ARROW STAGE LINES

2026

Employee Benefits Overview

This Benefits Overview summarizes your available benefits. Please take time to educate yourself about the options and choose the best coverage for you and your family.

Before You Enroll

- Carefully review the benefits listed in this guide and determine the medical, dental, vision and other coverage that's best for you and your family.
- Ensure family members meet the eligibility requirements.
- Understand the cost of the plans you selected.
- Typically, the right amount of coverage will depend on your age, your family situation, and any personal savings you may have.
- Select, review and submit your desired coverage.
- Check with Human Resources if you have questions.

Glossary

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

Copays — A fixed amount you pay for a health care service. Copays do not count toward your annual deductible but do count toward your annual out-of-pocket maximum.

Coinsurances — Once you've met your deductible, you and the plan share the cost of care, which is called coinsurance. For example, you pay 20% for services and the plan pays 80% of the cost until you reach your annual out-of-pocket maximum.

Out-of-pocket maximums — The most you will pay each year for eligible in- or out-of-network services, including prescriptions. After you reach your out-of-pocket maximum, the plan pays the full cost of eligible health care services for the rest of the year.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate."

If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

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

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

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

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

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

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

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

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

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

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

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

Eligibility

Full-time employees (30 hours per week) and their dependents are eligible the first of the month following 30 days of employment.

Employer Contributions

Arrow Stage Lines / Busco, Inc contributes:

Line of Coverage	Contribution
Medical	70% towards Traditional Plan 77% towards HDHP Plan
Life/AD&D	100%

Enrollment Process

Initial Enrollment

Arrow Stage Lines / Busco, Inc utilizes an online system or call center to make your benefit elections. Your benefit information and login will be emailed to you soon after your full-time start date.

Open Enrollment

Open enrollment is a short time period each year when you can make changes to your benefits. Elections you make during open enrollment will become effective on January 1, 2026. **You must submit your changes via the online benefit system or call center by 11/26/2025.**

IMPORTANT: If you wish to enroll in the FSA and/or DCA benefits for the 2026 plan year, you must submit your election via the online benefit system or call center by 11/26/2025.

If you have questions about any of the benefits mentioned in this overview, please reach out to Tracy Akers, tracy.akers@arrowstagelines.com, 402-738-3237.

Special Enrollment

Elections completed during the Open Enrollment period will remain in place until the next Open Enrollment period **unless** a qualified change in status occurs and the associated update is requested **within 30-days** of the qualifying event-date. Qualifying events include birth or adoption, marriage, divorce, gain of other coverage, loss of other coverage, etc.

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 and the last 4 digits of your SSN.
- Call Center – 877-282-0808
  - Available Monday – Friday, 7am – 5pm CST

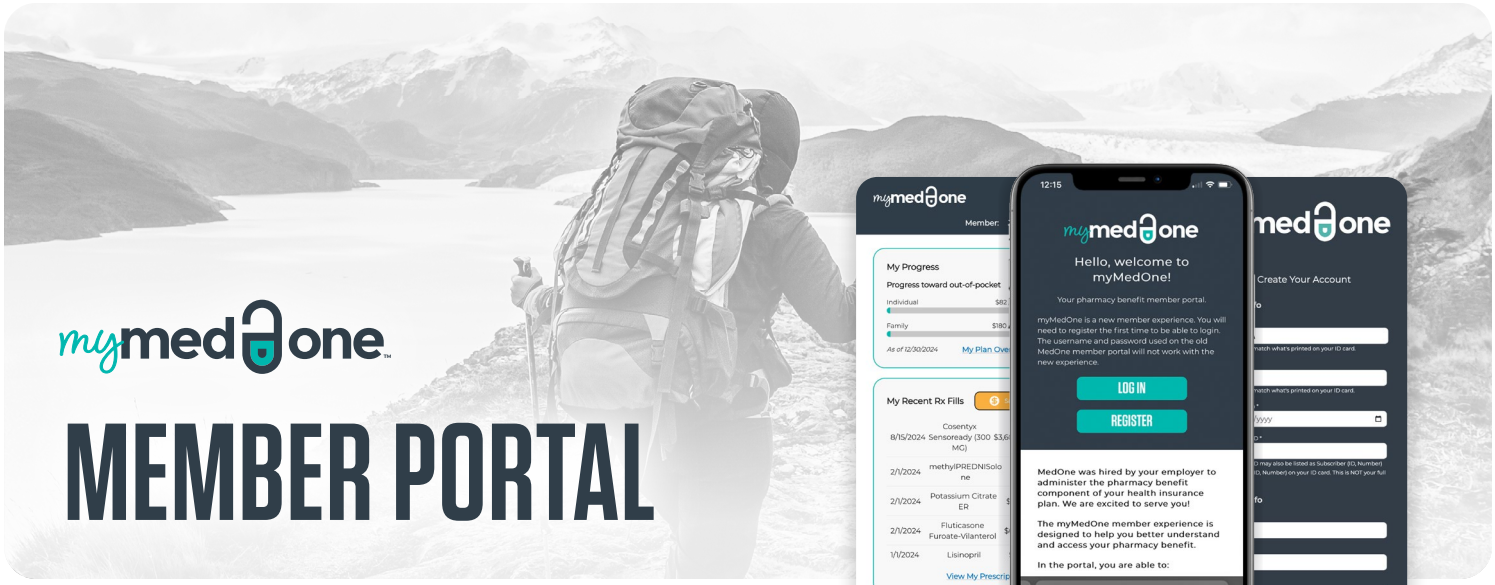
The following details In-Network benefits only. See plan documents for out-of-network benefits.

Medical | UMR – Choice Plus Network NEW CARRIER!

In-Network Services	Traditional Plan Amount You Pay	HDHP Plan (HSA Eligible) Amount You Pay
Calendar Year Deductible **- Individual** **- Family**	 $3,000 $6,000	 $5,000 $10,000
Coinsurance	20%	20%
Out-of-Pocket Maximum **- Individual** **- Family**	 $6,350 $12,700	 $8,050 $16,100
Preventive Care	Covered at 100%	
Physician Office Services	$30 Copay	Deductible, then Coinsurance
Specialist Office Services	$60 Copay	Deductible, then Coinsurance
Virtual Care	Covered at 100%	
Urgent Care Center	$100 Copay	Deductible, then Coinsurance
Emergency Room	$250 Copay, then Coinsurance	Deductible, then Coinsurance
Prescription Drugs **30-day supply** **- Generic** **- Preferred Brand** **- Non-Preferred Brand** **- Specialty**	 $15 Copay $35 Copay $100 Copay $300 Copay or MedOne RxAlly Program	 Deductible, then $10 Copay Deductible, then $35 Copay Deductible, then $100 Copay Deductible, then $300 Copay or MedOne RxAlly Program

Payroll Deductions – 24 Pay Periods				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Traditional Plan Employee Cost Per Pay Period	$224.28	$446.31	$356.59	$578.62
HDHP Plan Employee Cost Per Pay Period	$131.79	$262.26	$209.76	$340.23

For a list of in-network providers, go to: www.umr.com/find-a-provider



Welcome to myMedOne!

The myMedOne Member Portal, found online at **my.medone-rx.com,** is designed to provide you everything you need to know about your prescription benefit plan in a clean, responsive, self-serve portal.

Visit myMedOne
SCAN HERE

Register for the Member Portal

There are two ways to navigate to the myMedOne Member Portal. Either visit our website at **www.medone-rx.com** and select **MEMBER PORTAL** in the navigation bar along the top of the page or visit **my.medone-rx.com** directly.

- To register, click **LOG IN.** A registration pop-up will appear.
- Enter your first name, last name, date of birth, and cardholder ID. This ID number can be found on your insurance card.

  Please Note: Do not include the last two digits (Ie: -01, -2, etc).
- Create your portal login by entering a preferred email, username, and password.
- Click **CREATE MY ACCOUNT.**
- A verification email will be sent to the email address you supplied. Please click the link provided to verify your email.
- Return to the portal to log in and begin accessing your pharmacy benefit information.

Add myMedOne to Your Phone's Home Screen

It is in our future plans to develop an app for direct download to your phone. In the meantime, we offer a convenient workaround to add and view your prescription benefit via a quick link on your phone's home screen. Follow these simple steps below to add myMedOne to your home screen:

Apple iPhone

- In Safari, visit **my.medone-rx.com** or scan the QR code above.
- Tap the **SHARE** option on the menu bar.
- Scroll down and choose **ADD TO HOME SCREEN.**

Android Phone

- In Google Chrome, visit **my.medone-rx.com** or scan the QR code above.
- Tap the menu icon located in the upper right corner.
- Scroll down and choose **ADD TO HOME SCREEN,** then tap **ADD.**

Key Features

MyMedOne has several features designed to help members understand their prescription benefit. Below are brief summaries of each of the features available to you as a MedOne member.

Plan Overview

Upon entering the the myMedOne Member Portal, members are met with an active overview of their plan that includes progress trackers toward deductibles and out-of-pocket maximums as well as a history of recent fills. Each of these sections can be expanded to review payment structures, plan features, and additional fill information including the cost, prescriber, and location of previously filled prescriptions.

My Recent Rx Fills

Members have the option to review their recent medication fills and access their entire fill history. Each prescription listed can be expanded to view details including cost, prescription details, prescriber information, and the filling pharmacy.

My Savings Opportunities

My Savings Opportunities helps members save on their prescriptions by recommending other local pharmacies who offer their medication at more affordable costs.

My Rx Lookup

The My Rx Lookup feature is an interactive tool that allows you to access pricing for any medication(s) you have been or may be prescribed. This allows you to actively compare drug prices based on zip code, allowing you to identify the most cost-efficient pharmacies in your area.

My Prior Authorizations

The My Prior Authorizations feature enables members to access both current and historical records. Expand the medication section by clicking the down arrow to reveal more details. Here, members can view information such as the start date, completion date, expiration date of the prior authorization, and the decision made.

My ID Card

Members can conveniently access their pharmacy ID card at any time. If a member has a pharmacy-specific ID card and misplaces it, they can easily request a replacement card.

My Mail Order

MyMedOne makes enrolling in mail order easy!

Use the main navigation menu in the top right corner to select **MY MAIL ORDER.** Upon selecting **MY MAIL ORDER,** you are prompted to either begin the enrollment process if you are new to mail order or request refills and update your prescription info if you are an existing mail order member.

Contact, Meet MedOne, & Resources

As always, our team is here to help! On myMedOne, you will find the resources and forms you may need, as well as contact information for our support teams. You are able to connect with our member advocate team for general support and even schedule a one-on-one consultation with an on-staff pharmacist. Want to learn more about us? Click or tap **MEET MEDONE!**

Notifications Opt-In Options

You can choose how you'd like to receive myMedOne notifications by going to the **Manage Notification Preferences** section in your portal, filling out the form, and selecting whether you'd prefer text messages, emails, or both.

Questions?

Our Member Advocate team can also assist with any questions you may have regarding your prescription benefit. Call **866-335-9057** or check out our LIVE chat feature on our website at **www.medone-rx.com.**

mymedone™

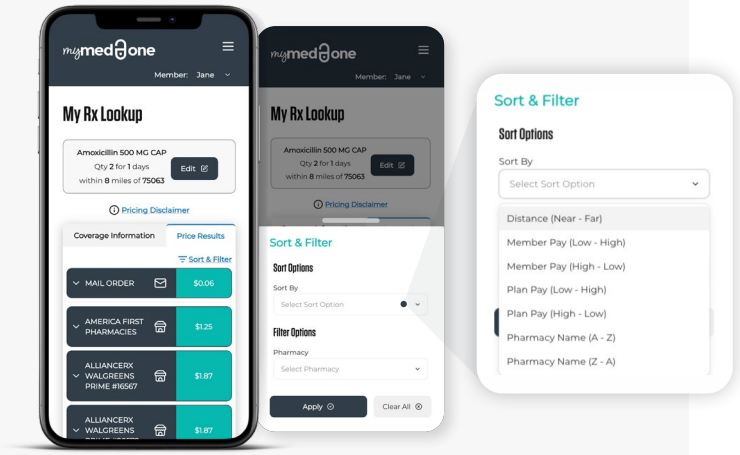
MY Rx LOOKUP

What Prescriptions Are Covered on Your Plan?

In order to help you understand the drug coverage of your pharmacy benefit plan, MedOne created the My Rx Lookup tool. Found on the myMedOne Member Portal, at **my.medone-rx.com,** it is designed to help you better understand what's covered on your specific prescription benefit plan. The My Rx Lookup tool allows you to search for medications, review coverage information, see the drug tier, identify any limitations or restrictions, and find alternatives.

How to Navigate

- Select **MY RX LOOKUP** from the main menu to begin your Rx lookup, then click **SELECT MEDICATION**.
- Enter the name of your medication, along with the dosage, days' supply, zip code, and desired distance.
- Clicking **UPDATE**, the prescription details you provided will appear at the top.
- Scrolling down, you'll see the **COVERAGE INFORMATION** tab, which features drug information and fill rules according to your plan's specifications.
- In the **PRICE RESULTS** tab, you'll find a list of pharmacies and their corresponding price you can expect to pay should you choose to fill there.



Visit myMedOne
SCAN HERE

- You have the option to **SORT & FILTER** your pricing results by distance, price, and more.
- Once your results are filtered, click the **DROP-DOWN ARROW** to the left of the pharmacy name. This offers a snapshot of the plan and member payment estimations along with the pharmacy's address and contact details.

Questions?

Our Member Advocate team can also assist with any questions you may have regarding your prescription benefit plan. Call **866-335-9057** or check out our LIVE chat feature on our website at **www.medone-rx.com**.

INTERNATIONAL PRESCRIPTION SOURCING

MedOne's Network of International Pharmacies

Overview

As health care costs as a whole continue to rise, prescription costs are no exception. The United States spends 30-190% more on prescription drugs than other countries. Through MedOne's RxAlly® suite of specialty cost containment solutions, we collaborate with a network of international pharmacies to offer you alternative sourcing options for obtaining prescription medications at reduced prices.

SAVINGS OF UP TO 70%

when compared to United States prices

How It Works

MedOne identifies members - like you! - taking medications eligible for international sourcing. MedOne's team of patient care coordinators will then reach out alerting you of the saving opportunities available, should you choose to shift your prescription to an international pharmacy.

Program Enrollment

RxAlly Patient Care Coordinators assist you throughout the enrollment process. Even after enrollment is complete, the Patient Care Coordinators follow up with you regularly to ensure satisfaction & troubleshoot any issues.

About International Sourcing

Our international network sources medications from pharmacies in Australia, Canada, New Zealand, and the United Kingdom. These countries are classed as Tier One countries (designated by the US Congress) for pharmaceutical supply. All prescription drugs are from certified manufacturing plants that follow regulated manufacturing practices. Due to proximity, any temperature-sensitive medication will be sourced exclusively from Canada.

INTERNATIONAL SOURCING

A New Savings Opportunity

RxAlly is MedOne's suite of specialty cost containment solutions. Now available in 2024 is the opportunity for international sourcing specialty medications. We've partnered with a selection of international pharmacy vendors that offer access to medications from other countries at much lower costs to MedOne clients and members.

Through this new offering, we are able to provide additional access to the most appropriate prescriptions at the most affordable costs. The below outlines some frequently asked questions about international sourcing and enrollment.

Frequently Asked Questions

Where is the medication coming from?

While our contracted vendors are able to source medications from Australia, Canada, New Zealand, and the United Kingdom, temperature-sensitive medication will be sourced exclusively from pharmacies in Canada.

Is the enrollment process difficult?

The enrollment process is simple, and our Patient Care Coordinators are here to walk you through the whole process. This involves enrolling in mail order through the international sourcing vendor and is very similar to what you do currently to fill your specialty medications.

What's expected of the member?

While the Patient Care Coordinator is responsible for much of the enrollment process, there are a few requirements that differ from other mail order pharmacies you must do. Outlined here are the only enrollment expectations:

1. Members need to consent to their prescription being transfered to an international pharmacy.
2. Members will be required to provide a copy of government-issued identification, like a driver's license.
3. Members will be asked to sign a Declaration of U.S. Citizenship form.

Additionally, you will have to validate a phone number and/or email address for record-keeping purposes.

What happens after enrollment?

After the enrollment process is complete and the prescriber has successfully sent the prescription to the international pharmacy, members begin receiving medication by FedEx or USPS by way of the international postal service.

Our Patient Care Coordinator team continues to communicate with the member to ensure shipments are received on time, answer any remaining questions, mitigate any issues that may arise, etc. We are here to help!

Is participation required?

International sourcing cannot be mandated or forced, both you and your prescriber must willingly make this switch. Current regulation only allows personal importation.

What if I refuse to use international sourcing?

You are not mandated to make the switch to an international pharmacy. We are simply offering you the opportunity to save on your prescription with this alternative option to source your medication internationally.

COPAY ASSISTANCE PROGRAMS

How to Save Extra on your Prescriptions!

Overview | What is Copay Assistance?

A Copay Assistance Program or Copay Assistance is financial assistance for patients taking specific medications to help them cover the cost of their copay. These programs are for patients who have commercial insurance but still need to bridge a financial gap to afford their medication.

Copay Assistance Programs are funded by pharmaceutical manufacturers who produce the medication for which the assistance is available. Assistance often comes in the form of coupons or what are referred to as “copay cards” or “savings cards.” Most copay assistance is given and utilized on brand medications and higher-cost prescriptions, often classified as “specialty.”

How does it Copay Assistance work?

As mentioned, Copay Assistance Programs are funded through manufacturer-backed foundations, and are designed to provide patients with easier access to the medications they need.

If Copay Assistance is available for a patient’s prescription, that patient will follow the following steps for using the program.

1. **Procure the card.** Many doctors’ offices and clinics have physical copay cards they can provide when patients are prescribed a medication. Digital cards are growing in popularity and can be found by searching the name of your medication alongside “coupon” or similar verbiage.
2. **Present the coupon or copay card at the pharmacy.** When you go to pick up your medication, provide the pharmacy with the assistance card alongside your insurance card.
3. **Pay the remainder of the copay, if applicable.** Depending on the card, you may have a small portion of your prescription copay to cover after the coupon is applied.

Need Help?

If you have any questions about or need help finding Copay Assistance Programs, please reach out to our member advocate team at **866-335-9057**. They will be happy to assist you!

FREQUENTLY ASKED QUESTIONS

About Copay Assistance Programs

While Copay Assistance is a great way to save money on your prescriptions, there are a few things to note when it comes to accessing these funds.

How can I find Copay Assistance?

The MedOne Member Advocate team is happy to help you find Copay Assistance. Call us at 866-335-9057 for further information.

Your prescriber or doctor's office is also a great resource. They may have resources on hand they can equip you with that pertain to your specific medication. You may also search for Copay Assistance Programs yourself by visiting the website for your prescribed medication or the manufacturer of that medication. Entering words like "coupon" or "copay card" may help you search more efficiently. Additionally, you can search prescription assistance program databases to see what is available for you and your prescription.

What medications can I use copay cards on?

Copay cards are offered exclusively for brand medications, and oftentimes copay cards can only be used on one specific medication. If you take several medications and want to leverage copay assistance, you may have to research programs for each of your medications and present more than one card to access the available financial assistance.

Please note: Even with the copay card/coupon, a lower-cost alternative or generic may be available. We recommend looking up your prescription on the **myMedOne Member Portal** or speaking with a MedOne Member Advocate to seeing if a Savings Opportunity is available. You can also talk through other options or alternatives with your prescriber.

Where can I use a copay card?

You can use a copay card at any in-network pharmacy when you pick up your prescription. Coupons/copay cards should be presented alongside your insurance card at pick-up, before payment.

How much assistance is available?

The amount of assistance that is available will vary from program to program and/or will vary by medication.

It is important to note that there is usually a "cap" on Copay Assistance; foundations will offer you funds up to a certain dollar amount. Be aware that this amount differs from card to card and may not cover the entirety of your copay. When a copay card "runs out" or you have exhausted all of the funding available, you are then responsible for your full copay moving forward.

Are there any restrictions with using a copay card?

Patients must be eligible for a commercial insurance plan in order to access Copay Assistance.

Foundations may also have additional restrictions or requirements for accessing Copay Assistance. Patients should visit the website associated with the coupon or copay card to learn more.

Do copay cards expire?

Yes, copay cards often do expire so remember to verify the coupon is still valid before attempting to use it.

RxAlly®

PROCESS OVERVIEW

medone Pharmacy Benefit Solutions

Program Overview

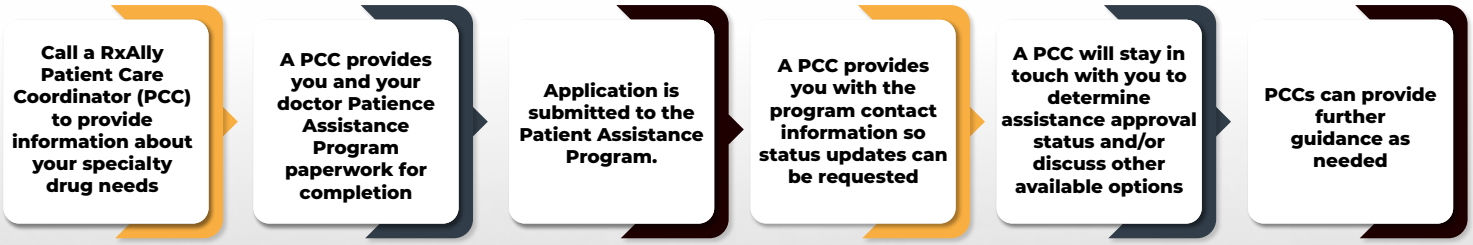
The RxAlly® Specialty Advocacy Program is designed to help members secure access to specialty medications through Patient Assistance Programs. A specialty medication is a medication that treats complex medical conditions such as cancer, psoriatic arthritis, and multiple sclerosis, and often require specific handling and storage requirements.

Patient Assistance Programs can be offered by drug manufacturers to offer specialty drug coverage when coverage is not available under an employer sponsored prescription benefit plan. RxAlly provides help to members by identifying and coordinating application to these Patient Assistance Programs as the process can be complex. A designated RxAlly Patient Care Coordinator (PCC) will work directly with you and your doctor to gather, prepare, and apply for patient assistance. Once a RxAlly PCC submits both your portion and your doctor's portion of the application, the Patient Assistance Program will review the application and determine if you qualify for assistance. This review process can take a few days or even weeks. It is important that you call or email the Patient Assistance Program frequently to request the status of your application (this status check request must be made by the patient directly and not an outside party).

If your application is approved, please contact your Patient Care Coordinator to update your case accordingly. The Patient Assistance Program will work with you directly to provide instructions on how to obtain your medication. In most cases your medication will be shipped directly to you by the program's preferred specialty pharmacy.

If your assistance application is denied, please contact your dedicated Patient Care Coordinator as soon as possible to determine additional opportunities for accessing your requested medication.

Assistance Process Overview



Key Action Steps

1. Call a RxAlly Patient Care Coordinator (PCC) today at **877-794-2218** to enroll and provide information about your specialty drug.
2. Review & sign the prepared application by your PCC. We may also ask you to nudge your doctor in completing their portion of the paperwork if the PCC is unable to get a direct response.
3. Once the PCC submits the application, please call the program directly for a status update if you do not hear from them in 5-7 business days.
4. If you need your medication within the next 7 days please contact your PCC immediately and they will work your plan to determine a course of action.
5. Respond or reach out to your PCC with application status or any questions.

Questions?

Call **877-794-2218** to speak with a RxAlly Patient Care Coordinator.

www.medone-rx.com

RXALLY

Frequently Asked Questions

What is a specialty medication?

Specialty drugs are used to treat complex conditions, can require frequent dosing adjustments and intensive monitoring to decrease the likelihood of adverse events, and improve treatment outcomes. They are often high-cost, treat rare conditions, and have specialty storage and delivery requirements.

Why do I have to change how I get my specialty medication?

The benefit you are requesting coverage from does not provide coverage for specialty medications. This may be a change from what was covered under the benefit in the past. This means you are unable to access your specialty medication in the same way you had previously. Your plan has partnered with RxAlly to provide additional support services to help you access your specialty medication through alternative programs.

What does the general process look like?

Members must call a RxAlly Patient Care Coordinator (PCC) to begin the process for obtaining their specialty medication.

How do I fill my specialty medication?

Your RxAlly Patient Care Coordinator will be your resource in determining the best available options on how to access your specialty medication. Most patients will apply for access through a Manufacturer Patient Assistance Program (PAP) and receive their specialty medication at little to no cost. You, too, can secure your medication if you and your prescriber follow a few steps. Your Patient Care Coordinator will be your dedicated resource to help you along this journey.

What is a Patient Assistance Program (PAP)? And why do I need this?

Some drug manufacturers sponsor patient assistance programs (PAPs) that offer access to certain medications to eligible patients at little to no cost. In order to enroll in these services, which can include shipment of free medication straight to your door, an application to the PAP is required. Eligibility requirements include, but not limited to, prescription drug plan coverage, household income, and indication. Because your medication is excluded by your prescription drug plan, you are eligible for most PAPs.

Your RxAlly PCC will....

1. Gather information about you, your insurance coverage, and your specialty medication.
2. Start a medical necessity review for your medication.
3. Coordinate any necessary bridge fill(s) upon approval of the medical necessity review.
4. Send any required paperwork to you which must completed, signed, and returned to RxAlly.™
5. Contact your prescriber, request paperwork to be completed, and follow-up to ensure this paperwork will be completed and returned to RxAlly.™
6. Gather these documents, prepare the patient assistance application, and submit these to the manufacturer program.
7. Let you know when the application for assistance has been submitted.
8. Request that you follow up with the Patient Assistance Program – via email or phone - to ask about application status.
9. Be accessible to you at 877-794-2218 or PCC@RxAlly.com for any questions while you are enrolled with RxAlly.™

Programs require that status checks be made by the patients directly and cannot be made by an outside party like RxAlly.

www.medone-rx.com

What if I need to fill my specialty medication but my patient assistance application is still in process?

While your patient assistance application is in process, you may be eligible to receive your medication through a bridge fill. A bridge fill is a fill of your specialty medication through your prescription drug coverage administered by MedOne. Prior to receiving your bridge fill, a medical necessity review may need to be completed.

What does the medical necessity review process look like?

In general, all specialty drugs required a medical necessity review to verify that the medication is going to be used safely, effectively, and for an FDA-approved indication. Once you connect with a Patient Care Coordinator, they will start the medical necessity review process which typically takes a few days. The clinical team requests information from your physician about your therapy and makes a determination.

How long will it take before I find out if I'm approved from the Patient Assistance Program?

After your application has been submitted, the Patient Access Program will take anywhere from a few days to several weeks to review your application. They typically will take longer during busier times of the year, such as January through March. Unfortunately, the RxAlly Patient Care Coordinator is unable to contact the Patient Access Program directly for status updates as PAPs will only speak with patients directly. If you are waiting on a response from the Patient Assistance Program and are in need of your next fill of medication, contact your Patient Care Coordinator and they will determine the options available to support your continued access to treatment while waiting on a response.

Who is MedOne? I thought this program was called RxAlly?

MedOne is the prescription benefit manager that administers your prescription benefit on behalf of your employer's sponsored prescription plan. RxAlly is a program operated separately from your prescription drug plan, which serves to support members whose plans exclude certain drugs.

Why is it only this specific medication that has to go through RxAlly?

The RxAlly program supports patients in accessing any specialty medication. If your medication is classified as a specialty medication and excluded by your prescription drug plan, RxAlly provides additional support to identify alternative means to access your treatment. Patient Access Programs are available for most specialty medications, and patients who are unable obtain coverage through a commercial benefit are often eligible.

Is there an alternative medication I can take that doesn't involve a Patient Assistance Program?

If you wish to explore alternative therapies, please reach out to your prescriber. In general, any medications classified as specialty are excluded by the plan and are eligible for support from a RxAlly Patient Care Coordinator. Medications that are not classified as specialty may be covered by your plan and accessible through your prescription benefit. You, or your prescriber, may contact MedOne at 888-884-6331 to determine covered alternative medications.

What is the difference between copay assistance and patient assistance?

Copay Assistance Programs and Patient Assistance Programs are both offered by drug manufacturers to help limit financial barriers for patients to access their medications. Copay Assistance Programs help cover part or all of an insured, eligible.

patient's financial responsibility for their specialty medication. Patient Assistance Programs support patients whose prescription plan does not provide coverage for certain medications. Patients must complete an application and meet certain eligibility requirements to obtain medications at no cost.

Is there a coupon for my medication to help cover the cost of my bridge fill?

Patients may use Copay Assistance Programs for assistance in covering the cost of bridge fills to reduce their out-of-pocket expense. It is common to have patients enroll in both a Patient Assistance Program and Copay Assistance Program simultaneously. There may be a coupon available for your specialty medication to reduce your copay. Contact your Patient Care Coordinator to see if your medication is eligible for Copay Assistance as well as Patient Assistance.

What is required of me?

Your designated RxAlly Patient Care Coordinator will send you a patient assistance application through your preferred method of communication (email, fax, or mail). You will fill out the information needed, sign as indicated, and return this paperwork to RxAlly along with a copy of your most recent 1040 tax document, and a copy of your insurance card(s).

Why do I have to provide my tax/income information?

Nearly all patient assistance programs have an income eligibility requirement and will need proof of income to verify this. Therefore, your PCC may request a copy of your most recent 1040, W2, and/or pay stub history. Most PAPs set their income requirement between 400-600% of the Federal Poverty Level (FPL) which can be calculated here: **www.needymeds.org/FPL_Calculator**

How do I return this application to RxAlly?

The Patient Care Coordinators can receive this information through secure email, secure fax, or through mail.

Secure Email: PCC@RxAlly.com
Fax: 855-476-4062
Mail: 1590 University Avenue
Dubuque, IA 52001

Why do I have to reach out to the Patient Assistance Program for status updates once the application is submitted?

The Patient Assistance Programs will only speak to the patient and not to outside parties, like RxAlly. We are happy to assist in enrolling in the Patient Assistance Program and in gathering any information required, but once enrolled, you will have to reach out to the program for any status updates personally.

What happens if I get denied by the Patient Assistance Program?

Do not fret! It is common that we see denials on initial submissions. Our Patient Care Coordinators are here to aid you in these situations and can provide direction on how to complete a second submission. We will explore all avenues for available coverage: it is our goal that you do not go without your medically necessary medication. Please call your Patient Care Coordinator as soon as possible once you have heard a determination from the Patient Assistance Program.

What do I do if I have any questions?

Your Patient Care Coordinator would be happy to answer any questions you may have. We are also able to schedule a consultation with a clinical pharmacist should you have questions regarding your specialty medication. Please call your Patient Care Coordinator at 877-794-22181 or email at PCC@RxAlly.com for additional assistance.

CANARX

CANARX is a voluntary international mail order option. To be eligible for the CANARX program, you must be an existing member of a health insurance plan that currently has CANARX implemented as an additional option for prescription medication coverage.

FREE Brand-Name Medications

No Shipping and Handling Charges to You!

ZERO COPAYS

SIMPLE.

SAFE.

SMART.

Who is CANARX?

We're the easy way for you to get prescription medications. CANARX offers hundreds of brand-name maintenance medications that you can get — **copay-free** — in just a few easy steps.

Medications are shipped direct to you from licensed and regulated pharmacies located in Canada, the United Kingdom and Australia. All medications are backed by a Quality Assurance Team of doctors and pharmacists, as well as 20-plus years of experience in the industry.

With our program, you pay **$0** in copays and your medications are shipped right to your door for **FREE**. How? Your health plan pays less for the medication and shares these savings with you.

Ready to Start Saving?

ENROLL ONLINE TODAY!

Let's Get Started

JOINING IS EASY!

Visit our website today to enroll and view:

- Frequently Asked Questions (FAQs)
- Video Overview
- List of Available Medications

Call 1-866-893-6337 for your plan's WebID.

canarx.com/enroll

Scan to go to the website

Before ordering through CANARX, you or your doctor must attest that you have been taking your prescribed medication for at least 30 days – this is to ensure you have not experienced any complications with the medication.

STEP 1

Check medication availability.

STEP 2

Enroll online by completing the online form and uploading a copy of your photo ID, or complete the enclosed enrollment form and mail it to us.

STEP 3

Submit the original prescription via mail or arrange to have it sent directly from your prescriber. We can help with this step if required.

STEP 4

A licensed pharmacy will ship your medications directly to you.

STEP 5

CANARX will call you prior to each refill to ensure you have a continuous supply.

ENROLL ONLINE TODAY!

HSA | Optum Bank

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.
- Your contribution election may be changed throughout the year. Please 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.

IRS Maximum	Individual	Employee & Spouse	Employee & Children	Family	Catch-Up for 55+
2026	$4,400	$8,750	$8,750	$8,750	$1,000
Employee Contribution Maximum					
Per Pay Period	$183.33	$364.58	$364.58	$364.58	$41.66

How to Open Your HSA

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

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

Voluntary Dental | Principal NEW CARRIER!

In-Network Services	Amount You Pay
Preventive Services – Deductible Waived **- Exams, Cleanings, X-rays** **- Fluoride application (for dependent children under 14)**	Covered at 100%
Calendar Year Deductible **- Basic & Major Services**	$50 Individual / $150 Family
Basic Services **- Oral Surgery, Periodontics, Endodontics, Fillings**	Deductible, then 20%
Major Services **- Bridges, Dentures, Crowns, Repairs**	Deductible, then 50%
Calendar Year Maximum (per person)	$1,000
Orthodontia Services (for Children up to age 19) **- Lifetime maximum (per child)**	50% Coinsurance $1,000

Payroll Deductions – 24 Pay Periods				
	Employee Only	Employee & Spouse	Employee & Child(ren)	Family
Employee Cost Per Pay Period	$16.50	$32.55	$30.76	$50.92

For a list of in-network providers, go to: www.principal.com/dental-providers

MAXIMUM ACCUMULATION

A portion of unused dollars can be rolled over to next year's maximum benefit amount. To qualify, a member must have had a dental service performed within the calendar year and use less than a maximum threshold. The threshold is $500 and if the qualification is met, $250 will be carried over to the next year's maximum benefit. A member can accumulate no more than four times the carry over amount. The entire accumulation amount will be forfeited if no dental service is submitted within a calendar year.

Voluntary Vision | EyeMed

In-Network Services	Amount You Pay
Exam	$10 Copay
Materials	$25 Copay
Frames	Up to $100 Allowance 20% Off Balance over Allowance
Frequency (based on date of service) **- Exams** **- Lenses or Contact Lenses** **- Frames**	 12 Months 12 Months 12 Months
Lenses **- Single** **- Bifocal** **- Trifocal** **- Progressive (Standard/Premium)**	 Materials Copay Materials Copay Materials Copay Materials Copay, then 20% Off Retail Price less $55 Allowance
Contact Lenses **- Conventional** **- Medically Necessary**	 Up to $115 Allowance, then 15% Off Balance over Allowance Covered at 100%
Laser Vision Correction	Discounts available

Note: You may only receive benefits for either contact lenses or lenses for your glasses in a given year (but not both); however additional discounts will be available.

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

For a list of in-network providers, go to: www.eyemed.com/en-us

Flexible Spending Accounts | Omnify NEW LIMITS!

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	**$3,400**	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	**$3,400**	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.	**$3,750** Married filing single **$7,500** Married filing joint **$7,500** Single filing single	1. Participant Name 2. Date of Service 3. Amount of Service 4. Provider 5. Provider EIN

Basic Life/AD&D | Principal NEW CARRIER!

Plan Features	Group Life/AD&D Benefit	Benefit Reduction*
Employee Benefit	$50,000	35% reduction at age 70 with an additional 20% reduction at age 75

A Beneficiary Designation Form will be provided by Tracy upon initial enrollment in the plan. If you need to update your beneficiaries at any point, please request a Beneficiary Designation Form from Tracy Akers, tracy.akers@arrowstagelines.com or 402-738-3237.

Voluntary Short-Term Disability | Principal

Plan Features	Short-Term Disability
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 maximum

Employees must fill out an EOI form if coverage not elected during initial eligibility. Subject to underwriting approval.

Voluntary Short Term Disability coverage cost is calculated based on age and weekly income.

Age	Rate per $10 of Coverage
24 & Under	$0.41
25-29	$0.43
30-34	$0.41
35-39	$0.49
40-44	$0.62
45-49	$0.54
50-54	$0.71
55-59	$1.02
60-64	$1.24
65-69	$1.19
70 & Above	$1.50

Voluntary Life/AD&D | Principal NEW CARRIER & PLAN DESIGN!

Who is Eligible?	Voluntary Term Life/AD&D	Guarantee Issue Amount for Life at Initial Eligibility
Employee	$10,000 Increments Up to $500,000 maximum	Under 70: $200,000 70 or Older: $10,000
Spouse	$5,000 Increments Up to $250,000 maximum Can elect up to 50% of Employee election	Under 70: $30,000 70 or Older: $10,000
Child(ren) – to age 26	$5,000 Increments Up to $25,000 maximum Can elect up to 50% of Employee election	N/A

Employee and Spouse benefits reduce by 35% reduction at age 70 with an additional 20% reduction at age 75.

**Spouse's premium based on spouse's age.*

INITIAL ENROLLMENT
Employees may apply for coverage up to $200,000 for self and up to $30,000 for spouse WITHOUT answering health questions. Any life insurance coverage requested over the Guarantee Issue amount(s) will be subject to evidence of insurability and are not guaranteed.

OPEN ENROLLMENT
Employees may apply for coverage or elect to increase their coverage up to $200,000 for self and up to $30,000 for spouse WITHOUT answering health questions. Any amount of coverage requested over the Guarantee Issue amounts will be subject to evidence of insurability and are not guaranteed.

Voluntary Term Life Monthly Rate per $1,000 of Coverage		
Age	**Employee**	**Spouse**
29 & under	$0.105	$0.103
30 – 34	$0.107	$0.107
35 – 39	$0.144	$0.147
40 – 44	$0.206	$0.211
45 – 49	$0.329	$0.331
50 – 54	$0.523	$0.515
55 – 59	$0.805	$0.791
60 – 64	$1.34	$1.352
65 – 69	$2.179	$2.309
70 & over	$3.888	$4.114
Child(ren)	$0.20	
Voluntary AD&D Monthly Term Rate per $1,000 of Coverage		
Employee & Spouse	$0.037	

Voluntary Worksite Benefits | Allstate

Accident

Accident Expense insurance pays a benefit directly to you when you receive treatment from a physician for a covered accident. If you have an accident and receive medical attention, you will file a claim to receive cash benefits (subject to exclusions and limitations).

Please see the brochure in the enrollment system for additional information.

Critical Illness

Critical Illness insurance pays a lump-sum benefit directly to you if you are diagnosed with a covered critical illness. If you or a covered family member are diagnosed with a covered critical illness, you will file a claim to receive a cash benefit based on the percentage payable for the condition (subject to exclusions and limitations).

Please see the brochure in the enrollment system for additional information.

Hospital Indemnity

Hospital Indemnity coverage pays a lump sum benefit directly to you for hospital confinement. If you or a family member requires a hospital stay, you will file a claim to receive a cash benefit based on the covered benefit (subject to exclusions and limitations).

Please see the brochure in the enrollment system for additional information.

Whole Life Insurance

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. Upon your passing, your beneficiary will file a claim to receive a lump-sum cash benefit to be used however they wish (subject to exclusions and limitations).

Please see the brochure in the enrollment system for additional information.

petpartners

Benefits Basics

Pet Insurance, Simplified.

Welcome to the pack! Here's a quick look at how PetPartners makes pet insurance simple.

Reimbursements are quick and easy

Our average reimbursement time is just 2-5 business days!

No insurance cards are necessary

When your pet needs medical treatment, take them to the vet of your choice and pay for services at time of treatment.

Ask your vet for an itemized invoice — many offices will email you a digital copy. Then, you can upload and submit your claim for reimbursement via the Pet Portal.

Perks in the Pet Portal

- Log in to easily manage your pet's policy at:

  https://portal.independenceamerican.com/

  Note: You will be able to access the portal once your policy becomes effective.
- Submit and track **claims**.
- View your **coverage documents**.
- Get answers to your pet questions anytime, anywhere with our **24/7 Vet Helpline**.
- Get the best deals on pet meds from our partners at **PetGeniusRx**.

Support when you need it

Questions about coverage, claims, or your policy? We're here to help.

Contact PetPartners Customer Care:

Email us at **mypolicy@petpartners.com** or call 800-956-2495

*Program applies to human-equivalent medication only. Not available in Kansas and Tennessee.

Arrow Stage Lines

2026 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.

Group benefits

Help handling life's ups and downs

Life can be unpredictable. And it's not always easy. So it's a big deal to know there's help available when you need it. That's what the employee assistance program (EAP), provided by ComPsych®, is all about.

With an EAP, you and your family have access to **free, confidential** resources to help handle life's everyday—and not so everyday—challenges. You'll have **24/7 access** to support through phone consultations, a mobile app, online resources, and self-screening tools. You can connect with licensed professionals for counseling, coaching, and more—**in person, by text, live chat, video, or phone.**

You might use your EAP to help: manage stress, handle relationship issues, balance work and life, work through grief, cope with anxiety, and more. Plus, your EAP gives you access to discounts on major brands and everyday needs.

Services for you and your family

In-person or virtual counseling

One valuable way to work through personal or work issues is by talking with a professional. Individuals can call 24/7 to speak with a licensed professional or use GuidanceConnect® to schedule a time that works for them. Users are then matched with a local provider. Three counseling sessions per person, per issue, per year are included.

Work life services

You and your loved ones can receive support from licensed professionals with FamilySource®, FinancialConnect®, and LegalConnect® services.

- FamilySource provides employees and their families with an initial assessment and consultation, followed by customized, timely referrals for child and elder care, adoption, education, pet care, and other personal needs.
- FinancialConnect connects individuals with financial experts, including certified public accounts (CPAs), certified financial planners (CFPs), and experienced financial professionals, who can address a wide range of issues.
- LegalConnect connects users with attorneys for non-employment legal issues, plus tools for simple wills, legal forms, and resources on topics like estate planning, complaints, housing, and identity theft.

Coaching

Mental health, work-life challenges, and physical issues are often intertwined. Certified coaches understand this vital connection between mind, body, and lifestyle—they offer coaching services that address mental health, physical health, and overall well-being through one holistic solution. Coaches work one-on-one with participants to reduce personal roadblocks before they evolve into long-term, bigger challenges.

Computerized cognitive behavioral therapy (CCBT)

The EAP offers an interactive, multilingual digital program—accessible via app, tablet, or desktop—that addresses common behavioral health challenges. Guided modules are available to help reduce stress, overcome mental barriers, and improve well-being, with content covering topics such as depression, anxiety, mindfulness, sleep, self-esteem, and resilience.

Individuals can access EAP support anytime, anywhere—when and where it matters most.

GuidanceResources® online

ComPsych wants to meet people where they are, offering a digital experience as dynamic and comprehensive as live clinical care. The platform delivers personalized assessments, recommendations, and holistic care journeys tailored to each user's needs.

Through the GuidanceResources website, users can explore partner discounts—including Nationwide® Pet Insurance and TurboTax®—and the member-only Working Advantage portal for exclusive savings on movies, theme parks, travel, shopping, and more.

GuidanceNow℠ mobile app

The GuidanceResources mobile app, GuidanceNow℠, offers the same features as the website, letting members explore journey options, browse content (HelpSheets, assessments, Q&As, podcasts, and articles), and find local counseling, legal, childcare, and elder care providers.

24/7 **live assistance**

Visit **guidanceresources.com** and when you create an account, enter *PrincipalCore* as the program name.

Download the **GuidanceNow℠ app**

Call 844-869-2365 | **TTY** 711

Scan for **more resources.**

More about your EAP provider

ComPsych GuidanceResources® isn't just a support solution—it's a lifeline. With over 40 years of experience and more than 160 million people supported, ComPsych offers services that enhance employee well-being and strengthen organizational effectiveness at every stage of life. Through its employee assistance program (EAP), ComPsych provides meaningful support to help individuals manage stress, improve mental health, and navigate life's challenges through their network of 120,000+ clinical care providers. ComPsych also helps businesses reduce absenteeism and offers support during critical incidents. These programs are built to meet the unique needs of employees while equipping employers with tools to create healthier, more resilient workplaces.

principal.com

Insurance products issued by Principal Life Insurance Company®, a member of the Principal Financial Group®, Des Moines, IA 50392.

Principal® has arranged with ComPsych to make its employee assistance program (EAP) available to employees with select group coverage insured by Principal Life Insurance Company®. EAP is not part of the insurance contract or policy and may be changed or canceled at any time. Not all services available to group policies issued in New York. ComPsych is responsible for all EAP services provided through this program. ComPsych is not a member of the Principal Financial Group®.

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401(k) Plan | Nationwide

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: $24,500 for 2026 or $32,500 if over age 50 ($8,000 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

Service	Contact
General Benefit Questions	**Call Center** 877-282-0808 www.buscobenefits.com **Tracy Akers | Payroll & Benefits Manager** 402-738-3237 tracy.akers@arrowstagelines.com
Medical and Prescriptions	**Medical | UMR** 1-800-826-9781 www.umr.com **Pharmacy/Prescriptions | MedOne** 1-866-335-9057 www.medone-rx.com
Dental **Basic Life/AD&D** **Voluntary Life/AD&D** **Voluntary Short-Term Disability**	Principal 1-800-986-3343 www.principal.com
Vision	EyeMed 1-866-268-4063 https://eyemed.com/en-us
Health Savings Account (HSA)	Optum Bank 1-800-791-9361 www.optumbank.com
Flexible Spending Account (FSA)	Omnify 1-844-472-6567 www.ubt.com/health
Pet Insurance	PetPartners 1-866-774-1113 www.petpartners.com
Employee Assistance Program (EAP)	Principal – ComPsych Guidance Resources 1-844-869-2365 www.guidanceresources.com
Accident **Critical Illness** **Hospital Indemnity** **Whole Life**	Allstate 1-800-248-4489 www.allstate.com
401k Retirement Program	**Nationwide** 1-855-224-9869 www.nationwide.com **Ameriprise Financial Advisors** Darrin Deichmann | Darrin.p.deichmann@amph.com Isaac Deichmann | Isaac.deichmann@ampf.com 402-371-1074

ADDITIONAL HEALTH PLAN INFORMATION FOR
Arrow Stage Lines / Busco, Inc. -- 1/1/2026

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 **Tracy Akers** / **tracy.akers@arrowstagelines.com** / **402-738-3237**. **Additional information about your benefits can be located online at www.buscobenefits.com**

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 **Tracy Akers** / **tracy.akers@arrowstagelines.com** / **402-738-3237**. **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 **Tracy Akers** / **tracy.akers@arrowstagelines.com** / **402-738-3237. 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.

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 benefit 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 **Tracy Akers** / **tracy.akers@arrowstagelines.com** / **402-738-3237. 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 Tracy Akers / tracy.akers@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 (1/1/2025) 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 ***Tracy Akers / tracy.akers@arrowstagelines.com / 402-738-3237*** 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, 2025. 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)	KENTUCKY – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) 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://kynect.ky.gov 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	**MASSACHUSETTS – Medicaid and CHIP**
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://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
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	UTAH – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
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	**RHODE ISLAND – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
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
WYOMING – Medicaid	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	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	**WASHINGTON – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

To see if any other states have added a premium assistance program since July 31, 2025, 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.

Important Notice from
Arrow Stage Lines / Busco, Inc.
About Your Prescription Drug Coverage and Medicare
Traditional -- Creditable Coverage
For Coverage Effective 1/1/2026

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 1/1/2025 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:	11/3/2025
Name of Entity/Sender:	Arrow Stage Lines / Busco, Inc.
Contact--Position/Office:	Tracy Akers
Address:	4220 S 52nd St Omaha, NE 68117
Phone Number:	402-738-3237

Important Notice from Arrow Stage Lines / Busco, Inc.
About Your Prescription Drug Coverage and Medicare
HDHP -- Non-Creditable Coverage
For Coverage Effective 1/1/2026

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 three 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 Arrow Stage Lines / Busco, Inc. is, on average for all plan participants, NOT expected to pay out as much as standard Medicare prescription drug coverage pays. Therefore, your coverage is considered NON-CREDITABLE COVERAGE. This is important because, most likely, you will get more help with your drug costs if you join a Medicare drug plan, than if you only have prescription drug coverage from the Arrow Stage Lines / Busco, Inc. Plan with United HeathCare. This also is important because it may mean that you may pay a higher premium (a penalty) if you do not join a Medicare drug plan when you first become eligible.

- You can keep your current coverage from Arrow Stage Lines / Busco, Inc. Plan with United HeathCare. However, because your coverage is non-creditable, you have decisions to make about Medicare prescription drug coverage that may affect how much you pay for that coverage, depending on if and when you join a drug plan. When you make your decision, you should compare your current coverage, including what drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area. Read this notice carefully - it explains your options.

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 decide to drop your current coverage Arrow Stage Lines / Busco, Inc., since it is employer-sponsored group coverage, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan; however you also may pay a higher premium (a penalty) because you did not have creditable coverage under the Arrow Stage Lines / Busco, Inc. Plan with United HeathCare.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?
Since the coverage under Arrow Stage Lines / Busco, Inc. with United HeathCare is not creditable, depending on how long you go without creditable prescription drug coverage you may pay a penalty to join a Medicare drug plan. Starting with the end of the last month that you were first eligible to join a Medicare drug plan but didn't join, if you go 63 continuous days or longer without prescription drug coverage that's creditable, 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 (penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

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.

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 November 12 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.

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).

Date:	11/3/2025
Name of Entity/Sender:	Arrow Stage Lines / Busco, Inc.
Contact--Position/Office:	Tracy Akers
Address:	4220 S 52nd St Omaha, NE 68117
Phone Number:	402-738-3237

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
402-738-3237