Spending Accounts (FSA):
  We are switching to Omnify as our vendor for the Flex Spending Accounting to offer you more efficient services. Rest assured; services will remain the same.

- Introduction of New Allstate Products:
  We are thrilled to introduce new Allstate products to our benefits portfolio. From enhanced insurance options to valuable discounts, these additions aim to provide you with even more ways to protect and maximize your well-being.

During our benefit enrollment period, you'll have the opportunity to review, make changes, and enroll in the benefits that best align with your lifestyle and preferences. You may also waive coverage during this time.

For more detailed information and resources to assist you in making informed decisions about your benefits, please review the following Benefits Overview. Our dedicated call center team (877-282-0808) is available to answer any questions you may have throughout the enrollment process.

We appreciate your ongoing commitment to Arrow Stage Lines, and we look forward to continuing to support your health and well-being.

Best regards,

Chelle Cooper
VP Human Resources

Arrow Stage Lines / Busco Inc. provides an array of benefits to help you maximize your well-being, offer support with an unexpected illness or accident, build and protect your financial security, and balance your personal and professional life. We are pleased to offer benefits that are affordable, comprehensive, and competitive to assist you and your family in navigating and fulfilling everyday needs.

What's New for 2024

Medical HDHP Update

- Increased deductible to $5,000 individual / $10,000 family and out-of-pocket maximums to $8,050 individual / $16,100 family
- After the deductible has been met, there will be prescription drug copays. They will be $10 for Tier 1, $35 for Tier 2, and $70 for Tier 3 prescription drugs.

Basic Life / AD&D Policy

- Increased to $50,000

Voluntary Short-Term Disability

- Enhanced benefit option offered through Principal

New FSA Partner

- Moving from Mid-American Benefits to Omnify

HSA Contribution Limits

- $4,150 Individual / $8,300 family

401k Contribution Limits

- $23,000 with $7,500 catch up contribution if 50 years and older.

New Pet Insurance Partner

- Moving from Nationwide to PetPartners

Allstate

- The Accident and Hospital Plans will be transitioning to the new offerings from Allstate. Additionally, we will be offering Allstate's Whole Life Insurance with a Long Term Care benefit rider.

2024 Benefits At-A-Glance

Coverage	Carrier
Medical	UnitedHealthcare
Voluntary Dental	UnitedHealthcare
Voluntary Vision	EyeMed
Basic Life/AD&D and Voluntary Life/AD&D	UnitedHealthcare
Employee Assistance Program (EAP)	UnitedHealthcare
Flexible Spending Accounts	Omnify
Health Savings Accounts	Optum Bank
Critical Illness, Accident, Cancer, Hospital, Whole Life with Long Term Care	Allstate
Disability Income Insurance	Principal
Pet Insurance	PetPartners
401K	Nationwide

Eligibility

If you are an eligible employee, your coverage under the benefits plan will begin on the first of the month following 30 days of employment with Arrow Stage Lines / Busco, Inc.

Enrollment Process

Initial Enrollment (when newly benefit-eligible)

Arrow Stage Lines / Busco Inc. utilizes an online enrollment system or call center option to make your benefit elections. Your benefit information and login will be emailed to you soon after your full-time start date. Elections completed during an employee's **initial enrollment** will remain in effect until the current Plan Year ends unless a change is requested for a qualified event. Without a qualified event, the next opportunity to change elections is offered annually during the Open Enrollment period.

Open Enrollment (occurs annually)

Open enrollment is a designated time period each year when you may make changes to your benefits without experiencing a qualified event. Elections you make during open enrollment will become effective on January 1.

Open enrollment for the 2024 Plan Year begins November 14. Open Enrollment is **mandatory**, so every employee must make an active election, either accepting or waiving each benefit.

The deadline to enroll / remit changes for a January 1 effective date is November 30, 2023.

Special Enrollment (within 30-days of a qualified event)

Elections completed during open enrollment remain in place until the next open enrollment period **unless** a qualified event occurs and the associated election update is requested **within 30-days** of the qualifying event date. It is the employee's responsibility to timely report qualified events / remit elections if wishing to update benefits during a **special enrollment** period.

How to Enroll

You may access the online enrollment link or contact the Call Center to complete elections.

- Log on to www.buscobenefits.com and click on the "Enroll Online Now" button to enroll.
  - **Employee#:** The first 4 letters of your last name and the last 4 digits of your SSN
  - **PIN#:** The initials of your first and last name plus the last 4 digits of your SSN
- Call Center 877-282-0808 **/** Available Monday through Friday, 7am to 5pm CST

Changes and Qualifying Events

When Coverage Begins and Ends

- Coverage begins the first of the month following 30 days as measured from your eligibility date.
- Coverage begins the first of the month following a qualifying event election change unless the date of the qualifying event supersedes the first of the month.
- Court-ordered coverage begins when legally stipulated, provided the impacted employee meets eligibility requirements.
- Coverage ends the last day of the month in which you no longer meet the eligibility requirements, if you gain other coverage with a qualifying event, if your contributions are discontinued, if you terminate employment, or if the Group Insurance Policy is terminated.

Qualifying Events

Changes requested due to qualifying events must be remitted within 30-days of the event date. Changes reported outside of the 30-days will be determined ineligible. Examples of qualifying events include, but are not limited to:

- Changes in employment status
- Changes in legal marital status
- Changes in number of dependents
- Taking an unpaid leave of absence
- Dependent satisfies or ceases to satisfy eligibility requirement
- Family Medical Leave Act (FMLA) leave
- A COBRA-qualifying event
- Entitlement to Medicare or Medicaid
- A change in the place of residence of the employee, resulting in the current carrier not being available

Key Terminology

Annual Deductible

The amount you must pay each year before the plan starts paying a portion of medical expenses. All family members' expenses that count toward a health plan deductible accumulate together in the aggregate; however, each person also has a limit on their own individual accumulated expenses (the amount varies by plan).

Out-Of-Pocket Maximum

This is the total amount you can pay out of pocket each calendar year before the plan pays 100 percent of covered expenses for the rest of the calendar year. Most expenses that meet provider network requirements count toward the annual out-of-pocket maximum, including expenses paid to the annual deductible, copays and coinsurance.

Copays and Coinsurance

These expenses are your share of cost paid for covered health care services. Copays are a fixed dollar amount and are usually due at the time you receive care. Coinsurance is your share of the allowed amount charged for a service and is generally billed to you after the health insurance company reconciles the bill with the provider.

Plan Types

PPO Plan – A plan that offers discounted services for utilizing a contracted network of doctors, hospitals and other health care providers.

High Deductible Health Plan (HDHP) – A plan that typically has higher annual deductibles in exchange for lower premiums.

In Network Vs. Out of Network

In-network health care providers have agreed to accept certain rates, so you will typically pay less when you use them. Out-of-network health care providers can charge you any amount they want. Because there is no negotiated rate, these services usually cost you more.

Premiums

A premium is the money that is automatically taken out of your paycheck for health insurance. In addition to the premium, you also pay costs for health care when you use it, such as a deductible, copayment, and coinsurance.

Medical

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Plan Features	Co-Pay Option	HDHP Option
Deductibles *Individual / Family*	$3,000 / $6,000 In-Network $6,000 / $12,000 Non-Network	$5,000 / $10,000 In-Network $5,000 / $10,000 Non-Network
Out-of-Pocket Max *Individual / Family*	$6,350 / $12,700 In-Network $10,000 / $20,000 Non-Network	$8,050 / $16,100 In-Network $10,000 / $20,000 Non-Network
Plan Cost Sharing	Plan Pays 80% - You Pay 20%	Plan Pays 80% - You Pay 20%
Primary Care Visit *The number of visits for which a copay will apply are combined with any Specialist Office visits*	$30 copay per visit for the first 4 visits in a year; then deductible + 20% for all other visits in the same year	Deductible then 20%
Specialist Visit *The number of visits for which a copay will apply are combined with any Primary Care Physician Office visits*	**Designated**: $30 copay per visit for the first 4 visits in a year; then deductible + 20% for all other visits in the same year **Non-Designated**: $60 copay per visit for the first 4 visits in a year; then deductible + 20% for all other visits in the same year	Deductible then 20%
Virtual Care	Covered 100%	
Preventive Care	Covered 100%	
Outpatient Procedure	Deductible then 20%	Deductible then 20%
Emergency Room	$250 copay, then 20%	Deductible then 20%
Urgent Care	$100 copay per visit for the first 4 visits in a year; then deductible + 20% for all other visits in the same year	Deductible then 20%
Inpatient Visit	Deductible then 20%	Deductible then 20%
Pharmacy (Retail 31 Day Supply)		
Generic Drugs	$15 copay	Deductible then $10 copay
Preferred Brand Drugs	$35 copay	Deductible then $35 copay
Non-Preferred Brand Drugs	$70 copay	Deductible then $70 copay
Mail Order (90 Day Supply)	3x Retail cost	Deductible then 3x Retail cost

Payroll Deductions – 24 Pay Periods				
Medical Plan	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Co-Pay Plan	$165.73	$391.30	$286.44	$464.80
High Deductible Health Plan	$70.20	$215.87	$169.16	$274.38

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Medical

Medicare Eligible Notice

Your benefits may be reduced if you are eligible for Medicare but do not enroll in and maintain coverage under both Medicare Part A and Part B. Your benefits may also be reduced if you are enrolled in a Medicare Advantage (Medicare C) plan but do not follow the rules of that plan. Please refer to the Certificate of Coverage for more details.

Wellness and Preventive Services

Understanding the full value of covered benefits allows you to take responsibility for maintaining good health and incorporating healthy habits into your lifestyle. Some examples include getting regular physical examinations, mammograms, and immunizations. Through the plans offered by Arrow Stage Lines / Busco, Inc., all covered employees and covered family members are **eligible to receive routine wellness services like these, at no cost; all copays, coinsurance, and deductibles are waived.**

Covered Preventive Services

The US Preventive Services Task Force maintains a regular list of recommended services that all Affordable Care Act (i.e., Health Care Reform) compliant insurance plans should cover at 100% for in-network providers. Below is a list of common services that are included in the plans offered this year:

- Routine Physical Exam
- Well Baby and Childcare
- Well Woman Visits
- Immunizations
- Routine Bone Density Test
- Routine Breast Exam
- Routine Gynecological Exam
- Screening for Gestational Diabetes
- Obesity Screening and Counseling
- Routine Digital Rectal Exam
- Routine Colonoscopy
- Routine Colorectal Cancer Screening
- Routine Prostate Test
- Routine Lab Procedures
- Routine Mammograms
- Routine Pap Smear
- Smoking Cessation
- Health Education/Counseling Services
- Health Counseling for STDs and HIV
- Testing for HPV and HIV
- Screening and Counseling for Domestic Violence

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Put your medical, dental, pharmacy and vision coverage* at your fingertips

Your personalized website **myuhc.com** features tools designed to help you:

- **Find, price and save on care—**you may save an average of 36%** when you compare costs for providers and services in your network
- **Get care from anywhere** with Virtual Visits.*** A doctor can diagnose common conditions by phone or video 24/7.
- **Understand your benefits** and the financial impact of care decisions
- **Find tailored recommendations** regarding providers, products and services. You can even generate an out-of-pocket estimate based on your specific health plan status.
- **Access claim details,** plan balances and your health plan ID card quickly
- **Follow through on clinical recommendations** and access wellness programs
- **Order prescription refills,** get estimates and compare medication pricing
- **Check your plan balances,** access financial accounts and more

Download the UnitedHealthcare® app

It's perfect for on-the-go access to help you find a nearby doctor and more.

Registering is quick. Go to myuhc.com

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*Experience may vary by individual plan type.

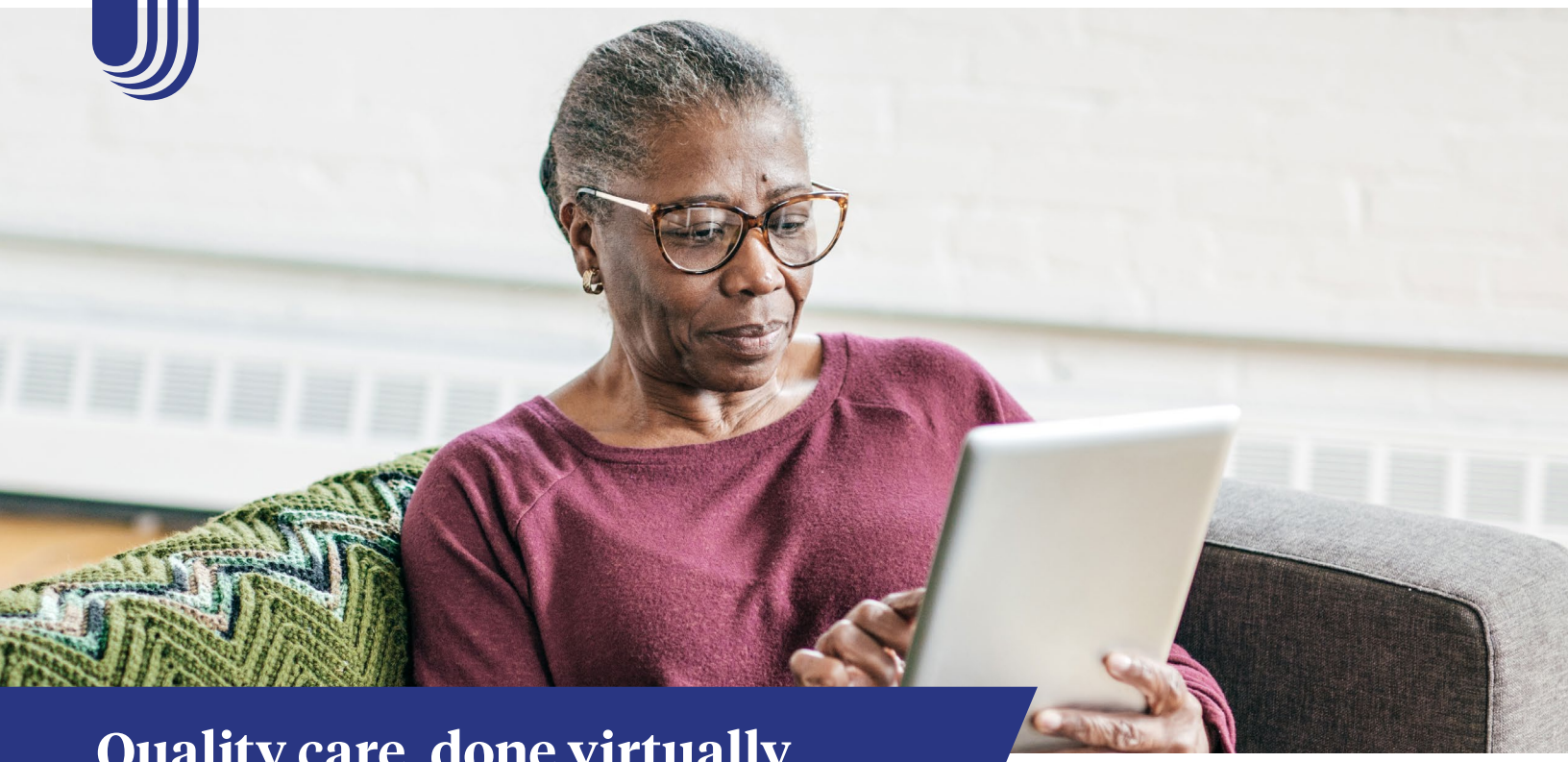
**UnitedHealthcare Internal Claims Analysis, 2019.

***Virtual Visits phone and video chat with a doctor are not an insurance product, health care provider or a health plan. Unless otherwise required, benefits are available only when services are delivered through a Designated Virtual Network Provider. Virtual Visits are not intended to address emergency or life-threatening medical conditions and should not be used in those circumstances. Services may not be available at all times, or in all locations, or for all members. Check your benefit plan to determine if these services are available.

All UnitedHealthcare members can access a cost estimate online or on the mobile app. None of the cost estimates are intended to be a guarantee of your costs or benefits. Your actual costs may vary. When accessing a cost estimate, please refer to the Website or Mobile application terms of use under Find Care & Costs section.

The UnitedHealthcare® app is available for download for iPhone® or Android®. iPhone is a registered trademark of Apple, Inc. Android is a registered trademark of Google LLC.

Insurance coverage provided by or through UnitedHealthcare Insurance Company or its affiliates. Administrative services provided by United HealthCare Services, Inc. or their affiliates.



Quality care, done virtually

See a primary care provider or get same-day urgent care on your phone, tablet or computer

With virtual care through your UnitedHealthcare plan, get care any time.

Using your smartphone or other connected device,* like a tablet or a computer, you can access virtual primary and urgent care.

To schedule a virtual primary care appointment or access urgent care through 24/7 Virtual Visits, just download the UnitedHealthcare® app or visit myuhc.com/virtualcare.

What kind of virtual care might be right for you?

Virtual primary care:

- Annual wellness visits
- Regular follow-ups for conditions like asthma, diabetes, etc.
- Lab tests and preventive screenings
- Referrals to quality network specialists
- Medication review and prescriptions, if needed**
- Cost aligns with PCP benefit

24/7 Virtual Visits:

- Non-emergency care for common health issues like the flu, fevers, sore throats, etc.
- Non-emergency care for sudden health issues like pinkeye, migraines, back pain, even allergies and anxiety
- Prescription refills, if needed**
- Cost aligns with 24/7 Virtual Visits benefit

Scan the QR code to access your virtual care options

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Get to Know UHC Rewards

UnitedHealthcare Rewards is an incentive program that's included in your health plan. It rewards employees with dollars for reaching program goals and completing activities.

Employees get to choose their activities as well as how to spend their earnings.

How employees get started:

UnitedHealthcare plan members can register and start UHC Rewards through the UnitedHealthcare app or myuhc.com.

UnitedHealthcare app

1. Download the **UnitedHealthcare app**
2. Sign in or register
3. Select the **Menu** tab and choose UHC Rewards
4. Activate rewards
5. Choose reward activities and start earning
6. Connect a tracker and get access to even more reward activities

myuhc.com

1. Visit myuhc.com
2. Sign in or register
3. Select **UHC Rewards** on the home page
4. Activate rewards
5. Choose reward activities and start earning

Downloading the app

The UnitedHealthcare app is available for both iOS® and Android® and can be downloaded in the App Store® or on Google Play®.

Download on the App Store

GET IT ON Google Play

Compare care options to help keep costs down

Getting care at the place that may best fit your condition or situation may save you up to $2,300 compared to an emergency room (ER) visit.* If you have a life-threatening condition, call 911 or go to the ER. For everything else, it may be best to contact your primary care provider (PCP) first. If seeing your PCP isn't possible, it's important to know your other care options, especially before heading to the ER.

Care options to consider	START HERE PCP Care from the doctor who may know you best	24/7 Virtual Visits See a doctor whenever, wherever	Convenience care Basic conditions that aren't generally life-threatening	Urgent care Serious conditions that aren't generally life-threatening	Emergency room Life- and limb-threatening emergencies
Average cost*	**$165**	**$ 0**	**$100**	**$185**	**$2,500**
Hours	**Varies by location**	**24/7**	**Varies by location**	**Varies by location—may be open nights/weekends**	**24/7**
How to connect	**Contact your PCP**	**myuhc.com/virtualvisits**	**myuhc.com®**	**myuhc.com**	**myuhc.com**
✔ **indicates the recommended place for care for the following common conditions:**					
Broken bone				✔	✔
Chest pain					✔
Cough	✔	✔	✔		
Fever	✔	✔	✔		
Muscle strain	✔		✔		
Pinkeye	✔	✔	✔		
Shortness of breath					✔
Sinus problems	✔	✔	✔		
Sore throat	✔	✔	✔		
Sprain	✔		✔	✔	
Urinary tract infection	✔	✔	✔		

Need to find a network provider or PCP? Visiting an out-of-network provider could end up costing you more for care. To find a PCP, urgent care centers and emergency rooms in your network, go to **myuhc.com**.
Not sure where to go for care? Call the number on your health plan ID card.

continued

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Vital Medication Program

Preferred brand and generic medications at $0 cost share

Allergic reactions

- **Auvi-Q**
- epinephrine (generic Adrenalick, generic EpiPen, EpiPen Jr)
- **Symjepi**

Hypoglycemia

- **Baqsimi**
- glucagon (generic Glucagon Kit)
- **Gvoke**
- **Zegalogue**

Asthma

- albuterol HFA (generic ProAir HFA, generic Proventil HFA)
- albuterol nebulized solutions (generic Proventil)

Opioid overuse

- **Kloxxado**
- naloxone nasal spray (generic Narcan)[1]
- naloxone injection (generic Narcan)[2]
- **Narcan nasal spray**[1]
- **Zimhi**

Insulins[2]

- **Humalog cartridge, KwikPen**
- **Humalog Jr pen**
- **Humalog mix 50/50 KwikPen**
- **Humalog mix 75/25 KwikPen**
- **Humulin 70/30 KwikPen, vials**
- **Humulin N KwikPen, vials**
- **Humulin R pen, vials**
- **Insulin Lispro vial, KwikPen (unbranded Humalog)**
- **Insulin Lispro Junior KwikPen (unbranded Humalog Junior KwikPen)**
- **Humalog mix 50/50 KwikPen, vials**
- **Insulin Lispro Protamine/Insulin Lispro KwikPen Mix 75/25 (unbranded Humalog Mix 75/25 KwikPen)**
- **Lantus SoloStar, vials**
- **Lyumjev KwikPen, vials**
- **Toujeo Max SoloStar**
- **Toujeo SoloStar**

[1] Includes over-the-counter when processed through the pharmacy benefit at a participating pharmacy
[2] Syringes and needles used for the administration of these Vital Medications may also be covered at $0.
Vital Medication Program list is subject to change. Brand medications are bolded.

Voluntary Dental

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Plan Features	Dental Plan
Annual Deductible: Individual / Family	$50 / $150
Calendar Year Maximum Benefit	$1,000 per person
Orthodontia Benefit Children only, up to age 19	50% up to $1,000 lifetime
Preventive Care **(Calendar Year deductible is waived)**	**100%**
Oral Exam **Prophylaxis (Cleaning)** **Bitewing x-rays (radiographs)** **Panoramic x-rays** **Fluoride Treatments (preventive)** **Sealants**	Up to 2x per 12 months Up to 2x per 12 months Up to 1 series of films per calendar year Up to 1x per 36 months Up to 2x per 12 months (<16 years of age) Up to 1x per 1st or 2nd permanent molar every 36 months (<16 years of age)
Basic Procedures **(after Calendar Year Deductible is met)**	**80%**
Restorations (fillings), Amalgams, or Composite (anterior & posterior) **Space Maintainers** **Simple Extractions** **Oral Surgery (incl. surgical extractions)** **Periodontics** **Endodontics**	Amalgam or Composite-multiple restorations on one surface will be treated as a single filling Up to 1 per 60 months (<16 years of age) Periodontal Maintenance up to 2x per 12 months following active or adjunctive periodontal therapy, exclusive of gross debridement
Major Procedures **(after Calendar Year Deductible is met)**	**50%**
Inlays & Onlays **Crowns** **Dentures (full & partial)** **Fixed Partial Dentures (Bridges)**	Up to 1x per tooth per 60 months. Covered only when filling cannot restore tooth Up to 1x per tooth per 60 months. Covered only when filling cannot restore tooth Up to 1x every 60 months Limited to repairs & adjustments performed more than 12 months after initial insertion; Limited 1x per 6 months
Consumer Max Multiplier	Rewards members for keeping up with dental care by adding dollars to the established calendar maximum. If your total claims are less than $500, you'll earn a reward of $250. Plus, if all claims are with network dentists, you'll earn an extra $100. Your award dollars will be added to next year's annual maximum to pay for qualifying claims. $1,000 is the most award dollars that can be rolled over to the annual maximum. The total annual maximum threshold is $2,000.

Payroll Deductions – 24 Pay Periods				
Dental Plan	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Employee Cost	$14.76	$29.12	$27.52	$45.56

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Voluntary Vision

Plan Features	In-Network
Vision Exam	$10 copay
Contact Lens Fit & Follow-Up	Standard: Up to $40; contact lens fit & two follow up visits Premium: 10% off retail price
Frame	$0 copay; $100 allowance, then 20% off balance
Lenses	
Single	$25 copay
Bifocal	$25 copay
Trifocal	$25 copay
Progressive – Standard	$25 copay; 20% off retail price less $55 allowance
Progressive – Premium	$25 copay; 20% off retail price less $55 allowance
Lens Options	
Anti-Reflective Coating – Standard	$45 copay
Polycarbonate – Standard	$40 copay
Scratch Coating – Standard Plastic	$15 copay
Tint – Solid or Gradient	$15 copay
UV Treatment	$15 copay
All other Lens options	20% off retail price
Contact Lenses	
Contacts – Conventional	$0 copay; 15% off balance over $115 allowance
Contacts – Disposable	$0 copay; 100% off balance over $115 allowance
Contacts – Medically Necessary	$0 copay; 100% paid in full
***Frequency**	
Exam	Once every 12 months from date of service
***Frame**	Once every 12 months from date of service
***Lenses**	Once every 12 months from date of service
***Contact Lenses**	Once every 12 months from date of service
Value Added Features	
Hearing Care from Amplifon Network	Discounts on hearing aids and materials; call 1-877-203-0675
Lasik or PRK from U.S. Laser Network	15% off retail or 5% off promo price; call 1-800-988-4221
Additional Glasses	40% off additional pairs of glasses & a 15% discount on conventional lenses once funded benefit is used.

***Plan allows members to receive either contacts and frames or frames with lens services in one 12-month period.**

Payroll Deductions – 24 Pay Periods				
Vision Plan	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Employee Cost	$2.87	$5.44	$5.71	$8.41

Voluntary Short-Term Disability

Plan Features	Benefit Provisions
Benefits Begin	8th Day Accident or Illness
Maximum Benefits Payable	$1,500 per week
Percentage of Income Replaced	60%
Maximum Benefit Duration	Up to 25 weeks
Pre-existing Condition Limitation	3 months prior / 12 months insured

Initial enrollment / Open Enrollment 2024

The 2024 Open Enrollment period is the initial enrollment period for eligible employees to elect Short-Term Disability coverage through Principal. Your STD coverage will be automatically approved for a January 1 effective date **without** answering health questions. Subsequent to this, unless newly benefit eligible, any STD coverage requested outside of the initial enrollment period will require an evidence of insurability application process. If evidence of insurability is approved, coverage will become effective the 1st of the month following approval. Please note, coverage approval is not guaranteed.

STD coverage cost is calculated based on age and weekly income.

Employee Paid Short-Term Disability	Cost per $10 / weekly income
Age	**Monthly Rate Factor**
24 & under	.41
25 - 29	.43
30 - 34	.41
35 - 39	.49
40 - 44	.62
45 - 49	.54
50 - 54	.71
55 - 59	1.02
60 - 64	1.24
65 - 69	1.19
70 & over	1.50

Basic Life and AD&D

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Employer-paid Basic Life Insurance	
Employee Life Amount	$50,000
AD&D Benefit	$50,000
Age Benefit Reduction	
At age 70	Benefits will reduce by 35% of the original life volume
At age 75	Benefits will reduce an additional 15% of the original life volume

Beneficiary Designation Updates

Please request a Beneficiary Designation Form from Human Resources if you need to update your primary and contingent beneficiaries. A Beneficiary Designation Form will also be provided upon your initial enrollment in the plan, as well as during subsequent open enrollment periods. You will need to complete the Beneficiary Designation Form related to the $50,000 employer-provided life coverage (even if you decline other benefits).

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Voluntary Life Insurance and AD&D

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Employee-paid Voluntary Life Insurance		Guaranteed Issue
Employee Life Amount	$10,000 up to $500,000 Maximum 4 times annual earnings	$100,000
Spouse Life Amount	$5,000 up to 50% of Employee amount Maximum $250,000	$30,000
Child Life Amount **(14 days to age 26)**	$2,000 up to $10,000 Up to 50% of Employee amount	$10,000

Voluntary Life / AD&D Insurance Coverage / Evidence of Insurability

Initial Enrollment (when newly benefit eligible)

You may elect life insurance coverage up to $100,000 for self and up to $30,000 for spouse **without** answering health questions. You may also request coverage up to the plan maximums, however any life insurance coverage requested over the Guaranteed Issue amount(s) or requested outside of the initial enrollment period will be subject to evidence of insurability. If evidence of insurability is approved, coverage will become effective the 1st of the month following approval. Please note, coverage approval is not guaranteed.

Open Enrollment (occurs annually)

During annual open enrollment you may increase your coverage by $10,000 for self or up to $5,000 for spouse up to the guaranteed issue amount without providing evidence of insurability provided coverage has not been increased in the recent 12 months due to a qualified event. If you applied for coverage previously and your evidence of insurability was declined, you may be required to submit evidence of insurability for any new requests to increase coverage.

If evidence of insurability applies for requested coverage and is not completed, or if your requested coverage is not approved by the carrier, the Voluntary Life / AD&D amounts in force prior to the application will remain in effect.

Age Benefit Reduction

Your coverage amount will reduce by 35% when attaining age 70. An additional 15% reduction occurs when attaining age 75.

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Employee Assistance Program (EAP)

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The EAP is a free resource to assist those enrolled in the Medical Plan with 24/7 access to care support and resources. The EAP may help address many personal issues and concerns that arise in life. Calling an EAP coordinator for a no-cost, confidential assessment is a good first step in seeking assistance. EAP representatives are trained to assess your concerns and connect you with appropriate resources and services. Up to **3 free counseling sessions per incident** are available utilizing the EAP resource. Below are examples of when outreach to the EAP may apply:

- Depression, stress, anxiety or substance use issues
- Improve relationships at home or work
- Find support for child or elder care matters
- Work through emotional issues or grief
- Get legal or financial assistance.

***You may call the member phone number on your health plan ID card and ask to speak to an EAP consultant, or you may contact the EAP directly 24/7 at 1-888-887-4114.**

***Please note, you must be enrolled in the medical plan to use the United Healthcare EAP services.**

Creating value for employees:

- 24/7 access to emotional and mental health support
- A strong focus on employees and their families
- Guidance to relevant community and social resources
- Access to a network of more than 180,000 clinicians nationwide

Support that's available around the clock

EAP can help all employees (not just those in crisis) by providing support 365 days a year through:

Confidential consultations and counseling to help employees address grief or loss, as well as family, relationship and workplace concerns. Employees have unlimited, 24/7 access to an EAP team that can provide in-person referrals to one of more than 180,000 network clinicians nationwide.

Legal assistance and financial coaching, including brief consultations on specific legal or financial issues at no initial cost to the individual, and discounted fees for attorneys retained through the EAP.

UNICO

Flexible Spending Account (FSA)

Arrow Stage Lines / Busco, Inc. offers Flexible Spending Accounts (FSA) for both health and dependent care FSA eligible expenses.

Effective for the 2024 Plan Year, the FSA plan administrator is updating to Omnify, a division of Union Bank & Trust.

Black Out Period Notice (dates to be determined)

During the administrator transition from Mid-American Benefits to Omnify, account holders will experience a blackout period to allow year-end information to be assimilated and transferred to Omnify. During this period, account transactions and reimbursement processing will be unavailable. Please be assured Omnify will upload the account data within 48 hours of receipt to allow standard FSA processing to resume as timely as available. Omnify's services will also include handling any eligible runout claims for Plan Year 2023.

Flexible Spending Account Types

- Full Healthcare FSA
- Limited Purpose FSA
- Dependent Care Account

Additional details per account type are included in the upcoming Benefits Overview pages.

How the FSA works

- You set aside money for your FSA from your paycheck before taxes are taken out.
- You will receive a debit card from Omnify that links directly to your FSA funds.
- Then use your pre-tax FSA funds throughout the plan year to pay for eligible health care or dependent care expenses.
- You save money on expenses you're already paying for.
- **If you participate in a Health Savings Account, only Dental and Vision expenses are reimbursable through a Limited Purpose FSA.**
- **Plan your elections carefully, because if you do not use it, you lose it!**

Healthcare FSA	Qualified Expenses (examples)	Annual Limit	Documentation must include
✓ For use with Medical Expenses ✓ Offered with **Traditional Plans with Copays** ✓ Can be used for qualified medical, dental and vision expenses ✓ Annual election is available on first day of plan year ✓ Annual election is locked in throughout year unless you have a change in status ✓ Plan carefully as FSAs are "use it or lose it" (has Carryover/Grace period) ✓ You may be asked to provide supporting documentation for any claim	✓ Medical Copay ✓ Lab work ✓ Surgery ✓ Prescriptions ✓ Dental Copay ✓ Ortho ✓ Vision ✓ Eye exam ✓ Glasses ✓ Contacts A list of eligible expenses can be found at www.irs.gov	**$3,200**	1. Participant Name 2. Date of Service 3. Amount of Service 4. Provider 5. Description of Service Performed

Limited Purpose FSA	Qualified Expenses (examples)	Annual Limit	Documentation must include
✓ Flexible Spending Account ✓ Offered with **HDHP** ✓ Can be used for qualified dental and vision expenses ✓ Full annual election available on first day of plan year ✓ Annual election is locked in throughout year unless you have a change in status ✓ Plan carefully as LPFSAs are “use it or lose it” (has Carryover/Grace period) ✓ You may be asked to provide supporting documentation for any claim	✓ Dental ✓ Copay ✓ Fillings ✓ Root Canal ✓ Ortho ✓ Vision ✓ Eye exam ✓ Glasses ✓ Contacts ✓ Lasik A list of eligible expenses can be found at www.irs.gov	**$3,200**	1. Participant Name 2. Date of Service 3. Amount of Service 4. Provider 5. Description of Service Performed

Dependent Care Account (DCA)	Qualified Expenses (examples)	Annual Limit	Documentation must include
✓ Can be used for qualified dependent care expenses (Pre-K, before & after school, day camp) ✓ Funds available as withheld from pay ✓ Annual election is locked in throughout year unless you have a change in status ✓ Plan carefully as DCAs are “use it or lose it” ✓ Can only use as much as has been contributed. ✓ You may be asked to provide supporting documentation for any claim	✓ Pre-K ✓ Before school care ✓ After school care ✓ Licensed centers ✓ In home day care ✓ Day camps ✓ Summer camps ✓ Dependent adult care ✓ Allowed for children under age 13 or caring for elders.	**$2,500** Married filing single **$5,000** Married filing joint **$5,000** Single filing single	1. Participant Name 2. Date of Service 3. Amount of Service 4. Provider 5. Provider EIN

Health Savings Account (HSA)

When you enroll in the HDHP medical plan, you may also set up a personal savings account called a Health Savings Account (HSA). You may use your HSA to pay for qualified out-of-pocket medical expenses with pre-tax dollars, whether spending now or in the future. Once you're enrolled in the HSA, you will receive a debit card to help manage your HSA reimbursements. Your HSA may also be used to help pay for qualified medical expenses for your spouse and dependents, even if they are not covered by the HDHP medical plan.

How to Open your Health Savings Account

You are individually responsible for establishing your HSA with Optum Bank. The account must be in an active status to allow Arrow Stage Lines / Busco Inc. to remit your payroll contributions to the account. Please act timely to open your account using the below-noted link. Our Group # is 743074.

Enrollment Link: https://enrollhsa.optumbank.com/enrollment#/?group=743074

Health Savings Account Maximums & Provisions

IRS Maximum	Individual	Employee & Spouse	Employee & Children	Family	Catch-Up for 55+
2024	$4,150	$8,300	$8,300	$8,300	$1,000

HSA Eligibility

- Enrolled in a qualified High Deductible Health Plan
- Not enrolled under a traditional health plan. This includes a spouse's Section 125 FSA (unless it is a Limited Purpose FSA)
- Have not used VA benefits in the last 3 months
- Not enrolled in Medicare
- Not claimed as a dependent on someone else's tax return

HSA Benefits

- Contributions made to the HSA are pre-tax.
- Funds can be invested or spent – your decision. If invested, earnings grow tax-free.
- Distributions are tax-free if used for qualified expenses.
- Unused funds carry over from year to year, no "use it or lose it" rule.
- You own the account. Even when you change jobs, the HSA funds are yours to take with you.

I understand that when electing optional employee contributions to an HSA:

- The company and I hereby agree that my cash compensation will be reduced by the amounts elected.
- My social security benefits may be reduced by this election.
- My contribution election may be changed throughout the year. I will contact Human Resources for details.
- My employer may reduce or cancel this election as necessary to comply with the provisions of the Internal Revenue Code.

Arrow Stage Lines

2024 PetPartners Group Pet Insurance

Take the stress out of unexpected vet bills. Pet insurance reimburses you for the cost of accidents and illnesses. Coverage Includes: emergency treatments, surgeries, medications, laboratory services, and more. Plus, you can visit any licensed veterinarian or specialist.

	Accident Only	Accident/Illness
Annual Deductible	$300	$300
Coinsurance	80%	80%
Annual Limit	$5,000	$5,000
Age (Min/Max/Expiration)	8 weeks/None/None	8 weeks/10 years/None
Benefit Waiting Periods:		
– **Injuries & Illnesses**	Waived/Not Applicable	Waived
– **Orthopedics**	6 months	6 months
Pre-Existing Conditions	DOB look back, then covered after 12 months	6 months look back, then covered after 12 months
Final Respects*	$300	$300
Rehab and Physical Therapy	Deductible/Coinsurance	

*Not subject to deductible, coinsurance, or annual maximum

Bi-Weekly (per covered pet)	Accident Only	Accident/Illness
Dog	$5.03	$22.84
Cat	$5.03	$11.59

Take the Stress Out of Unexpected Vet Bills

Pet insurance reimburses you for the cost of accidents and illnesses throughout your pet's life.

Here's how it works:

1. Visit any licensed vet or clinic.
2. Pay your vet and submit a claim.
3. Get reimbursed for eligible expenses.

This is a brief summary of the benefits. Pre-Existing condition coverage may require a 365-day waiting period. Plans and coverage vary by state. For full plan terms, conditions, limitations and exclusions, go to PetPartners.com and click on Sample Policies. Policies are underwritten by Independence American Insurance Company, 485 Madison Ave. 14th Fl. New York, NY 10022 (in WA by American Pet Insurance Company, 6100 4th Ave. S., Seattle WA 98108). PetPartners, Inc. is a licensed insurance administrator located at 8051 Arco Corporate Drive, Suite 350, Raleigh, NC 27617.

Voluntary Benefits

The voluntary plan options are offered through Keeler and Associates. If you are interested in any of these plans call **1- 877-282-0808** Monday-Friday 7:00 am to 5:00 pm C.S.T. The premiums may be deducted from your paycheck, and you may enroll in any of these plans even if you do not carry the medical plans. You may want to consider these plans when you are making your enrollment decisions. **Some of the plan designs may have changed since you first elected a voluntary plan, this is a good opportunity to review your options.**

Please contact Keeler and Associates for more information.

Accident Insurance

Protection for accidental injuries on and off-the-job, 24 hours a day.

When an accidental injury requires medical attention, the costs can pile up quickly. Accident Insurance from Allstate Benefits can help pick up where other insurance leaves off, providing a cash benefit to help cover expenses.

Here's how it works: Select a benefit and premium amount that meets your needs. Premiums will be deducted each pay period. If you have an accident and receive medical attention, file a claim to receive cash benefits (subject to exclusions and limitations; see product brochure for more information).

Critical Illness Insurance

No one is ever prepared for a life-altering critical illness diagnosis. The whirlwind of appointments, tests, treatments and medications can add to your stress levels.

The treatment to recovery is vital, but it can also be expensive. Your medical coverage may only cover some of the costs associated with treatment. You are still responsible for deductibles and coinsurance. If treatment keeps you out of work, the financial worries can grow quickly, increasing stress.

Critical Illness Insurance coverage helps provide financial support if you are diagnosed with a covered critical illness. With the expense of treatment often high, seeking the treatment you need could seem like a financial burden. When a diagnosis occurs, you need to be focused on getting better and taking control of your health, not stressing over financial worries.

Here's how it works: You choose a benefit to protect yourself and any family members if diagnosed with a critical illness. Then, if diagnosed with a covered critical illness, you will receive a cash benefit based on the percentage payable for the condition (subject to exclusions and limitations; see product brochure for more information).

Hospital Indemnity Insurance

Protection for hospital stays when a sickness or injury occurs.

An illness or injury could land you in the hospital. Your medical insurance may only cover some of the costs and often require payment of a deductible and co-insurance fees. With Hospital Indemnity Insurance from Allstate Benefits, there is one less thing to worry about.

Here's how it works: Select the coverage that is right for you and your family. If you or a family member requires a hospital stay, you file a claim. A cash benefit is direct deposited or a check is mailed and may be used however you wish (subject to exclusions and limitations; see product brochure for more information).

Whole Life Insurance

Provides a cash benefit directly to your beneficiary.

Whole Life Insurance can help your family realize shared goals and dreams as it builds cash value you can draw on while still alive.

Whole Life Insurance can help to alleviate financial obligations. Upon your passing, you do not want to leave your family with financial burden.

Here's how it works: Select the coverage that is right for you and your family. Then upon your passing, your beneficiary files a claim. A lump-sum cash benefit is direct deposited or a check is mailed and may be used however they wish (subject to exclusions and limitations; see product brochure for more information).

401(k) Plan

What does retirement look like for you? Maybe you plan to travel the world. Or maybe you'd like to take up some hobbies closer to home. Whatever your goal, it's important to take responsibility for your own finances 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 allows you to save for retirement on a pre-tax basis (traditional) or after-tax (Roth plan) basis.

You are eligible to enroll in the 401(k) plan on the first of the month following 30 days of full-time employment (and 21 years of age). Part-time employees are eligible the first of the month following 1 year of service (and 21 years of age).

401k Highlights:

- Maximum contribution: $23,000 for 2024 or $30,500 if over age 50 ($7,500 catch up contribution). These amounts will increase based on inflation adjustments.
- Team member contributions can be made pre-tax (traditional) or after-tax (Roth) basis, depending on which is best for your particular tax situation.
- All contributions must be made through payroll deductions. All contributions are sent in on a semi-monthly basis.
- You may change your contributions at any time.
- 10% tax penalty plus current taxes if surrendered before age 59 ½.
- You will receive quarterly account statements.
- May make investment or allocation changes among the fund choices at any time, up to a maximum of 16 changes per year.
- Vesting: You are immediately 100% vested in your contributions or rollovers, plus any employer contributions made to the plan.
- Wide range of investment options to choose between from the fixed account to aggressive funds.
- A loan feature is now available.
- Monthly email newsletters are available, that cover a variety of economic, market & financial topics.
- Internet access to account information is available at: www.nationwide.com/login

Contact Information

Carrier Name	Coverage	Website	Phone Number
UnitedHealthcare	Medical Group # 743074	www.myuhc.com	1-866-314-0335
UnitedHealthcare	Voluntary Dental Group # 743074	www.myuhc.com	1-888-679-8925
EyeMed	Voluntary Vision Group # 9714767	https://eyemed.com/en-us	1-866-268-4063
UnitedHealthcare	Basic Life / AD&D Voluntary Life / AD&D Group # 00309721	www.myuhc.com	1-888-299-2070
UnitedHealthcare	Voluntary Life and AD&D Insurance	www.myuhc.com	1-866-615-8727
UnitedHealthcare	Employee Assistance Program	www.myuhc.com	1-888-887-4114
Omnify	Flexible Spending Accounts	https://www.ubt.com/health	1-844-472-6567
Optum Bank	Health Savings Account	https://www.optumbank.com **Enrollment Link:** https://enrollhsa.optumbank.com/enrollment#/?group=743074	1-800-791-9361
Principal	Disability Income Insurance	www.principal.com	1-800-986-3343
Allstate	Critical Illness, Accident, Cancer, Hospital, and Whole Life with Long Term Care	www.allstate.com	1-800-348-4489
PetPartners	Pet Insurance	www.petpartners.com	1-866-774-1113
Nationwide	401k Financial Account Access	www.nationwide.com	1-855-224-9869
Ameriprise Financial	401k Enrollment or Account Questions	Financial Advisors: Darrin.p.deichmann@ampf.com eric.a.luber@amph.com	Financial Advisors: Darrin Deichmann Eric Luber 402-371-1074
Danielle Neff	Busco, Inc. Payroll & Benefits Manager	danielle@arrowstagelines.com	402-738-3228
Benefits Enrollment & Questions	Call Center	www.buscobenefits.com	877-282-0808

ADDITIONAL HEALTH PLAN INFORMATION FOR Arrow Stage Lines / Busco, Inc. -- 1/1/2024

CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT NOTICE

Review this notice regarding access information about Medicaid and the Children's Health Insurance Program (CHIP). The CHIPRA Notice is included in this document and is available upon request from **Danielle Neff / danielle@arrowstagelines.com / 402-738-3228**. **Additional information about your benefits can be located online at www.buscobenefits.com**

COBRA CONTINUATION

If you are terminated for reasons other than gross misconduct in connection with your employment, you may be entitled to continue your health coverage by paying the applicable premium(s) on a monthly renewal basis. For more detailed information refer to www.dol.gov.

COVERAGE TO AGE 26 FOR ADULT CHILDREN

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in the group health plan. Individuals may request enrollment for such children during the group health plan's annual open enrollment period.

EMPLOYEE MARKETPLACE NOTICE

Review this information about health insurance marketplace coverage options. The Marketplace Notice is included in this document and is available upon request from **Danielle Neff / danielle@arrowstagelines.com / 402-738-3228. Additional information about your benefits can be located online at www.buscobenefits.com**

HSA PARTICIPANTS

You and your dependent(s) eligibility to make HSA contributions may be jeopardized if you are enrolled in other Non-HDHP coverage or Medicare, receiving Veteran's Administration Benefits or Tri-care or if you are claimed as a dependent on another individual's tax return.

MEDICARE PART D CREDITABLE COVERAGE NOTICE

If you are Medicare eligible, you can review these notices regarding prescription drug coverage provided through our group health plan. You will need this notice if you apply for Medicare Part D (Prescription Drug) coverage. The Medicare Creditable Coverage Notice is included in this document and is available upon request from **Danielle Neff / danielle@arrowstagelines.com / 402-738-3228**. **Additional information about your benefits can be located online at www.buscobenefits.com**

MICHELLE'S LAW

Group health plans that condition dependent eligibility on a child's full-time student status must provide a notice of the requirements of Michelle's Law in any materials describing a requirement for certifying student status for plan coverage. Under Michelle's Law, a plan cannot terminate a child's coverage for loss of full-time student status if the change in status is due to a medically necessary leave of absence.

PATIENT PROTECTIONS

The group health plan allows the designation of a Primary Care Provider. You have the right to designate any Primary Care Provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the Primary Care Provider. For information on how to select a Primary Care Provider and for a list of the participating Primary Care Providers, contact your Health Plan's Customer Service Department.

You do not need prior authorization from the group health plan or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Health Plan's Customer Service Department.

If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by non-participating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.

SECTION 125 PRE-TAX PREMIUM PLAN

This group benefit plan allows your portion of eligible employee benefit insurance premiums to be deducted from your paycheck on a pre-tax basis. When your premium contributions are deducted from your paycheck before taxes are calculated, that amount is not subject to federal, state, or Social Security taxes. This reduces your payroll tax and results in higher take-home pay.

All eligible employees will be automatically enrolled in this pre-tax plan. If you do not wish to participate, thereby paying your portion of the eligible employee bene?t insurance premiums with after-tax dollars, you must contact Human Resources and sign the necessary waiver form. Your employer pays all the administrative expenses associated with this pre-tax plan.

It is important to know that once your insurance premiums are being deducted on a pre-tax basis, you cannot change your election until the start of the next Plan Year unless you experience an eligible qualifying change in status. Reference your Section 125 Plan Document for eligible qualifying changes in status.

SPECIAL ENROLLMENT RIGHTS NOTICE

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents other coverage). However, you must request enrollment within 30 days after the other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption; you may be able to enroll you and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you are declining coverage for yourself or your dependents because of coverage under Medicaid or a State Child Health Insurance Program (SCHIP), you may be able to enroll yourself or your dependents in this plan if that coverage terminates due to a loss of eligibility. You must request enrollment in the plan no later than 60 days after the termination of coverage.

Additionally, if you decline coverage and you or your dependents become eligible for premium assistance for this group health plan under Medicaid or SCHIP, you or your dependents may be able to enroll in the plan at that time. You must request enrollment no later than 60 days after the date you are determined to be eligible for the premium assistance.

SUMMARY OF BENEFITS AND COVERAGE (SBC)

Understanding your health care benefits is important. The Summary of Benefits and Coverage (SBC) is a standardized document that is available to help you understand how your health plan works. The SBC is provided annually at Open Enrollment, upon hire and is available upon request from **Danielle Neff / danielle@arrowstagelines.com / 402-738-3228. Additional information about your benefits can be located online at www.buscobenefits.com**

SUMMARY OF HIPAA PRIVACY RIGHTS NOTICE

Arrow Stage Lines / Busco, Inc. is required to maintain the privacy of "protected health information," (PHI) which includes any identifiable information
that we obtain from you or others that relates to your health, your health care, or payment for your health care.

USES OF PROTECTED HEALTH INFORMATION (PHI)

The Plan can use or disclose your protected health information for purposes of health care treatment, health care payment and health care operations, as described below in the full notice.
The Plan may contact you to provide information about treatment alternatives or other health related benefits and services.
The Plan may disclose your protected health information to your family or friends, or any other individual identified by you.
The Plan will only disclose the PHI directly relevant to their involvement in your care or payment.
Save for exceptional situations, the Plan will not use or disclose your protected health information for any other purpose unless you provide written authorization. You have the right to revoke that authorization at any time

WOMEN'S HEALTH AND CANCER RIGHTS ACT

This Federal law provides protections for individuals who elect breast reconstruction after a mastectomy. Under WHCRA, group health plans offering mastectomy coverage must also provide coverage for certain services relating to the mastectomy in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses and treatment of physical complications of the mastectomy, including lymphedema.

YOUR RIGHTS

You have the right to request restrictions on the uses and disclosures of PHI, but the health plan is not required to agree to your request.
You have the right to request to receive communications of PHI by alternative means or at alternative locations.
With some exceptions detailed in the full notice, you have the right to inspect and copy the PHI contained in the plans' records.
You may request a correction to your PHI, but the plan may deny your request.
You have the right to receive an accounting of disclosures of PHI made by the plan.
You have the right to receive a paper copy of this notice.

Section 125 Pre-Tax Premium Plan
Employee Notice

Our group benefit plans allow your portion of eligible employee benefit premiums to be deducted from your paycheck on a pre-tax basis. When your premium contributions are deducted from your paycheck before taxes are calculated, they are not subject to federal, state, Medicare or Social Security taxes. This reduces your taxes and results in higher take-home pay.

All eligible employees will be automatically enrolled in this pre-tax plan. If you do not wish to participate, thereby paying your portion of the eligible insurance premiums with after-tax dollars, you must contact Danielle Neff / danielle@arrowstagelines.com to sign a waiver form.

It is important to understand that once your insurance premiums are being deducted on a pre-tax basis, you cannot change your election until the start of the next Plan Year (12:00:00 AM) unless you experience one of the following events that allow a mid-year change:

- Change in Family Status
- Significant Change in Cost or Benefits
- Change in Coverage of Spouse or Dependent under Other Employer's Plan
- FMLA Leave
- COBRA Event
- Judgment, Decree or Court Order
- Medicare or Medicaid Entitlement

New Health Insurance Marketplace Coverage Options and Your Health Coverage

Beginning in 2014, there is a new way to buy health insurance: the **Health Insurance Marketplace**. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace.

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away.

Each year, the open enrollment period for health insurance coverage through the Marketplace runs from Nov. 1 through Dec. 15 of the previous year. After Dec. 15, you can get coverage through the Marketplace only if you qualify for a special enrollment period or are applying for Medicaid or the Children's Health Insurance Program (CHIP).

Can I Save Money on my Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards.

If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5 percent (as adjusted each year after 2014) of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit. (An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.)

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution—as well as your employee contribution to employer-offered coverage—is often excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact from ***Danielle Neff / danielle@arrowstagelines.com / 402-738-3228*** that answers questions from employees about the health plan's coverage.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit **HealthCare.gov** for more information, as well as an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ARKANSAS – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)
ALASKA – Medicaid	**CALIFORNIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**GEORGIA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2
FLORIDA – Medicaid	**INDIANA – Medicaid**
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid

	Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KENTUCKY – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms
KANSAS – Medicaid	**LOUISIANA – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	**MINNESOTA – Medicaid**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
MASSACHUSETTS – Medicaid and CHIP	**MISSOURI – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
NEW YORK – Medicaid	**NEVADA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**

Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**OREGON – Medicaid**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2023, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA,

and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2026)

Important Notice from
Arrow Stage Lines / Busco, Inc.
About Your Prescription Drug Coverage and Medicare
Traditional & HDHP -- Creditable Coverage
For Coverage Effective 1/1/2024

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Arrow Stage Lines / Busco, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

- United HeathCare, your group health carrier, has determined that the prescription drug coverage offered by the Arrow Stage Lines / Busco, Inc. Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore, considered CREDITABLE COVERAGE. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?
You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?
If you decide to join a Medicare drug plan, your current Arrow Stage Lines / Busco, Inc. coverage will not be affected.

You can keep this coverage if you elect Part D and this plan will coordinate with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Arrow Stage Lines / Busco, Inc. coverage, be aware that you and your dependents will be able to get this coverage back annually as of 12:00:00 AM of each year during our Annual Open Enrollment Period. You have the option to change between the two plans each year during our Annual Open Enrollment Period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
You should also know that if you drop or lose your current coverage with Arrow Stage Lines / Busco, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that

coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage…
Refer to the contact information at the end of this notice. You will get this notice each year, and you will also get it if this coverage through Arrow Stage Lines / Busco, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	11/7/2023
Name of Entity/Sender:	Arrow Stage Lines / Busco, Inc.
Contact--Position/Office:	Danielle Neff
Address:	4220 S 52nd St Omaha, NE 68117
Phone Number:	402-738-3228

Arrow Stage Lines / Busco, Inc. Group Health Plan
NOTICE OF PRIVACY PRACTICES

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.

- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.
Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.
Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.
Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.

- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Contact Information

If you have any questions regarding this Notice or would like more information on how to exercise your rights, please contact our privacy official.

Privacy Official and Plan Administrator

Human Resources
4220 S 52nd St Omaha, NE 68117