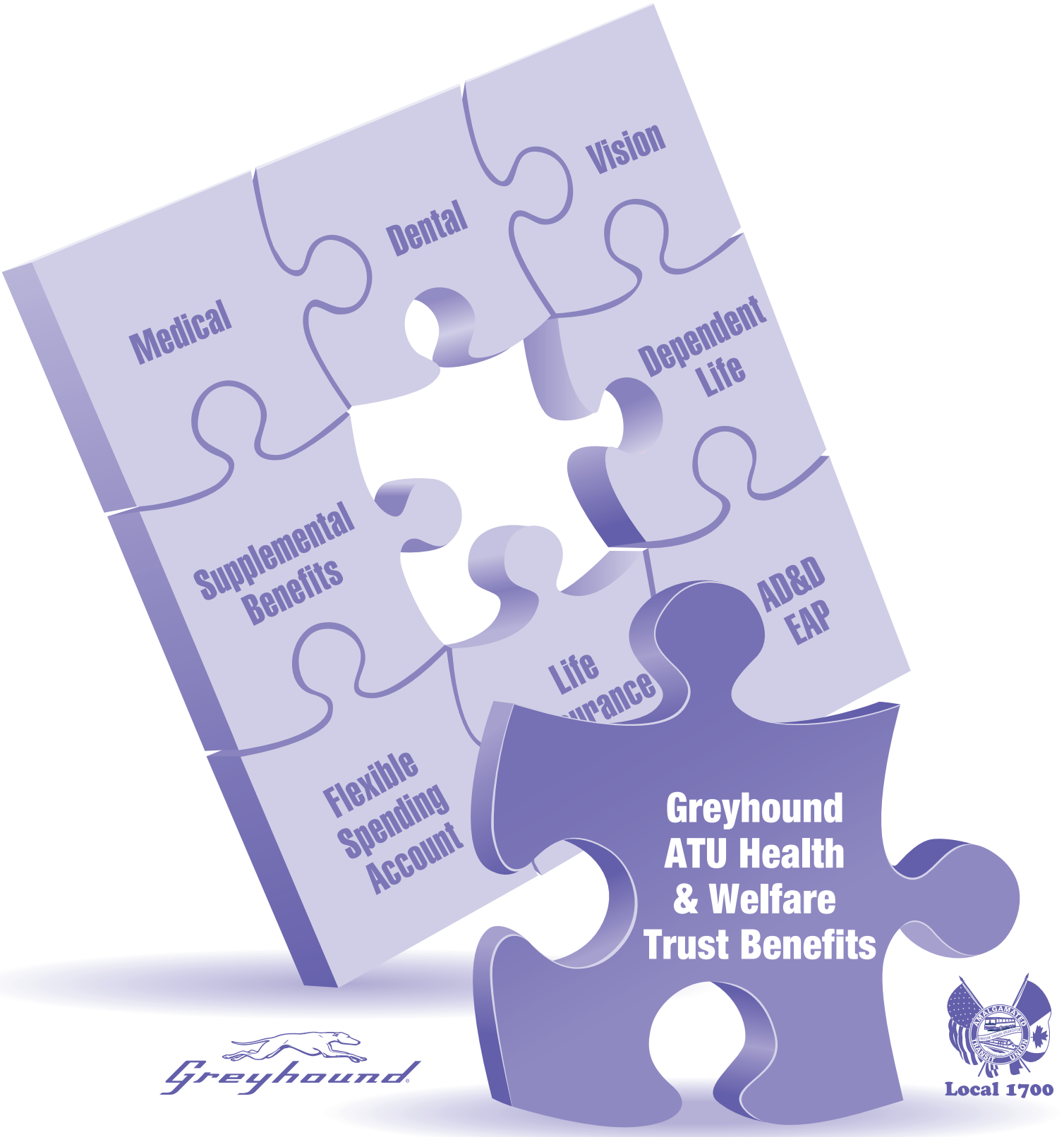
2022 Enrollment Highlights



Greyhound

Local 1700

2022 Greyhound / ATU Health & Welfare Trust
Enrollment Highlights

Dear Participant:

Your benefits are offered to you in cooperation by Greyhound Lines, Inc. and the Amalgamated Transit Union National Local 1700. Benefits available for enrollment in 2022 are: medical, dental, vision, life and accidental death and dismemberment insurance (AD&D), dependent life, employee assistance program, flexible spending account (FSA), short term disability (STD), accident insurance and critical illness insurance. **Enrollment in the medical, dental, vision, FSA, life insurance, AD&D, dependent life, STD, critical illness and accident insurance will be available through the online enrollment system.**

All full- and part-time employees are automatically enrolled in the employee assistance program as of their date of hire. All eligible employees are automatically enrolled in the $10,000 basic life insurance on the first of the month after **two** full months of continuous service. ***Please designate or update your life insurance beneficiary on the online enrollment system!***

The following information provides an overview of your benefits as a Greyhound/ATU employee. Refer to the Summary Plan Description (SPD) for detailed information on your benefit plans. Since the actual Plan documents, which describe your benefit plans, are legal and complex, a summary of this type cannot cover all provisions, limitations, and exclusions. In the event of any conflict or omission, between this summary and the official Plan documents, policies, and certificates of insurance, the official Plan documents, policies, and certificates of insurance will govern in every case. The official Plan documents, policies and certificates of insurance are available for inspection in the Health & Welfare Trust Office in Dallas. The Trustees reserve the right to amend, modify or terminate Plan benefits at any time. If you have questions about any of these plans, please contact the Trust at 1-800-288-7766 or by email at **greyhound.gliatubenefits@greyhound.com**.

The Greyhound ATU Health & Welfare Trust Office will administer benefits in accordance with all applicable laws and guidelines set forth by Greyhound Lines, Inc. and the Amalgamated Transit Union National Local 1700. We are proud to serve you and are available to assist with any questions and/or concerns.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see pages 45-46 for more details.

Your Health and Welfare Coverage "At-A-Glance"

As a new employee, and during annual open enrollment period, you will be choosing among the following health and welfare coverage types and amounts:

Enroll Online:

MEDICAL	Open Access Plus Value Plan	Open Access Plus Preferred	No Coverage
DENTAL	Dental Coverage		No Coverage
VISION	Vision Coverage		No Coverage
FLEXIBLE SPENDING ACCOUNT	You may set aside an annual amount of $50 to $2,750/year on a before-tax basis (or a per pay period amount within those guidelines) to pay for eligible health care expenses not reimbursed by your health care coverage.		
EMPLOYEE ASSISTANCE PROGRAM	Automatic enrollment for both full-time and part-time employees. Select dependent coverage for eligible dependents at no additional cost.		
BASIC LIFE INSURANCE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)	The Health & Welfare Trust provides $10,000 in coverage for each eligible employee. If you only select the basic life insurance, you will have the option to choose AD&D coverage of $10,000 or $20,000.		No Additional Coverage
VOLUNTARY LIFE INSURANCE AND AD&D	In addition to the basic life insurance provided, you may elect supplemental life insurance in $10,000 increments up to $120,000. This can provide total coverage of $130,000. AD&D coverage is included with the voluntary life insurance. Therefore, if you choose $120,000 of voluntary life insurance, you will also have $120,000 of AD&D coverage.		No Additional Coverage
DEPENDENT LIFE INSURANCE	Spouse only Coverage $10,000 or $20,000 Cannot exceed the Employee's coverage	Child(ren) Only Coverage $5,000 or $10,000 Cannot exceed 50% of the Employee's coverage	No Coverage
SHORT TERM DISABILITY INSURANCE	Weekly coverages range from $100 - $400 depending on your hourly rate and work location. If you work in California, New Jersey, New York, or Rhode Island the options are different, so be sure to review The Hartford enrollment package for details.		No Coverage
ACCIDENT INSURANCE	Pays a benefit if you or an insured dependent are unexpectedly injured in a covered accident.		No Coverage
CRITICAL ILLNESS INSURANCE	Employee may enroll for $5,000 or 10,000 in coverage, subject to age reduction. You may also enroll your eligible dependent(s) for the following amounts of coverage: • Spouse: 50% of your elected coverage amount • Child(ren): $5,000		No Coverage

Summary of Important Dates

2022 Annual Enrollment:	
October 18, 2021-November 12, 2021, (11:59 P.M. EST)	2022 Annual Benefit Enrollment
1st Payroll in 2022	Review deductions for accuracy and report any discrepancies to the H&W Trust office immediately
Other:	
Enrollment online must be completed **prior** to your **eligibility** effective date	New Hires/Rehires
Within 30 days from your return to work date	On an unpaid leave of absence of at least 30 days with no benefits
Within 30 days of the event	Status Changes and Special Enrollment Rights (excluding Medicaid or CHIP coverage)
Within 60 days	Medicaid or CHIP coverage changes
1st Payroll after enrollment	Review deductions for accuracy and report any discrepancies to the H&W Trust office immediately

2022 ENROLLMENT NEWS

This will be an "active" enrollment for the Flexible Spending Account. For all other coverages, this will be a "passive" enrollment, meaning re-enrollment is not required if you want to maintain your current coverage. **To make changes you must go online to www.benefitsolver.com and review your current benefits, dependents, and beneficiaries by 11:59 p.m. EST on November 12, 2021.**

New Benefit Administration

Effective July 1, 2021, Greyhound/ATU moved to a new Benefit Administration Portal at www.businessolver.com. You will no longer access your benefits through ADP HWSE. Please see the login instructions on pages 11-12 for more detailed instructions. All your benefit elections were transferred from ADP HWSE to the Businessolver System. Please check your coverage and beneficiaries for accuracy.

Even if you choose not to make any changes, be sure to designate or update your life insurance beneficiary on the online benefits enrollment site.

All forms and brochures are located on the online enrollment system.

Medical Plan

The medical plan is a self-insured plan, meaning that all claims are funded through employer and employee contributions. We are all responsible for cost control, not an insurance company. As part of the last two collective bargaining agreements, the benefits were improved to encourage preventive screenings. For example, it is less expensive to treat high blood pressure with medication rather than suffer a heart attack or stroke. Also, treating cancer can be more successful when caught early. It's a win-win situation if our participants are healthy! Unfortunately, our claim costs are escalating, and we have to make a few moderate plan design changes including adjusting premiums effective for January 1, 2022, to maintain the stability of the Trust. The following changes are:

What's New for Medical In 2022

- Increase in the Preferred Plan Annual Deductibles; In-Network Annual Deductible increased to $800 per person and $2,400 for family, and Out-of-Network Annual Deductible increased to $1,600 per person and $4,800 for family.

- Increase in the Value Plan Annual Deductibles; In-Network Annual Deductible increased to $6,000 per person and $18,000 for family, and Out-of-Network Annual Deductible increased to $12,000 per person and $36,000 for family.

- Increase in the Preferred Plan Annual Out-of-Pocket Maximums; the In-Network Out-of-Pocket Maximum increased to $8,700 per person and $17,400 per family and the Out-of-Network Out- of-Pocket Maximum increased to $26,100 per person and $52,200 for family.

- Increase in the Value Plan Annual Out-of-Pocket Maximum; In-Network Out-of-Pocket Maximum increased to $12,000 per person and $36,000 per family, and the Out-of-Network Out-of-Pocket Maximum increased $24,000 per person and $72,000 for family.

CIGNA One Guide

You may access Cigna One Guide by calling the customer service number on your ID card or through the myCigna.com website or App. Both the myCigna.com App and website includes a live chat option.

Cigna's One Guide service can help you make smarter, informed choices and get the most from your plan. It's the highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support, tools and reminders can help you stay healthy and save money.

Your One Guide team is a click away to help you:

Understand Your Plan

- Know your coverage and how it works.
  Get answers to all your health care or plan questions.

Get Care

- Find an in-network doctor, lab or urgent care center.
- Connect to health coaches.
- Stay on track with appointments and preventive care.
- Take advantage of dedicated one-on-one support for complex health situations.

Save and Earn

- Maximize your benefits.
- Get cost estimates and service comparisons to avoid surprises.

CIGNA Virtual Care:

Cigna Connection lets you get the care you need- including most prescriptions-for a wide range of minor conditions. This program allows you to connect with a board-certified doctor via video chat or phone. Services are available 24 hours a day, 7 days a week, 365 days a year through MDLIVE.

To Access Cigna's Virtual Care for Medical and Behavioral Health visits, go to myCigna.com and use the link provided. MDLIVE is Cigna's primary Virtual Health Partner.

Virtual Care copay and contact information:

- $15 copay
- MDLIVEforCigna.com or 888-726-3171

Flexible Spending Account (FSA)

You can contribute up to **$2,750** in the FSA.

The minimum of $50 up to $550 will carry over into the new plan year. Any amounts less than $50 or in excess of $550 will be forfeited. Your carryover balance will terminate if it goes unused or has no activity for one year.

Remember, for expenses incurred in 2021 (January 1- December 31, 2021), claim forms must be received by CIGNA no later than March 31, 2022. Also, you need to re-enroll every year if you want to maintain your FSA.

Medical Plan with Cigna & Pharmacy with Express Scripts

Due to the rising cost of medical care and prescription drugs, the premium rates are increasing. Additionally, In-Network and Out-of-Network Annual Deductibles and Out-of-Pocket Maximums are increasing. Copays for Generic, Preferred & Non-Preferred Brand prescriptions are also increasing.

What's New for Pharmacy In 2022

Express Scripts New SaveOnSP Program

If you participate in the SaveOnSP program, certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. In that case, manufacturer assistance may not be applied towards your deductible and out-of-pocket maximums. For information on whether your drug is covered under the SaveOnSP program, please contact SaveOnSP at 1-800-683-1074.

Vison Plan with VSP

There are no changes to the vision plan and the premium rates will remain the same.

Delta Dental Plan

There are no changes to the dental plan in 2022; however, the premium rates are increasing. As a reminder, the dental plan includes: a $500 lifetime maximum orthodontia benefit for children up to age 26, payable at 50% coinsurance and an annual dental maximum (for all services, excluding orthodontia) of $1,500 per person.

Employee Voluntary Life/ AD& D Insurance and Dependent Life Insurance

There are no changes to life insurance, the voluntary life insurance premiums may change if you enter a new age band. Evidence of Insurability will be required for voluntary life/AD&D and dependent life insurance only if you are electing additional amounts for yourself and/or your spouse beyond the current coverage amount.

Healthy Hound Program

Healthy Hound's mission is to improve the health and well-being of our members (and their spouses) *and* lower your premium rates for medical coverage. Just complete one of the Healthy Activities listed below between October 1, 2021 and September 30, 2022 to save up to $100 per individual on your medical premiums, up to a maximum of $200. Learn more about the Healthy Hound Program at **www.HealthyHounds.info**.

How does the Healthy Hound Program work?

- You (and your enrolled spouse, if applicable) must complete a Healthy Activity between October 1, 2021 and September 30, 2022.

- If you and your enrolled spouse do not each complete one activity by September 30, 2022, an annual surcharge of $100 per employee **and** $100 per spouse will be applied to your medical plan premiums (for a total of $200) beginning with your first paycheck in January 2023.

Here's a list of Healthy Activities under the Healthy Hound Program for 2022: Just choose one:

1. **Get a Preventive Wellness Exam or Test**. Schedule and complete one of the following wellness exams or preventive tests: annual routine physical exam/biometric screening, well-woman exam, colonoscopy (for participants age 50 and older), mammogram, pap test or PSA test. Please note that Department of Transportation (DOT) physicals does **not** count toward meeting this Healthy Activity.

   No cost to you in-network. These tests, when obtained from an in-network provider, are not subject to a deductible and are covered in full under both the Value and Preferred plans. In addition, if you get one of these tests from an in-network provider, no paperwork is necessary.

   A PB-1 form is required if the employee's provider is out-of-network. Your spouse **must** use an in- network provider for this Healthy Activity. You, as the employee, may use an out-of-network provider, but you must bring a PB1 form (available through the Trust Office or on www.healthyhounds.info) to the appointment for your provider to complete. Then, submit the form to the Trust Office so you can get credit through the Healthy Hound Program.

2. **Get a Biometric Screening or Complete an Online Health Assessment**. This Healthy Activity is designed to help you keep track of your health. You must obtain a biometric screening *or* complete an online health survey. **You are not required to do both. However, you are certainly welcome to complete both to better understand your health risks.** During the biometric screening, your provider will check your blood pressure, height, weight, BMI, HDL, LDL, total cholesterol, pulse, and fasting blood sugar.

Convenient one stop for your biometric screening at Quest Diagnostics. To make it easier, you can schedule and complete your full biometric screening directly with Quest Diagnostics. Another advantage of using Quest is that Cigna will automatically populate your results in your online Health Assessment to make completing that even easier.

To schedule with Quest, just visit **https://My.QuestForHealth.com**, and enter "Greyhound2021" for the Registration Key. You can also call 1-877-304-7055 to make an appointment.

Complete an Online Health Assessment. Log into myCigna.com and click "Take My Health Assessment." This typically takes about 15 minutes to complete (or shorter if you use Quest).

Note that you can use a provider other than Quest for the biometric screening, but you'll need to bring a Cigna Wellness Screening form with you to your doctor's appointment for them to record your screening results and send the completed form to Cigna. Visit **www.healthyhounds.info** for a copy of the Cigna Wellness Screening form or call the Trust Office.

3. **Complete the "Quit For Life" Tobacco Cessation Program**. This program provides coaching and support tools (such as free nicotine patches delivered to your home) to help you quit tobacco. To enroll, call 1-866-784-8454 or go to www.quitnow.net. Participate in just four coaching calls to get credit for this Healthy Activity. Coaching calls are available 24/7 to suit your schedule.

4. **Enroll in the Cigna Diabetes Prevention Program with Omada® lifestyle change program and reduce your weight by 5%.** Omada provides tools and support to help reduce your risk of developing diabetes and heart disease. Visit **www.healthyhounds.info** for more information, including a link to a 1-minute risk screener to see if you qualify for the program., Or, visit go.omadahealth.com/greyhoundatu to get started.

Participate in the Your Health First Program. The Your Health First Program is designed to help employees and spouses learn more about and better manage the following chronic conditions: asthma, diabetes, heart disease, COPD, lower back pain, mental health disorders, osteoarthritis, peripheral arterial disease, and metabolic syndrome. This Healthy Activity requires you to connect with a Cigna Health Advocate by telephone and set and make progress toward a goal. Call 855-246-1873 to get started.

If you have one of these chronic conditions and are identified by Cigna to participate in Your Health First Program, you can choose to participate in the program to complete your Healthy Activity, or you can choose to complete one of the other Healthy Activities from this list.

Good News! Healthy Hound Sweepstakes Drawing Continued for 2022

All Greyhound ATU members who complete a Healthy Activity between October 1, 2021 and September 30, 2022, will be automatically entered into a sweepstakes drawing for one of several prizes:

- A $500 grand prize gift card, or
- One of ten $100 gift cards.

The 2022 sweepstakes drawing will take place the first week of December 2022, with prizes awarded shortly thereafter. For additional information about the Healthy Hound Sweepstakes, visit **www.healthyhounds.info**.

Other Important Information

- **It's completely confidential**. Participation in all Healthy Activities is completely confidential, voluntary, and there is no cost to you. The Trustees, the Union, and the Company will not have any knowledge of anything related to your health condition or discussions you may have with any health advisors in the Healthy Hound Program.

- **More information available online!** For additional information**,** visit the Healthy Hound Program website at **www.healthyhounds.info**. Or you can link to it from the ATU site at **(www.atu1700.org**). You'll find details about the program including descriptions of Healthy Activities, links to contacts, and FAQS. Questions? Call the Trust Office at 1-800-288-7766.

- **ATU Members** can reduce their sick leave waiting period if they receive a wellness exam and biometric screening. See the website, www.healthyhounds.info, for details.

- **You and your spouse can track your Healthy Activities through CIGNA "MotivateMe".** Visit myCigna.com, click on "Manage My Health", then click on "Incentive Award Program" in the drop-down menu to find instructions on how to get started; view a list of eligible activities; and track your completed activities. Please note that Quit for Life and out-of-network claims that are not filed with Cigna cannot be tracked on MotivateMe.

- **Note:** The 2022 Healthy Hound premium surcharge of $100 per enrolled member and $100 per enrolled spouse will not apply to employees enrolled in the Value Plan who earn less than $13.50 per hour.

- **You must update all personal information** (address, phone number, etc.) directly with your work location.

- **If you are currently on a leave of absence** or you go on a leave of absence during the year, contact the Trust Office regarding direct payment of premiums to ensure benefits are not cancelled.

If you do not enroll for coverage during the Open Enrollment Period or during your new hire eligibility period, you will have to wait until the next annual Open Enrollment period and at that time, you must enroll in the Value Plan (with the exception of Massachusetts) for one year before you may elect to be covered under the Preferred Plan. The only exception to waiting until the next annual Open Enrollment period is if you have a qualifying status change or become eligible under the Special Enrollment rules.

- ***For Massachusetts Residents Only***:

  Under the Massachusetts Health Care Reform Act, most Massachusetts residents 18 or older must have health insurance that meets specific standards called "minimum creditable coverage." **Please be advised that the Value Plan does NOT meet the Massachusetts minimum creditable coverage standards in effect for 2022. Therefore, if you select the Value Plan, you will not meet the minimum creditable coverage requirements and may be required to pay a penalty when you file your Massachusetts tax return.**

  Based on our self-assessment, the Preferred Plan does satisfy Massachusetts minimum creditable coverage standards for 2022.

More Information

For more information regarding the Health & Welfare Plans please consult the Summary Plan Description for more details. You can also contact the Health & Welfare Trust Office at 1-800-288-7766 or greyhound.gliatubenefits@greyhound.com.

Completing Your Online Enrollment System

Complete the online enrollment if you want to enroll or make changes for Medical, Dental, Vision, Life Insurance and Accidental Death & Dismemberment (AD&D), Dependent Life (Spouse and/or Child), Short Term Disability (STD), Accident, Critical Illness, EAP for dependents, or the FSA.

REGISTER AND LOGIN

1.Visit **www.benefitsolver.com** and click the **Register** button to get started. The case-sensitive company key is **greyhoundatu**.

2.Create your username and password, verify your personal information, and answer a few security questions.

3.Log in using your new username and password.

EXPLORE YOUR OPTIONS

Explore the site to learn about your benefits. You'll find lots of helpful information in the

Reference Center.

The calendar at the top of the **Homepage** lets you know how many days you have to enroll.

START YOUR ENROLLMENT

Click the **Start Here** button to review your personal information and add or edit any dependents you wish to cover.

You will need to provide each dependent's legal name, Social Security Number, and birth date to add them to your coverage.

You will be required to provide documentation to prove your relationship to each dependent. If you are adding a new dependent, documentation (e.g., marriage certificate, current tax return (spouse only) and/or birth certificates) will be required to be submitted to the Trust Office before coverage will become effective. Court documents are required if you have legal custody for dependents. Mail or fax the documents to:

Greyhound ATU Health & Welfare Trust
350 N. St. Paul Street
Dallas, TX 75201
Fax: 214-481-5082

Please contact the office to verify documents were received!

2 WAYS TO ENROLL IN COVERAGE

- MyChoice Recommendation Engine Answer a few simple questions to receive a personalized benefits recommendation. Your answers are never shared.

- Explore on your own

Use the Next and Back buttons to review and elect options available to you. Choose or decline coverage for each option and select which family members you want to cover.

REVIEW AND FINALIZE YOUR ELECTIONS

Make sure your personal information, elections, dependents, and beneficiaries are accurate, then approve your elections.

To finish, click I Agree. When your enrollment is complete, you will receive a confirmation number and can print your Benefit Summary for your records.

Eligibility & Effective Dates

Employment Status	Eligibility Requirements	Coverage Effective Date
Annual Enrollment	If you are currently enrolled or meet the eligibility criteria of the employment status that follow.	January 1, 2022
Active Full-Time, including New Hires	You are eligible for coverage if you are a full-time employee (scheduled to work 1,500 hours or more per year) represented by the Amalgamated Transit Union (ATU).	First of the month on or after your full-time effective date, when you have completed at least **two** full calendar months of continuous service.
Change to Full-Time Employment	Part-time employees are not eligible for Greyhound/ATU coverage with the exception of the employee assistance program; however, if you transfer from part-time status to full-time status, part-time service counts toward the two-month eligibility-waiting period.	First of the month on or after your full-time effective date, when you have completed at least **two** full calendar months of continuous service.
Return from Leave or Reinstatement from Discharge for Cause	If you are enrolled in Greyhound/ATU coverage before going on leave or being discharged for cause, you are eligible to have your coverage reinstated upon your return to full-time work.	First of the month after your return-to-work date.
Transferring within Greyhound from a Non-Union Benefit Plan to a Union Benefit Plan	Within 30 days of your transfer date provided you have completed two full calendar months of continuous service and you are a full-time employee.	First of the month on or after your full-time effective date, when you have completed at least **two** full calendar months of continuous service.

Enrollment Requirements during Annual Open Enrollment

Status	Enrollment Information	Deadline
Current Enrolled Participants - Open Enrollment	**This will be an "active" enrollment for the Flexible Spending account. For all other coverages, this will be a "passive" enrollment, meaning re-enrollment is not required if you want to maintain your current coverage.**	November 12, 2021 11: 59 P.M. EST
Eligible but not enrolled – Open Enrollment	If you would like to elect coverage for the first time and have met the waiting period requirement, you must complete the online benefits enrollment for: medical, dental, vision, FSA, life insurance, dependent life, AD&D, accident, critical illness and STD coverages and designating a life insurance beneficiary for 2020. You must submit appropriate documents for your dependents (e.g., marriage certificates and current tax return (Spouse Only)/or birth certificates) to the Health & Welfare Trust office before coverage will be effective.	November 12, 2021 11:59 P.M EST
New Hires / Rehires	You may enroll yourself and eligible dependents by completing the online benefits enrollment for: medical, dental, vision, FSA, life insurance, dependent life, AD&D, accident, critical illness and STD coverages and designating a life insurance beneficiary prior to your eligibility effective date. You must submit appropriate documents for your dependents (e.g., marriage certificates and current tax return (Spouse Only)/or birth certificates) to the Health & Welfare Trust office before coverage will be effective.	Prior to eligibility effective date.
On leave – active benefits	If you are on leave with active benefits, see "Current Enrolled Participants - Open Enrollment" section in this chart.	November 12, 2021 11: 59 P.M EST
On leave – terminated benefits	If your benefits terminated while you were out on a leave and you are not currently enrolled, you may enroll when you return to work as an active employee.	Within 30 days from your return-to-work date.
Status Changes and Special Enrollment Rights	If you experience a qualified status change, you may be able to make changes during the plan year. You may be able to request a change by completing the appropriate online enrollment electing desired medical, dental, vision, FSA, life insurance, dependent life, AD&D, STD, accident and critical illness coverages for 2022 and provide supporting documentation to the ATU Health & Welfare Trust Office.	Within the applicable enrollment period (usually 30 days).

Enrolling Dependents

If you are enrolling a spouse or a dependent child for the first time, please include a copy of your certified marriage certificate, current tax return for your spouse and/or certified birth certificates for your children.

Eligible Dependents:

- Your legal spouse who is recognized as such under federal tax laws[1] (including a same-sex spouse), unless you are legally separated or divorced.
- Your child[2], as defined below.

Medical and EAP: Your child is eligible for coverage under the EAP and Medical Plan up to the end of the month in which your child reaches age 26. In addition, your child is eligible for coverage under the EAP and Medical Plan up to any age if: (i) such child is unable to support himself or herself because of mental or physical handicap[3], (ii) such child was covered before his or her 26th birthday, and (iii) such child currently depends on you for financial support. Proof of handicap status must be provided within 30 days of the child's 26th birthday. For purposes of the Medical Plan and EAP, the term "child" includes: a natural child, a legally adopted child, a child placed for adoption with you, a step-child, a foster child, a child for whom you have legal guardianship, or a child for whom a Qualified Medical Child Support Order directs you to provide coverage.

Dental: Your children who meet the following requirements are eligible for Dental coverage:

Children from birth to the end of the month in which they reach their 26th birthday: "Children" includes natural children, step-children, adopted children and foster children with no distinction made based on the marital status or lack of marital status between you and the other parent. Newborn infants are eligible from the moment of birth. An adopted child will be eligible from the moment you become a party in a suit to adopt the child. A newborn child or adopted child will automatically be covered for 31 days. To continue coverage after 31 days, notice of the birth or notice regarding the suit to adopt and additional premium, if any, must be received within the 31-day period.

Grandchildren who are less than 26 years of age are a dependent of the Eligible Person for federal income tax purposes at the time application for coverage of the grandchild is made. Coverage for said grandchild may not be terminated solely because the grandchild's parent is no longer dependent upon you for federal income tax purposes.

Children, including grandchildren, under 26 years of age for whom the Eligible Person is required to insure under a medical support order issued under Chapter 154 Family Code or enforceable by a court in Texas. Said child may request to be covered under the Eligible Person's coverage.

A child, including grandchild, 26 years of age or older who is not self-supporting because of mental retardation or physical handicap and the child is chiefly dependent upon the Eligible Person for support and maintenance. Proof of these facts must be given to Delta Dental within 31 days of the child's attainment of age 26. Proof will not be required more than once a year after the child is 28.

Dependents in military service are not eligible.

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[1] Certified marriage certificates, current tax return required upon enrollment.
[2] Certified birth certificates required upon enrollment.
[3] Proof of handicap status must be provided within 30 days of the child's 26th birthday.

Vision: Your child who meets the following requirements is eligible for Vision coverage:

Any natural child from the moment of birth, legally adopted child from the moment of placement in your residence or other child for whom a court holds you responsible. Dependent children are covered up to the end of the month in which they reach age 26.

A child of your child who has not yet attained the age of 26 years and is your dependent for federal income tax purposes at the time application for coverage of the child is made. Coverage for a child of your child may not be terminated solely because the covered child is no longer your dependent for federal income tax purposes.

If a dependent, unmarried child prior to attainment of the prescribed age for termination of eligibility becomes, and continues to be, incapable of self-sustaining employment because of mental or physical disability, that dependent's coverage will not terminate so long as he remains chiefly dependent on you for support and your coverage remains in force; provided that satisfactory proof of the dependent's incapacity can be furnished within thirty-one (31) days of the date the dependent's coverage would have otherwise terminated or at such other times as proof may be requested, but not more frequently than annually.

Dependent Life: Your unmarried child who is your dependent and meets the following requirements is eligible for Dependent Life Insurance:

Dependent Child(ren) means: Your natural child, stepchild, adopted child or any other child who is related to you by blood or marriage who is: 1) not yet age 26; or 2) age 26 or older and physically or mentally disabled and living under Your supervision. Your natural or adopted grandchildren will qualify as a Dependent provided the child is not yet age 26.

- If your child's eligibility is based on your legal guardianship of the child (such as if the child is your grandchild, niece, nephew, or other minor family member), you may enroll the child as a dependent only if you provide copies of the legal documentation along with your enrollment form.
- For purposes of these eligibility rules, your child will be considered to depend on you for financial support only if you (or you and the child's other parent) provide at least one-half of your child's support for the year and the child has the same principal place of abode as you for at least one-half of the calendar year.
- In the case of parents who are (1) divorced or legally separated under a decree of divorce or separate maintenance; (2) separated under a written separation agreement; or (3) live apart at all time during the last 6 months of the calendar year; your child will be considered to depend on you if your child receives over half of his/her support from one parent or both parents; and your child is in the custody of one or both parents for over half the year.

When Coverage Begins
When properly enrolled, coverage for you and your dependents begins on the first day of the month following **two** full calendar months of continuous service for new hires. For example, if you start work on January 1, your coverage may begin March 1, and if you start work on January 15, your coverage may begin April 1. You must submit your enrollment request **prior** to your eligibility effective date. If you started work on January 15 and completed the online enrollment and returned your appropriate documents to the Trust Office any time before April 1, you will have coverage effective April 1. Enroll early to avoid retroactive deductions being withheld from your paycheck.

Coverage for the open enrollment will begin January 1, 2022. **Be sure to review your deductions on the 1st payroll in 2022 and report any discrepancies to the ATU Health & Welfare Trust office timely**.

Option to Decline Coverage
You may decline to participate in any of the benefit programs available to you. If you previously did not have coverage, your coverage will be considered declined if you fail to complete the online enrollment prior to your eligibility effective date or during the annual open enrollment.

If you decline coverage, you and your eligible dependents will not be able to enroll in benefits until the next annual open enrollment, unless you have a qualifying status change. Please see the ***Status Change*** section of the SPD for more information.

If you are not enrolled in either the Value Plan or the Preferred Plan and wish to enroll at a later date, you must enroll for one year in the Value Plan before becoming eligible to enroll in the Preferred Plan. This does not apply if you are a Massachusetts resident or the reason for not enrolling in the Value Plan or the Preferred Plan is because you had other health coverage or if you qualify for a special enrollment.

Remember that the ACA requires most individuals to have minimum essential health coverage. Additionally, several states now require most individuals to have minimum essential health coverage or pay a tax penalty.

If you choose not to enroll in any or all of the benefit Plans, be sure to designate or update your life insurance beneficiary on the online benefits enrollment system.

Status Changes and Special Enrollment Rights
Due to IRS regulations, you are unable to make changes during the year (including dropping coverage) to your benefit elections once the Plan year has begun, unless you have a qualifying status change. That is, during the Plan year, you cannot merely decide that you no longer desire Medical coverage or no longer wish to put money into your Flexible Spending Account. You may, however, make any changes you wish during the open enrollment period.

Federal law also allows certain "special enrollment" opportunities if you decline coverage under this Plan because you have other health coverage, or you acquire a new dependent through marriage, birth, adoption, or placement for adoption. In order to be able to take advantage of a special enrollment period as a result of losing other coverage, you must generally have declined coverage under this Plan due to having other health coverage.

This notice requirement does not apply to the 60-day special enrollment period for loss of Medicaid or CHIP coverage.

Special Enrollment Rights

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 toward your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If the qualifying event is the loss of Medicaid or a State's Children's Health Insurance Program ("CHIP") coverage, or the gain of eligibility for a Medicaid/CHIP premium assistance program, the 30-day special enrollment period is extended to 60 days.

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 yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To request special enrollment or obtain more information, contact the Health & Welfare Trust at 1-800-288-7766 or at greyhound.gliatubenefits@greyhound.com.

A detailed listing of Status Changes and Special Enrollment Rights when a Plan participant may revoke an existing election and/ or make a new election is available in the Summary Plan Description (SPD). The following are only a few examples:

- Change in legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- Your number of dependents changes, such as through birth, death, adoption, placement for adoption, change in legal custody (including a Qualified Medical Child Support Order), or placement of a foster child (if the foster child otherwise qualifies as your dependent),
- Your employment status, or that of your dependent, changes as a result of: a termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence, or a change in worksite,
- You experience a change in employment status (such as from part-time to full-time, or from a non-bargaining unit position to one covered by the collective bargaining agreement) that results in you becoming eligible for this Plan,
- Your dependent becomes eligible for coverage under the rules of this Plan or ceases to be an eligible dependent (for example, when your child reaches age 26).
- You or your dependent becomes enrolled under Medicare or Medicaid (State plan names may vary),
- The cost to be charged to you for a benefit package option significantly increases or significantly decreases during the period of coverage (during the Plan year),
- You or your dependent has a significant curtailment of coverage under another plan (such as if there is a significant increase in the deductible, co-pay, or the out-of-pocket cost sharing limit under an accident or health plan),
- You or your dependent lose coverage under any group health coverage sponsored by a governmental or educational institution, including: A State's Children's Health Insurance Program "CHIP"; a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a State health benefits risk pool; or a Foreign government group health plan.
- You or your dependent becomes eligible to participate in a premium assistance program under Medicaid or CHIP.

Changes must be requested by completing the online enrollment within 30 days of the eligible event (60 days for loss of Medicaid/CHIP coverage or gain of eligibility for a Medicaid/CHIP premium assistance program). Proof of the event is required, such as marriage, birth, or death certificate; court document(s); or certificate of creditable coverage stating the covered parties, type and dates of coverage, and reason for loss of coverage. Any requested change in elections must be consistent with the applicable status change.

Payroll Deductions
Please review the rate sheet for premiums. All premiums are withheld from every paycheck. **If you are enrolled in the Plan and deductions are not being taken from your paycheck, it is your responsibility to notify the Health & Welfare Trust immediately. Failure to notify the Trust timely could result in termination of your coverage under the Plan.**

Retroactive Payments
Retroactive Payments will be taken if deductions are missed. The deductions will be withheld until the balance is paid. Failure to pay benefit premiums may result in termination of coverage for nonpayment for you and your eligible dependents. If you are currently on a leave of absence or you go on a leave of absence during the year, contact the Trust Office regarding direct payment of premiums to ensure benefits are not cancelled.

Medical Benefits

You can enroll in a Point of Service (POS) plan, either the Open Access Plus (OA+) Preferred or OA+ Value, depending on the level of benefit you desire. You may also choose to elect no medical coverage.

Open Access Plus Preferred

- $800 In-Network Annual Individual Deductible ($1,600 Out-of-Network) / $2,400 In-Network ($4,800 Out-of-Network) Annual Family Deductible.
- Out-of-Pocket Maximums (includes medical and pharmacy co-pays, deductibles and coinsurance) of $8,700 per person and $17,400 per family In-Network and $26,100 per person/$52,200 family Out-of-Network.
- $35 co-payment/visit for In-Network Primary Care Physicians office visits (General Practice, Family Practice, Internal Medicine, and Pediatricians) and $50 for Specialists (all other practitioners, including OB GYN's).
- Plan pays 70% Coinsurance for In-Network services (unless co-payment applicable).
- Plan pays 50% Coinsurance for Out-of-Network services (Out-of-Network dialysis services are not covered)

Open Access Plus Value

- $6,000 In-Network ($12,000 Out-of-Network) Annual Individual Deductible/ $18,000 In-Network ($36,000 Out-of-Network) Annual Family Deductible.
- Out-of-Pocket Maximums of $12,000 per person and $36,000 per family In-Network and $24,000 per person/$72,000 family Out-of-Network.
- $35 co-payment/visit for In-Network office visits
- Plan pays 70% Coinsurance for In-Network services (unless co-payment applicable)
- Plan pays 50% Coinsurance for Out-of-Network services

Notice of "Grandfathered Health Plan" Status

The Greyhound / ATU Health & Welfare Trust believes the Value Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at 1-800-288-7766. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Detailed information is available in the Summary Plan Description and the following **Schedule of Medical Benefits Chart.**

Provider Directories and Networks

If you need a copy of the provider list, or need updated information, you can access the information in various ways. You will, without charge, receive a separate listing of Participating Providers upon request. You may have access to a list of Providers who participate in the network by visiting www.mycigna.com, or by calling the toll-free number on your ID Card.

Your Participating Provider Network consists of a group of local medical practitioners, and hospitals, of varied specialties as well as general practice or a group of local pharmacies who are employed by or contracted with CIGNA HealthCare.

Claim Submission

Most doctors in the CIGNA network (in-network) will have 90 days from the date of service to submit claims for payment. Any claim received by CIGNA from an impacted doctor that is over the 90-day limit will be denied as a late filing. **You cannot be billed for a claim that was filed late and denied when you visit an in-network doctor.**

Doctors and facilities outside of CIGNA's network (out-of- network) will have 180 days from the date of service to submit out-of-network claims. Any claim received by CIGNA that is over the 180-day limit will be denied as a late filing. This applies whether the claim is submitted by the doctor, facility or by the patient. **You may be billed for a claim that was filed late and denied since CIGNA has no contract with the out-of-network doctor or facility**. If you are submitting a claim yourself for out-of-network services, be sure to submit it within 180 days of the date of service.

24-Hour Health Information Line
Helpful health information is available by phone through the CIGNA HealthCare 24-Hour Health Information Line for members enrolled in medical coverage. It gives members toll-free, 24/7 access to a specially trained registered nurse and an audiotape library of more than 1,000 health-related topics. The articles are regularly updated to include new treatments and medical data. Some of the topics include aging, women's health, nutrition, and surgery.

The information line is personal and confidential and can give you added confidence and reassurance when you have a health question or concern. Nurses are also standing by to answer any questions you may have. Should you choose to speak with a registered nurse; the nurse will ask you a few questions about your symptoms and situation then direct you to the type of care that should make you more comfortable. Care directions can range from self-care tips until you see the doctor, assistance with locating a participating provider if you need urgent care, or for emergency care redirect you to 911, and contact your Primary Care Physician. See your ID card for the 24-Hour Health Information number.

Women's Health and Cancer Rights Act
When a person covered under this Plan has a mastectomy at any time and decides to have breast reconstruction, based on consultation between the attending physician and the patient, the following benefits will be subject to the same coinsurance and deductibles that apply to other Plan benefits:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Treatment of physical complications in all stages of mastectomy, including lymphedema; and
- Mastectomy bras and external prostheses, subject to the same limitations on coverage as other external prostheses and garments covered under this Plan. If you have any questions about your benefits under this Plan, please call the number on your ID card or contact the Trust Office at 1-800-288-7766.

Coverage for Maternity Hospital Stay
Group health plans and health insurance issuers offering group health insurance coverage generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess for the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or her newborn earlier than 48 hours or 96 hours, as applicable. Please review the Summary Plan Description for further details on the specific coverage available to you and your dependents.

Prescription Drug Benefits through Express Scripts

Express Scripts will provide the prescription drug benefits for both the Preferred and Value Medical Plans. The prescription drug benefits through Express Scripts include a retail network pharmacy program, a mail order pharmacy program, and a specialty pharmacy program.

Retail Network Pharmacy Program Prescription drugs purchased at pharmacies not in the Express Scripts pharmacy network are not covered. Generally, prescription drugs purchased at retail pharmacies will be limited to a maximum of a 30-day supply. To find a participating retail network pharmacy you can contact Express Scripts at 877-804-5415, visit **www.express-scripts.com/NATPLSNATPREF14**, log into your member portal or use the Express Scripts app on your mobile phone.

Home Delivery Pharmacy and 90 Day Retail Network Program for Maintenance Drugs
You may purchase "maintenance" prescription drugs through the Express Scripts' home delivery pharmacy or through Express Scripts' retail network pharmacies. Maintenance prescription drugs are drugs and medications that are typically used to treat chronic or long-term conditions, such as high blood pressure, cardiac or pulmonary conditions, asthma, etc., and are generally taken for longer than 90 days. Prescription drugs purchased through Express Scripts' home delivery pharmacy or 90-day retail network program will be limited to a maximum of a 90-day supply.

Specialty Prescription Drugs Must be Received Express Scripts Specialty Pharmacy, Accredo
Specialty prescription drugs are generally high-cost drugs, such as biologicals and other "high-tech" medications used to treat chronic and/or complex conditions such as anemia, cancer, cystic fibrosis, HIV, hepatitis C, immune deficiency, multiple sclerosis, osteoarthritis, and rheumatoid arthritis. Many of these drugs require injection and have special shipping and handling needs. These drugs could also be oral or infusion medications. Often specialty drugs may not be readily available at a retail network pharmacy. You may purchase an initial 30-day supply of a specialty prescription drug through a retail network pharmacy or you can arrange to purchase your initial fill of a specialty prescription drug directly with Accredo. Thereafter, all refills of a specialty drug must be dispensed through Accredo.

Accredo is especially equipped to provide the required special handling of these drugs. In addition, when you purchase drugs through Accredo, a dedicated pharmacist is available to answer your questions and provide advice concerning the administration and care of the drug.

All specialty prescription drugs are limited to a maximum 30-day supply at a retail network pharmacy or through Accredo. In addition, specialty drugs may be subject to prior authorization, step therapy or other clinical management programs.

Prescription Drug Formulary
The Express Scripts prescription drug benefits include an extensive list of generic and brand name prescription medications that are covered by the Plan. The formulary is regularly evaluated and updated by a committee of medical personnel and pharmacists and can change from time to time. The formulary used for the Plan covers medications only when prescribed for a purpose approved by the Food and Drug Administration (FDA).

For any prescription drug that is excluded on the formulary, there will be other therapeutically equivalent medications that are covered. If a drug you are currently taking is excluded, you should talk with your Physician about prescribing an alternate drug that is covered under the formulary.

Absent advanced approval from Express Scripts, if you receive a drug that is excluded from the formulary, you will be required to pay the full cost of the drug without any reimbursement under the Plan. If your Physician believes that an excluded drug is (1) medically necessary and essential for your health and safety and/or (2) all formulary prescription drugs comparable to the excluded drug have been tried, the Physician should take the necessary steps to initiate a formulary exception review with Express Scripts. For additional information on the formulary exception process, contact Express Scripts.

To confirm that a drug you are currently taking is covered under the new formulary, you can contact Express Scripts at 877-804-5415 or visit **www.express-cripts.com/NATPLSNATPREF14**, or log into your member portal or app.

Important reminder - certain prescription drugs, even if covered on the Express Scripts formulary, will require prior authorization in advance of receiving the drug, and/or may be subject to drug quantity management. Other formulary-covered drugs may not be covered under the Plan unless an established protocol is followed first; this is known as step therapy.

Prescription Drug Utilization and Clinical Programs

Prescription drug coverage is subject to utilization and clinical management programs administered through Express Scripts. These programs include, but are not limited to, prior authorization, drug quantity management and step therapy. These programs are described below.

- **Prior Authorization**
  Prior authorization is a program that requires authorization from your physician before your prescription is filled. Generally, specialty prescription drugs, as well as certain brand name prescription drugs are subject to prior authorization.

  Examples of prescription drugs that require prior authorization include, but are not limited to Enbrel, Humira, Eliquis, Fentanyl, Stelara, Entresto, Growth Hormones, Harvoni, Restasis, weight loss drugs, certain oncology drugs, topical or injectable testosterone.

  If your prescription drug requires prior authorization, your physician must contact Express Scripts to obtain the required authorization. Express Scripts' prior authorization phone lines are available 24 hours a day, seven days a week, and a determination can generally be made quickly.

  If prior authorization is obtained, you will pay your normal coinsurance or copay. If prior authorization is not obtained and you still have the prescription filled, you must pay the full price for that drug.

- **Drug Quantity Management**

  Drug quantity management is a program designed to ensure that you receive the right amount of medication and that it is prescribed in the most affordable and least wasteful way.

  The drug quantity management program also ensures that your prescriptions don't exceed the amount of medication covered under the Plan.

  Examples of the types of prescription drugs that may require drug quantity management include, but are not limited to migraine medications, sleep disorder medications, asthma medications and anti-fungal medications. The prescription drugs that are subject to the drug quantity management requirement can change from time to time.

  Any prescription drug that exceeds the quantity limit under the Plan will not be covered by the Plan. However, you have the option to pay the full price for any prescription drug not covered by the Plan.

- **Step Therapy**

  Step therapy is a program that generally requires you to try "first-line" prescription drugs before trying more expensive "second-line" prescription drugs.

  First-line prescription drugs are generic and lower-cost brand-name medicines approved by the U.S. Food & Drug Administration (FDA). They are proven to be safe, effective and affordable. First-line prescription drugs should be tried first because, in most cases, they provide the same health benefit as more expensive drugs, but at a lower cost.

  Second-line prescription drugs typically are brand-name drugs and are the most expensive options. They are best suited for patients who don't respond to first-line prescription drugs.

  Examples of the types or classes of prescription drugs that require step therapy include, but are not limited to: inhaled corticosteroids, nonsteroidal anti-inflammatory drugs (NSAIDs), proton pump inhibitors (PPIs), attention-deficit hyperactivity disorder (ADHD) drugs, long-acting opioids, topical antifungals, and oral tetracyclines, topical acne/rosacea drugs, overactive bladder drugs, SSRIs and other antidepressants. The prescription drugs subject to the step therapy requirement can change from time to time.

  If your prescription drug requires step therapy (i.e., your prescription drug is a second-line prescription drug and you have not tried a first-line prescription drug), you or your pharmacist should contact your physician to obtain a new prescription for a first-line prescription drug.

  If you obtain a new prescription for a first-line prescription drug, you will pay your normal copay. If you have a prescription filled for a second-line prescription drug, without having considered a first-line medicine to treat your condition, you will pay full price for that second-line prescription drug.

While prior authorization, drug quantity limits, and step therapy are not new requirements, the medications subject to these programs may change in 2021. To determine whether a prescription drug is subject to any utilization or clinical programs, you can contact Express Scripts at 877-804-5415, or your pharmacist should advise you when a prescription is requested to be filled.

Mandatory Generic Pricing
Prescriptions will be filled with a generic drug unless a generic drug is not available. If you choose to have a brand name drug over an available generic drug, you will pay the copay for the generic drug plus the difference in cost between the brand and the generic drug.

Compound Drug Management
Certain compound medications are excluded from coverage under Express Scripts. To determine whether a compound medication is covered or excluded from coverage, Express Scripts' program evaluates every ingredient within a compound prescription, cross matching it to an exclusion and inclusion list.

A product is placed on Express Scripts' Compound Management exclusion list if it meets one or more of the following criteria:
1. It represents a significant cost or is within the top 200 most expensive compound ingredients.
2. There are commercially alternative medications available.
3. It is available as an over-the-counter (OTC) product.
4. It lacks clinical evidence within compounds.
5. It has a history of significant or continuous price increases.

JANUARY 1, 2022 SCHEDULE OF MEDICAL BENEFITS CHART

	CIGNA Open Access Plus Value		CIGNA Open Access Plus Preferred	
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductibles				
Individual	$6,000	$12,000	$800	$1,600
Family	$18,000	$36,000	$2,400	$4,800
Coinsurance Levels (unless copayment is applicable)	You pay 30%[1]	You pay 50%[1]	You pay 30%[1]	You pay 50%[1]
Annual Out-of-Pocket Maximums				
Individual	$12,000[2]	$24,000[2]	$8,700[5]	$26,100[5]
Family	$36,000[2]	$72,000[2]	$17,400[5]	$52,200[5]
Pre-Existing Condition Limitation	None	None	None	None
Inpatient Precertification, Continued Stay Review & Prior Authorization for Outpatient Procedures[4]	Coordinated by your in-network provider	If not obtained, $500 penalty and/or 50% reduction in benefits	Coordinated by your in-network provider	If not obtained, $500 penalty and/or 50% reduction in benefits
Benefit Maximums				
Lifetime	Unlimited	Unlimited	Unlimited	Unlimited
Chiropractic	7 visits/calendar year[6]	7 visits/calendar year[6]	7 visits/calendar year[6]	7 visits/calendar year[6]
Home Health Care	40 days/calendar year[9]	40 days/calendar year[9]	40 days/calendar year[9]	40 days/calendar year[9]
Skilled Nursing Facility	60 days/calendar year[6]	60 days/calendar year[6]	60 days/calendar year[6]	60 days/calendar year[6]
Rehabilitation Therapy (Physical, Speech, or Occupational)	60 days/calendar year[6] (limit does not apply for the treatment of a mental health condition)	60 days/calendar year[6] (limit does not apply for the treatment of a mental health condition)	60 days/calendar year[6] (limit does not apply for the treatment of a mental health condition)	60 days/calendar year[6] (limit does not apply for the treatment of a mental health condition)
Outpatient Services (other than Family Planning and Mental Health/ Substance Abuse Treatment)				
Office Visits	$35 copay/visit	You pay 50%[3]	$35 PCP copay and $50 specialist copay/visit	You pay 50%[3]
Urgent Care Facility	$50 copay/visit	$50 copay/visit	$50 copay/visit	$50 copay/visit
Physical Exams (Wellness)	Plan pays 100%, deductible waived	Not Covered	Plan pays 100%, deductible waived	Not Covered
Well Child Care	Plan pays 100%, deductible waived	Not Covered	Plan pays 100%, deductible waived	Not Covered
Well Child Immunizations	Plan pays 100%, deductible waived	Not Covered	Plan pays 100%, deductible waived	Not Covered
Preventive Mammograms, PSA, Pap Smear[7]	Plan pays 100%, deductible waived	You pay 50%[3]	Plan pays 100%, deductible	You pay 50%[3]
Durable Medical Equipment	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]

	CIGNA Open Access Plus Value		CIGNA Open Access Plus Preferred	
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Home Health Care[9]	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Colon Cancer Screening-Colonoscopy[8]	Plan pays 100%, deductible waived	You pay 50%[3]	Plan pays 100%, deductible waived	You pay 50%[3]
Surgical Facility[4]	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Lab and X-ray Services	You pay 30%[3] at independent labs and outpatient facilities; included in $35 copay if performed in doctor's office	You pay 50%[3]	You pay 30% at independent labs and outpatient facilities; included in $35 PCP copay or $50 specialist copay if performed in doctor's office	You pay 50%[3]
Dialysis Treatment				
Physician's Services/Office Visit	$35 copay/visit	You pay 50%[3]	$35 PCP copay and $50 specialist copay/visit	Not covered
Home Dialysis	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	Not covered
Outpatient Facility Services	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	Not covered
Outpatient Professional Services	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	Not covered
Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)				
Physician's Office	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Outpatient Facility	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Inpatient Services[4]				
Hospitalization	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Surgeon's Fees	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Lab and X-ray	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Emergency Room Care	You pay 30%[3]	You pay 30%[3]	You pay 30%[3]	You pay 30%[3]
Other Health Care Facilities: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities[10]	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Hospice				
Inpatient Services	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Outpatient Services	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Family Planning				
Prenatal Office Visits	$35 copay for initial visit; you pay 30%[3] for subsequent visits	You pay 50%[3]	$35 PCP copay and $50 specialist copay for initial visit; you pay 30%[3] for subsequent visits[11,12]	You pay 50%[3]
Delivery	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Vasectomy	$35 copay in physician's office; otherwise you pay 30%[3]	You pay 50%[3]	$35 PCP copay and $50 specialist copay in physician's office; otherwise you pay 30%[3]	You pay 50%[3]

	CIGNA Open Access Plus Value		CIGNA Open Access Plus Preferred	
PLAN FEATURE	**IN-NETWORK**	**OUT-OF-NETWORK**	**IN-NETWORK**	**OUT-OF-NETWORK**
Tubal Ligation[4]	Surgery in the office covered at 70% after the deductible[3]	You pay 50%[3]	Plan pays 100%,[3]deductible waived	You pay 50%[3]
Infertility Office Visits	$35 copay	You pay 50%[3]	$35 PCP copay and $50 specialist copay/visit	You pay 50%[3]
Mental Health/ Substance Abuse Treatment (combined with medical plan)				
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Treatment	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Outpatient Treatment – Physician's Office	$35 copay	You pay 50%[3]	$50 copay	You pay 50%[3]
Outpatient Treatment – Outpatient Facility	You pay 30%[3]	You pay 50%[3]	You pay 30%[3]	You pay 50%[3]
Prescription Drugs Provided through Express Scripts, Inc.				
Retail Network (up to 30-day supply, including first fill on a Specialty Medication)				
Generic	$30 copay	Not Covered	$20 copay	Not Covered
Preferred Brand	$50 copay	Not Covered	$60 copay	Not Covered
Non-Preferred Brand	$75 copay	Not Covered	$80 copay	Not Covered
Mail Order or Retail Network 90 Day (up to 90-day supply for Maintenance Medications Only)				
Generic	$45 copay	Not Covered	$33 copay	Not Covered
Brand, Preferred and Non-Preferred	$80/90 copay	Not Covered	$120/160 copay	Not Covered
Exclusive Specialty Pharmacy (up to 30-day Supply) May receive up to one prescription through retail network pharmacy, thereafter all refills must be obtained through Accredo				
Generic	$30 copay	Not Covered	$20 copay	Not Covered
Brand, Preferred and Non-Preferred	$50 copay $75 copay	Not Covered Not Covered	$60 copay $80 copay[13]	Not Covered Not Covered
Does Plan provide ACA mandated drug coverage?	No, Value Plan does not cover ACA mandated preventive care and contraceptive drug coverage at $0-member copay		Yes, Preferred Plan covers ACA mandated preventive care and contraceptive drug coverage at $0-member copay	

[1] Once you reach the annual out-of-pocket maximum, the Plan pays eligible expenses at 100% coinsurance for the remainder of the calendar year.
[2] Excludes deductibles, copayments, penalties and other charges not covered.
[3] After you meet the annual deductible: Reasonable & Customary charges apply.
[4] You are responsible for obtaining precertification, continued stay review for any out-of-network inpatient admissions and prior authorization for certain out-of-network outpatient procedures and diagnostic testing. To determine if an outpatient procedure is subject to prior authorization contact Cigna. Call within 24 hours of emergency admission.
[5] Includes medical deductibles, copayments, and coinsurance.
[6] In and out-of-network combined.
[7] If billed by an independent diagnostic facility or outpatient hospital, all other non-preventive Mammograms, PSA's & Pap Smears will pay under the X-ray/Lab benefit.
[8] Subject to age and frequency guidelines. Benefits may be subject to PCP or Specialist copay.
[9] Includes outpatient private duty nursing when approved as medically necessary.
[10] 60 days combined maximum per calendar year
[11] Primary Care Physicians include General Practice, Family Practice, Internal Medicine, and Pediatricians. Specialists are all other practitioners, including OB-GYN's.
[12] Certain prenatal care is covered at 100% without deductible as required under the Patient Protection and Affordable Care Act
[13] If you in the SaveOnSP program, certain specialty pharmacy drugs may be considered non-essential health benefits and may fall outside of the deductible and out-of-pocket limits. In that case, manufacturer assistance may not be applied towards your deductible and out-of-pocket maximums. For information on whether your drug is covered under the SaveOnSP program, please contact SaveOnSP at 1-800-683-1074.

Employee Assistance Program (EAP) (MHN)

The EAP is available to all Greyhound/ATU employees, both full-time and part-time, and their eligible dependent(s), whether or not you are enrolled in the Medical Plan. The EAP provides up to eight sessions (office visits, telephonic consultations, or web-video consultations) per individual per incident, per calendar year free of charge. You are automatically enrolled in the EAP.

In order to access your EAP services (outlined below), simply call MHN at 1-888-779-2235, 24 hours a day, 7 days a week. You can also access assessments, self-help programs, tools and articles to balance your health, work and life by visiting members.mhn.com and using your access code "greyhound". This is a confidential service available to all active full and part time employees and their eligible dependents at no cost.

Clinical Counseling

- Marriage, family and relationship issues
- Alcohol and drug dependency
- Other emotional health issues
- Grief and loss
- Depression

Work & Life Services

- Financial services
- Legal services
- Identity theft recovery services
- Childcare and eldercare assistance
- Daily living services

Any additional mental health/substance abuse treatment (beyond the eight free EAP visits) may be covered under your Medical Plan. If you are not enrolled in one of the Medical Plans offered through Greyhound/ATU, you will be responsible for paying the cost of any such additional mental health/substance abuse or counseling services.

Dental Program (Delta Dental)

Delta Dental offers a choice of selecting a Dentist from their network of DPO Dentists and Premier Dentists, or you may choose a Non-Delta Dental Dentist. A list of Delta Dental Dentists can be obtained by accessing the Delta Dental National Dentist Directory at www.deltadentalins.com or 1-800-521-2651. You are responsible for verifying whether the Dentist you select is a DPO Dentist or a Premier Dentist. Dentists are regularly added to the network. Additionally, you should always confirm with the dentist's office that a listed Dentist is still a contracted DPO Dentist or a Premier Dentist.

You are free to choose any dentist for treatment. Delta Dental Contracting Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge. If you go to a Non-Delta Dental Dentist, you will have to complete your own claim forms and in addition to the portion you pay, you will also be responsible for any charges in excess of the maximum plan allowance. See the Chart on the next page.

Note on additional benefits during pregnancy **-** When an Enrollee is pregnant, Delta Dental will pay for additional services to help improve the oral health of the Enrollee during the pregnancy. The additional services each Calendar Year while the Enrollee is covered under this dental program include: one (1) additional oral exam and either one (1) additional routine cleaning or one (1) additional periodontal scaling and root planning per quadrant. Written confirmation of the pregnancy must be provided by the Enrollee or her dentist when the claim is submitted.

Dental

PLAN FEATURES	PLAN COVERAGE
Annual Deductible	$100/ person $300/ family
Diagnostic and Preventive Services (does not count towards the Annual Maximum Benefit), including:	
Two oral exams/year	90%
Two cleanings/year	90%
Most x-rays	90%
Basic Services, including:	
Fillings	80% after annual deductible
Sealants on permanent posterior molars (under the age of 15, once every 36 months)	80% after annual deductible
Major Services, including:	
Endodontics	50% after annual deductible
Oral surgery	50% after annual deductible
Periodontic treatment	50% after annual deductible
Crowns	50% after annual deductible
Bridgework	50% after annual deductible
Dentures	50% after annual deductible
Orthodontia (for children up to age 26 only)	50% up to a $500 lifetime maximum
Annual Maximum Benefit (excludes orthodontia)	$1,500 per person

Vision Program (VSP)

Under the Vision Plan, you may use a VSP doctor, a non-VSP provider, or both (refer to the SPD for differences in benefit levels).

In addition, coverage is available through certain network retail providers such as Costco. Coverage through a network retail provider may be different than coverage available through a VSP doctor. Generally, you will receive the highest benefits if you utilize a VSP doctor. Once your benefit is effective, you can call VSP at 1-800-877-7195 (TDD for the hearing impaired: 1-800-428-4833) or visit the VSP web site at www.vsp.com for information on doctors and network retail providers in your area.

VSP will pay a doctor and a network retail provider directly for covered services and eyewear. You are responsible for paying the doctor any applicable co-pay(s) and any additional costs resulting from cosmetic options, or non-covered services and eyewear you have selected. If you use a non-VSP provider, you are responsible for submitting a claim to VSP to request reimbursement after paying the non-VSP provider directly. See the Chart on the next page.

Extra Discounts and Savings for VSP Doctors (Not Available through all Network Retail Providers, except as noted):

Glasses and Prescription Sunglasses

- Average 20-25% discount on all non-covered lens options.
- 20% off additional glasses and prescription sunglasses, including lens options, from the same VSP doctor within 12 months of your last Well Vision Exam.
- Available at Network Retail Providers, except Costco.

Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price. Discounts only available from contracted facilities.
- 20% off additional complete pairs of glasses and non-prescription sunglasses from any VSP doctor within 12 months of your last Well Vision Exam.

Vision

PLAN FEATURE	VSP DOCTOR	NON-VSP PROVIDER
Exam (Every Calendar year)	Covered in full, you pay $25 exam co-pay	VSP will reimburse up to a $45 maximum, copays may apply
Lenses (One pair Every Calendar year) – You pay $25 materials co-pay that applies to lenses and a frame.		
Single vision	Covered in full	Reimbursed up to $30
Lined bifocal	Covered in full	Reimbursed up to $50
Lined trifocal	Covered in full	Reimbursed up to $65
Standard Progressive	Covered in full	Reimbursed up to $50
Photochromic	Covered in full	Not covered
Tints	Covered in full	Reimbursed up to $5
Polycarbonate lenses (for dependent children)	Covered in full	Not covered
Lenticular	Covered in full	Reimbursed up to $100
Frame – See **Lenses** above for co-pay information (Every other calendar year)	Plan pays up to 100% on most frames, up to $150 retail allowance. Plus 20% off any out-of-pocket costs ** $80 allowance at Costco or Walmart, with no additional discount offered and $150 at all other network retail providers, plus additional 20% off any out-of-pocket costs.*	Plan pays up to $70, you pay the rest
Contact Lens Contact Exam (Every calendar year instead of glasses)	**Elective** Plan pays up to $120 for the materials. 15% discount off the exam and will not exceed a maximum of $60. **Medically Necessary** Contact lens and exam are covered in full once the $25 material copay is met. **Contact lens exam is not covered at Network Retail Providers.*	Plan pays up to $105 for the contact lens materials and exam, you pay the rest Plan pays up to $210, you pay the rest

Low Vision

Professional services for severe visual problems not corrected with regular lenses, including:

Supplemental Testing (Includes evaluation, diagnosis and prescription of vision aids where indicated)	Up to $1,000	Up to $1,000
Supplemental Aids	75% of cost	75% of cost

Maximum allowable for all Low Vision benefits of $1000.00 every two (2) years.

Lenses and Frame
As stated in the **PLAN FEATURES** section, if you buy your frame from a VSP doctor, the Plan covers a wide selection of frames to choose from, but not all frames will be covered in full. Please consult your VSP doctor about the frame and lens options that may be cosmetic in nature and may result in additional costs to you.

Contacts
Contacts may be provided instead of glasses. Patients choosing contacts lose their eligibility for a frame and lenses.

If you prefer contacts over glasses to correct your vision, the Plan pays a maximum benefit of $120 if you use a VSP doctor and up to $105 if you use a non-VSP provider. You pay any excess over the maximum amount. Disposable contacts are included; just ask your doctor to bill you "up front" for a one-year supply. You will also receive a 15% discount off the cost of your contact lens exam (fitting & evaluation) when you receive contact lens services from a VSP network doctor. Any additional costs exceeding the allowance are your responsibility.

Diabetic Eyecare Program
VSP's Diabetic Eyecare Program provides coverage of additional eyecare services specifically for members with type 1 and type 2 diabetes, glaucoma, or age-related macular degeneration (AMD) including: medical follow-up exams, specialized screening and tests, and medically necessary retinal imaging. Coverage is only available through a VSP doctor.

The program also provides coverage for non-surgical medical eye conditions associated with diabetes such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis), and diabetic macular edema.

Members never need a referral and only pay a $20 co-pay for services.

Flexible Spending Account (FSA)

The FSA offers you a very special tax savings opportunity, the ability to pay for certain out-of-pocket health care expenses with before-tax dollars. By spending before-tax dollars, you reduce your current taxable income by the amount you contribute and pay less federal income and Social Security taxes for the year. You may contribute from $50 up to $2,750 per year to your account. IRS regulations now allow you to carryover up to $550 from one plan year to the next. Any unused amount, under $50 and over $550, left in your account at the end of the year will be forfeited and used to offset administrative expenses. Your carryover balance will terminate if it goes unused or has no activity for one year.

Examples of eligible expenses
- Medical deductibles and/or co-payments, including chiropractic services
- Dental deductibles and/or co-payments, including orthodontia
- Vision expenses and/or co-payments
- Any other health care expense that is recognized by the IRS as a legitimate federal tax deduction. For a complete list, please visit www.cigna.com/expenses.

You can now enjoy the convenience of using the debit card to cover eligible expenses.
Over-the-counter drugs are generally no longer eligible for reimbursement unless you have a written prescription from a doctor. You do not need a prescription for insulin or non-drug over-the-counter (OTC) items.

Life Insurance, Accidental Death & Dismemberment (AD&D) and Dependent Life Insurance (The Hartford)

Greyhound/ATU provides $10,000 coverage for each eligible employee, paid for by Greyhound. In addition, you may elect additional life insurance in $10,000 increments from $10,000 to $120,000 to provide total coverage up to $130,000. If you have selected supplemental life insurance, then an equal amount of accidental death and dismemberment (AD&D) insurance will be included (For example, if you've selected supplemental life insurance of $120,000, then you will also have AD&D coverage of $120,000). AD&D is designed to help protect you and your family in the event that you have a serious covered accidental injury or death. If you only have the basic $10,000 life insurance, then you may select either $10,000 or $20,000 of AD&D coverage.

Your cost for supplemental life coverage will be determined by your age bracket and coverage level. See The Hartford rate sheet for details.

Dependent Life Insurance of $5,000 or $10,000 can also be elected for eligible children. Spouses are eligible for $10,000 or $20,000 of coverage. The dependent child's coverage cannot exceed 50% of the employee's coverage and the spouse's coverage may not exceed the employee's coverage.

Please note that there is a reduction in benefit for employees (basic $10,000, supplemental life and AD&D amounts) and their spouses age 65 and older. At age 65, coverage is reduced to 65% of the elected amount. At age 70, coverage is reduced by another 15% to 50% of the elected amount.

You can enroll via the online benefits system for these coverages if you are selecting coverage for the first time and designate a beneficiary.

Evidence of Insurability (EOI)

If you or your eligible dependents enroll at any other time then when you are first eligible, or you choose to increase the life insurance amount, any time after the initial enrollment with The Hartford, you must provide evidence of good health.

"Evidence of Insurability" (EOI) is proof that you or your dependent is in good health. It is usually obtained through a health questionnaire and/or physical exam. If The Hartford, the Greyhound/ATU life insurance carrier, does not approve proof of good health, coverage will be denied for the requested additional amount.

When evidence of good health is required and approved, coverage and deductions begin the first day of the month following the date the evidence of good health is approved or on the eligibility effective date if during annual enrollment. If the approval date is the first of the month, coverage begins on the date approved.

Short Term Disability (The Hartford)

Short Term Disability (STD) pays benefits for a specific period of time for a covered illness or injury. Maximum weekly benefits are $100, $200, $300, and $400 depending on your hourly rate. The benefits are payable up to a maximum of 52 weeks (with a 14-day waiting period).

Benefit Offset Rule: Before Short Term Disability (STD) insurance benefits are payable, you must use up other sources of disability income, including salary continuation or accumulated sick leave, but excluding any Statutory Benefits.

Minimum Benefit: If you are determined to be disabled and your weekly STD benefit is entirely offset by other sources of disability income, such as accumulated sick leave, you will be eligible to receive a minimum weekly benefit.

If you are enrolled in the $100 or $200 weekly STD benefit, you will receive a minimum benefit of $25 per week. If you are enrolled in the $300 or $400 weekly STD benefit, you will receive a minimum benefit of $50 per week.

Evidence of Insurability Rules: If this is the first time you are eligible to elect STD insurance, Evidence of Insurability is not required. If you did not elect coverage the first time it was offered to you or you want to increase the amount of STD insurance you are currently enrolled in, Evidence of Insurability (or proof of your medical history) is required. The Hartford reviews the Evidence of Insurability to determine if you are accepted for insurance before your coverage can begin.

Pre-Existing Condition Exclusion: For employees who enroll in new or additional coverage, the STD insurance will not pay for a disability related to a sickness or injury that began up to 6 months prior to your effective date of coverage. The pre-existing condition limit will end after you have been covered under the STD insurance for 6 months without needing treatment for the condition or, if later, after you have been covered under the policy for 12 consecutive months.

Short Term Disability Benefit Levels

Hourly Wage Rate:	**In All States Excluding CA, NJ, NY, or RI**
Less than $16 per hour	$100 or $200 per week maximum benefit
$16 per hour but less than $22 per hour	$100, $200 or $300 per week maximum benefit
$22 per hour or more	$100, $200, $300 or $400 per week maximum benefit
Hourly Wage Rate:	**In NY**
Less than $16 per hour	$100 or $200 per week maximum benefit
$16 per hour but less than $22 per hour	$100, $200 or $300 per week maximum benefit
$22 per hour or more	$100, $200, $300 or $400 per week maximum benefit
Hourly Wage Rate:	**In CA, NJ, RI**
Less than $22 per hour	$100 per week maximum benefit
$22 per hour or more	$100 or $200 per week maximum benefit

Critical Illness Insurance (The Hartford)

The critical illness insurance can assist you financially if you or a covered dependent are ever diagnosed with a covered critical illness while insured under the policy (subject to plan terms and conditions, including limitations and exclusions). The benefits are paid in lump sum amounts and can serve as a source of cash to use as you wish, whether to help pay for health care expenses not covered by your major medical insurance, help replace income lost while working, or however you choose.

You (as the employee) may enroll for $5,000 or $10,000 critical illness insurance. You may also enroll your eligible dependent(s) for the following amounts of coverage:

- Spouse: 50% of your elected coverage amount
- Child(ren): $5,000

A benefit reduction of 50% will apply to the coverage amount for you and your dependent(s) when you reach the age 70.

Getting coverage is easy and affordable with:

- Guaranteed issue; no health questions asked (subject to plan terms and conditions, including pre-existing condition limitations)
- Easy payroll deduction of premiums
- Benefits are payable to the estate in the event of a death
- Coverage portability. The coverage amount that you (the primary insured) can request under the group critical illness portability policy must be equal to or less than the coverage amount that was in effect for you under the prior group plan(s), but in no event more than $50,000. Your coverage amount cannot be less than $5,000 and must be an increment of $5,000. Your coverage amount reduces by 50% when you reach age 70. (If you don't know your coverage amount under the prior group plan(s), contact The Hartford toll-free at 1-866-547-4205 for assistance.)
- The coverage amount for your insured spouse (if applicable) under the portability policy is 50% of your coverage amount. (When your coverage amount reduces at age 70, your spouse amount also reduces.) The coverage amount for any insured dependent child(ren) is $5,000. Dependent coverage is only available if a coverage tier including dependent(s) is elected under the portability policy.
-

Please refer to the Hartford Critical Illness Insurance Benefits Highlights for additional information on this coverage.

The critical illness policy provides limited benefits for specified diseases only. This limited health benefit plan (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

Accident Insurance (The Hartford)

Accident insurance pays a cash benefit if you or an insured dependent (spouse or child) are unexpectedly injured in a covered accident that occurs while the insured person is not working. The benefits are paid in lump sum amounts to you (or your beneficiary) and can be used to pay for health care expenses not covered by your major medical insurance, help maintain your standard of living while out of work, or however you choose. Accident insurance through The Hartford's group accident portability policy is available in certain circumstances when insurance under a group accident insurance plan offered by an employer (or other group) ends.

Under The Hartford's group accident portability policy, you have a choice of three accident plans each with varying levels of benefits. This choice allows you the flexibility to enroll for the coverage that best meets your current financial protection needs. Unless otherwise noted, the benefit amounts payable under each plan are the same for you and your insured dependent(s).

Accident insurance provides benefits for covered accidental injuries, related services and treatments.
Examples include:

- $100 diagnostic exam benefit
- $75 x-ray benefit
- $150 ambulance benefit - ground transportation
- Initial and follow-up physician visits
- Hospital admission and confinement
- Follow-up/recovery services, including physical therapy and chiropractic care
- Emergency services and more...

Getting coverage is easy and affordable with:

- Guaranteed issue; no health questions asked
- Easy payroll deduction of premiums (that will never increase due to your age)
- Benefits available for your spouse and dependent child(ren)
- Direct payment to you or to your beneficiary
- Coverage portability. If you change jobs, you can take the same benefits with you at the same cost.

Please refer to the Hartford Accident Insurance Benefit Highlights for additional information on this coverage.

This accident policy provides a limited health benefit that (1) does not constitute major medical coverage, and (2) does not satisfy the individual mandate of the Affordable Care Act (ACA) because the coverage does not meet the requirements of minimum essential coverage.

Privacy Notice

Section 1: Purpose of This Notice and Effective Date

This Notice Describes:

1. How medical information about you may be used and disclosed; and

2. How you may obtain access to this information.

Please review this information carefully.

Effective date. The effective date of this Notice is October 1, 2017

This Notice is required by law. The Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust (the "Plan") is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

1. The Plan's uses and disclosures of Protected Health Information (PHI),

2. Your rights to privacy with respect to your PHI,

3. The Plan's duties with respect to your PHI,

4. Your right to file a complaint with the Plan and with the Secretary of the U.S. Department of Health and Human Services, and

5. The person or office you should contact for further information about the Plan's privacy practices.

Section 2: Your Protected Health Information

Protected Health Information (PHI) Defined

The term "Protected Health Information" (PHI) includes all information related to your past or present health condition that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.

PHI refers to your health information held by the Plan.

When the Plan May Disclose Your PHI

The Plan Sponsor has amended its Plan Documents to protect your PHI as required by federal law. Under the law, the Plan may disclose your PHI without your consent in the following cases:

- ***At your request.*** If you request it, the Plan is required to give you access to certain PHI in order to inspect it and copy it.
- ***As required by an agency of the government.*** The Secretary of the Department of Health and Human Services may require the disclosure of your PHI to investigate or determine the Plan's compliance with the privacy regulations.

- ***For treatment, payment or health care operations.*** The Plan and its business associates will use PHI without your consent, authorization or opportunity to agree or object in order to carry out:
  - Treatment,
  - Payment, or
  - Health care operations.

The Plan does not need your consent to release your PHI when:

- you request it,
- a government agency requires it, or
- the Plan uses it for treatment, payment or health care operations.

Definitions of Treatment, Payment or Operations	
Treatment is health care.	Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. ***For example:*** The Plan discloses to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.
Payment is paying claims for health care and related activities.	Payment includes but is not limited to making coverage determinations and payment. These actions include billing, claims management, subrogation, Plan reimbursement, reviews for medical necessity and appropriateness of care, utilization review and preauthorization. ***For example:*** The Plan tells your doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.
Health Care Operations keep the Plan operating soundly.	Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. ***For example:*** The Plan uses information about your medical claims to refer you to a disease management program, to project future benefit costs or to audit the accuracy of its claims processing functions.

When the Disclosure of Your PHI Requires Your Written Authorization

The Plan must generally obtain your written authorization before (each of these includes defined exceptions under which the Plan use or disclose your PHI for these purposes without your authorization):

- Using or disclosing psychotherapy notes about you from your psychotherapist.
- Using or disclosing your PHI for marketing purposes (a communication that encourages you to purchase or use a product or service) if the Plan receives direct or indirect financial remuneration (payment) from the entity whose product or service is being marketed.
- Receiving direct or indirect remuneration (payment or other benefit) in exchange for receipt of your PHI.

Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. They do not include summary information about your mental health treatment. The Plan is not likely to have access to or maintain these types of notes.

Use or Disclosure of Your PHI That Requires You Be Given an Opportunity to Agree or Disagree Before the Use or Release

Disclosure of your PHI to family members, other relatives and your close personal friends without your written consent or authorization is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Use or Disclosure of Your PHI For Which Consent, Authorization or Opportunity to Object Is Not Required

The Plan is allowed to use and disclose your PHI without your consent, authorization or request under the following circumstances:

1. ***When required by law.***

2. ***Public health purposes.*** When permitted for purposes of public health activities. This includes reporting product defects, permitting product recalls and conducting post-marketing surveillance. PHI may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized by law.

In general, the Plan does not need your consent to release your PHI if required by law or for public health and safety purposes.

3. ***Domestic violence or abuse situations.*** When authorized by law to report information about abuse, neglect or domestic violence to public authorities if a reasonable belief exists that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. ***Oversight activities.*** To a public health oversight agency for oversight activities authorized by law. These activities include civil, administrative or criminal investigations, inspections, licensure or disciplinary actions (for example, to investigate complaints against providers) and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).

5. ***Court proceedings.*** When required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request, provided certain conditions are met, including that:

    a. the requesting party must give the Plan satisfactory assurances a good faith attempt has been made to provide you with written notice, and

    b. the notice provided sufficient information about the proceeding to permit you to raise an objection, and

    c. no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. ***Law enforcement health purposes.*** When required for law enforcement purposes (for example, to report certain types of wounds).

7. ***Law enforcement emergency purposes.*** For law enforcement purposes if the law enforcement official represents that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and the Plan in its best judgment determines that disclosure is in the best interest of the individual. Law enforcement purposes include:

    a. identifying or locating a suspect, fugitive, material witness or missing person, and

    b. disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances.

8. ***Determining cause of death.*** When required to be given to a coroner or medical examiner to identify a deceased person, determine a cause of death or other authorized duties.

9. ***Funeral purposes.*** When required to be given to funeral directors to carry out their duties with respect to the decedent.

10. ***Research.*** For research, subject to certain conditions.

11. ***Health or safety threats.*** When, consistent with applicable law and standards of ethical conduct, the Plan in good faith believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

12. ***Workers compensation programs.*** When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Any other Plan uses and disclosures not described in Section 2 of this Notice will be made only if you provide the Plan with written authorization, subject to your right to revoke your authorization.

Section 3: Your Individual Privacy Rights

Breach Notification

If a breach of your unsecured PHI occurs, the Plan will notify you.

You May Request Restrictions on PHI Uses and Disclosures

You may request the Plan to:

1. Restrict the uses and disclosures of your PHI to carry out treatment, payment or health care operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

The Plan, however, is not required to agree to your request.

The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations.

You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Contact the Privacy Officer.

Protected Health Information (PHI): includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form of the PHI.

You May Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI (in hardcopy or electronic form) contained in a "designated record set," for as long as the Plan maintains the PHI. You may request your hardcopy or electronic information in a format that is convenient for you, and the Plan will honor that request to the extent possible. You also may request a summary of your PHI.

The Plan must provide the requested information within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline and if the Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. You may be charged a reasonable, cost-based fee for creating or copying the PHI, or preparing a summary of your PHI. Requests for access to PHI should be made to the Privacy Officer:

Designated Record Set: includes your medical records and billing records that are maintained by or for a covered health care provider. Records include enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan or other information used in whole or in part by or for the covered entity to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you is not included.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

You Have the Right to Amend Your PHI

You have the right to request that the Plan amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set.

The Plan has 60 days after receiving your request to act on it. The Plan is allowed a single 30-day extension if the Plan is unable to comply with the 60-day deadline. If the Plan denied your request in whole or part, the Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

You should make your request to amend PHI to the Privacy Officer.

You or your personal representative will be required to complete a form to request amendment of the PHI.

If you disagree with the record of your PHI, you may amend it.

If the Plan denies your request to amend your PHI, you still have the right to have your written statement disagreeing with that denial included in your PHI.

Forms are available for these purposes.

You Have the Right to Receive an Accounting of the Plan's PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years before the date of your request. However, such accounting need not include PHI disclosures made:

- To carry out treatment, payment or health care operations,
- To you about your own PHI, or
- Before the privacy rule compliance date.

The Plan has 60 days to provide the accounting. The Plan is allowed an additional 30 days if the Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

You Have the Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact the Privacy Officer.

This right applies even if you have agreed to receive the Notice electronically.

Your Personal Representative

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to your PHI or be allowed to take any action for you. Proof of such authority may take one of the following forms:

You may designate a personal representative by completing a form that is available from the Trust Office.

- A power of attorney for health care purposes, notarized by a notary public,
- A court order of appointment of the person as the conservator or guardian of the individual,
- An Appointment of Personal Representative form that is completed and signed by you, or

- The status of the personal representative as the parent of a minor child.

The Plan retains discretion to deny access to your PHI to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Section 4: The Plan's Duties

Maintaining Your Privacy

This notice is written to inform you of the Plan's obligation to maintain the privacy of your PHI.

The Plan is required by law to maintain the privacy of your PHI and to provide you and your eligible dependents with notice of its legal duties and privacy practices. In addition, the Plan may not (and does not) use your genetic information that is PHI for underwriting purposes. This notice is effective beginning on April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to you and to all past and present participants and beneficiaries for whom the Plan still maintains PHI.

If material changes are made to this Notice, it will be distributed with 60 days of the effective date of the material change.

Material changes are changes to:

- The uses or disclosures of PHI,
- Your individual rights,
- The duties of the Plan, or
- Other privacy practices stated in this notice

Disclosing Only the Minimum Necessary Protected Health Information

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

The Plan must limit its uses and disclosures of PHI or requests for PHI to the ***minimum necessary*** amount to accomplish its purposes.

However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment,
- Uses or disclosures made to you,
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services,
- Uses of disclosures required by law, and
- Uses of disclosures required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that:

- Does not identify you, and
- With respect to which there is no reasonable basis to believe that the information can be used to identify you.

Disclosures to the Plan Sponsor (Board of Trustees)

As described in the amended Plan document, the Plan may share PHI with the Plan Sponsor (Board of Trustees) for limited administrative purposes, such as determining claims and appeals, performing quality assurance functions and auditing and monitoring the Plan. The Plan shares the minimum information necessary to accomplish these purposes.

In addition, the Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health Plan. Summary information summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan. Identifying information will be deleted from summary health information, in accordance with HIPAA.

Section 5: Your Right to File a Complaint with the Plan or the HHS Secretary

If you believe that your privacy rights have been violated, you may file a complaint with the Plan in care of the Privacy Officer.

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services. Filing instructions are available at: http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

The Plan will not retaliate against you for filing a complaint.

You have the right to file a complaint if you feel your privacy rights have been violated.

The Plan may not retaliate against you for filing a complaint.

Section 6: If You Need More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the Privacy Officer at the Trust Office:

Name: Tyneeta Morris

Address: 350 N. St Paul Street, Dallas, TX 75201

Phone Number: 800-288-7766

Section 7: Conclusion

PHI use and disclosure by the Plan is regulated by the federal Health Insurance Portability and Accountability Act, known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This notice attempts to summarize the regulations. The regulations will supersede this notice if there is any discrepancy between the information in this notice and the regulations.

Important Notice from Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust 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:

1. 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.

2. Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust has determined that the prescription drug coverage offered by the Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare 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 to 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 Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust 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 Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust coverage, be aware that you and your dependents may not be able to get this coverage back.

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 Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust 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…

Contact the person listed below for further information or call the Trust office at 800-288-7766. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust 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: October 1, 2021
Name of Entity/Sender: Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust
Contact--Position/Office: Tyneeta Morris
Address: 350 N. St. Paul Street, Dallas, TX 75201
Phone Number: 800-288-7766

IMPORTANT TELEPHONE NUMBERS AND OTHER INFORMATION

ADMINISTRATORS	Phone Number	GROUP #	INTERNET ADDRESS
Greyhound/ATU Health & Welfare Trust	800-288-7766 Fax : 214-481-5082 Email : greyhound.gliatubenefits@greyhound.com		
CIGNA Open Access Plus	800-244-6224	2461738	www.mycigna.com
CIGNA 24 Hour Health Information Line	800-564-9286	2461738	www.mycigna.com
CIGNA (Medical Case Management)	800-244-6224	2461738	
Mental Health / Substance Abuse	800-244-6224	2461738	www.mycigna.com
Flexible Spending Account	800-244-6224	2461738	www.mycigna.com
CIGNA NY Disability & NY Paid Family	888-842-4462	NYD075550	www.mycigna.com
Express Scripts	877-804-5415	GREYATU	www.express-scripts.com
SaveOnSP Program	800-683-1074		
Vision Service Plan	800-877-7195	12173151-004	www.vsp.com
Delta Dental	800-521-2651	03850	www.deltadentalins.com
The Hartford	Life/AD&D: 888-563-1124 STD: 800-549-6514 Critical Illness & Accident: 1-866-547-4205 Fax: 1-469-417-1952	402756 460154 460155	www.thehartfordatwork.com Critical Illness/Accident Website THEHARTFORD.COM/BENEFITS/MYCLAIM
Employee Assistance Program (EAP)	888-779-2235		member.mhn.com company code: greyhound
Bus Pass	800-454-2638 Fax : 214-849-6201 Email : buspassusa@greyhound.com		
ATU 401K	800-440-1548		www.atu401k.com

GREYHOUND/ ATU
JANUARY 1, 2022 ACTIVE RATES

This rate sheet gives you the cost for each coverage level, with the exception of the Flexible Spending Account. Deductions are withheld on each paycheck prorated for the payroll frequency (weekly or bi-weekly).

		EMPLOYEE ONLY	EMPLOYEE + ONE	EMPLOYEE + FAMILY
Medical Plan (If you qualify for the Healthy Hound discount, otherwise there will be a $100 annual surcharge per Adult)				
Option A:	No Coverage	$0.00	$0.00	$0.00
Option B:	Open Access Plus Value Plan (weekly)	$36.99	$70.28	$103.57
Option B:	Open Access Plus Value Plan (bi-weekly)	$73.97	$140.56	$207.15
Option C:	Open Access Plus Preferred Plan (weekly)	$70.41	$140.82	$197.15
Option C:	Open Access Plus Preferred Plan (bi-weekly)	$140.82	$281.65	$394.30

	EMPLOYEE ONLY	EMPLOYEE + CHILDREN	EMPLOYEE + SPOUSE	EMPLOYEE + FAMILY
Dental Plan				
No Coverage	$0.00	$0.00	$0.00	$0.00
Coverage (weekly)	$4.22	$7.88	$7.88	$12.84
Coverage (bi-weekly)	$8.44	$15.76	$15.76	$25.68
Vision Plan				
No Coverage	$0.00	$0.00	$0.00	$0.00
Coverage (weekly)	$1.08	$1.89	$1.86	$3.10
Coverage (bi-weekly)	$2.16	$3.79	$3.71	$6.19
Employee Life Insurance				
Basic Coverage: $10,000	$0.00	(Trust-Provided)		
Employee Assistance Program	$0.00	(Trust-Provided)		

Note: the 2022 Healthy Hound premium surcharge of $100 per employee and $100 per spouse will not apply to employees earning less than $13.50/hour who are enrolled in the Value Plan.

See: The Hartford enrollment materials for the rates for:

- **Voluntary Life Insurance**
- **Accidental Death and Dismemberment**
- **Dependent Life Insurance**
- **Short Term Disability Insurance**

Accident Insurance/Critical Illness Insurance

AT YOU LOCAL 1700

HEALTHY HOUND

1-800-288-7766
greyhound.gliatubenefits@greyhound.com

350 N. St. Paul Street
Dallas, TX 75201