2026 | All Employees

Benefits Guide

Inside

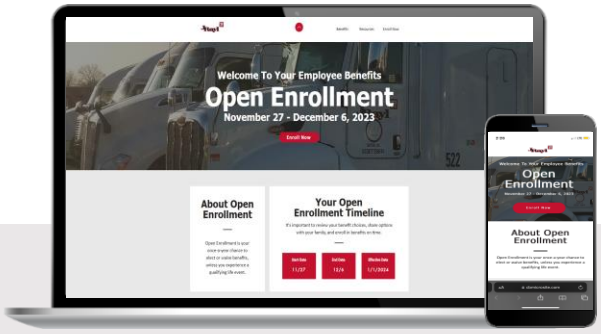
Disclaimer: The information described within this guide is only intended to be a summary of your benefits. It does not describe or include all benefit provisions, limitations, exclusions, or qualifications for coverage. Please review your Summary Plan Description for a complete explanation of your benefits. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail. You can obtain a copy of the Summary Plan Description from the Human Resources Department.

Welcome

We understand that your life extends beyond the workplace. That's why we offer a variety of benefits to help you be an advocate of your health and well-being. Our goal is to provide choices for you and your family to be appropriately covered through all stages of life.

How to Enroll

- **Current Employees:** Open Enrollment, which usually occurs in November, is your once-a-year opportunity to adjust benefit coverages and update any dependents and beneficiaries.
- **New Hires:** Once eligible, you must complete your enrollment within 30 days. Some benefits have "guarantee issue" at your first opportunity only, so please carefully consider this before you decline any coverage.



Learn More & Enroll on our Benefits Microsite!

Scan QR code or visit
https://bit.ly/JRAYLgMicrosite

SISCO Call Center:

You may enroll in your J Rayl benefits via telephone by calling 1-855-447-4726 ext. 4463 and speak with a licensed benefit counselor from SISCO.

How to Make Changes

Unless you experience a qualifying life event, you cannot make changes to your benefits until the next open enrollment period. An election change must be made within 30 days of the qualifying event. Examples include:

- Marriage, divorce, legal separation, or death of a spouse
- Birth, adoption, or death of a child
- Change in child's dependent status
- Change in residence
- Change in employment status or a change in coverage under another employer-sponsored plan

Medicare Part D Notice: If you or your dependents are on Medicare or will be eligible within 12 months, federal law offers more prescription drug coverage options. Refer to pages **30-31** for details.

Contacts

J Rayl Transport Benefits Contact		
Bruce Minotti	(330) 784-1134 ext. 3375	Bruce.minotti@jrayl.com
Human Resources	(330) 784-1134 ext. 3423	HR@jrayl.com

Coverage	Carrier	Phone Number	Website/Email
Medical Insurance	UMR	(800) 826-9781	www.umr.com
Pharmacy Benefit Manager	MedOne/ControlRx	(866) 335 9057	www.medone-rx.com
$0 Meds Pharmacy Mail Order	CanaRx	(866) 715-6337	www.canarx.com
Pharmacy Savings Card	CleverRx	(800) 873-1195	www.cleverrx.com/jraytransport
24/7 Medical Virtual Visits	Teladoc	(800) 835-2362	www.teladoc.com
Dental Insurance	Sun Life	(800) 442-7742	www.sunlife.com
Vision Insurance	Sun Life/VSP	(800) 877-7195	www.sunlife.com
Life Insurance	Sun Life	See HR	www.sunlife.com
Disability	Sun Life	See HR	www.sunlife.com
Accident, Critical Illness, and Hospital Indemnity	Sun Life	See HR	www.sunlife.com
Chronic Condition Management	HealthCheck360	(866) 511-0360 ext. 5635	www.myhealthcheck360.com
Flexible Spending Account	BCC SmartCare	(800) 685-6100	www.mywealthcareonline.com
Medicare Information	Next Level Planning	(414) 369-6628	www.NLWPM.com
Employee Assistance Program	ComPsych	(800) 460-4374	www.guidanceresources.com
State/Federal Benefits Assistance	FEDlogic	(877) 837-4196	www.fedlogicgroup.com
Identity Theft Protection	LifeLock	(800) 543-3562	www.lifelock.com

Eligibility

Employee Eligibility

All full-time employees working 30 or more hours per week will be eligible for benefits. As a new employee, you have 30 days from your initial start date to enroll in benefits.

- **All Coverages** will take effect on the first of the month following 60 days of employment.

*** IMPORTANT:** These benefits may require employees to be actively at work at the time benefits become effective. Please review policy documents, or contact HR, for additional information.

Dependent Eligibility

If you are enrolled in coverage, you may also have the option to enroll your dependents in coverage.

Definition of "Eligible Dependents"

Medical, Dental, and Vision Coverage dependents include:

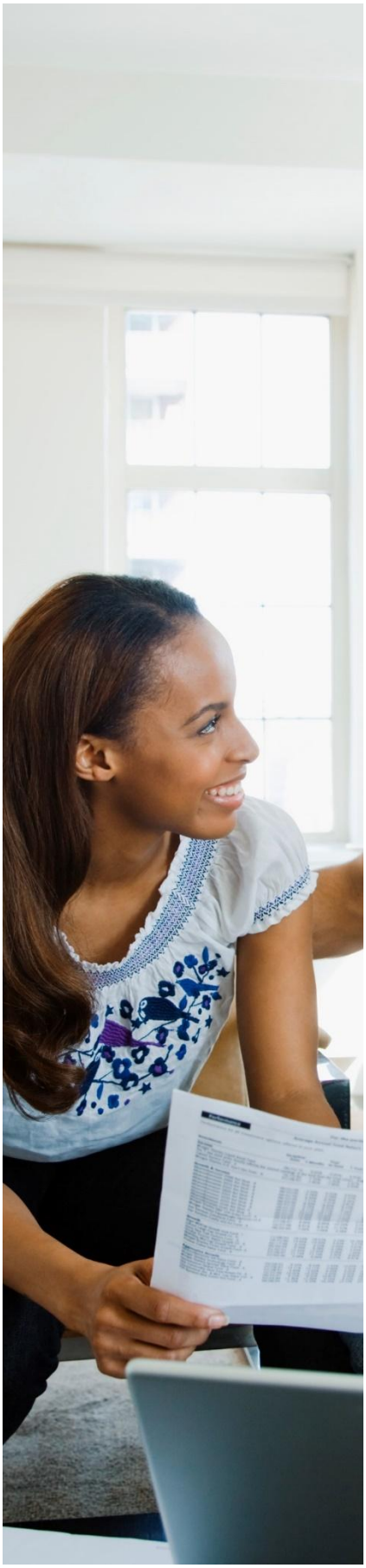
- **Your legally married spouse.** Such spouse must have met all requirements of a valid marriage contract of the State in which the marriage of such parties was performed. For the purposes of this definition, "spouse" shall not mean a common law spouse or domestic partner.
- **Your dependent children under age 26**. This includes natural, step, foster, adopted, or other children under your legal guardianship.
- For additional eligibility details, please refer to the policy contract or summary plan documents.

Other Coverages: See page 16 for definitions of an "eligible dependent" under the Voluntary Life/AD&D Policy. Please note that benefit-eligible employees cannot be enrolled as a "spouse", and dependent children cannot be covered more than once. Please refer to the policy certificate or HR for more information.

Working Spouse Provision

If your legal spouse has medical insurance offered through his or her employer, they are not eligible for the medical plan.

To verify your spouse's eligibility, you must complete a Working Spouse Provision Form. Failure to complete this form will result in coverage being terminated for your spouse. If the working status of your spouse changes during the year, you must confirm eligibility by completing an updated Working Spouse Provision Form. The Form can be found on UKG/PlanSource or you may request it from HR.



Employee Contributions

If you elect coverage, your premiums will be conveniently deducted from your **weekly payroll deductions (52 per year)**. Please contact Human Resources regarding any questions or concerns.

Medical	
Employee Only	$59.20
Employee + Spouse	$169.58
Employee + Child(ren)	$129.62
Family	$196.26

Dental	
Employee Only	$1.61
Employee + Spouse	$2.95
Employee + Child(ren)	$3.86
Family	$6.04

Vision	
Employee Only	$1.56
Employee + Spouse	$3.14
Employee + Child(ren)	$2.66
Family	$4.36

Basic Life/AD&D **Long-Term Disability**	**Employer-provided**

Voluntary Life/AD&D **Short-Term Disability** **Accident** **Critical Illness** **Hospital Indemnity** **LifeLock**	To view your personalized rates, log in **UKG/PlanSource** for details.

Medical

UMR

Locate an in-network provider near you at www.umr.com or call (800) 826-9781.

This coverage allows you to visit any doctor or facility you choose—however, you will get the best coverage when you choose an in-network provider.

Medical	J Rayl Medical Plan	
	In-Network	Out-of-Network
Annual Deductible		
Individual	$3,000	$6,000
Family	$6,000	$12,000
Coinsurance (Plan Pays/You Pay)	70% / 30%	50% / 50%
Annual Out-of-Pocket Maximum		
Individual	$6,000	$12,000
Family	$9,000	$24,000
Services	In-Network	Out-of-Network
Preventive Care	Covered 100%	50% after deductible
Telemedicine Visit	$54	N/A
Primary Care Office Visit	$25	50% after deductible
Specialist Office Visit	$50	50% after deductible
Urgent Care	$75	50% after deductible
Emergency Room	$500 + 30% coinsurance	$500 + 30% coinsurance
Hospitalization	30% after deductible	50% after deductible
Prescription Drugs	In-Network	
Annual Pharmacy Deductible	$250	
Tier 1	$10	
Tier 2	$40 after deductible	
Tier 3	$60 after deductible	

Please review the full plan documents for details. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

How My Medical Plan Works

Medical Plan Options

The UHC Choice Plus network offers a broad network of providers to choose between.

J Rayl Medical Plan

The J Rayl medical plan has a low deductible and convenient copays on some services before you meet your deductible. On the J Rayl plan, you have coverage for office visits, emergency room visits, urgent care visits, and prescription drugs without meeting your deductible. Most other services like hospitalization and surgery are subject to your deductible before the plan shares costs.

If you enroll on the J Rayl plan, you may use a Flexible Spending Account for qualified medical, dental, and vision expenses.

Individual and Family Deductibles

On all plans, when you are enrolled in employee + child or spouse or family coverage, each person cannot incur more than the "individual deductible" before the plan pays coinsurance on that person. When the family deductible is met, through a combination of 2 or more family members, the plan pays coinsurance on all family members.

Under the UHC Choice Plus Network:

When you visit a hospital, clinic, emergency room, or other facility that is not a doctor's office, you will receive an Explanation of Benefits (EOB) in the mail which tells you what portion of the medical services are yours to pay.

Find a Provider

Finding a network provider on umr.com has never been easier.

- Go to umr.com and select "Find a provider"
- Search for UnitedHealthcare Choice Plus Network using our alphabet navigation or type UnitedHealthcare Choice Plus into the search box
- For medical providers, choose View Providers. For behavioral health providers (including counseling and substance abuse), select Behavioral health directory.

You will never be asked to pay more than your portion based on the plan you have chosen. It is very important that you read this EOB and keep it on-hand for future reference. You may also receive bills from your hospital or facility that say you owe larger amounts, but you are truly only responsible for paying what your EOB states is your responsibility.

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

IMPORTANT: You may not utilize the standard Health FSA if you elect a Health Savings Account (HSA). When you use an HSA you may participate in a limited medical FSA, valid for qualifying vision and dental expenses only, and Dependent Care FSA.

Prescription Drug Coverage

MedOne | CanaRx | NaviCareRx | www.medone-rx.com | (866) 335-9057

MedOne is the prescription drug manager pharmacy drug portion of the medical plan. MedOne is designed to bring more value to employees, and provide access to some of MedOne's cost savings programs, such as NaviCareRx and CanaRx.

Member Assistance:

MedOne's Member Advocate team, all certified pharmacy technicians, is equipped to assist you with questions you may have.

- Phone: (866) 335-9057
- Fax: (563) 588-8725
- Prior authorization fax: (563) 293-8156
- Live Chat – www.medone-rx.com
- Drug Lookup Tool - www.medone-rx.com/members/drug-lookup – Group ID is XXUMRJRYTR

Member Resources:

MedOne's website features a variety of resources for MedOne members:

- On the main website, tap or click the MEMBERS tile along the bottom of the home page, or select MEMBERS in the main menu
- Here, you can check the status of a prior authorization, schedule a consultation with a registered pharmacist, review FAQs, download documents and forms, and access the Member Portal

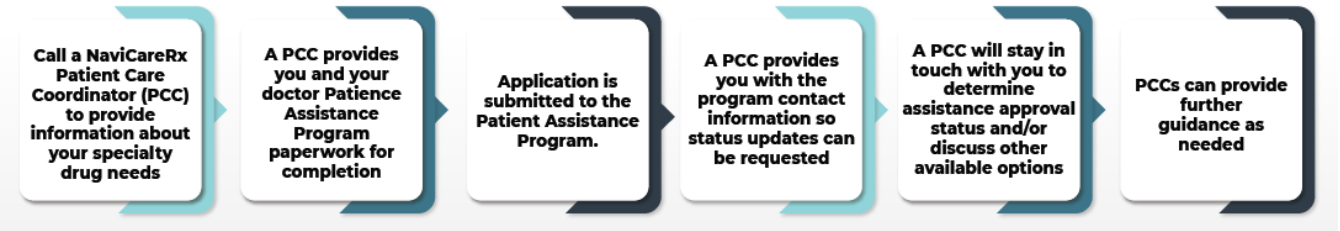
Member Portal:

To access the member portal, go to www.medone-rx.com and click on MEMBER PORTAL:

- View claims details and Rx history
- Look up in-network pharmacies in your area
- Obtain pricing for your medications
- Review Out of Pocket Maximum
- Access the Drug Information Directory
- Gather ID card processing information
- Enroll in MedOne Mail Order

Specialty Medications:

Specialty medications are managed through the **NaviCareRx** program. Members can reach their dedicated **Patient Care Coordinator at 877-371-3351** for assistance



Condition Management

HealthCheck360

The myCare360 program provides education and support for employees and their spouses who are managing a chronic condition. The program is a benefit included in your health plan and is provided at no additional cost to you.

You'll receive exclusive access to HealthCheck360's team of clinical experts and support via the easy-to-use mycare360 mobile app.

Conditions covered include:

Diabetes

High Cholesterol

Hypertension

myCare360 helps you:

Stay healthy and manage your condition

Control your out-of-pocket medical costs

Learn how recommended care guidelines impact your health

Have informed conversations with your primary care physician

Getting started

Enrollment in the program is automatic. If you or your spouse are currently managing a chronic condition, you will receive a welcome letter from HealthCheck360 as well as a call from one of our Care Managers.

Participants who qualify for the program are contacted each quarter by phone, email, or regular mail.

Stay on track with the mycare360 mobile app!

- Company Code: JRAYL
- Unique ID: Last 4 SSN

Health Plan Rates

We want you and your families to enjoy a healthy life and pay attention to your personal health.

By completing the action items listed on your myCare360 account, you will be considered compliant and avoid paying a non-compliant surcharge for health insurance.

Compliant and non-compliant rates will be applied for 2027 employee contributions based on compliance during the 2026 measurement period. Compliance will be monitored November 1, 2025 through September 30, 2026 with the compliance surcharge effective January 1, 2027.

See page 31 for information on a Reasonable Alternative Standard.

$0 Copay Mail-Order Prescriptions

CANARX

Available to those enrolled in our medical coverage.

Check to see if your brand name medication is offered!

1-866-893-6337

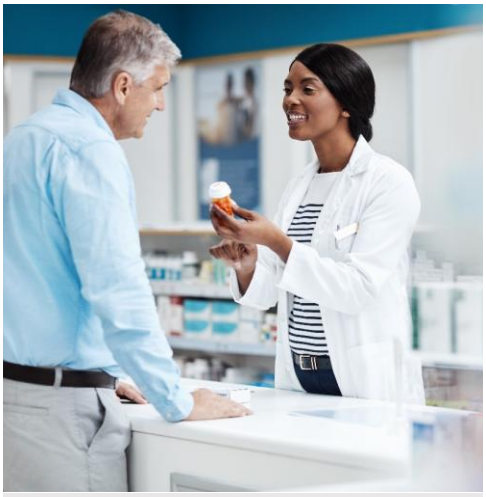
www.canarx.com/plan/?planid=JRAYL

Brand name medications FREE to your door!

Order brand name maintenance medications, in the original factory-sealed manufactures packaging directly to your door from certified pharmacies in Canada, the United Kingdom and Australia. **You pay NOTHING ($0 copay)** thanks to the savings this program brings to our medical coverage!

Getting started is easy!

1. **Check to see if your medication is offered.** Call and speak with a Customer Service Representative or view the complete formulary and print enrollment materials online. WebID is **JRAYL**
2. **Ask your doctor for a prescription for a 3-month supply, with 3 refills** – so long as you have been taking the prescription for at least 30 days.
3. **Submit documentation** (completed enrollment form, prescription, and a copy of your photo ID).
4. **Sit back and relax.** Medication will be mailed direct to your home within 4 weeks!



Find savings near you!

www.cleverrx.com/jrayltransport

Group: 3024 | Member ID: 1008

Customer Help Line:
1-800-873-1195

Pharmacy Savings Card

Clever RX

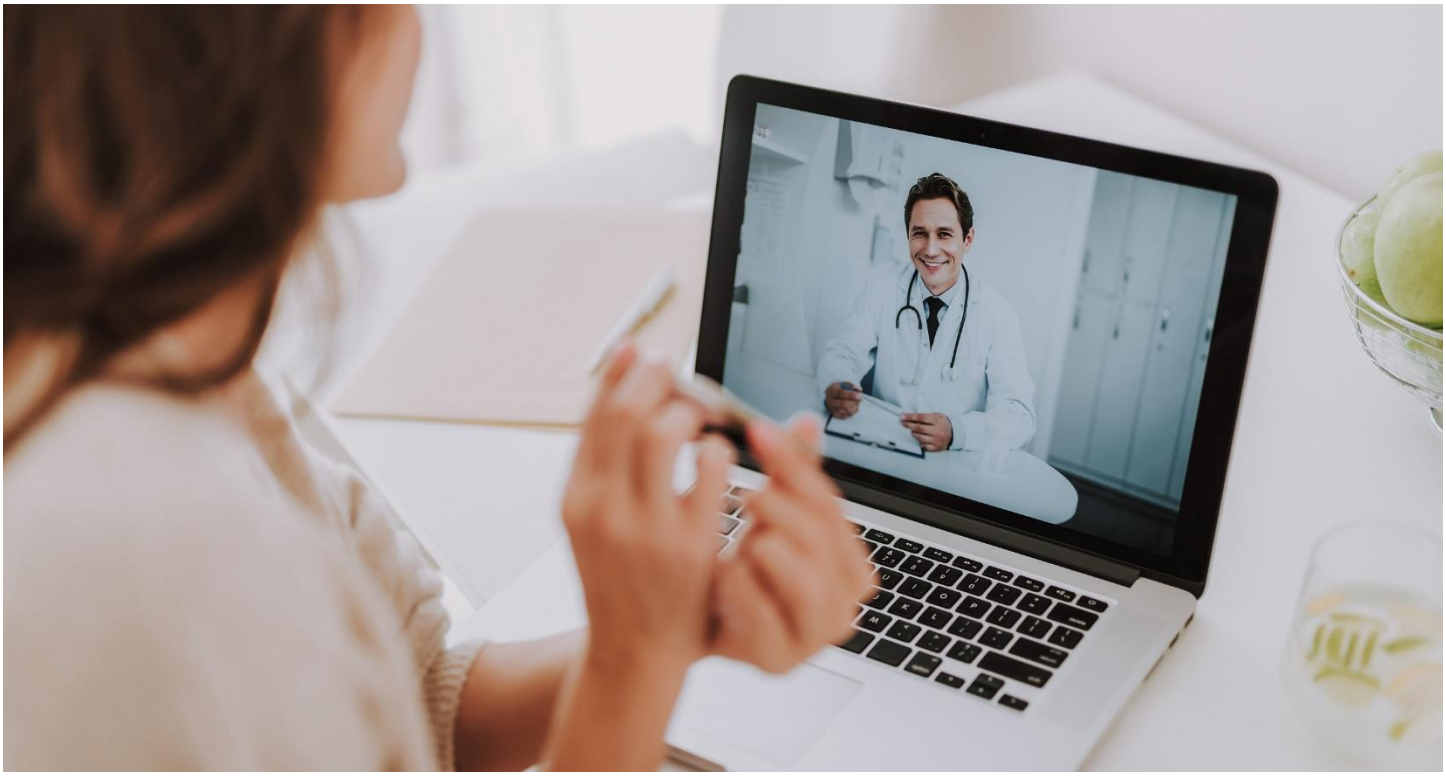
Available to all employees.

Save up to 80% off prescription drugs with this **FREE** pharmacy savings card. Clever RX is accepted at most pharmacies nationwide.

Unlock exclusive savings!

1. **Download the Clever RX card or mobile app.** Be sure to enter your group number and member ID.
2. **Use your zip code** to find discounts near you.
3. **Present your savings card or app** to your pharmacist and enjoy the savings!

Clever RX is not insurance.



Telemedicine

Teladoc

Available for those enrolled on the medical plan as well as eligible employees who waive medical coverage through UMR.

Telemedicine can be a great alternative to visiting your normal doctor or an urgent care, when you are suffering from one of many common, non-emergency medical conditions.

Using your computer, tablet, or smartphone device, you can conveniently access to U.S. board-certified doctors and licensed professionals from the comfort of your home or wherever you happen to be.

In some cases, doctors can write a prescription to a local pharmacy near you.[1]

When can I use telemedicine?

- When you need care now.
- If you're considering the ER or urgent care center for a non-emergency issue.
- On vacation, on a business trip, or away from home.
- For short-term prescription refills.

Access care wherever you are!

Connect with a virtual doctor at www.teladoc.com or the mobile app.

Get the treatment you need:

- Allergies
- Colds, respiratory problems, flu
- Ear infections
- Sore throat
- Pink eye
- Urinary tract infections

[1] Prescription services may not be available in all states.

Health Navigator

Sun Life, Powered by PinnacleCare

As a member, you have access to personal support for any healthcare challenge you are facing. Our team provides you access to top experts, and helps you navigate the complicated world of healthcare so you can have peace of mind, and focus on what really matters—your health.

Access Health Navigator for the confidence that you are making the right healthcare decisions for you and your family.

Learn More

Scan QR code or visit: www.sunlife.com/healthnav
Call: 888-352-4969

Available to those enrolled in the Medical Plan!

We specialize in providing access to top specialists, especially when you...

Receive a new diagnosis

Have a surgery recommendation

Feel unsure of your doctor's medical advice

Require a top healthcare specialist

Want help to find a new primary care provider

When facing an unexpected healthcare challenge, our advisors will help you...

Review your case

Understand your condition

Gather your medical records

Understand your treatment options

Schedule appointments

Facilitate second opinions from experts

Make informed decisions

Achieve better health outcomes

Orthopedic Surgery Alternative

Regenexx

*Available to employees enrolled in the **medical plan**.*

Enhance your body's natural healing with Regenexx!

Regenexx offers a lower-risk, lower-cost, minimally invasive option for many orthopedic surgeries, avoiding up to 70 percent of elective procedures. Using your blood platelets and bone marrow aspirate, Regenexx will process and inject them precisely at the injury site with image guidance. With Regenexx, you can get back to doing what you love without invasive surgery and lengthy recovery.

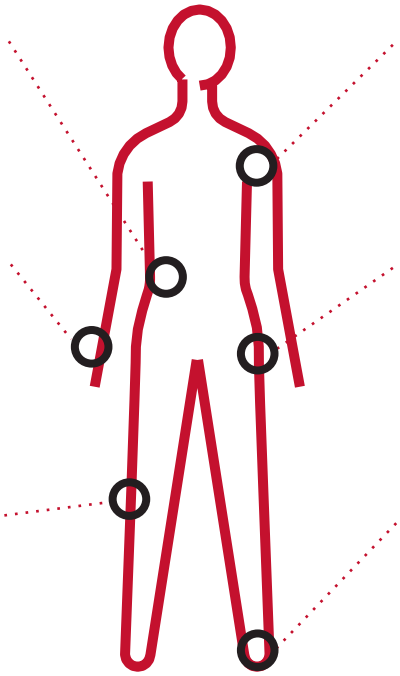
Regenexx offers a nonsurgical outpatient procedure, done in a day or three treatments over two weeks. Many patients, even those with health concerns like heart issues, can safely return to activity within a week, making it a preferable alternative to surgery.

Conditions Treated

Spine
back or neck nerve pain
bulging, collapsed, or herniated disc
ruptured or torn disc
degenerative disc disease
disc extrusion or protrusion

Hand/Wrist/Elbow
arthritis
carpal tunnel
CMC joint arthritis (thumb)
tennis elbow
trigger finger
ulnar nerve entrapment

Knee
arthritis
joint-replacement alternative
meniscus tear
sprain or tear of ACL/PCL or MCL/LCL
tendinopathy



Shoulder
arthritis
joint replacement alternative
labral tear
rotator cuff tears or tendinosis

Hip
arthritis
bursitis labral/labrum tear
joint-replacement alternative
osteonecrosis
tendinopathy

Ankle/Foot
achilles tendinopathy
arthritis
bunions
instability
ligament sprain or tear
plantar fasciitis

Learn More

Consult with your health insurance to verify how Regenexx is covered.

For information on the Regenexx benefit and eligibility, contact the education center.

- Register for weekly webinars at www.regenexxbenefits.com/webinar?mailer.
- Contact us at (866) 761-2595 or visit https://regenexxbenefits.com/jrayl/

Flexible Spending Account

BCC

FSAs can save you money on eligible expenses because you don't have to pay taxes on the amount contributed to the account. However, using an FSA does require careful planning to reap the financial benefits.

Is a Health FSA Right for You?
www.cbmicrosite.com/video/healthfsa

Health FSA

Pay for eligible medical, dental, vision, and prescription expenses, such as:

- Deductibles
- Copays
- Coinsurance
- Other health-related expenses

2026* Annual contribution limit	$3,400
Rollover	$680

Your eligibility for an FSA may be misrepresented if you and/or your spouse currently utilize an HSA. Check with the plan administrator or Human Resources to learn more.
*Typically FSA contribution limits are not announced until the end of the year prior, please see HR or visit www.irs.gov for the latest information.

Dependent Care FSA

Set aside tax-free money to care for children under age 13 or an elderly, dependent parent who is unable to care for themselves. Cover care expenses while you work, such as:

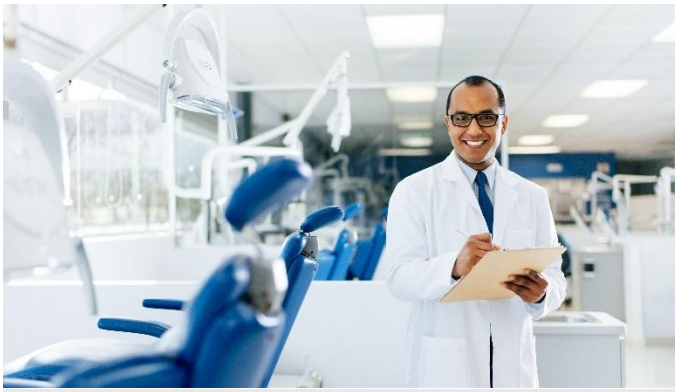
- Preschool
- Summer day camp
- Before and after school programs
- Elder care

Annual contribution limit	Married (Filing separately)	$3,750
	Single/Married (Filing jointly)	$7,500

Visit www.irs.gov and search for IRS Publications 502 (Medical and Dental) and 503 (Dependent Care) to learn more about eligible expenses.

Dental

Sun Life



Locate an in-network provider near you at Sun Life Financial (sunlifeconnect.com) or call (800) 442-7742.

Dental	In-Network
Annual Deductible	$50 per individual $150 per family
Annual Benefit Maximum	$1,000
Lifetime Orthodontia Maximum	$1,500
Plan Pays	
Preventive Care (Deductible waived)	100% covered
Type 1	100%
Type 2	60%
Type 3	60%
Orthodontia	60%

Vision

Sun Life/VSP

Locate an in-network provider near you at VSP Vision Care | Vision Insurance or call (800) 877-7195

Vision	In-Network
Exam	$10 copay
Lenses	$25 copay
Frames	$130 allowance
Contact Lenses	$130 copay
Frequencies	
Exams	1 per 12 months
Lenses or Contacts	1 per 12 months
Frames	1 per 24 months

Actively-at-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-at-Work/eligible status.

Please review the full plan documents for details including out-of-network coverage. If the benefits described herein conflict in any way with the Summary Plan Description, the Summary Plan Description will prevail.

Life/AD&D

Sun Life

Life insurance protects your loved ones financially in the event of your death. Accidental death and dismemberment (AD&D) provides an additional benefit if you die or experience other covered catastrophic loss due to a covered accident.

Basic Life/AD&D	
Benefit Amount	**Employee:** $10,000*
Benefit Cost	Employer-provided

Voluntary Term Life/AD&D	
Benefit Amount	**Employee:** Up to $500,000 **Spouse:** Up to $150,000 or 50% of employee amount^ **Child(ren):** Up to $10,000^
Guaranteed Issue Amount[1]	**Employee:** $200,000 **Spouse:** $50,000 **Child(ren):** $10,000
Benefit Cost	To view your personalized rates, log in to **UKG/PlanSource** for details.

Benefits may be reduced for employees over age 65 per ADEA.

Actively-At-Work Requirement:
New Enrollees must be actively at work on the effective date for coverage to be in force. If not, enrolled coverage will become effective upon return to Active-At-Work/eligible status.

Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Definition of "Eligible Dependents"
It is the responsibility of the employee to ensure dependents are eligible for coverage under these policies.

- **Spouse:** Eligibility may terminate at Spouse age 70.
- **Child:** Eligibility terminates earliest of age 26, married, or employed full time, or no longer a Full Time Student. Terms may vary for children with special needs. Benefits may be limited for children under age 6 months.

Please refer to the policy certificate or HR for more information.

Remember to update your beneficiaries.

It is important to update your beneficiaries and make sure they are accurate periodically. Having out of date beneficiaries listed will make it difficult to pay the benefit to the correct person in case it is ever needed.

* The value of employer-funded life insurance benefits in excess of $50,000 is taxable to you.

^ Dependent elections require employee enrollment and may be limited by employee volume.

[1] If you enroll when first offered, you may receive up to the listed amount without having to answer medical questions.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Disability

Sun Life

If you become disabled due to a covered injury or illness, disability income benefits may provide a partial replacement of lost income.

Voluntary Short-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to $1,000 per week
Benefit Begins	Injury: after 14 days Illness: after 14 days
Benefit Duration	Up to 24 weeks
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period
Benefit Cost	To view your personalized rates, log in to **UKG/PlanSource** for details.

Short-term disability excludes work-related injury or illness.

Company Provided Long-Term Disability	
Benefit Amount	Replaces 60% of earnings, up to $5,000 per month
Benefit Begins	After a period of 180 days
Benefit Duration	2 Years
Pre-Existing Condition Limitations	3-month look back period 12-month exclusion period
Benefit Cost	Company Provided!

Pre-Existing Condition Limitations:
If you file a claim within the exclusion period following your plan effective date, the carrier will review to determine if the condition existed during the look back period. If so, benefits may be denied.

Actively-At-Work Requirement:
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Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Supplemental Health

Sun Life

The following benefits may protect your financial security in the event of an unexpected medical expense.

Accident

Helps cover the cost of expenses if you are injured in a non-work-related, covered accident.

Benefit Amount	Benefit amounts vary by severity. See schedule of benefits for details.	
Wellness Benefit	$100	
Common Covered Injuries	Dislocations Fractures	Concussions Lacerations
Common Medical Services	Ambulance Emergency room visits Hospital admission	Surgical benefits Follow-up treatments
Other Benefits	Travel Lodging	Accidental death and dismemberment

Critical Illness

Helps cover the cost of expenses if you are diagnosed with a covered condition.

Benefit Amount	Employee: Up to $40,000 Spouse: Up to employee amount Child: Up to 50% of employee amount	
Wellness Benefit	$100	
Pre-Existing Condition Limitations	None	
Common Covered Conditions	Cancer Heart attack Stroke	Major organ failure Degenerative neurological disorders

Get paid for taking care of your health!

If you are enrolled in coverage, you can receive a wellness benefit payment each year when you have a qualifying screening or test.

Hospital Indemnity

Helps cover the cost of hospital stays—including pregnancy and childbirth.

Benefit Amount	$1,000 hospital admission benefit $100 daily confinement
Wellness Benefit	$50
Pre-Existing Condition Limitations	None

Supplemental Health Cost	To view your personalized rates, log in to **UKG/PlanSource** for details.

Actively-at-Work Requirement:
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Dependent Delayed Effective Date:
Dependents may have a delayed effective date based on his/her health status at time of enrollment. Please refer to the policy certificate or HR for more details.

Please review the full plan documents for plan details including exclusions and limitations. This plan highlight is a summary provided to help you understand your insurance coverage. Details may differ from state to state. If the terms of this plan highlight summary or your certificate differ from your policy, the policy will govern.

Employee Assistance Program

Sun Life/ComPsych

Available to all employees.

Life. Just when you think you've got it figured out, along comes a challenge. This safe and confidential program is here for you and can help you and your family find solutions and peace of mind.

Confidential Support

- Alcohol or substance abuse
- Childcare
- Eldercare
- Financial problems
- Gambling addiction
- Grief and loss
- Job pressures
- Mental health
- Legal concerns
- Relationships

Connect with a counselor.

(800) 460-4374

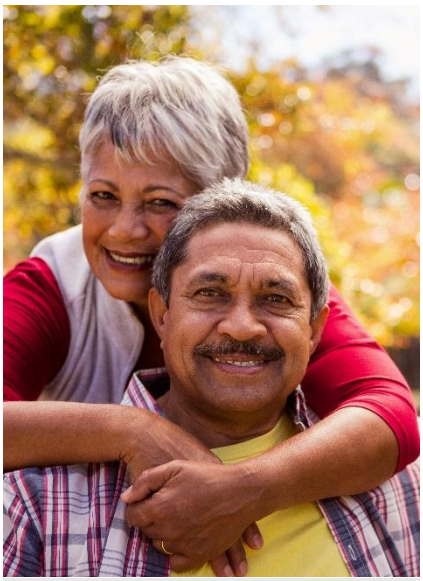
www.guidanceresources.com

App: GuidanceNow

Web ID: EAPEssential

Receive up to 3 FREE counseling sessions each year!

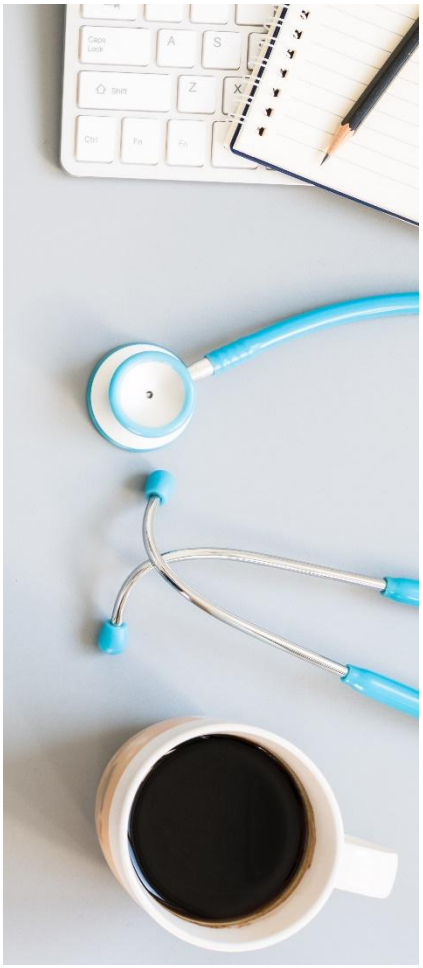
If you need additional support, the EAP team will try to refer you to resources that are affordable or covered by your medical insurance.



Schedule a consultation today!

(877) 837-4196

www.fedlogicgroup.com
services@fedlogicgroup.com



State & Federal Benefits Assistance

FEDlogic

We have partnered with FEDlogic to provide state and federal benefits information and advocacy to you and your household members.

The service is free, unlimited, and confidential!

Get help navigating resources that you may be eligible for, such as:

- Medicare
- Medicaid
- Disability
- Social Security Retirement
- Child Benefits
- Widow Benefits
- Veterans Benefits
- Supplemental Security Income (SSI)
- Healthcare.gov (COBRA alternatives)
- End Stage Renal Disease
- ALS (Lou Gehrig's Disease)
- Cancer or Terminal Illness

Here's how it works:

① **Make a phone consultation appointment.**

Call to schedule time with a federal and state benefits expert. Invite your family to join. Calls typically last an hour.

② **Tell us your story, ask questions, and learn.**

Experts will listen to your story and understand your needs, then empower you with unbiased information so you can make the best decisions for your situation.

③ **If qualified, get enrolled.**

Once you feel confident with the information, experts will walk you through the application and approval process.

④ **Enjoy peace of mind.**

Now you know you have access to assistance programs created for situations like this.

Identity Theft Protection

LifeLock

LifeLock Benefit Elite Plus focuses on what matters to employees—helping protect their identities and their nest eggs.

While many employees have a 401(k), they often set it and forget it—which could result in missing cues that may indicate potential fraud. LifeLock scans millions of transactions per second for potential threats to members' personal identities. We monitor for new credit application alerts,1 bank and investment account activity alerts† used to obtain unauthorized loans, credit and services in your name. If a threat is detected, it notifies employees via email, text, phone‡‡ or mobile app alerts. If they become a victim of identity theft while a LifeLock member, we'll provide a dedicated, U.S.-Based Identity Restoration Specialist to personally manage their case, including coverage for experts and lawyers, if needed.†††

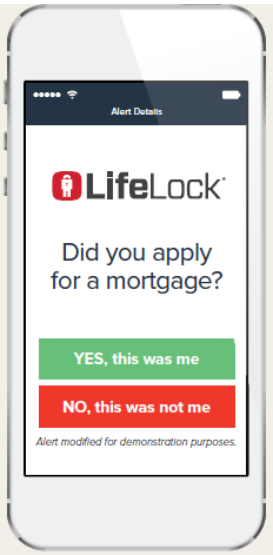
LifeLock Benefit Elite Premium helps provide employees peace of mind with LifeLock's comprehensive identity theft protection. It helps protect 401(k) and other investment accounts from fraudulent withdrawals and balance transfer. Enhanced services include bank account application and takeover alerts,† one-bureau annual credit score and report1, monthly credit score tracking1 and three-bureau annual credit monitoring.1 If a potential threat is detected, employees are notified via email, text, phone‡‡ or mobile app alerts.† Should an employee become a victim of identity theft while a LifeLock member, LifeLock provides a dedicated, U.S.-Based Identity Restoration Specialist and helps protect them with our Million Dollar Protection™ Package††† including coverage for experts and lawyers, if needed.

LifeLock Identity Alert® System†

It's the foundation for all LifeLock services. We monitor for fraudulent use of your Social Security number, name, address, or date of birth in applications for credit and services. The patented system sends alerts by text, phone‡‡, email, or mobile app.

Dark Web Monitoring

Identity thieves can sell your personal information on hard-to-find dark web sites and forums. LifeLock patrols the dark web and notifies you if we find your information



HOW LIFELOCK WORKS

LifeLock monitors your identity and when activity occurs involving your information, you're alerted† by email, text or a phone‡‡ call.

You can respond to confirm whether the activity is legitimate, and if it's not, a U.S.-Based LifeLock Identity Restoration Specialist will help you resolve the issue.

If you become a victim of identity theft, LifeLock helps protect you with our Million Dollar Protection™ Package. This includes reimbursement for stolen funds and coverage for personal expenses.†††

1 The credit scores provided are VantageScore 3.0 credit scores based on data from Equifax, Experian and TransUnion respectively. Any One Bureau VantageScore mentioned is based on Equifax data only. Third parties use many different types of credit scores and are likely to use a different type of credit score to assess your creditworthiness. No one can prevent all identity theft. † LifeLock does not monitor all transactions at all businesses.‡‡ Phone alerts made during normal local business hours.††† Reimbursement and Expense Compensation, each with limits of up to $1 million for Benefit Elite Plus and Benefit Elite Premium. And up to $1 million for coverage for lawyers and experts if needed, for all plans. Benefits provided by Master Policy issued by United Specialty Insurance Company (State National Insurance Company, Inc. for NY State members). Policy terms, conditions and exclusions at: LifeLock.com/legal See full plan summaries for adiditonal information; this is only a brief summary.

Medicare Information

What are my options once I turn 65?

If you continue to work full-time, you may remain on the company medical plan as long as you meet the eligibility requirements. However, you may also be eligible for Medicare A & B, a Medicare Supplement and Medicare D. Please read the summary below and explore your options to determine what is best in your situation.

Working Beyond Age 65: If you are purchasing medical insurance through your employer, a Medicare plan could help you save money on your health care expenses. It may make sense for you to sign up for Medicare in addition to OR instead of the coverage you have today. If you enroll in Medicare and remain on the company health plan be sure to check the coordination rules to determine which coverage is primary.

Medicare Options: Many people who choose to work past age 65 enroll in Part A (Hospital Insurance) because there is no monthly premium. You may choose to enroll in Medicare Part B, a Medicare Supplement, and/or Medicare Part D (these options will be subject to a monthly premium cost).

- Medicare Part B – Physician Insurance
- Medicare Part D – Drug Coverage
- Supplemental Coverage – This can include Medigap coverages, employer plans or Medicaid.

It is recommended that you explore all options to determine what is best for you. You may also shop for and change plans each year based on your specific needs.

Understanding Your Options: Employees who choose to remain on the group health plan can sign up for premium-free Part A (if eligible) during or after their Initial Enrollment Period begins. You can only sign up for Part B (or Part A if you have to buy it) during certain enrollment periods as dictated by Medicare. For additional information on Medicare enrollment opportunities visit www.medicare.gov or reach out to your local SHIP office (see Medicare Resources for contact information).

Making Changes to Your Medicare Plans: Health care needs can change from year to year. Be sure to review your needs annually (upcoming surgeries, current prescription drugs, new wellness goals) so you can find a plan to best meet them.

Medicare Open Enrollment Period: You can enroll in or change your plan once a year during the Open Enrollment Period (OEP) even if you do not have a qualifying event. The OEP is a seven-week period from October 15 through December 7.

Retiring At or After Age 65: Whether you retire or decide to work part-time, once you turn age 65 you will be eligible for Medicare (Parts A and B) and other Medicare Supplement Plans. If you don't have employer-sponsored coverage, you should consider enrolling during your Initial Enrollment Period. You can enroll any time within the 3 months before your 65th birthday month, your birthday month or 3 months after.

Medicare Resources Available

Next Level Planning and Wealth Management

- Get advice from Licensed insurance agents at no cost or obligation to enroll.
- Explore plans from numerous health insurance companies.
- Learn more about Medicare and be guided through the process.
- 1 on 1 assistance with benefit and financial planning
- Call (414) 369-6628 or visit www.NLPWM.com.

Our Medicare library is available 24/7 online. Here you can browse videos, download guides/presentations, listen to an agent and access information at your convenience.

Visit: www.employeenavigator.com/benefits/Account/Login
Login using the following credentials:

- USERNAME: Medicare
- PASSWORD: Benefits65

You may also complete the Permission to Contact Form to speak to an agent and receive assistance with questions related to Medicare as well as explore affordable options available based on your specific needs.

It is important to note that **Medicare resources and options vary by state**. Each state has a **SHIP** (Senior Health Insurance Information Program) that offers free education and assistance specific to their state. To find your state resource and get the number to speak to a licensed counselor, you may either visit www.shiptacenter.org, call (877) 839-2675 or email info@shiptacenter.org.

Additional Information (Government resources):
Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week or visit www.Medicare.gov.

Discount Program

PerkSpot through our partnership with Cottingham & Butler

This program provides you access to an online marketplace that delivers thousands of discounts for everyday business and personal purchases, leveraging the purchasing power of some of the largest employers in the United States.

Discount Program			
Shop for a Variety of Coupons & Deals from these Categories:	Apparel Auto Buying Automotive Beauty & Fragrance Books, Movies, & Music Business Perks Cell Phones Education Electronics Financial Wellness Flowers & Gifts Food Health & Wellness Hobbies & Creative Arts	Home & Garden Home Services Insurance & Protection Services Jewelry & Watches Movie Tickets Office & Business Pets Real Estate & Moving Services Sports & Outdoors Tickets & Entertainment Toys, Kids & Babies Travel	
Popular Discounted Brands*	Avis Canon Casper Columbia	Dell Enterprise Holiday Inn	Home Chef HP Ray-Ban
Benefit Cost	Included in our partnership with Cottingham & Butler!		

* All brands and discounts available are subject to change. For a current listing of discounts and brands offered visit the website at https://cottinghambutler.perkspot.com.

Create your account and start saving today.

Visit: https://cottinghambutler.perkspot.com

Who is PerkSpot?

- Online savings resource for employees
- Headquartered in Chicago, IL – Founded in 2006
- 750+ clients nationwide, 15 million members
- 30,000+ discount offers

Website Features

- Recommended for You: chosen based on your top interests
- Featured Offers: hand-selected to help you stretch your dollars
- Today's Perk Alters: today's best limited-time sales
- Popular Savings: trending offers
- Categories: shop by category
- Local Discounts: shop by location

Healthcare Tips

Get the Most Out of Your Care

Knowing the difference between an in-network and out-of-network provider can save you a lot of money.

- **In-Network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Out-of-Network Provider**—A provider who is not contracted with your health insurance company.

Calling the physician directly and double-checking with your insurance company is the best way to ensure that the provider is in-network. If you are receiving surgery, make sure to ask if the service is completely in-network. Often times, things such as anesthesia are not covered even though the primary physician is in-network.

Where Should I Go for Care?
http://www.cottinghambutler.com/KnowWhereToGo/

Billing & Claim Differences

Because in-network and out-of-network providers are treated differently by your insurance company, you will be billed differently depending on the type of provider you use for your care.

Provider The patient receives treatment. The doctor then sends the bill to the insurance company.	>	**In-Network Discount** Appropriate discount for using an in-network provider is applied.	>	**Bill** The bill for services is presented to the insurance company. Payment responsibilities are calculated and divided between the patient and the insurance company.
				v
Patient Patient pays doctor's office for copayments, deductibles and/or coinsurance that he or she is responsible for.	<	**Insurance Company Payments, Explanation of Benefits (EOB)** Insurance pays for its portion of the bill from the provider. A summary of charges and insurance payments is sent to the patient via the insurance company.		

Take advantage of preventive care.

Preventive care is a type of health care whose purpose is to shift the focus of health care from treating sickness to maintaining wellness and good health. This includes a variety of health care services, such as a physical examination, screenings, laboratory tests, and immunizations.

Preventive care also helps lower the long-term cost of managing disease because it helps catch problems in the early stages when most diseases are more readily treatable. The cost of early treatment or diet or lifestyle changes is less than the cost of treating and managing a full-blown chronic disease or serious illness.

Benefit Terms

The world of health insurance has many terms that can be confusing. Understanding your costs and benefits—and estimating the price of a visit to the doctor—becomes much easier once you are able to make sense of the terminology.

Definitions

- **Annual limit**—Cap on the benefits your insurance company will pay in a given year while you are enrolled in a particular health insurance plan.
- **Claim**—A bill for medical services rendered.
- **Cost-sharing**—Health care provider charges for which a patient is responsible under the terms of a health plan. This includes deductibles, coinsurance and copayments.
- **Coinsurance**—Your share of the costs of a covered health care service calculated as a percentage of the allowed amount for the service.
- **Copayment (copay)**—A fixed amount you pay for a covered health care service, usually when you receive the service.
- **Deductible**—The amount you owe for health care services each year before the insurance company begins to pay. Example: John has a health plan with a $1,000 annual deductible. John falls off his roof and has to have three knee surgeries, the first of which is $800. Because John hasn't paid anything toward his deductible yet this year, and because the $800 surgery doesn't meet the deductible, John is responsible for 100 percent of his first surgery.
- **Dependent Coverage**—Coverage extended to the spouse and children of the primary insured member. Age restrictions on the coverage may apply.
- **Explanation of Benefits (EOB)**—A statement sent from the health insurance company to a member listing services that were billed by a provider, how those charges were processed and the total amount of patient responsibility for the claim.
- **Group Health Plan**—A health insurance plan that provides benefits for employees of a business.
- **In-network Provider**—A provider who is contracted with your health insurance company to provide services to plan members at pre-negotiated rates.
- **Inpatient Care**—Care rendered in a hospital when the duration of the hospital stay is at least 24 hours.
- **Insurer (carrier)**—The insurance company providing coverage.
- **Insured**—The person with the health insurance coverage. For group health insurance, your employer will typically be the policyholder and you will be the insured.
- **Open Enrollment Period**—Time period during which eligible persons may opt to sign up for coverage under a group health plan.
- **Out-of-network Provider**—A provider who is not contracted with your health insurance company.
- **Out-of-pocket Maximum (OOPM)**—The maximum amount you should have to pay for your health care during one year, excluding the monthly premium. After you reach the annual OOPM, your health insurance or plan begins to pay 100 percent of the allowed amount for covered health care services or items for the rest of the year.
- **Outpatient Care**—Care rendered at a medical facility that does not require overnight hospital admittance or a hospital stay lasting 24 hours or more.
- **Policyholder**—The individual or entity that has entered into a contractual relationship with the insurance carrier.
- **Premium**—Amount of money charged by an insurance company for coverage.
- **Preventive Care**—Medical checkups and tests, immunizations and counseling services used to prevent chronic illnesses from occurring.
- **Provider**—A clinic, hospital, doctor, laboratory, health care practitioner or pharmacy.
- **Qualifying Life Event**—A life event designated by the IRS that allows you to amend your current plan or enroll in new health insurance. Common life events include marriage, divorce, and having or adopting a child.
- **Qualified Medical Expense**—Expenses defined by the IRS as the costs attached to the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body.
- **Summary of Benefits and Coverage (SBC)**—An easy-to-read outline that lets you compare costs and coverage between health plans.

Acronyms

- **ACA**—Affordable Care Act
- **CDHC**—Consumer driven or consumer directed health care
- **CDHP**—Consumer driven health plan
- **CHIP**—The Children's Health Insurance Program. A program that provides health insurance to low-income children, and in some states, pregnant women who do not qualify for Medicaid but cannot afford to purchase private health insurance.
- **CPT Code**—Current procedural terminology code. A medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities, such as physicians, health insurance companies and accreditation organizations.
- **FPL**—Federal poverty level. A measure of income level issued annually by the Department of Health and Human Services (HHS) and used to determine eligibility for certain programs and benefits.
- **FSA**—Flexible spending account. An employer-sponsored savings account for health care expenses.
- **HDHP**—High deductible health plan
- **HMO**—Health maintenance organization
- **HRA**—Health reimbursement arrangement. An employer-funded arrangement that reimburses employees for certain medical expenses.
- **HSA**—Health savings account. A tax-advantaged savings account that accompanies HDHPs.
- **OOP**—Out-of-pocket limit. The maximum amount you have to pay for covered services in a plan year.
- **PCE**—Pre-existing condition exclusion. A plan provision imposing an exclusion of benefits due to a pre-existing condition.
- **PPO**—Preferred provider organization. A type of health plan that contracts with medical providers (doctors and hospitals) to create a network of participating providers. You pay less when using providers in the plan's network, but can use providers outside the network for an additional cost.
- **QHP**—Qualified health plan. A certified health plan that provides an essential health benefits package. Offered by a licensed health insurer.

J Rayl Transport Health and Welfare Plan: Important Disclosures & Notices

Michelle's Law Notice

If the Plan provides for dependent coverage that is based on a dependent's full-time student status, then this Michelle's Law Notice applies. If there is a medically necessary leave of absence from a post-secondary educational institution or other change in enrollment that: (1) begins while a dependent child is suffering from a serious illness or injury; (2) is certified by a physician as being medically necessary; and (3) causes the dependent child to lose student status for purposes of coverage under the plan, that child may maintain dependent eligibility for up to one year. If the treating physician does not provide written documentation when requested by the Plan Administrator that the serious illness or injury has continued, making the leave of absence medically necessary, the plan will no longer provide continued coverage. ❖

Benefits during a Leave of Absence

Your health benefits may be protected and maintained during a leave of absence, such as a leave qualifying under the Family Medical Leave Act. Other leaves of absence may, however, render you ineligible to participate in the health plan. If coverage is lost due to a leave of absence, you may be eligible to continue coverage under COBRA. Similarly, if you become ineligible for health benefits due to a leave of absence for military reasons, you may be eligible to continue that coverage under USERRA. Please contact your Human Resources Department or your manager for more information regarding what benefits are protected and maintained during a leave of absence and for more information about FMLA, COBRA and USERRA. ❖

Premium Assistance under Medicaid and The Children's Health Insurance Program (CHIP)

If an Employee or an Employee's children are eligible for Medicaid or CHIP and are eligible for health coverage from an employer, the state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If the Employee or his/her children are not eligible for Medicaid or CHIP, they will not be eligible for these premium assistance programs but they may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If an Employee or his/her dependents are already enrolled in Medicaid or CHIP and they live in a State listed below, they may contact the State Medicaid or CHIP office to find out if premium assistance is available.

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

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

Employees living in one of the following States may be eligible for assistance paying employer health plan premiums. The following list of States is current as of July 31, 2025. V 0.6.0. The most recent CHIP notice can be found at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/chipra. Contact the respective State for more information on eligibility –

ALABAMA – Medicaid
Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – Medicaid
AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
https://dhss.alaska.gov/dpa/Pages/default.aspx

ARKANSAS – Medicaid
Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – Medicaid
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+)
Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/State Relay 711
CHP+ Website: https://hcpf.colorado.gov/child-health-plan-plus
CHP+ Customer Service:
1-800-359-1991/State Relay 771
Health Insurance Buy-In Program (HIBI) Website:
https://www.mycohibi.com/
HIBI Customer Service: 1-855-692-6442

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html
Phone: 1-877-357-3268

GEORGIA – 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

INDIANA – Medicaid
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)
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

KANSAS – Medicaid
Website: https://www.kancare.ks.gov/
Phone: 1-800-792-4884
HIPP Phone: 1-800-967-4660

KENTUCKY – 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: KIHIPP.PROGRAM@ky.gov
KCHIP Website: https://kynect.ky.gov
Phone: 1-877-524-4718
Kentucky Medicaid Website:
https://chfs.ky.gov/agencies/dms

LOUISIANA – Medicaid
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
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

MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa
Phone: 1-800-862-4840
TTY: 711
Email: masspremassistance@accenture.com

MINNESOTA – Medicaid
Website:
https://mn.gov/dhs/health-care-coverage/
Phone: 1-800-657-3672

MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084
Email: HHSHIPPProgram@mt.gov

NEBRASKA – Medicaid
Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – Medicaid
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
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Phone: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website:
http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare
Phone: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – Medicaid
Website:
http://healthcare.oregon.gov/Pages/index.aspx
Phone: 1-800-699-9075

PENNSYLVANIA – 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)

RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347 or
401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – Medicaid
Website: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
Phone: 1-800-440-0493

UTAH – Medicaid and CHIP
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
Website: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
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
Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/
http://mywvhipp.com/
Medicaid Phone: 304-558-1700
CHIP Toll-free phone:
1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING – Medicaid
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
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

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

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 us, Human Resources, 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. ❖

Patient Protection Notice

If the J Rayl Transport Health and Welfare Plan generally requires the designation of a primary care provider, you have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. If the plan or health insurance

coverage designates a primary care provider automatically, you will be able to designate a new provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources. ❖

Women's Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. ❖

Newborns' and Mothers' Health Protection Act

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 normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours, as applicable. Additionally, no group health plan or issuer may require that a provider obtain authorization from the Plan or insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). ❖

Medical Child Support Orders

A Component Benefit Plan must recognize certain legal documents presented to the Plan Administrator by participants or their representatives. The Plan Administrator may be presented court orders which require child support, including health benefit coverage. The Plan Sponsor must recognize a Qualified Medical Child Support Order (QMCSO), within the meaning of ERISA section 609(a)(2)(B), under any Component Benefit Plan providing health benefit coverage.

A QMCSO is a state court or administrative agency order that requires an employer's medical plan to provide benefits to the child of an employee who is covered, or eligible for coverage, under the employer's plan. QMCSOs usually apply to a child who is born out of wedlock or whose parents are divorced. If a QMCSO applies, the employee must pay for the child's medical coverage and will be required to join the Plan if not already enrolled.

The Plan Administrator, when receiving a QMCSO, must promptly notify the employee and the child that the order has been received and what procedures will be used to determine if the order is "qualified." If the Plan Administrator determines the order is qualified and the employee must provide coverage for the child pursuant to the QMCSO, contributions for such coverage will be deducted from the employee's paycheck in an amount necessary to pay for such coverage. The affected employee will be notified once it is determined the order is qualified. Participants and beneficiaries can obtain a copy of the procedure governing QMCSO determinations from the Plan Administrator without charge. ❖

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information
When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist Employees as they evaluate options for themselves and their family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by their employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help individuals and families find health insurance that meets their needs and fits their budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. Employees may also be eligible for a new kind of tax credit that lowers their monthly premium right away. The open enrollment period for health insurance coverage through the Marketplace began on Nov. 1st, and ended on Dec. 15. Individuals must have enrolled or changed plans prior to Dec. 15, for coverage starting as early as Jan. 1st. After Dec. 15th, individuals can get coverage through the Marketplace only if they qualify for a special enrollment period.

Can individuals Save Money on Health Insurance Premiums in the Marketplace?
Individuals may qualify to save money and lower monthly premiums, but only if their employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on premiums depends on household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If the Employee has an offer of health coverage from his/her employer that meets certain standards, they will not be eligible for a tax credit through the Marketplace and may wish to enroll in their employer's health plan. However, an individual may be eligible for a tax credit that lowers their monthly premium, or a reduction in certain cost-sharing if their employer does not offer coverage at all or does not offer coverage that meets certain standards. If the cost of a plan from an employer that would cover the Employee (and not any other members of their family) is more than 9.96% of household income for the plan year beginning in 2026, or if the coverage the employer provides does not meet the "minimum value" standard set by the Affordable Care Act, the Employee may be eligible for a tax credit.*

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

How Can Individuals Get More Information?
For more information about coverage offered by the Employer, please check the summary plan description or contact Human Resources.

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

* An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60% of such costs. ❖

Special Enrollment Rights

If an employee declines enrollment for him/herself or for their dependents (including their spouse) because of other health insurance coverage, they may be able to enroll him/herself or their dependents in this Plan in the future, provided they request enrollment within 30 days after their other coverage ends. Coverage will begin under this Plan no later than the first day of the first month beginning after the date the plan receives a timely request for enrollment.

If an employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, they may be able to enroll him/herself and their dependents provided that they request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. If an employee adds coverage under these circumstances, they may add coverage mid-year. For a new spouse or dependent acquired by marriage, coverage is effective no later than the first day of the first month beginning after the date the plan receives a timely request for the enrollment. When a new dependent is acquired through birth, adoption, or placement for adoption, coverage will become effective retroactive to the date of the birth, adoption, or placement for adoption. The plan does not permit mid-year additions of coverage except for newly eligible persons and special enrollees.

Individuals gaining or losing Medicaid or State Child Health Insurance Coverage (SCHIP)
If an employee or their dependent was:

1. covered under Medicaid or a state child health insurance program and that coverage terminated due to loss of eligibility, or
2. becomes eligible for premium assistance under Medicaid or state child health insurance program, a special enrollment period under this Plan will apply.

The employee must request coverage under this Plan within 60 days after the termination of such Medicaid or SCHIP, or within 60 days of becoming eligible for the premium assistance from Medicaid or the SCHIP. Coverage under the plan will become effective on the date of termination of eligibility for Medicaid/state child health insurance program, or the date of eligibility for premium assistance under Medicaid or SCHIP. ❖

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INDIVIDUAL MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW TO GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

HIPAA Notice of Privacy Practices
The J Rayl Transport Inc. Group Medical Plan (the "Plan"), which may include other health and welfare benefit offerings, are required by law (under the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 HIPAA's privacy rule) to take reasonable steps to ensure the privacy of personally identifiable health information. This Notice is being provided to inform employees (and any of their dependents) of the policies and procedures J Rayl Transport Inc. has implemented and their rights under them, as well as under HIPAA. These policies are meant to prevent any unnecessary disclosure of individual health information.

Use and Disclosure of individually identifiable Health Information by the Plan that Does Not Require the Individual's Authorization: The plan may use or disclose health information (that is protected health information (PHI)), as defined by HIPAA's privacy rule) for:

1. Payment and Health Care Operations: In order to make coverage determinations and payment (including, but not limited to, billing, claims management, subrogation, and plan reimbursement). For example, the Plan may provide information regarding an individual's coverage or health care treatment to other health plans to coordinate payment of benefits. Health information may also be used or disclosed to carry out Plan operations, such as the administration of the Plan and to provide coverage and services to the Plan's participants. For example, the Plan may use health information to project future benefit costs, to determine premiums, conduct or arrange for case management or medical review, for internal grievances, for auditing purposes, business planning and management activities such as planning related analysis, or to contract for stop-loss coverage. Pursuant to the Genetic Information Non-Discrimination Act (GINA), the Plan does not use or disclose genetic information for underwriting purposes.

2. Disclosure to the Plan Sponsor:
As required, in order to administer benefits under the Plan. The Plan may also provide health information to the plan sponsor to allow the plan sponsor to solicit premium bids from health insurers, to modify the Plan, or to amend the Plan.

3. Requirements of Law:
When required to do so by any federal, state or local law.

4. Health Oversight Activities:
To a health oversight agency for activities such as audits, investigations, inspections, licensure, and other proceedings related to the oversight of the health plan.

5. Threats to Health or Safety:
As required by law, to public health authorities if the Plan, in good faith, believes the disclosure is necessary to prevent or lessen a serious or imminent threat to an individual's health or safety or to the health and safety of the public.

6. Judicial and Administrative Proceedings: In the course of any administrative or judicial proceeding in response to an order from a court or administrative tribunal, in response to a subpoena, discovery request or other similar process. The Plan will make a good faith attempt to provide written notice to the individual to allow them to raise an objection.

7. Law Enforcement Purposes:
To a law enforcement official for certain enforcement purposes, including, but not limited to, the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

8. Coroners, Medical Examiners, or Funeral Directors: For the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.

9. Organ or Tissue Donation:
If the person is an organ or tissue donor, for purposes related to that donation.

10. Specified Government Functions:
For military, national security and intelligence activities, protective services, and correctional institutions and inmates.

11. Workers' Compensation:
As necessary to comply with workers' compensation or other similar programs.

12. Distribution of Health-Related Benefits and Services: To provide information to the individual on health-related benefits and services that may be of interest to them.

Notice in Case of Breach
J Rayl Transport Inc. is required to maintain the privacy of PHI; to provide individuals with this notice of the Plan's legal duties and privacy practices with respect to PHI; and to notify individuals of any breach of their PHI.

Use and Disclosure of Individual Health Information by the Plan that Does Require Individual Authorization: Other than as listed above, the Plan will not use or disclose without your written authorization. You may revoke your

authorization in writing at any time, and the Plan will no longer be able to use or disclose the health information. However, the Plan will not be able to take back any disclosures already made in accordance with the Authorization prior to its revocation. The following uses and disclosures will be made only with authorization from the individual: (i) most uses and disclosures of psychotherapy notes (if recorded by a covered entity); (ii) uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this notice.

Individual Rights with Respect to Personal Health Information: Each individual has the following rights under the Plan's policies and procedures, and as required by HIPAA's privacy rule:

Right to Request Restrictions on Uses and Disclosures: An individual may request the Plan to restrict uses and disclosures of their health information. The Plan will accommodate reasonable requests; however, it is not required to agree to the request, unless it is for services paid completely by the individual out of their own pocket. A wish to request a restriction must be sent in writing to HIPAA Privacy Officer, at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134.

Right to Inspect and Copy Individual Health Information: An individual may inspect and obtain a copy of their individual health information maintained by the Plan. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. A written request must be provided to HIPAA Privacy Officer at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134. If the individual requests a copy of their health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with their request.

Right to Amend Your Health Information: You may request the Plan to amend your health information if you feel that it is incorrect or incomplete. The Plan has 60 days after the request is made to make the amendment. A single 30-day extension is allowed if the Plan is unable to comply with this deadline. A written request must be provided to HIPAA Privacy Officer, at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134. The request may be denied in whole or part and if so, the Plan will provide a written explanation of the denial.

Right to an Accounting of Disclosures: An individual may request a list of disclosures made by the Plan of their health information during the six years prior to their request (or for a specified shorter period of time). However, the list will not include disclosures made: (1) to carry out treatment, payment or health care operations; (2) disclosures made prior to April 14, 2004; (3) to individuals about their own health information; and (4) disclosures for which the individual provided a valid authorization.

A request for an accounting form must be used to make the request and can be obtained by contacting the HIPAA Privacy Officer at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134. The accounting will be provided within 60 days from the submission of the request form. An additional 30 days is allowed if this deadline cannot be met.

Right to Receive Confidential Communications: An individual may request that the Plan communicate with them about their health information in a certain way or at a certain location if they feel the disclosure could endanger them. The individual must provide the request in writing to the HIPAA Privacy Officer at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134. The Plan will attempt to honor all reasonable requests.

Right to a Paper Copy of this Notice: Individuals may request a paper copy of this Notice at any time, even if they have agreed to receive this Notice electronically. They must contact their HIPAA Privacy Officer at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134 to make this request.

The Plan's Duties: The Plan is required by law to maintain the privacy of individual health information as related in this Notice and to provide this Notice of its duties and privacy practices. The Plan is required to abide by the terms of this Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains.

Complaints and Contact Person: If an individual wishes to exercise their rights under this Notice, communicate with the Plan about its privacy policies and procedures, or file a complaint with the Plan, they must contact the HIPAA Contact Person, at J Rayl Transport Inc., 1016 Triplett Blvd. Akron, OH 44306, (330) 787-1134. They may also file a complaint with the Secretary of Health and Human Services if they believe their privacy rights have been violated. ❖

Important Notice from J Rayl Transport Health and Welfare Plan about Your Prescription Drug Coverage and Medicare (Creditable Coverage)

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with J Rayl Transport Inc. and about your options under Medicare's prescription drug

coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

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

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. J Rayl Transport Inc. has determined that the prescription drug coverage offered by the J Rayl Transport Inc. Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

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

If you do decide to join a Medicare drug plan and drop your current J Rayl Transport Inc. coverage, be aware that you and your dependents will 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 J Rayl Transport Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information about this Notice or Your Current Prescription Drug Coverage
Contact the person listed below for further information. **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 J Rayl Transport Inc. changes. You also may request a copy of this notice at any time.

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

For more information about Medicare prescription drug coverage:

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

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

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

Date: October 21, 2025
Name of Entity/Sender: J Rayl Transport Inc.
Contact--Position/Office: Human Resources
Address: 1016 Triplett Blvd. Akron, OH 44306
Phone Number: (330) 787-1134 ❖

Reasonable Alternative Standard: If you believe you may be unable to meet the requirements of the HealthCheck360 Condition Management Program, you may still be eligible to earn the same reward, if applicable, by completing a Reasonable Alternative Standard. HealthCheck360 will work with you—and, if necessary, your primary care provider—to identify an appropriate alternative based on your health status. To explore available options, please contact a HealthCheck360 representative at (866) 511-0360.