

Employee Benefits Guide

2027 Annual Open Enrollment:
October 26 to November 20, 2026



Welcome to Your 2027 Benefits

Greyhound Lines recognizes that employees are our number-one asset and a main driver of the Company's success. For that reason, the wellbeing of you and your family is one of our top priorities. Greyhound Lines and the Amalgamated Transit Union National Local 1700 are proud to join together to offer employees a benefits package that provides vital protection for all of your healthcare needs. This comprehensive suite of benefits is designed to support you and your family along every journey.

This Benefits Guide includes an overview of your healthcare benefits. The Guide will help you evaluate your 2027 benefits and make the choices that best meet your and your family's needs.

What's Inside

To help you understand your healthcare benefits, this Guide contains:

- Information about your healthcare plans and their costs
- Important reminders and notices
- A list of resources for when you have questions
- Instructions for completing your enrollment

If you can't find the information you need, you can reach out to the Health & Welfare Trust Office. Call **800-288-7766** or email greyhound.gliatubenefits.flixna@flixbus.com.

2027 Annual Benefits Enrollment

October 26 to November 20, 2026

Visit www.benefitsolver.com to review your current coverages, dependents and beneficiaries. If you wish to make changes, you must complete your elections by 11:59 p.m. ET on November 20, 2026. For more information, see page 6.

Please note: This Guide 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, this Guide does not cover all provisions, limitations and exclusions. In the event of any conflict or omission between this Guide 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.

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.

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What's New for 2027

This year's enrollment is active. **That means you must actively enroll online between October 26 and November 20, 2026 by 11:59 p.m. ET** to choose a medical plan, make a change to your benefits or elect the FSA for 2027. **If you choose not to enroll, you and your family will not have medical coverage for 2027.**

Please make note of these important changes to your Greyhound/ATU benefits for the coming year.

- **Medical Rate Increases**

Although health care costs continue to rise, we have worked hard to offer meaningful coverage for you and your family at affordable costs. Review your options and choose the plans that best meet your needs. See the rate sheet on page 43 for the amount of your 2027 per-paycheck premiums.

- **Medical and Prescription Drug Benefits Will Transition to Aetna**

Beginning January 1, 2027, Aetna will become the administrator for your medical and prescription drug benefits, replacing Cigna. As part of this transition, employees and covered family members will have access to new provider-search tools, member resources and customer support services.

- **New Lyra Health EAP**

Greyhound/ATU is introducing Lyra Health as the Employee Assistance Program (EAP) provider for 2027. Lyra Health offers confidential support and resources for employees and eligible family members.

- **Updates to Your Health Care FSA**

Flexible spending accounts (FSAs) will be administered through Inspira beginning January 1, 2027. If you contribute to the FSA, review the updated information about account access, reimbursement requests, debit card usage and account management.

Important Reminders About Annual Open Enrollment

- 1 This year, Open Enrollment runs from October 26 to November 20, 2026. For your elections to take effect, you must complete your enrollment online by 11:59 p.m. on November 20, 2026. See page 6 to start your enrollment.
- 2 If you wish to have medical coverage for yourself and your family in 2027, you must enroll during the Open Enrollment period. If you choose not to enroll, you will not have medical coverage in 2027.
- 3 If you take no action during Open Enrollment, your dental, vision, life insurance and accidental death & dismemberment (AD&D), dependent life (spouse and/or child), short-term disability (STD), accident, critical illness and EAP for dependents will remain the same in 2027.
- 4 If you want to contribute to a flexible spending account (FSA) in 2027, you must make an election during Open Enrollment.
- 5 Your Open Enrollment benefit elections will take effect on January 1, 2027. See page 36 for benefit effective dates for new hires, returning employees and status changes.



For 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 **800-288-7766** or greyhound.gliatubenefits.flixna@flixbus.com.

Enrollment Quick Start Guide

Follow these instructions to complete your online benefits enrollment. For more details about enrollment, including important eligibility information, see pages 36–42.

Completing Your Online Enrollment

Complete the online enrollment to enroll in the medical plan or make changes to 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 Log In

1. Visit www.benefitsolver.com and click the **Register** button to get started. The company key is **greyhoundatu** (case sensitive).
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 and Review Your Benefit 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.

As you explore, use the **Next** and **Back** buttons to review and select your available options. Then simply elect or decline each option and select which family members you wish to cover.



Start Your Enrollment

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

Verifying and Adding Dependents

You will need to provide each dependent's legal name, Social Security number and birth date to add a dependent to your coverage. You will be required to provide documentation to prove your relationship to each dependent.

If you are adding a new dependent, you must submit documentation – for example, marriage certificate, current tax return (spouse only) and/or birth certificates – to the Trust Office before coverage becomes effective. Court documents are required if you have legal custody for dependents.

Email your documents to:

greyhound.gliatubenefits.flixna@flibxbus.com

Please contact the Trust Office to be sure that it has received your documentation.

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.

Get help making your benefits election.

If you'd like help with your benefit choices, try the MyChoice Recommendation Engine on the Benefitsolver website. Answer a few simple questions to receive a personalized benefits recommendation. Your responses are completely confidential and are never shared.

When Your Benefits Begin

When you receive your first paycheck of 2027 or your first paycheck after a new enrollment takes effect (see page 36), it's important to review your payroll deductions for accuracy. If you notice any discrepancies, call the Health & Welfare Trust Office right away.

Medical and Prescription Drug

Your enrollment decision:

Aetna Choice
POS II Value Plan

Aetna Choice
POS II Preferred Plan

No coverage

Coverage

Eligible Greyhound/ATU employees have two options for medical coverage: **the Aetna Choice POS II Value Plan and the Aetna Choice POS II Preferred Plan**. While both plans offer similar coverage, they differ in the amount you pay when you need care and the premium contributions from your paycheck. **See the table on pages 16–19 for a comparison of how the plans pay for common expenses.**

Our medical plans are self-insured. That means the Greyhound ATU Health & Welfare Trust, funded by employer and employee contributions, covers the full expense for your medical claims. We contract with Aetna as our plan administrator to process claims and provide access to their network of providers. However, Aetna does not assume any financial risk or liability for the claims; the Trust does.

Why is this important? Self-insurance gives us more control over our health care costs and benefits. We can design our plans to meet the specific needs of our employees, rather than paying for a one-size-fits-all plan from an insurance company. This way, we can offer you high-quality coverage at affordable rates.

How YOU can help. As a self-insured employer, we depend on the collective health and wellness of our employees and their families. **The more claims we pay, the higher costs will be for all of us.** Therefore, we encourage you to use your medical benefits wisely and responsibly. Here are some ways you can help keep costs down for yourself and the Trust:

- **Choose in-network providers whenever possible.** They have agreed to charge lower rates for their services and to follow quality standards. You can find in-network providers on the [aetna.com](https://www.aetna.com) website or mobile app.
- **Use urgent care centers or telehealth services instead of emergency rooms for non-life-threatening conditions.** Emergency room visits are very expensive and should be reserved for serious or life-threatening situations.
- **Take advantage of preventive care services, such as annual physicals, screenings and immunizations.** They are covered at 100% in-network by both plans with no deductible and can help you stay healthy, detect potential problems early and avoid costly treatments later.
- **Participate in the Healthy Hound wellness program.** You'll not only improve your health and wellbeing, you'll also save on your medical premiums in the coming year. See pages 20–22 for more information.

Choosing Your Medical Plan

Which Plan Is Right for You?

You have the option to choose between two Point of Service (POS) medical plans: Value or Preferred. Here are some things to keep in mind as you make your choice.

1. Both plans cover the same medical services.
2. Both plans use the same Aetna network.
3. Both plans require you to pay a portion of the costs (coinsurance) after you have met your annual deductible.

How are the plans different?

The biggest difference in the plans is *when* you pay for coverage. Do you prefer to pay more in premiums from your paycheck in exchange for lower deductibles and coinsurance, or pay less in payroll deductions but potentially more when you seek care?

The choice is yours. For some employees, protection from unknown healthcare costs is worth a higher deduction from their paycheck. For others, for example those who don't use medical care often, they'd prefer to save on premium deductions.

It's important to do the math. Review the costs for the plans, and consider your and your family's medical needs in the coming year.



Medical Plan Highlights

The table below provides a quick look at what each plan pays for in-network medical services.

	Choice POS II Value	Choice POS II Preferred
Annual Deductible	\$6,000 individual \$12,000 family	\$800 individual \$1,600 family
Do I have to meet the deductible for preventive care services?	No	No
PCP Copayment	\$35 PCP office visit \$50 Specialist visit	\$35 PCP office visit \$50 Specialist visit
Coinsurance	Plan pays 60% You pay 40%	Plan pays 70% You pay 30%
What is the most I will pay in medical and prescription drug expenses each year? (Out-of-pocket maximum)	\$9,100 per individual \$18,200 per family	\$8,700 per individual \$17,400 per family
What is my annual premium deduction from my paycheck?	See page 43 for 2027 Premium Rates	

For a more complete comparison of how common expenses are covered, view the table on pages 16–19.

Looking for a Network Provider?

You'll save on expenses when you receive care from a network provider. Your participating provider network consists of local providers, facilities and pharmacies who are contracted by Aetna and who have agreed to charge lower fees when you receive care.

If you're looking for a primary care physician (PCP) or other in-network provider, visit the [aetna.com](https://www.aetna.com) website or mobile app, or call the toll-free number on your Aetna ID card or on page 62 of this Guide.

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 2026. 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 2027.

Terms to Know

Annual Deductible

The amount you pay before the Plan begins to pay its share for covered medical expenses. Some services (like preventive care and any copays for doctor visits or prescriptions) do not require you to meet a deductible. If you meet your deductible, you'll begin paying your share of coinsurance for covered medical expenses until you reach the out-of-pocket maximum for the year. At that point, the Plan pays 100% of your covered medical expenses.

Coinsurance

Once you meet your annual deductible, you and the Plan share in the cost of covered medical expenses. This is called "coinsurance." Coinsurance is considered an out-of-pocket cost, just like copays.

Out-of-Pocket Maximum

The out-of-pocket maximum is your protection against high medical expenses. It's a cap or limit on what you can spend in deductible expenses, copays and coinsurance each year. If you hit your out-of-pocket maximum, the Plan will pay your remaining covered medical/prescription expenses at 100% for the rest of the year.

Premium

A premium is the contribution you pay to have medical insurance. Your premiums are deducted from your pay on a per-paycheck basis. The amount of your premium depends on the plan you elect and whether you choose employee only, employee + 1, or family coverage. You pay your premium regardless of how often you use the Plan.



Additional Aetna Medical Plan Benefits

CVS Virtual Care for Virtual Visits (Telemedicine)

CVS Virtual Care currently provides virtual medical services on-demand 24/7/365 for urgent care at a copayment of \$55 per visit. CVS Virtual Care is your online resource for:

- Coughs, colds, flu and strep
- Joint, head, and stomach pain
- Infections (ear, sinus, skin, UTI)
- Medication refills

In addition, mental health services are available for adults and children (ages 13+) from 8 a.m to 7:30 p.m., 7 days a week. Costs vary by service:

- Counseling: \$85 (ages 13+)
- Psychiatry first visit: \$215 (ages 18+)
- Medication management: \$99 (ages 18+)

You can access CVS Virtual Care to get treatment for:

- Anxiety and mood disorders
- Depression screening
- Medication management
- Support with stress, life adjustments and conflict resolution
- Sleep and related health behaviors

To make an appointment, visit [CVS.com/virtual-care](https://www.cvs.com/virtual-care) or call **866-211-5678**.



24-Hour Nurse Line

When you enroll in medical coverage, you have access by phone to helpful health information, toll-free, 24/7/365. The Aetna 24-Hour Nurse Line connects you with specially trained registered nurses who can talk to you about tests, procedures and treatment options. They can also advise you on many health and wellness topics.

The Information Line is your confidential resource when you have a health question or concern. When you call, the nurse will ask you about your symptoms or situation and then direct you to the appropriate type of care, from self-care tips until you see the doctor to assistance with locating a participating provider if you need urgent care. Get answers and guidance with the 24-Hour Nurse Line by calling **800-556-1555 (TTY: 711)**.



Prescription Drug Coverage

When you elect medical coverage, you automatically receive prescription drug coverage administered by Aetna. If you elect no medical coverage, you are not covered for prescription drugs.

For short-term (non-maintenance) or emergency prescriptions, you should fill your prescription, up to a 30-day supply, at a participating retail pharmacy. For long-term (maintenance) prescriptions, you can save money by obtaining up to a 90-day supply by mail order or at a retail network pharmacy through the [maintenance pharmacy].

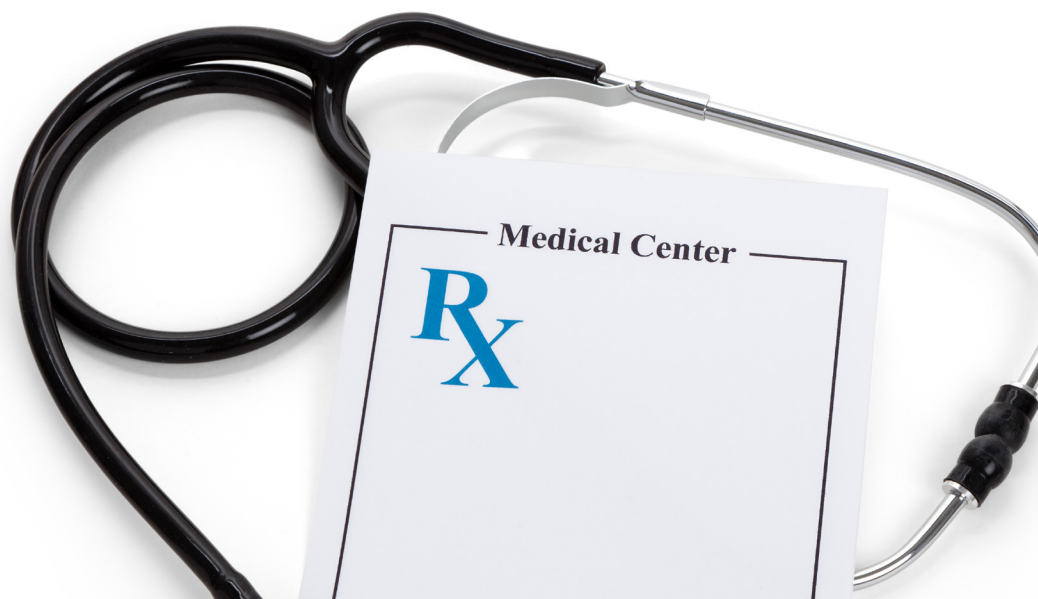
The amount you pay depends on the medical plan you choose and whether the drug is generic, preferred brand or non-preferred brand. See the table on page 19 for a complete comparison of your prescription drug costs.

Additional Aetna Rx Information

Refill Reminders. If you choose mail order home delivery, you can sign up for Aetna's refill reminder service. When you enroll, you'll receive a reminder by email or voice message before your prescription is due for a refill. Call the number on your ID card or on page 62 of this Guide to enroll.

Step Therapy. When there are several equally effective medication choices available, it makes sense to try the least expensive options first. For example, if your doctor prescribes a brand-name medication, Aetna may suggest a generic alternative. At your next refill, you would be required to use the Step 1 generic medication. If that is not effective, you would then try the Step 2 preferred brand medication. Step 3 would be a non-preferred brand medication if the other options were not successful. Your doctor can complete a prior authorization form at any time if you and your doctor believe you should continue with the brand-name drug and submit it to Aetna for authorization. The step-therapy program is designed to save you and the Plan money; this could save you at least \$20 per refill.

Mandatory Generic Pricing. Generally, prescriptions are 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.



PrudentRx Specialty Copay Program

Specialty medications are used to treat complex health conditions and often require special handling, administration or monitoring. Because these medications can be expensive, Greyhound/ATU is introducing the PrudentRx Specialty Copay Program as part of its prescription drug benefit.

The PrudentRx solution is designed to help eligible participants reduce out-of-pocket costs for specialty medications while supporting access to important therapies. For participating members, eligible specialty medications included on the program drug list may be available at a \$0 out-of-pocket cost, subject to program requirements and applicable plan rules.

Personalized Member Support

PrudentRx advocates work directly with eligible members to help them:

- Understand available specialty medication savings opportunities
- Complete enrollment in the program
- Access available manufacturer copay assistance programs, where applicable
- Navigate program requirements
- Receive ongoing support throughout the year

Eligible participants may be contacted directly regarding program enrollment and support services. Members may also contact PrudentRx for assistance and program information.

A Seamless Experience

The PrudentRx solution is integrated with the prescription drug program and specialty pharmacy process. Eligible members receive outreach through mail, phone and digital communications, making it easy to enroll and participate. PrudentRx advocates provide ongoing support and assistance, including help with annual copay assistance renewals when applicable.

A word about specialty drugs.

If you take a specialty medication, watch for communications regarding the PrudentRx Specialty Copay Program.

Eligible members may be automatically identified for participation and contacted by a PrudentRx advocate. Participation in the program helps ensure that available specialty medication savings opportunities can be applied appropriately. Members may choose to opt out of the program; however, doing so may affect their out-of-pocket costs for eligible specialty medications.

For more information, contact PrudentRx or refer to program communications provided during the year.

Medical and Prescription Drug

Plan Feature	Aetna Choice POS II Value		Aetna Choice POS II Preferred	
	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 40% ¹	You pay 50% ¹	You pay 30% ¹	You pay 50% ¹
Annual Out-of-Pocket Maximums				
Individual	\$9,100 ⁴	\$24,000 ⁴	\$8,700 ⁴	\$26,100 ⁴
Family	\$18,200 ⁴	\$72,000 ⁴	\$17,400 ⁴	\$52,200 ⁴
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 benefit	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	12 visits/ calendar year ⁵	12 visits/ calendar year ⁵	12 visits/ calendar year ⁵	12 visits/ calendar year ⁵
Home Health Care	40 days/ calendar year ⁸ 16-hour maximum per day	40 days/ calendar year ⁸ 16-hour maximum per day	40 days/ calendar year ⁸ 16-hour maximum per day	40 days/ calendar year ⁸ 16-hour maximum per day
Skilled Nursing Facility	60 days/ calendar year ⁵	60 days/ calendar year ⁵	60 days/ calendar year ⁵	60 days/ calendar year ⁵
Rehabilitation Therapy (Physical, Speech, or Occupational)	60 visits/ calendar year ⁵ (limit does not apply for the treatment of a mental health condition)	60 visits/ calendar year ⁵ (limit does not apply for the treatment of a mental health condition)	60 visits/ calendar year ⁵ (limit does not apply for the treatment of a mental health condition)	60 visits/ calendar year ⁵ (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 PCP copay/visit and \$50 specialist copay/visit	You pay 50% ²	\$35 PCP copay/visit and \$50 specialist copay/visit	You pay 50% ²
Urgent Care Facility	\$50 copay/visit	\$50 copay/visit	\$50 copay/visit	\$50 copay/visit
Physical Exams (Wellness)	Plan pays 100%, deductible waived	You pay 50% ²	Plan pays 100%, deductible waived	You pay 50% ²
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 Smear⁶	Plan pays 100%, deductible waived	You pay 50% ²	Plan pays 100%, deductible	You pay 50% ²
Durable Medical Equipment	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Home Health Care⁸	Home Health Care ⁸	You pay 50% ²	You pay 30% ²	You pay 50% ²
Colon Cancer Screening-Colonoscopy⁷	Plan pays 100%, deductible waived	You pay 50% ²	Plan pays 100%, deductible waived	You pay 50% ²
Surgical Facility³	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Lab and X-ray Services	You pay 40% ² at independent labs and outpatient facilities; included in \$35 copay performed in doctor's office	You pay 50% ²	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% ²
Dialysis Treatment				
Physician's Services/Office Visit	\$35 PCP copay /visit and \$50 specialist copay/visit	You pay 50% ²	\$35 PCP copay/ visit and \$50 specialist copay/visit	Not covered
Home Dialysis	You pay 40% ²	You pay 50% ²	You pay 30% ²	Not covered
Outpatient Facility Services	You pay 40% ²	You pay 50% ²	You pay 30% ²	Not covered
Outpatient Professional Services	You pay 40% ²	You pay 50% ²	You pay 30% ²	Not covered

Advanced Radiology Imaging (MRI, MRA, CAT Scan, PET Scan, etc.)				
Physician's Office	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Outpatient Facility	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Inpatient Services³				
Hospitalization	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Surgeon's Fees	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Lab and X-ray	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Emergency Room Care	You pay 40% ²	You pay 40% ²	You pay 30% ²	You pay 30% ²
Other Health Care Facilities: Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities⁹	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Hospice				
Inpatient Services	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Outpatient Services	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Family Planning				
Prenatal Office Visits	You pay 40% ² for subsequent visits	You pay 50% ²	You pay 30% ² for subsequent visits ^{10,11}	You pay 50% ²
Delivery	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Vasectomy	\$35 PCP copay/visit and \$50 specialist copay/visit physician's office; otherwise you pay 40% ²	You pay 50% ²	\$35 PCP copay/visit and \$50 specialist copay/visit in physician's office; otherwise you pay 30% ²	You pay 50% ²
Tubal Ligation³	Plan pays 100% ² , deductible waived	Plan pays 100% ² , deductible waived	Plan pays 100% ² , deductible waived	Plan pays 100% ² , deductible waived
Infertility Office Visits	\$35 PCP copay/visit and \$50 specialist copay/visit	You pay 50% ²	\$35 PCP copay/visit and \$50 specialist copay/visit	You pay 50% ²

Mental Health/ Substance Abuse Treatment (combined with medical plan)				
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited
Inpatient Treatment	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Outpatient Treatment – Physician's Office	\$35 copay	You pay 50% ²	\$50 copay	You pay 50% ²
Outpatient Treatment – Outpatient Facility	You pay 40% ²	You pay 50% ²	You pay 30% ²	You pay 50% ²
Prescription Drugs (Includes products for smoking cessation)				
Retail (30-day supply)				
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 (90-day supply)				
Generic	\$45 copay	Not Covered	\$33 copay	Not Covered
Preferred Brand	\$80 copay	Not Covered	\$120 copay	Not Covered
Non-Preferred Brand	\$90 copay	Not Covered	\$160 copay	Not Covered
Does Plan provide ACA mandated drug coverage?	Yes, Value Plan covers 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 After you meet the annual deductible: Reasonable & Customary charges apply.

³ 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 Aetna. Call within 24 hours of emergency admission.

⁴ Includes medical deductibles, copayments, and coinsurance.

⁵ In and out-of-network combined.

⁶ 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.

⁷ Subject to age and frequency guidelines. Benefits may be subject to PCP or Specialist copay.

⁸ Includes outpatient private duty nursing when approved as medically necessary.

⁹ 60 days combined maximum per calendar year

¹⁰ Primary Care Physicians include General Practice, Family Practice, Internal Medicine, and Pediatricians. Specialists are all other practitioners, including OB-GYN's.

¹¹ Certain prenatal care is covered at 100% without deductible as required under the Patient Protection and Affordable Care Act

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 **two** of the Healthy Activities listed below between January 1, 2027, and September 30, 2027, to save up to \$300 per individual on your medical premiums in 2028, up to a maximum of \$600. Learn more about the Healthy Hound Program at healthyhound.greyhound.com.

How does the Healthy Hound Program work?

- You (and your enrolled spouse, if applicable) must complete **two** Healthy Activities between January 1, 2027, and September 30, 2027.
- If you and your enrolled spouse do not each complete two activities by September 30, 2027, an annual surcharge of \$300 per employee and \$300 per spouse will be applied to your medical plan premiums (for a total of \$600) beginning with your first paycheck in January 2028.

Here's a list of Healthy Activities under the Healthy Hound Program for 2027 (choose two):

1. **Get a preventive wellness exam or test.** Schedule and complete one or more of the following wellness exams or preventive tests: annual routine physical exam/preventive labs, well-woman exam, colonoscopy (for participants age 45 and older), mammogram, pap test or PSA test. Please note that Department of Transportation (DOT) physicals do 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. You, as the employee, may use an out-of-network provider, but you must bring a PB-1 form (available through the Trust Office or on healthyhound.greyhound.com) 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. Your spouse must use an in-network provider for this Healthy Activity.

- 2. Complete an online health assessment.** This Healthy Activity is designed to help you keep track of your health. You must complete an online health assessment.

Access Aetna Health Your Way through [aetna.com](https://www.aetna.com) or the MyActiveHealth app to complete your annual preventive care visit. Schedule and attend your annual well adult or well woman visit with your primary care physician. This visit will be captured when the claim processes and you will see that it is completed in the Aetna Health Your Way program.

Complete an online health assessment. Log into [aetna.com](https://www.aetna.com), scroll down the page and click on Aetna Health Your Way. Once on the Aetna Health Your Way platform, complete your health assessment. You may also access your health assessment through the MyActiveHealth app available for iOS and Android and the app store. The health assessment typically takes about 15 minutes to complete.

- 3. Complete coaching for tobacco cessation through the Lifestyle Coaching program.** This program provides coaching and support tools (such as free nicotine patches delivered to your home) to help you quit tobacco. To enroll, schedule your 1;1 telephonic coaching sessions through Aetna Health Your Way. Participate in just four coaching calls to get credit for this Healthy Activity. Coaching calls are available to suit your schedule.
- 4. Complete coaching calls to improve your overall wellbeing through the Lifestyle Coaching program.** This program provides coaching and support tools to help you make lifestyle changes such as eating better, moving more and managing stress.. To enroll, schedule your 1;1 telephonic coaching sessions through Aetna Health Your Way. Participate in just four coaching calls to get credit for this Healthy Activity. Coaching calls are available to suit your schedule.
- 5. Enroll in the diabetes prevention program with the 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 healthyhound.greylhound.com for more information, including a link to a one-minute risk screener to see if you qualify for the program, or visit go.omadahealth.com/greylhound to get started. To get credit for this health activity, you will need to attest to your enrollment in the Aetna Health Your Way program.
- 6. Enroll in the Aetna Back and Joint program.** This program is specially designed to help you manage your musculoskeletal health and reduce pain and discomfort in your spine, shoulders, hips or knees. The program offers a guided digital experience tailored to your individual situation and personalized support from a dedicated Care Advocate who can help motivate you and encourage your success. Go to [aetna.com](https://www.aetna.com) and access the musculoskeletal digital support center to start your enrollment. To get credit for this health activity, you will need to attest to your enrollment on Aetna Health Your Way.

Good News! Healthy Hound Sweepstakes Drawing Continued for 2027

All Greyhound ATU members who complete a Healthy Activity between January 1, 2027, and September 30, 2027, 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 2027 sweepstakes drawing will take place the first week of December 2027, with prizes awarded shortly thereafter. For additional information about the Healthy Hound Sweepstakes, visit healthyhound.greyhound.com.

Other Important Information

- **It's completely confidential.** Participation in all Healthy Activities is completely confidential, voluntary and available at 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 is available online.** For additional information, visit the Healthy Hound Program website at healthyhound.greyhound.com, 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. If you have questions, call the Trust Office at **800-288-7766**.
- **ATU Members** can reduce their sick leave waiting period if they receive a wellness exam. Visit healthyhound.greyhound.com for details.
- The 2028 Healthy Hound premium surcharge of \$300 per enrolled member and \$300 per enrolled spouse will not apply to employees enrolled in the Value Plan who earn less than \$17.25 per hour.

Dental Program

Your enrollment decision:

Dental Coverage

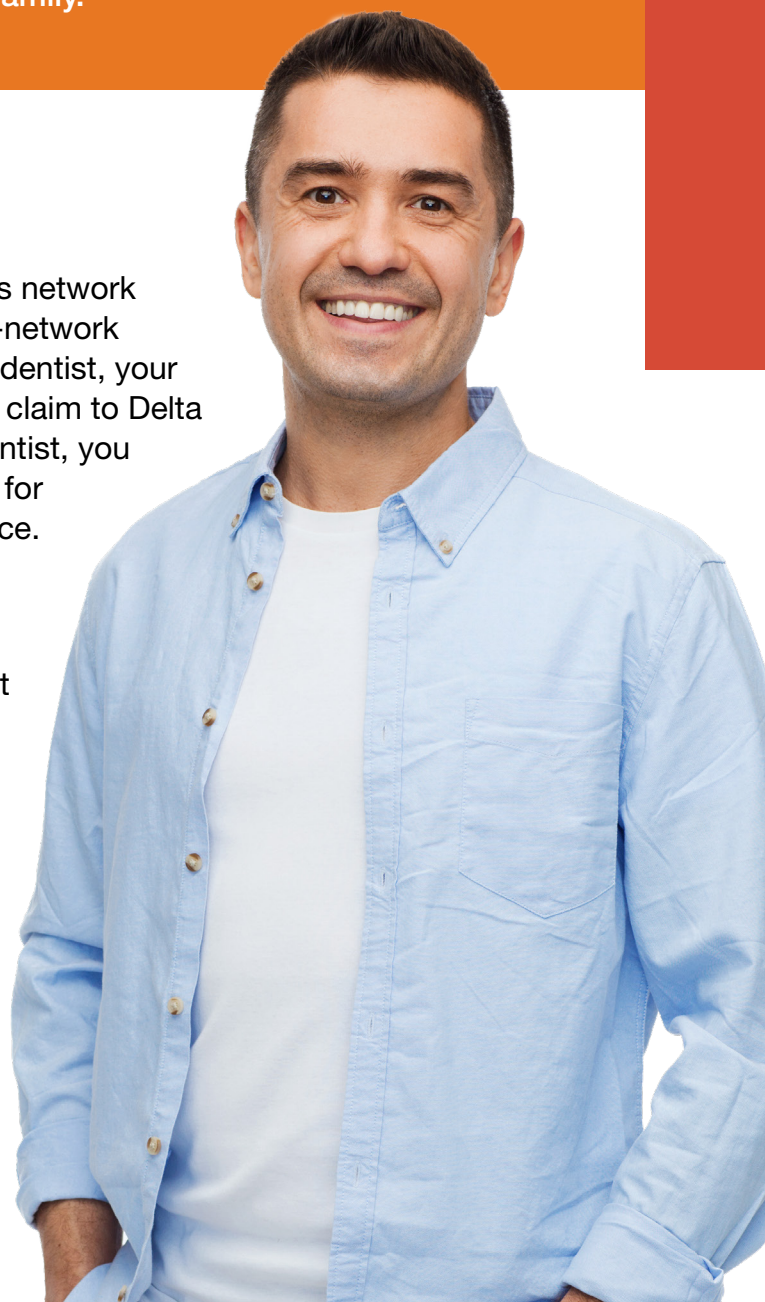
No coverage

Healthy teeth and gums are an important part of your overall health. In fact, a routine dental checkup could help uncover more serious conditions like lupus, sleep apnea, arthritis and diabetes. That's why Greyhound/ATU is proud to offer comprehensive dental care through Delta Dental for you and your family.

Choosing Network Providers

Delta Dental offers a choice of obtaining care from its network of DPO Dentists and Premier Dentists or from a non-network dentist. In general, when you choose a participating dentist, your costs will be lower, and the provider will submit your claim to Delta Dental on your behalf. If you go to a non-network dentist, you will have to complete your own claim forms and pay for any charges in excess of the maximum plan allowance.

To find a network dentist, visit www.deltadentalins.com or call **800-521-2651**. You are responsible for verifying whether the dentist you select is a DPO or Premier Dentist. Network dentists can change, so it's a good idea to confirm your dentist's network status with the provider's office before your visit.



See the table below for an overview of your coverage under the plan.

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 per year Two cleanings per year Most x-rays	 90% 90% 90%
Basic Services, including: Fillings Sealants on permanent posterior molars (under the age of 15, once every 36 months)	 80% after annual deductible 80% after annual deductible
Major Services, including: Endodontics Oral surgery Periodontic treatment Crowns Bridgework Dentures	 50% after annual deductible 50% after annual deductible 50% after annual deductible 50% after annual deductible 50% after annual deductible 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

A Word About Additional Benefits During Pregnancy

When an enrollee is pregnant, the plan pays for additional services to help improve oral health. The additional services each calendar year during pregnancy include one additional oral exam and either one routine cleaning or one periodontal scaling and root planing per quadrant. You or your dentist must submit written confirmation of the pregnancy when the claim is submitted.

Vision Program

Your enrollment decision:

Vision Coverage

No coverage

When it comes to preventive care, make sure to include regular vision care checkups, even if your eyesight is 20/20. A simple exam could help uncover health issues like diabetes, arthritis, cancer and more.

The Vision Program, offered through VSP, gives you options for taking care of your eyesight. You can choose a VSP doctor, a non-VSP provider or both (see the table below and the SPD for how this affects your benefits).

You can also get your vision care from certain network retail providers like Costco, but be aware that their coverage may not be the same as what you get from a VSP provider. Generally, you will get the most out of your benefits when you see a VSP doctor. You can find out which doctors and network retail providers are near you by calling VSP at **800-877-7195** (TDD for the hearing impaired: **800-428-4833**) or visiting the VSP web site at www.vsp.com.

VSP will pay the doctor or the network retail provider directly for the services and eyewear that are covered by the plan. You pay only for any copays and expenses that are not covered by the plan, like cosmetic options or non-covered services and eyewear. If you use a non-VSP provider, you will have to pay the provider first and then send a claim to VSP to get your money back.



Lenses and Frames

The Plan covers a wide selection of frames, 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.

Contact Lenses

You have the option to choose contact lenses instead of glasses for vision correction. If you choose this option, you will not receive benefits for a frame and lenses.

When you choose contacts, 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. 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 and evaluation) when you receive contact lens services from a VSP network doctor. Any costs exceeding the maximum allowance are your responsibility.

Diabetic Eyecare Program

If you have type 1 or type 2 diabetes, glaucoma or age-related macular degeneration (AMD), you can receive extra eyecare services as part of VSP's Diabetic Eyecare Program. These services include medical follow-up exams, specialized screening and tests, and medically necessary retinal imaging. You can get these services only from a VSP doctor.

The program also covers non-surgical medical eye conditions that are related to diabetes, such as diabetic retinopathy, abnormal blood vessel growth on the eye (rubeosis) and diabetic macular edema.

You don't need a referral to access these services, and you pay only a \$20 co-pay for each visit.

Extra Discounts and Savings from VSP Doctors

The following additional discounts are available when you use a VSP doctor. Please note that discounts are not available through 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 are available only 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

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 <i>* \$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.</i>	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. You get a 15% discount off the exam, and cost will not exceed a maximum of \$60. Medically Necessary Contact lens and exam are covered in full once the \$25 material copay is met. <i>*Contact lens exam is not covered at network retail providers.</i>	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
<i>Maximum allowable for all Low Vision benefits of \$1,000.00 every two (2) years.</i>		

Flexible Spending Account (FSA)

Your enrollment decision:

Annual election amount (up to \$3,400)

No election

An FSA is a great way to save money on health care expenses because you can set aside some of your pay before taxes to use for these expenses. This means you pay less federal income and Social Security taxes for the year. You can use your FSA money for eligible (as defined by the IRS) medical, dental or vision expenses that are not covered by your health plans.

You decide how much you want to contribute to your FSA each year, from a minimum of \$50 up to a maximum of \$3,400 for 2027. The money will be deducted from your paycheck in equal amounts each pay period and put into your FSA. You can use your full annual amount on the first day of the plan year, even if you haven't paid it all in yet. You will also get a debit card to pay for your eligible expenses easily.

It's important to plan carefully how much you want to contribute because you have to use your FSA money during the tax year. The good news is that you can carry over up to \$680 of unused FSA money to the next year. However, if you have less than \$50 or more than \$680 left in your account at the end of the year, you will lose it, so make sure you use it or roll it over. Your carryover balance will expire if you don't use it or have any 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 [inspirafinancial.com](https://www.inspirafinancial.com).

Annual FSA limits and eligible expenses are set by the IRS and are subject to change.

Employee Assistance Program (EAP)

Your enrollment decision:

Automatic coverage, no election needed

The EAP, offered through Lyra Health, is a free and confidential service that supports you and your eligible family members with any personal or work-related challenges. The EAP is available to all Greyhound/ATU employees, both full-time and part-time, and their eligible dependents, regardless of medical plan enrollment. You are automatically enrolled in the EAP, so you don't need to do anything to sign up.

The EAP provides up to eight sessions per issue, per year, at no cost to you. You can choose how you want to access your sessions: in person, over the phone or online.

To use your EAP services, just call Lyra at **844-614-3457**, 24 hours a day, seven days a week. You can also visit **greyhoundatu.lyrahealth.com** and register to access online resources, such as assessments, self-help programs, tools and articles to help you balance your health, work and life.

Services include:

Clinical Counseling

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

Work and 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 a Greyhound/ATU medical plan, you will be responsible for paying your portion of the cost of any additional mental health/substance abuse or counseling services.

Life Insurance

Your enrollment decision:

Basic Life:

Coverage is automatic, no election needed

Supplemental Life and AD&D:

\$10,000 to \$120,000

No additional coverage

Dependent Life:

Spouse \$10,000/\$20,000

Children \$5,000/\$10,000

No coverage

Basic Life Insurance

Greyhound/ATU values your contribution to our company and is dedicated to supporting you and your loved ones in case of an unexpected event. That's why we provide basic life insurance for you, which can help cover your final expenses and ease the financial burden on your family.

As an eligible employee, the company automatically provides you with \$10,000 life insurance coverage at no cost to you.

Supplemental Life and AD&D Insurance

In addition to your basic life insurance coverage, you may elect supplemental life insurance in \$10,000 increments from \$10,000 to \$120,000 for total coverage of up to \$130,000.

When you elect supplemental life insurance, 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 if you have a serious covered accidental injury or death. If you have only 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. Login to benefitsolver.com and visit the **Reference Center** to view the rate sheet from The Hartford for details.

Dependent Life Insurance

You also have the option to elect life insurance for your spouse and dependent children in the following amounts:

- Spouse life insurance: \$10,000 or \$20,000, not to exceed the amount of your coverage
- Eligible children: \$5,000 or \$10,000, not to exceed 50% of your coverage.

Age-Related Benefit Reductions

Be aware that employees (basic life insurance of \$10,000, along with additional supplemental life and AD&D coverages) and their spouses who are 65 years old or over will experience a decrease in benefits. At the age of 65, the coverage is reduced to 65% of the chosen amount. When reaching 70 years old, the coverage is further reduced by 15%, bringing it down to 50% of the initially elected amount.

Evidence of Insurability (EOI)

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

EOI is usually obtained through a health questionnaire and/or physical exam. If The Hartford does not approve proof of good health, coverage will be denied for the requested additional amount.

When EOI is required and approved, coverage and deductions begin the first day of the month following the date of approval or on the eligibility effective date if during annual Open Enrollment. If the approval date is the first of the month, coverage begins on the date approved.

If you are selecting these coverages for the first time, visit the online benefits system to enroll and designate a beneficiary.

Short-Term Disability

Your enrollment decision:

Choose weekly coverages from \$100 - \$400 depending on hourly rate and work location

No election

Short-Term Disability (STD) helps you replace some of your income if you can't work because of an illness or injury. You will be eligible to receive a maximum weekly benefit of \$100, \$200, \$300 or \$400 depending on your hourly pay. You can get this benefit for up to 52 weeks (after a 14-day waiting period). See the table below for the STD benefit levels.

STD benefits are offered through The Hartford. If you work in California, New Jersey, New York or Rhode Island, your options will be different. Refer to The Hartford enrollment materials for details.

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 NJ

Less than \$22 per hour	\$100 for the first 26 weeks and \$200 for the next 26 weeks, reduced by other income benefits
\$22 per hour or more	\$200 for the first 26 weeks and \$400 for the next 26 weeks, reduced by other income benefits

Hourly Wage Rate:

In CA, RI

Less than \$22 per hour	\$100 per week maximum benefit
\$22 per hour or more	\$100 or \$200 per week maximum benefit

Important Plan Information

Benefit Offset Rule

You may have other sources of income while you are disabled, such as sick pay or state benefits. Before STD benefits are payable, you must first use up other sources of disability income, including salary continuation or accumulated sick leave, but excluding any Statutory Benefits.

Minimum Benefit

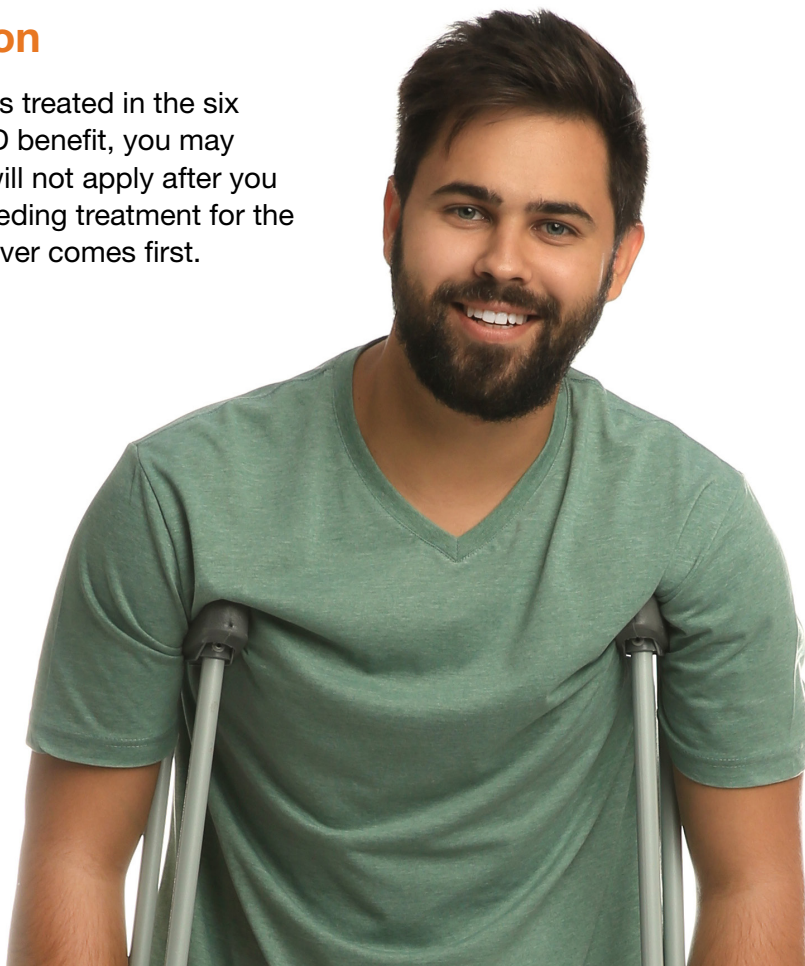
If your STD benefit is reduced by other sources of disability income, such as accumulated sick leave, you are still eligible to receive a minimum weekly benefit. If you are enrolled in the \$100 or \$200 weekly STD benefit, you will receive a minimum benefit of \$25 per week. If you are enrolled in the \$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 (EOI) is not required. If you did not elect coverage the first time it was offered or want to increase the amount of STD insurance for which you are currently enrolled, EOI (or proof of your medical history) is required. The Hartford reviews the EOI to determine if you are accepted for insurance before your coverage can begin.

Pre-Existing Condition Exclusion

If you have a health condition that started or was treated in the six months before you joined or increased your STD benefit, you may not get the benefit for that condition. This rule will not apply after you have been in the plan for six months without needing treatment for the condition or after 12 months in the plan, whichever comes first.



Voluntary Benefits

Your enrollment decision:

Accident Insurance

No coverage

Your enrollment decision:

Employee: \$5,000/\$10,000

Spouse: 50% of employee amount

Children: \$5,000

No coverage

Accident Insurance

Accident insurance, offered through The Hartford, is a type of coverage that pays you a cash benefit if you or an insured family member are hurt in a covered accident, whether it happens at work or not. You can get this money as a lump sum and use it for any purpose you want, such as paying for medical bills that your main health plan doesn't cover or covering your living expenses while you recover. If you lose your accident insurance from your employer or another group, in certain circumstances you can keep it through 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.

Login to benefitsolver.com and visit the **Reference Center** to view the Hartford Accident Insurance Benefit Highlights for additional information on this coverage.

Critical Illness Insurance

Critical illness insurance can help you and your family cope with the financial impact of a serious health problem. If you or a family member covered by this policy are diagnosed with a critical illness that is covered by the plan (subject to plan terms and conditions, including limitations and exclusions), you will receive a lump-sum payment that you can use however you need. You can use it to cover medical costs that are not paid by your health insurance, to make up for lost income while you recover or for any other purpose you choose.

You may enroll for \$5,000 or \$10,000 critical illness insurance. You may also enroll your eligible dependents as follows:

- Spouse: the greater of \$5,000 or 50% of your elected coverage amount
- Children: \$5,000

A benefit reduction of 50% will apply to the coverage amount for you and your dependents when you reach the age of 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 **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.

Login to benefitsolver.com and visit the **Reference Center** to view the Hartford Critical Illness Insurance Benefits Highlights for additional information on this coverage.

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

Enrolling for Coverage

Do I Need to Enroll and When?

If you need to actively enroll, and the date you need to enroll by, depends on your employment status. Refer to the following table to check your enrollment requirements.

Status	Enrollment Information	Deadline
Currently Enrolled – Open Enrollment	If you wish to have medical coverage in 2027, you must actively enroll. In addition, you must actively enroll to participate in the FSA or update/change your covered dependents.	November 20, 2026,, 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 2027. 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 20, 2026, 11:59 p.m. EST
New Hires / Rehires – New Enrollment	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 <i>Currently Enrolled – Open Enrollment</i> above.	November 20, 2026, 11:59 p.m. EST
On leave – terminated benefits	If your benefits terminated while you were out on 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 2026 and provide supporting documentation to the ATU Health & Welfare Trust Office.	Within the applicable enrollment period (usually 30 days).

Who Is Eligible to Enroll?

In general, you are eligible to enroll in the benefits described in this Guide if you are a full-time Greyhound employee scheduled to work 1,500 hours or more per year and are represented by the Amalgamated Transit Union (ATU). You may also enroll your legal spouse and dependent children, provided they meet the definition as outlined on pages 38–39. Coverage elected during annual Open Enrollment is effective on January 1, 2027.

If you are newly hired, returning to work or have had a change in employment status, review the following table for your eligibility requirements and the date your coverage begins.

Employment Status	Eligibility Requirements	Your Coverage Begins
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.

Enrolling Your 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.

Who Are Your Eligible Dependents?

- Your legal spouse who is recognized as such under federal tax laws (including a same-sex spouse) unless you are legally separated or divorced.
- Your child, as defined below for each of the benefit plans.
 - **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, (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 stepchild, 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, stepchildren, 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 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.

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 of 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 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 dependents provided they are 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 times during the last six months of the calendar year, your child will be considered to depend on you if your child receives over half of his or 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 you elect during the October 26, 2026, to November 20, 2026, annual Open Enrollment period will begin January 1, 2027. **Be sure to review your deductions on the first payroll in 2027 and report any discrepancies to the Health & Welfare Trust office as soon as possible.**

Declining Coverage

You have the right to decline coverage 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 pages 41–42 of this Guide or the **Status Change** section of the SPD for more information.

If You Decline Medical Coverage

If you choose not to enroll in either the Value Plan or the Preferred Plan and wish to enroll at a later date, you must first 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,
- If the reason for not enrolling in the Value Plan or the Preferred Plan is because you had other health coverage, or
- You qualify for a special enrollment (see pages 41–42).

Keep in mind that a number of states, including California, Massachusetts, New Jersey, Rhode Island, Vermont and the District of Columbia require eligible residents to have health coverage. If you live in one of these states and choose not to enroll in a benefit plan, you may be responsible for a tax penalty or assessment.

Remember to Designate Your Beneficiary

Even if you choose not to enroll in any or all of the benefit Plans, it's still important to designate or update your life insurance beneficiary. Please log in to the online benefits enrollment system at www.benefitsolver.com (company key: greyhoundatu) to do so.

Status Changes and Special Enrollment Rights

Due to IRS regulations, you are unable to make changes to your benefit elections or drop coverage 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 want to contribute to your flexible spending account. If you wish to make changes, you will need to wait for the next annual Open Enrollment period unless you have a qualifying event. Qualifying events include things like marriage, divorce, the birth or death of a dependent, adoption or the loss of other medical coverage.

If that happens, federal law permits you to have a special enrollment opportunity. This notice requirement does not apply to the 60-day special enrollment period for loss of Medicaid or CHIP coverage (see below).

Special Enrollment Rights

If you declined enrollment for yourself, your spouse, or your dependents because of other health coverage, you may be able to enroll 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 800-288-7766 or at greyhound.gliatubenefits.flixna@flixbus.com.

A detailed listing of Status Changes and Special Enrollment Rights when you may revoke an existing election 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.

You must request the change 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 documents; 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 on page 43 for the amount of your per-paycheck premiums. 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 Office immediately. If you don't notify the Trust Office right away, your coverage under the Plan could be terminated.

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 your benefits are not cancelled.

Greyhound/ATU Active Employee Premium Rates

Effective January 1, 2027

The rates shown below are the cost for each coverage level, with the exception of the flexible spending account. Deductions are withheld from each weekly paycheck.

		Employee Only	Employee + One	Employee + Family
Option A:	No Coverage	\$0.00	\$0.00	\$0.00
Option B:	Aetna Choice POS II Value Plan (weekly)	\$47.08	\$84.69	\$123.46
Option C:	Aetna Choice POS II Preferred Plan (weekly)	\$90.00	\$161.31	\$223.15

	Employee Only	Employee + Children	Employee + Spouse	Employee + Family
Dental Plan				
No Coverage	\$0.00	\$0.00	\$0.00	\$0.00
Coverage (weekly)	\$5.01	\$9.36	\$9.36	\$15.24
Vision Plan				
No Coverage	\$0.00	\$0.00	\$0.00	\$0.00
Coverage (weekly)	\$1.24	\$2.18	\$2.13	\$3.56
Employee Life Insurance				
Basic Coverage: \$10,000	\$0.00	(Trust-Provided)		
Employee Assistance Program	\$0.00	(Trust-Provided)		

Please note: The 2027 Healthy Hound premium surcharge of \$300 per employee and \$300 per spouse will not apply to employees earning less than \$17.25 per hour who are enrolled in the Value Plan.

Refer to The Hartford enrollment materials for the rates for:

- Supplemental life insurance and accidental death and dismemberment (AD&D)
- Dependent life insurance
- Short-term disability insurance
- Accident insurance/critical illness insurance

Required Notices and Other Important Information

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 applicable copays, referral requirements, coinsurance and annual 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
- 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 **800-288-7766**.

Newborns' and Mothers' Health Protection Act of 1996

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 of 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.



Medical Claim Submission

Most Aetna in-network providers have 90 days from the date of service to submit claims for payment. Any claim received by Aetna after 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 Aetna's network (out-of-network) have 180 days from the date of service to submit claims. Any claim received by Aetna beyond the 180-day limit will be denied as a late filing. This applies whether the claim is submitted by the doctor, by the facility or by the patient. You may be billed for a claim that was filed late and denied, as Aetna 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.

Notice Regarding Wellness Program

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all employees. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Health & Welfare Trust Office and we will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

Healthy Hound Program is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you may be asked to complete a voluntary health risk assessment or "HRA" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You may also be asked to complete a biometric screening, which may include a blood test for HDL, LDL, total cholesterol and fasting blood sugar level. You are not required to complete the HRA or to participate in the blood test or other medical examinations.

However, employees who choose to participate in the wellness program will receive an incentive towards their medical plan premiums. You are not required to complete the HRA or participate in the biometric screening as there are alternative options available to participate in the program.

Additional incentives may be available for employees who successfully participate in the program or achieve certain health outcomes. If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting Sherrondria Haywood at the Health & Welfare Trust Office. Call **800-288-7766** or email greyhound.gliatubenefits.flixna@flixbus.com to submit your request.

HIPAA: Use and Disclosure of Protected Health Information

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, 2026

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

PHI refers to your health information held by the Plan.

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.

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.

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 healthcare operations.
- For treatment, payment or healthcare 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
 - Healthcare operations.

Definitions of Treatment, Payment or Operations

Treatment is healthcare.	Treatment is the provision, coordination or management of healthcare 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 healthcare 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.
Healthcare Operations keep the Plan operating soundly.	Healthcare operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of healthcare 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.

Disclosure of Reproductive Health PHI

The Plan will not use or disclose your information to conduct a criminal, civil, or administrative investigation into, or to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care, or to identify any person for the purpose of conducting such investigation or imposing such liability.

For example, a state law might require a health plan to disclose PHI to law enforcement for an investigation. If the requested PHI involved reproductive health care that was lawful under the circumstances in which it was provided, the health plan could not disclose the PHI to law enforcement.

Attestation requirement: The Plan may not use or disclose PHI potentially related to reproductive health care for the activities listed above, without obtaining a valid attestation from the person requesting the use or disclosure.

For example, if an investigator requests information from a health plan about claims for coverage of certain reproductive health care provided by a particular health care provider, the investigator must supply an attestation. The health plan must presume that the reproductive health care was lawful unless the health plan has actual knowledge that the reproductive health care was not lawful or the investigator supplied information that demonstrates a substantial factual basis to believe that the reproductive health care was not lawful under these circumstances.

Information that is disclosed by the health plan in accordance with the regulations is subject to redisclosure by the recipient and no longer protected by HIPAA.

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 may use or disclose your PHI for these purposes without your authorization):

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.

- 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.

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:

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

- 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. Public health does not include activities to conduct a criminal, civil, or administrative investigation or impose liability on any person for the mere act of seeking, obtaining, providing, or facilitating health care, or to identify any person for these activities.
- 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 that 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 healthcare operations, or
2. Restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care.

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

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.

You May Inspect and Copy PHI

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.

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.

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.

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.

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.

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 healthcare 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 healthcare 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. However, the Plan cannot elect to not treat a person as your personal representative primarily because the person has provided or facilitated reproductive health care at the request of the individual.

Section 4: The Plan's Duties

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

Maintaining Your Privacy

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

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

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.

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

- Disclosures to or requests by a healthcare 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 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.

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.

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:

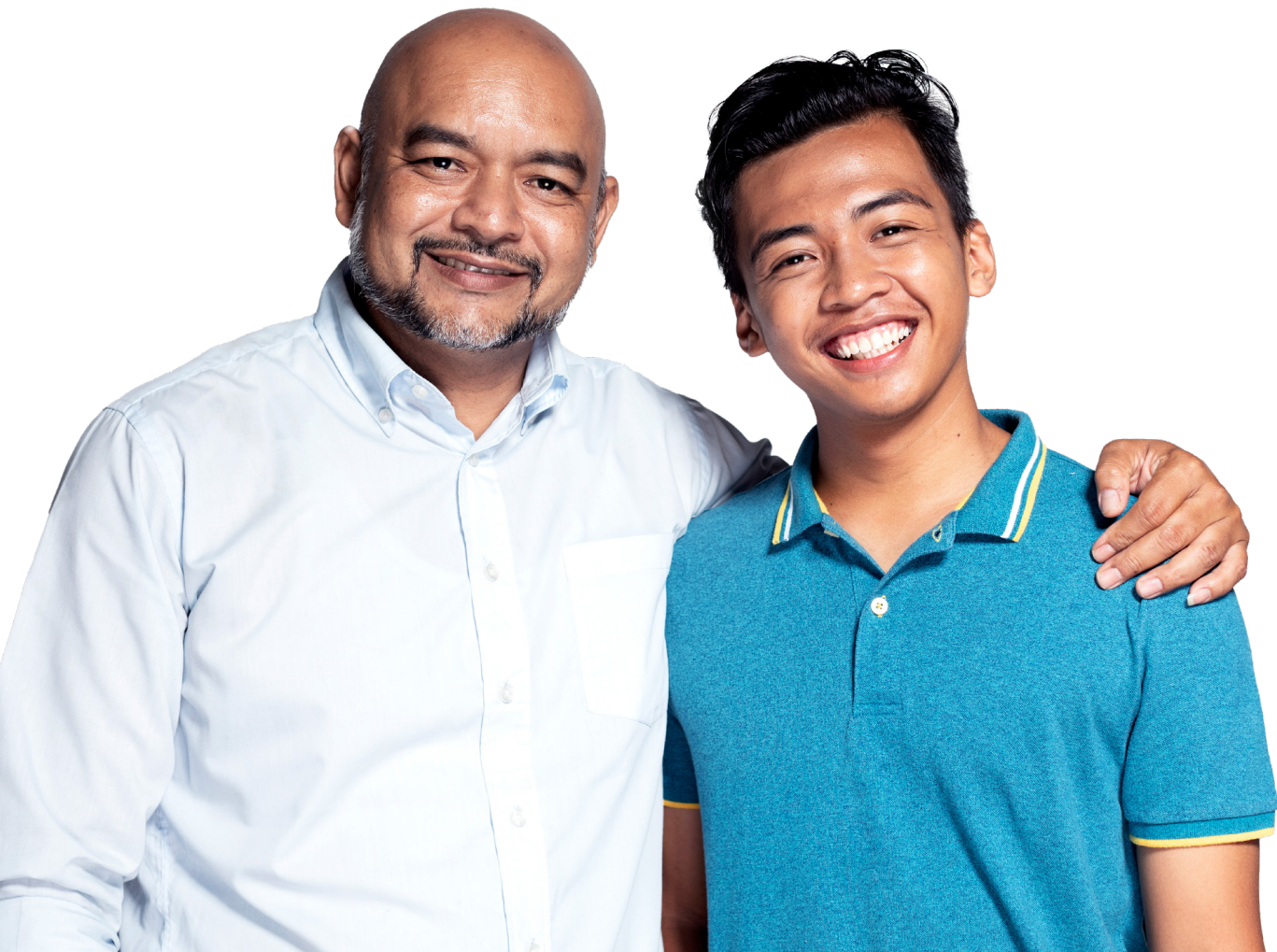
Name: Glenda Snowden, c/o Greyhound ATU Health & Welfare Trust

Address: P.O. Box 660362, Dallas, TX 75266-0362

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 15 to December 7.

However, if you lose your current creditable prescription drug coverage through no fault of your own, you will also be eligible for a two-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 19 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 telephone numbers) for personalized help
- Call **800-MEDICARE (800-633-4227)**. TTY users should call 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 **800-772-1213** (TTY: **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, 2026

Name of Entity/Sender: Greyhound Lines, Inc. – National Local 1700 of the Amalgamated Transit Union Health & Welfare Trust

Contact--Position/Office: Glenda Snowden

Address: P.O. Box 660362, Dallas, TX 75266-0362

Phone Number: **800-288-7766**

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov

COLORADO – Health First Colorado (Colorado’s Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660

KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	NEW HAMPSHIRE – Medicaid
Medicaid Website: http://dhcftp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov

NEW JERSEY – Medicaid and CHIP	NEW YORK – Medicaid
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	NORTH DAKOTA – Medicaid
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	RHODE ISLAND – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rlte Share Line)
SOUTH CAROLINA – Medicaid	SOUTH DAKOTA - Medicaid
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Texas Health and Human Services Phone: 1-800-440-0493	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/

VERMONT– Medicaid	VIRGINIA – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program Department of Vermont Health Access Phone: 1-800-250-8427	Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid	WEST VIRGINIA – Medicaid and CHIP
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	WYOMING – Medicaid
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

U.S. Department of Labor Services

Employee Benefits Security Administration

www.dol.gov/agencies/ebsa

1-866-444-EBSA (3272)

61565

U.S. Department of Health and Human

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

1-877-267-2323, Menu Option 4, Ext.

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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

Plan Resource Guide: When You Have Questions

Keep this list of Plan resources handy and refer to it when you have questions.

If You Need More Information About	Contact	
General questions about your benefits, eligibility, dependents, life events and enrollment	Greyhound/ATU Health & Welfare Trust	800-288-7766 Email: greyhound.gliatubenefits.flixna@flixbus.com
Questions related to completing your enrollment	Businessolver	833-925-0479 www.benefitsolver.com
Medical coverage, case management, mental health/substance abuse or flexible spending account (FSA)	Aetna Medical Group #286428	Concierge Member Services PO Box 981106 El Paso, TX 79998-1106 833-821-3949 www.aetna.com
Prescription drug coverage	Aetna RX Member Services	PO Box 52444 Phoenix, AZ 85072-2444 888-792-3862
	Aetna Pharmacy Mail Order (CVS Caremark)	P.O. Box 94467 Palatine, IL 60094-4467 888-792-3862
	Aetna CVS Specialty Pharmacy	800-237-2767
24-hour Nurse Line	Aetna	800-556-1555
N.Y. Disability & N.Y. Paid Family Leave	New York Life Group #NYD075550	888-842-4462 www.mynylgbs.com
Dental Plan	Delta Dental Group #03850	800-521-2651 www.deltadentalins.com
Vision coverage	Vision Service Plan Group #12173151-004	800-877-7195 www.vsp.com
Life, AD&D and short-term disability coverage	The Hartford Group #402756	Life/AD&D: 888-563-1124 STD: 888-277-4767 www.thehartfordatwork.com
Critical illness and accident insurance	The Hartford Critical Illness Group #VCI460154 Accident Insurance Group #VAC460155	866-547-4205 Fax: 469-417-1952 www.thehartford.com/benefits/myclaim
Employee Assistance Program (EAP)	Lyra Health	844-614-3457 greyhoundatu.lyrahealth.com
Bus Pass	Greyhound	800-454-2638 Email: buspassusa.flixna@flixbus.com
401(k)	ATU 401(k) Plan	800-440-1548 www.atu401k.com
Lincoln Financial (FMLA Only)		800-423-2765 www.lincolnfinancial.com