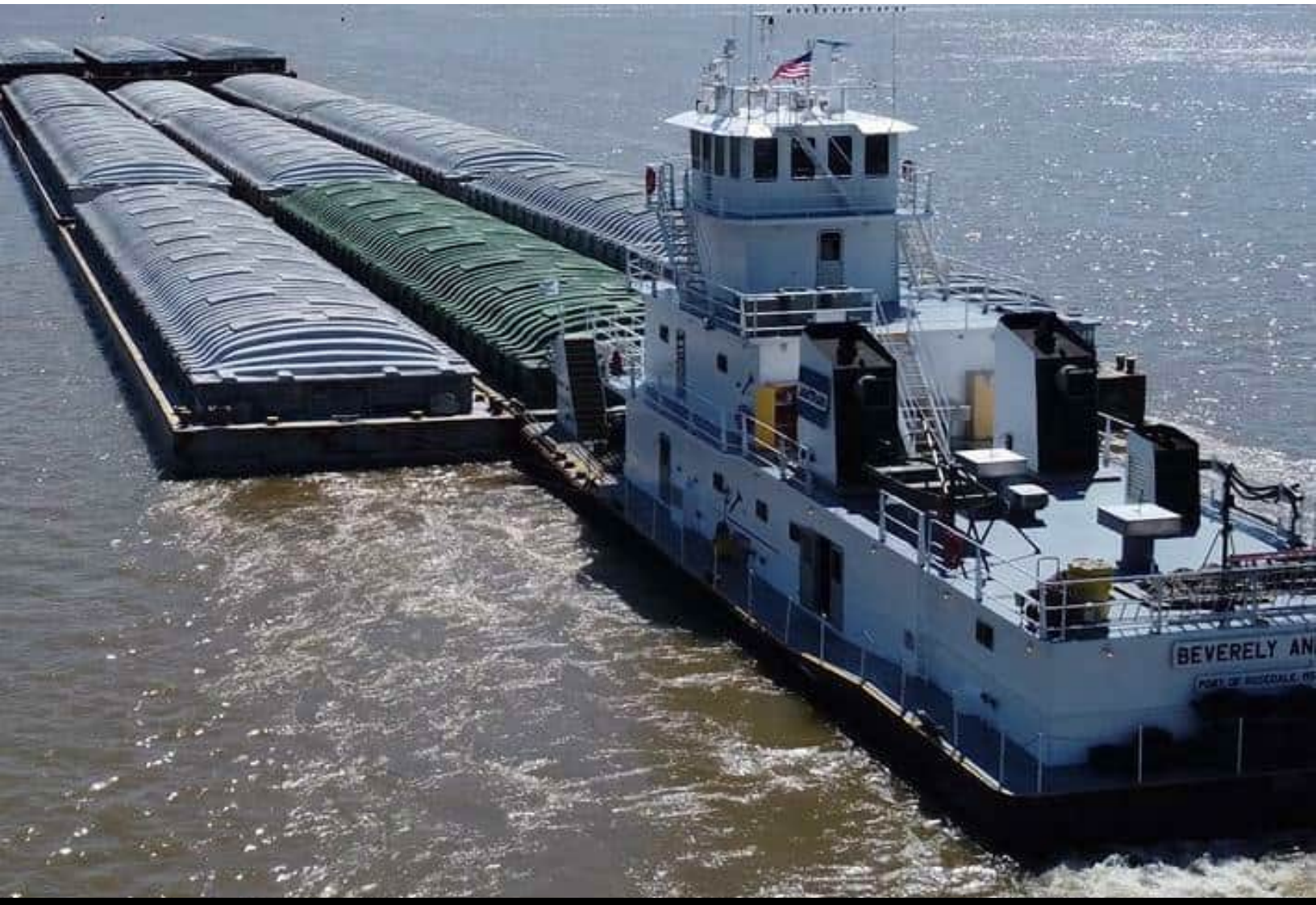
JANTRAN

2027



YOUR EMPLOYEE BENEFITS

Class 1 | Effective January 1, 2027 – December 31, 2027

WELCOME TO YOUR BENEFITS

Our most important asset is our people. That's why JANTRAN offers a comprehensive benefits program to meet all your needs. Review this guide to learn about all the benefits you are offered and determine which benefits are best for you and your family. Many resources are available during enrollment and throughout the year to help you make the most of your benefits plans and answer your questions.

The health care coverage you elect begins with your initial eligibility date and continues through the end of the enrollment year. JANTRAN's health care benefit year begins January 1st and ends December 31st. You may also enroll or change your benefits during the annual Open Enrollment period.

ABOUT THIS GUIDE

Look for underlined links and clickable resources throughout this guide for additional information.

Return to this page anytime by clicking this icon in the footer on the following pages.

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CONTACTS & RESOURCES

Contact one of our Benefits Counselors at the Benefits Service Center to learn more about your benefits and complete your enrollment process by either electing, changing, or waiving benefits. Register on the insurance carrier websites to access plan information, including your ID cards, coverages, claims, network providers, and more. Search for the carrier apps on Google Play ™or the App Store® to access your benefits information anytime, anywhere from your mobile device.

BENEFIT	CARRIER	PHONE	WEBSITE/EMAIL
Medical	BlueCross BlueShield of Arkansas	888-872-2531	blueadvantagearkansas.com
Virtual Visits	Virtual Health	888-872-2531	myvirtualhealth.com
Dental	Delta Dental	800-462-5410	deltadentalar.com
Vision	MetLife	800-638-5433	metlife.com
Life and AD&D	Mutual of Omaha	800-775-6000	mutualofomaha.com
Disability	Mutual of Omaha	800-775-6000	mutualofomaha.com
Worksite	Symetra	800-497-3699	symetra.com
Employee Assistance Program	Mutual of Omaha	800-316-2796	mutualofomaha.com
401(k) Retirement	John Hancock	800-294-3575	myplan.johnhancock.com
Human Resources	Lisa Hicks	501-320-8449	lhicks@bruceoakley.com
Human Resources	Leslie Jenkins	662-759-6841	Leslie@JANTRAN.com

Call Center Enrollment

Before you speak with a Benefit Counselor, please have the following information ready: *dependents' names, birth dates, social security numbers, addresses, and phone numbers.*

Benefits Service Center: 855-206-2926

Monday - Friday: *9:00 AM - 5:00 PM (CST)*

If you would like to schedule a time for a benefit counselor to reach out to you please use the QR code to the right or visit: **https://go.oncehub.com/BruceOakleyJANTRAN**

ELIGIBILITY & ENROLLMENT

All regular full-time JANTRAN employees

working at least 30 hours per week are eligible for benefits. As a new hire, you are eligible for benefits on the first day of the month following 60 days of employment. You may also enroll for a January 1st effective date during annual Open Enrollment.

Who Can Enroll

You may enroll the following dependents in our group benefit plans:

- Your legal spouse
- Your natural, adopted, or stepchildren living with you, or children whom you have legal guardianship, up to age 26
- Unmarried children of any age if disabled and claimed as a dependent on your federal income taxes

When You Can Enroll

You can enroll in benefits during the following times:

- Your initial new hire eligibility period
- The annual Open Enrollment period for a January 1st effective date

Making Changes to Your Benefits

Outside of your initial new hire or the Open Enrollment period, changes to your benefits can only be made throughout the year within 30 days of a qualifying life event. Examples of the most common events include:

- Marriage or divorce
- Birth or adoption of an eligible child
- Death of a covered dependent
- Change in your or your spouse's work status that affects your benefits
- Change in residence that affects your eligibility for coverage
- Change in your child's eligibility for coverage
- Receipt of a Qualified Medical Child Support Order (QMCSO)

To see a complete list or to report an event, contact Human Resources. Documentation may be required.

Termination of Coverage

Benefits coverage is terminated as follows:

- If you leave, coverage will terminate on the last day of the month following the termination or resignation date.
- When a covered dependent reaches age 26, their coverage will terminate on the last day of the month following their date of birth.

If you fail to enroll within your new hire eligibility or the Open Enrollment period, you will not be able to elect benefits again until the next annual enrollment period, and you will not have coverage.

MEDICAL AND PRESCRIPTION BENEFITS

JANTRAN employees can enroll in either of the PPO medical plans offered through BlueCross BlueShield of Arkansas. Both PPO plans offer preventive care visits covered at 100%, an out-of-pocket maximum to protect you should a catastrophic event occur, and out-of-network coverage if needed. Although out-of-network coverage is available, using in-network providers will save you money. You can find BlueCross BlueShield of Arkansas network providers online at blueadvantagearkansas.com.

Prescription Drugs

When you enroll in either of the PPO medical plans, you are automatically enrolled in prescription drug coverage. If you regularly take the same medications, a mail-order program may allow you to get a 90-day supply for a lower cost, saving you trips to the pharmacy and time waiting in line.

Check with your pharmacy to determine if any special programs are available. Discuss lower-cost alternatives with your physician and check the insurance company's website for a complete drug list at blueadvantagearkansas.com.

Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. For more information about a particular pharmacy or pharmacy claim, visit blueadvantagearkansas.com or call 888-872-2531.

Mail Order Program

The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). Your medications are mailed directly to your home. To order prescriptions through the mail order program, please visit blueadvantagearkansas.com or call 888-872-2531.

SHARx Program for Specialty Medication

Coverage for specialty drugs is only applicable through the pharmacy program if the SHARx program fails to provide a solution. SHARx solutions assist members in obtaining specialty medication through a variety of sources, including manufacturer assistance programs, copay cards, grants, and mail order pharmacies. Contact SHARx customer service at 341-451-3555.

MEDICAL AND PRESCRIPTION BENEFITS

BCBS BASE PPO Plan

BCBS BASE PPO Plan	In-Network	Out-of-Network
Annual Deductible » Individual » Family	 $3,500 $7,000	 $7,000 $14,000
Coinsurance	20% after deductible	40% after deductible
Out-of-Pocket Maximum » Individual » Family	 $9,500 $19,000	 $19,000 $38,000
Preventive Care Visit	Covered in full	40% after deductible
Office Visits » Primary Care visit » Specialist visit » Urgent care visit	 $20 copay $20 copay $50 copay	 $50 copay $20 copay $50 copay
Virtual Health » General Medical » Behavioral Health	 $0 copay $20 copay	 N/A N/A
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Diagnostic Services » Labs & X-rays » Advanced Imaging	 20% after deductible 20% after deductible	 40% after deductible 40% after deductible
Emergency Room » With Emergency Diagnosis » Without Emergency Diagnosis	 $100 copay plus 20% after deductible $200 copay plus 20% after deductible	 $100 copay plus 20% after deductible $200 copay plus 40% after deductible
Prescription Drugs		
Retail *(up to 31 days)* » Generic » Formulary » Non-Formulary » Specialty	 $15 copay $30 copay $55 copay $100 copay	Not covered
Mail Order *(up to 90 days)* » Generic » Formulary » Non-Formulary	 $30 copay $60 copay $110 copay	Not covered

Benefit Costs	Weekly	Semi-Monthly	Monthly
Employee Only	$0.00	$0.00	$0.00
Employee + Spouse	$85.71	$185.70	$371.40
Employee + Child(ren)	$53.01	$114.87	$229.73
Employee + Family	$138.99	$301.14	$602.27

Refer to the plan documents for the full plan description. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage.

MEDICAL AND PRESCRIPTION BENEFITS

BCBS BUY UP PPO Plan

BCBS BUY UP PPO Plan	In-Network	Out-of-Network
Annual Deductible » Individual » Family	 $1,500 $3,000	 $3,000 $6,000
Coinsurance	20% after deductible	40% after deductible
Out-of-Pocket Maximum » Individual » Family	 $7,500 $15,000	 $15,000 $30,000
Preventive Care Visit	Covered in full	40% after deductible
Office Visits » Primary Care visit » Specialist visit » Urgent care visit	 $20 copay $20 copay $50 copay	 $50 copay $20 copay $50 copay
Virtual Health » General Medical » Behavioral Health	 $0 copay $20 copay	 N/A N/A
Inpatient Hospital	20% after deductible	40% after deductible
Outpatient Surgery	20% after deductible	40% after deductible
Diagnostic Services » Labs & X-rays » Advanced Imaging	 20% after deductible 20% after deductible	 40% after deductible 40% after deductible
Emergency Room » With Emergency Diagnosis » Without Emergency Diagnosis	 $100 copay plus 20% after deductible $200 copay plus 20% after deductible	 $100 copay plus 20% after deductible $200 copay plus 40% after deductible
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Mail Order *(up to 90 days)* » Generic » Formulary » Non-Formulary	 $30 copay $60 copay $110 copay	Not covered

Benefit Costs	Weekly	Semi-Monthly	Monthly
Employee Only	$13.85	$30.00	$60.00
Employee + Spouse	$119.28	$258.45	$516.90
Employee + Child(ren)	$95.43	$206.76	$413.52
Employee + Family	$183.88	$398.40	$796.80

Refer to the plan documents for the full plan description. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage.

My Blueprint Member Portal

Our online member portal puts your health plan's power in the palm of your hand. With My Blueprint, you can access and/or manage:

Claims and Policy Info

- View individual claim information and claims documents
- See who's covered
- See what's covered
- Check your copay (a fixed amount you must pay for a covered service)
- View your healthcare spending details (see where you are on your deductible levels and out-of-pocket expense limits)
- Choose your primary care physician (PCP)

Member ID Cards

- Access to your digital ID card and email, fax or print it
- Request an ID card electronically
- Speak to a customer service rep about an ID card issue

Your Personal Health Record

- Medications you've been prescribed
- A history of your outpatient and inpatient visits (including dates, symptoms, diagnoses, treatment, etc.)
- Your lab and radiology history (with dates and testing / imaging performed)
- Your immunization history
- A Personal Health Record summary you can save, print, or share

Find Care & Costs

- Procedures (with cost estimates)
- Conditions
- Doctors, hospitals, or facilities
- Pharmacies
- Durable medical equipment (DME)

My Blueprint Member Portal

Pharmacy

- Your claims history
- Drug costs
- Your pharmacy orders (medicines you have received, prescriptions ready for refills, etc.)
- Your cumulative out-of-pocket prescription costs

Blueprint Wellness

- Health risk assessment or Wellbeing assessment
- Wellness progress tracking
- Access to a health library
- Nurse helpline
- Resources like action plans, challenges, decision tree for medical tests, search medical conditions, and virtual coaching
- Health education
- Chronic condition and case management

Virtual Health

- Medical help for non-emergencies, via smartphone, tablet, or computer
- Available 24/7
- Accessible from home or around the globe
- Board-certified, state-licensed physicians (including pediatricians)
- Short wait times (usually 10 minutes or less)

So, the next time you're wondering how much a tonsillectomy will cost you, or when you start that blood pressure medicine, or whether you've met your deductible - just sign in or register for My Blueprint and take a look. The answers you need are all there at your fingertips.

Registration is Easy!

- Visit blueadvantagearkansas.com
- Select the **Member Portal** tab, then click the **Register** button
- Follow the instructions. All you need is your:
  - » Member ID or the last four digits of your Social Security number
  - » Name
  - » Date of birth

If you're already a My Blueprint user, simply enter your username and password to sign in and access your account.

On the Go?

Download the My Blueprint Mobile App to view, print, or email your ID card while you are in your doctor's office. You can also access many more features through the app to manage your health plan.

Download on the App Store

GET IT ON Google Play

Using Your Pharmacy Benefits

Whether you're healing from an illness or managing a chronic condition – prescription medications can play an important role in your wellness journey. As a card-carrying Arkansas BlueCross and BlueShield member, you have access to a full suite of pharmacy benefits that connect you to the prescriptions you need as easily and cost effectively as possible. Access to your medications starts with your member ID card, which is accepted at in-network pharmacies.

You can access our extensive pharmacy center by signing into My Blueprint and completing a one time sign up for a CVS Caremark account. You will have direct access to your pharmacy account information, find ways to save on your prescriptions, sign up for email or text alerts about your medications, request refills and more. From there, you'll be able to conveniently manage your prescriptions, as well as the prescriptions of everyone else on your health plan.

ID Card

You'll always have your ID card available, which you can view and/or print from My Blueprint, blueadvantagearkansas.com/myblueprint, or access directly from our mobile app.

Pharmacy Locator

Find network pharmacies near you by entering a zip code, or specific pharmacy you are trying to locate at My Blueprint, blueadvantagearkansas.com/myblueprint, or by using your current location with our mobile app. Select **Find Care**, then **Pharmacies**.

Drug Cost and Coverage

Find out how much your medication will cost under your plan, and whether there are opportunities to save money from your phone, tablet, or our member portal.

Request a New Prescription

With this feature, just enter the name and strength of your medication, and your doctor's name.

Using Your Pharmacy Benefits

Delivery by Mail and Text Reminders

You can have a 90-day supply of maintenance medications delivered by mail. They are filled by a licensed pharmacist, checked for quality and delivered in discreet, weather-proof, secure packages. Typically, a 90-day supply of a prescription will cost less than the same amount of medication split into three 30-day supplies. We'll send a reminder text 10 days before you're due for your next supply. Talk with your doctor about this option so your prescriptions can be written accordingly.

Easy Refills

Refill your mail order prescriptions without logging in. Just enter the prescription number from your pill bottle, and your date of birth.

Visit blueadvantagearkansas.com/myblueprint to register, or download the mobile app.

And if you already have an account, sign in to access your medications 24 hours a day, seven days a week.

Download on the App Store

GET IT ON Google Play

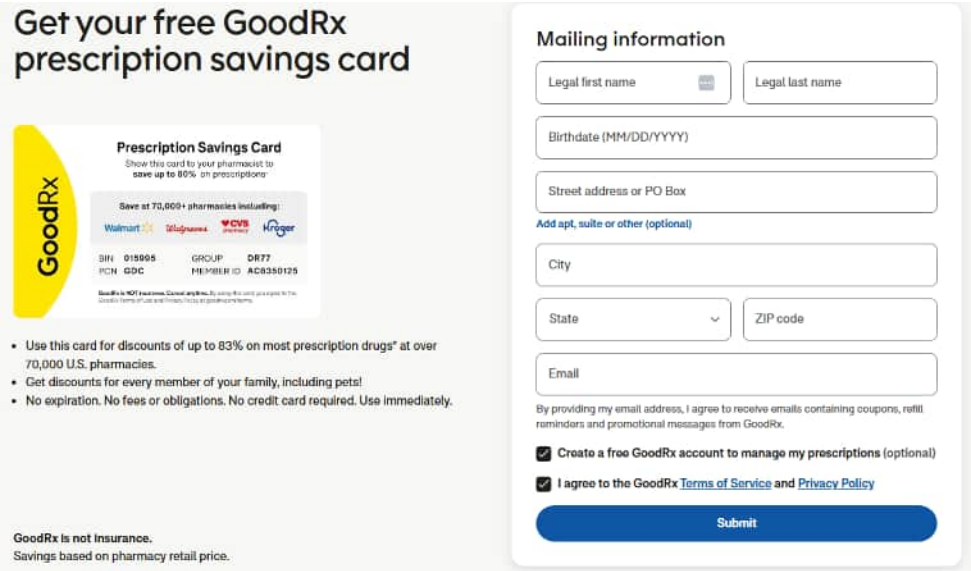
GoodRx

Additional Saving on Prescriptions through GoodRx

JANTRAN understands that one of the largest expenses to our employees in regard to healthcare is prescription drugs. This is of particular concern when covered by High-Deductible Health Plans. There are several ways to save money on prescription costs. In addition to comparing pharmacy pricing, GoodRx offers discounts of up to 80% on most prescription drugs at over 70,000 U.S. pharmacies.

You do not have to wait to begin saving! You can logon to goodrx.com/discount-card to request a card be mailed to you or you can download the app by using the QR code below.

There is no expiration date, no fees or obligations and no credit card information is required. Once you are in the site you will complete the personal information and a card will be mailed to you within 4 weeks. You will also have the opportunity to print a temporary card right away. This card will work for every member of your family. The card is already activated and ready to use.



Download the GoodRx App

Where to Go for Care

The cost for care and the time you wait can vary greatly depending on where you go. Below is a simple guide to choosing the right place for health care. In addition to clinical settings, you can access Virtual Health for virtual visits.

24/7 Nurseline

If an unexpected medical situation arises, a nurse can help you decide whether to call your doctor, visit the ER or urgent care, or treat the problem yourself. A nurse can also tell you if you can wait to see the doctor the next day.

Doctor's Office

Your primary care physician (PCP) should be your first choice for non-emergency care and ongoing health conditions. Your PCP knows your medical history, can help manage chronic conditions, and recommend specialists or other medical care.

Virtual Visit

If your doctor isn't available, you are out of town, or you need care after hours for a simple condition, try a virtual visit. Go online or access the app to make an appointment with a physician anytime, 24/7, wherever you are.

Urgent Care and Retail Clinics

If your doctor isn't available or you need care after hours for a non-life-threatening issue, visit an urgent care or retail health clinic for simple conditions such as a cold or the flu. Urgent care centers can provide a greater range of care, including X-rays.

Emergency Room

Only visit the ER for serious, life-threatening medical care. If you are dealing with a health emergency, call 911 or go to the ER immediately. Do not visit for routine care or minor ailments.

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Virtual Health

BEHAVIORAL

Wouldn't it be great if you had your own professional counselors who would be on call 24/7 to help you with emotional/mental health issues? Actually you do!

Help for your behavioral health needs is as close as your smartphone or computer. Virtual Health (powered by MDLIVE) is available for you 24/7.

Use it to talk through behavioral health nonemergencies like:

- **Family trouble**
- **Substance use problems**
- **Job stress**

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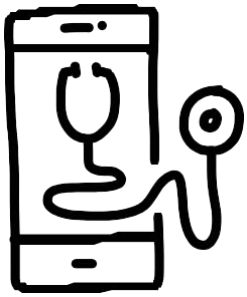
Register today, so when you need care, help is always available.

State-licensed, board-certified physicians are always ready and waiting **around the clock**.

Go to **myvirtualhealth.com** and follow the simple steps to sign up or log in.

For true emergencies (anytime your emotional condition might make you a danger to yourself or others) get inpatient care immediately.

But for nonemergencies, you can use virtual health to get the behavioral care you need without leaving home.



Use virtual health for:

- Addictions
- Anxiety
- Depression
- Bipolar disorders
- Eating disorders
- LGBTQ support
- Grief and loss
- Relationship issues
- Men's issues
- Panic disorders
- Stress management
- Trauma and PTSD
- Women's issues
- More

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MDLIVE is a separate company that provides telehealth services for members of BlueAdvantage Administrators of Arkansas.

Virtual Health currently is available to all fully insured health plans but not available to all health plans. Members with an active medical plan whose coverage includes Virtual Health should be able to successfully register via the link within My Blueprint. Your benefit summary will indicate if Virtual Health is available to you. Notably, it is not available to members who have limited duration plans, Medicare Prescription Drug and Medicare Supplement plans, or plans covering employees of FEP, Arkansas State and Public Schools, or Baptist Health.

Behavioral health benefits through Virtual Health are available for select members served by BlueAdvantage Administrators of Arkansas. For coverage verification, call the number on the back of your member ID card or contact your group administrator.

blueprint

Virtual Health

Set up access to online medical help

You need healthcare 24/7 — not just when it's convenient.

Virtual health (powered by MDLIVE) gives you access to medical help for nonemergency conditions on your smartphone or computer.

Get started!

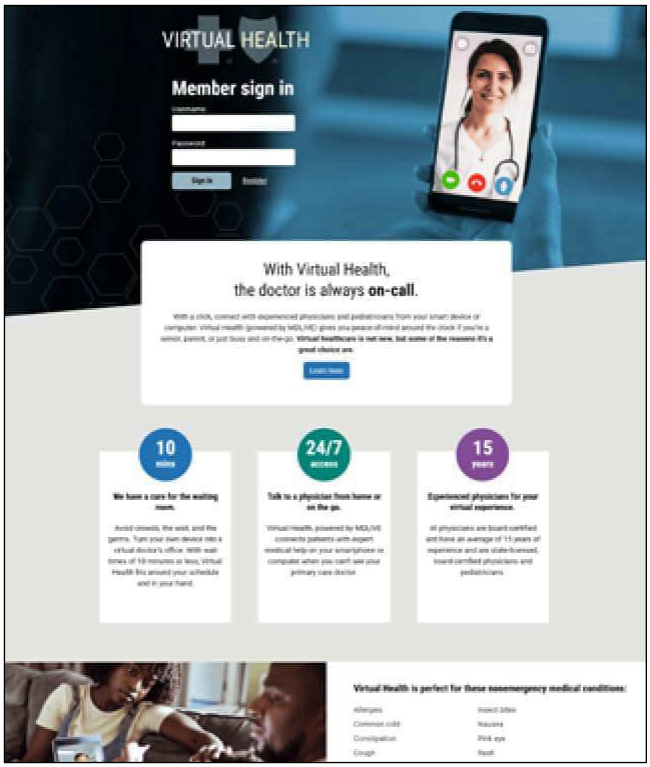
1. **Go to** MyVirtualHealth.com

2. **Go to Member sign in**
   - Sign in or register for your Blueprint Portal account.

3. **Activate your virtual health account**
   - In Blueprint Portal, select **Virtual Health** from the tHealth & Wellness tab, select **Visit MDLIVE** and follow the prompts to activate your account.

     (**Note**:You'll skip this step in the future and be sent directly to MDLIVE.)
   - Establish your account profile and those of your dependents if applicable.You will need member ID numbers to complete this step.

1. **Choose a doctor**
   - Choose from a large network of state-licensed, board- certified doctors (including pediatricians).



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5. **Start your virtual health visit**

You may be required to have your first call be a video call (like FaceTime or Skype).

- Choose to see the next available physician (usually within 10 minutes) or schedule an appointment at a specific time, with a specific physician.
- You will need to provide some details about your past history and medical problem(s):

Reason(s) for visit

Medicines you currently take

Payment information

What can be treated

- Allergies
- Common cold
- Constipation
- Cough
- Diarrhea
- Ear problems
- Fever
- Flu
- Headache
- Insect bites
- Nausea
- Pink eye
- Rash
- Respiratory problems
- Sore throat
- Urinary problems
- Vomiting
- More

We recommend setting up your account now. That way, when you need to speak with a doctor you can just sign in and get the help you need. The details of your call are confidential and secure. For emergencies (like broken bones, excessive bleeding, dangerously high fever, symptoms of heart attack or stroke, etc.) get to the nearest emergency room. But for many common conditions, Virtual Health is your healthcare solution. Anytime, anywhere.

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Dental Benefits

JANTRAN offers dental coverage through Delta Dental. This plan allow you to use in-network or out-of-network benefits. However, you will be responsible for paying the difference between the allowed amount and what the dentist may charge, also known as "balance billing," when you visit an out-of-network provider. To find an in-network provider, go to deltadentalar.com.

Services	In-Network	Out-of-Network
Annual Deductible Individual / Family	$50 / $150	$50 / $150
Annual Plan Maximum	$1,000 per member	$1,000 per member
Diagnostic & Preventive Exams, cleanings, X-rays	100%, deductible waived	100%, deductible waived
Basic Services Simple extractions, fillings, oral surgery	80% after deductible	80% after deductible
Major Services Crowns, bridges, dentures, inlays, onlays	50% after deductible	50% after deductible
Orthodontia Children to age 19 only	50% after deductible $1,000 lifetime maximum	50% after deductible $1,000 lifetime maximum

Benefit Costs	Weekly	Semi-Monthly	Monthly
Employee Only	$6.00	$13.00	$25.99
Employee + Spouse	$17.66	$38.26	$76.52
Employee + Child(ren)	$17.66	$38.26	$76.52
Employee + Family	$17.66	$38.26	$76.52

Refer to the plan documents for the full plan description. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage.

Prevention & Oral Hygiene

Oral health problems—ranging from cavities to cancer—are painful and costly. This is alarming because almost all oral diseases can be prevented with the proper knowledge and prevention techniques. Seeing a dentist twice a year is recommended for most people. However, people with a high risk of problems might need to see the dentist every three or four months for optimal care. Maintaining good oral hygiene is one of the most important things you can do for your teeth and gums.

Vision Benefits

JANTRAN offers vision coverage through MetLife on the VSP network. The vision plan allows you to use in-network or out-of-network providers. However, when using out-of-network providers, you will pay expenses at the time of service and file a claim for reimbursement. To find in-network providers, visit vsp.com and enter your search criteria.

Services	In-Network	Out-of-Network
Eye Exam (every 12 months)	$10 copay	Up to $45 reimbursement
Lenses (every 12 months)		
Single	$25 copay	Up to $30 reimbursement
Bifocal	$25 copay	Up to $50 reimbursement
Trifocal	$25 copay	Up to $65 reimbursement
Polycarbonate	$25 copay	Not covered
Frames (Every 12 months)	$150 allowance + 20% discount on remaining balance	Up to $70 reimbursement
Contact Lenses		
Fitting and Evaluation	Covered in full with $60 max copay	N/A
Elective	$150 allowance	Up to $105 reimbursement
Medically Necessary	Covered after eyewear copay	Up to $210 reimbursement
Retail Frame Benefit	$85 allowance at Costco, Walmart and Sam's Club	

Benefit Costs	Weekly	Semi-Monthly	Monthly
Employee Only	$2.10	$4.56	$9.12
Employee + Spouse	$3.37	$7.30	$14.60
Employee + Child(ren)	$3.44	$7.45	$14.90
Employee + Family	$5.55	$12.02	$24.03

Refer to the plan documents for the full plan description. This chart is intended only to highlight the benefits available and should not be relied upon to fully determine your coverage.

In-Network Value Added Features:

- **Additional Lens Enhancements:** In addition to standard lens enhancements, enjoy an average 20-25% savings on all other lens enhancements.*
- **Savings on glasses and sunglasses:** Get 20% savings on additional pairs of prescription glasses and non-prescription sunglasses, including lens enhancements. At times, other promotional offers may also be available.*
- **Laser Vision Correction**:** Savings averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK LASIK and Custom LASIK. This offer is only available at MetLife participating locations.

* All lens enhancements are available at participating private practices. Maximum copays and pricing are subject to change without notice. Please check with your provider for details and copays applicable to your lens choice. Please contact your local Costco, Walmart, and Sam's Club to confirm availability of lens enhancements and pricing prior to receiving services. Additional discounts may not be available in certain states.

** Custom LASIK coverage only available using wavefront technology with the microkeratome surgical device. Other LASIK procedures may be performed at an additional cost to the member. Additional savings on laser vision care is only available at participating locations.

MetLife | Vision Insurance

Learn more about your MetLife benefits

MetLife benefits information right from your laptop.

The MyBenefits website is a quick and easy way for you to get the information you need about your MetLife benefits—all in one place. Log in to **metlife.com/mybenefits** to see how we've taken personalization and integration to a new level.

Personalized homepage for all your MetLife benefits

Perform tasks, get links to detailed coverage and read further about your MetLife benefits and information, such as:

Vision Plans – Easily find an in-network or participating vision provider or view your benefits and claims online.

Vision ID cards – Available online for you to download and print at your convenience. Cards contain your name, MetLife's claims submission address, website and customer service telephone number.

Additional MyBenefits features include:

- Planning tools to help you make informed decisions about your retirement, benefits coverage and other useful information on a variety of everyday topics.
- Important forms and documents are available to download in the "Tools & Resources" area at the bottom of the MyBenefits homepage.
- In the "News & Updates" section, you'll find information from MetLife and your employer, including enrollment dates and new product offerings.

metlife.com/mybenefits

Did you know?

The MetLife mobile app is available in the App Store and on Google Play. Download the app and use it to find a participating provider.

MetLife | MetLife VisionAccess

Help your employees monitor their vision at no additional cost to you

Detecting vision problems is an important part of employees' overall health[1], but it may not be a benefit you can afford to offer. That's why we offer MetLife VisionAccess. It can provide your employees with savings on vision care and eyewear so they can stay on top of their vision health — with no additional cost to you.

92%

of employees say vision coverage is a must-have benefit.[4]

Choice. Potential Savings. Convenience.

We help make it easier for employees to get the vision care they need.

- Choice of over 91,000 private practice network access points[2]
- Potential savings on a broad range of services — including laser vision correction[3]
- Online servicing to quickly find a provider, review covered services or print an ID card

It's easy to get started.

Just provide your employees with the program ID card flyer, and we'll take care of the rest.

- No additional benefit costs
- No eligibility files or administration
- No enrollment or claim forms

Potential Member Savings

Exam	
Exam	20% off of Usual and Customary fee, with a maximum copay of: **Region 1:** $90 **Region 2:** $90 **Region 3:** $80 **Region 4:** $75
Exam — Contact Lens	15% off of Usual and Customary fee Discounts on contact lens materials are not available. Members should check with their participating private practice for available offers.
Standard Corrective Lenses — Glass or Plastic	
Single Vision	20% off of Usual and Customary fee, with a maximum copay of: **Region 1:** $50 **Region 2:** $45 **Region 3:** $45 **Region 4:** $40
Lined Bifocal	20% off of Usual and Customary fee, with a maximum copay of: **Region 1:** $70 **Region 2:** $65 **Region 3:** $65 **Region 4:** $60
Lined Trifocal	20% off of Usual and Customary fee, with a maximum copay of: **Region 1:** $90 **Region 2:** $85 **Region 3:** $85 **Region 4:** $75
Standard Lens Options	
Ultraviolet Coating	20% off of Usual and Customary fee, with a maximum copay of $15
Tint-Solid or Gradient	20% off of Usual and Customary fee
Standard Scratch-Resistant Coating (Scratch A)	20% off of Usual and Customary fee, with a maximum copay of $15
Standard Polycarbonate	20% off of Usual and Customary fee, with a maximum copay of $40
Standard Progressive	20% off of Usual and Customary fee, add on to bifocal, with a maximum copay of $55
Basic Anti-Reflective Coating	20% off of Usual and Customary fee, with a maximum copay of $45
Blended Invisible Bifocal	20% off of Usual and Customary fee
Intermediate Vision Lenses	20% off of Usual and Customary fee
High Index	20% off of Usual and Customary fee
Polarized	20% off of Usual and Customary fee
All Other Lens Options/Features	20% off of Usual and Customary fee
Additional Discounts	
Frames	25% off of Usual and Customary fee
Laser Vision Correction[2]	Discounts averaging 15% off the regular price or 5% off a promotional offer for laser surgery including PRK, LASIK and Custom LASIK. Discounts only available from participating facilities.
Non-Prescription Sunglasses	20% off of Usual and Customary fee

REGION KEY

Region 1
AK, CA (Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano), CT, DC, HI, MA, NJ, and NY (Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester)

Region 2
CA (all except Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano), DE, FL, IL, MD, MI, NH, NV, PA, RI, and WA

Region 3
AZ, CO, GA, LA, ME, MN, NM, NY (all except Bronx, Kings, Nassau, New York, Queens, Richmond, Rockland, Suffolk, Westchester), OH, OR, TX, UT, VA, and VT

Region 4
AL, AR, IA, ID, IN, KS, KY, MO, MS, MT, NC, ND, NE, OK, SC, SD, TN, WI, WV, WY, and PR

Discounts are only available through private practices participating in the MetLife VisionAccess network.

The Usual and Customary fee is based on the lowest of (1) the vision provider's actual charge, (2) the vision provider's usual charge for the same or similar services, or (3) the charge of most vision providers in the same geographic area for the same or similar services as determined by Vision Service Plan (VSP).

Get expert guidance for confident decisions — for your organization and your employees.
Contact your MetLife representative today.

MetLife

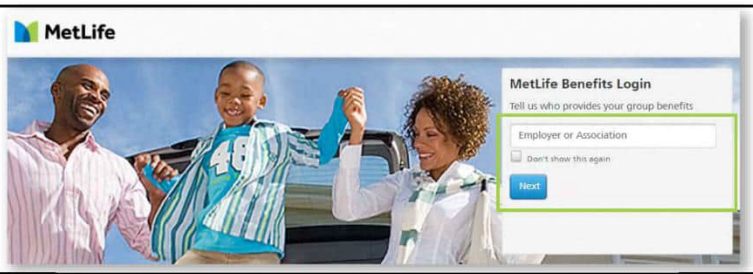
How To Register On MyBenefits

MyBenefits provides you with a personalized, integrated and secure view of your MetLife delivered benefits. You can take advantage of a number of self-service capabilities as well as easy to access information. As a first-time user, you will need to register on MyBenefits by following the steps outlined below:

Registration Process For MyBenefits:

STEP 1 – Provide A Group Name

Access MyBenefits at mybenefits.metlife.com. Enter your employer name, select it in the drop down and select 'Next'. Save this URL to access your MyBenefits account in the future.



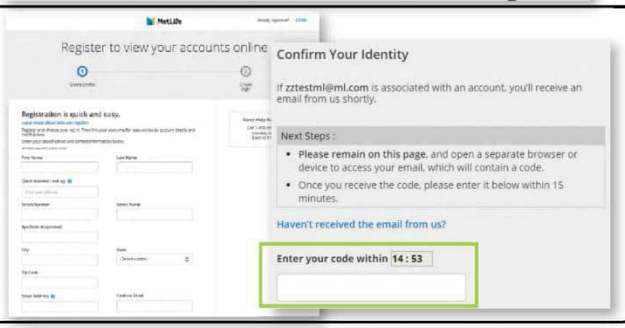
STEP 2 – Register

Once you have selected your employer, from the MyBenefits Home Page you will then select the 'Register' button.

Note – Current users will select 'Log In' and enter their username and password.

STEP 3 – Enter Authentication Information

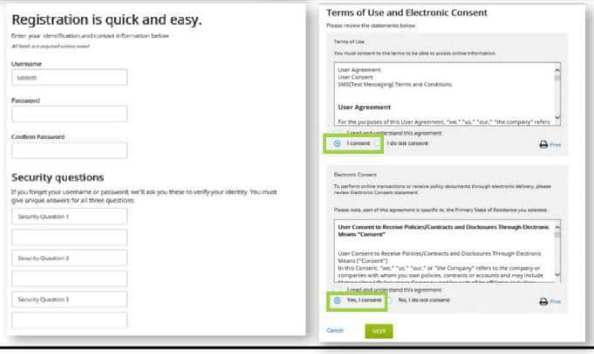
The next screen will begin by entering your name, address, phone number, e-mail (required) and unique security identifiers to confirm your identity. You will then receive a security code, via email or text, that you will need to enter to continue the registration process.



STEP 4 – Establish Account Credentials

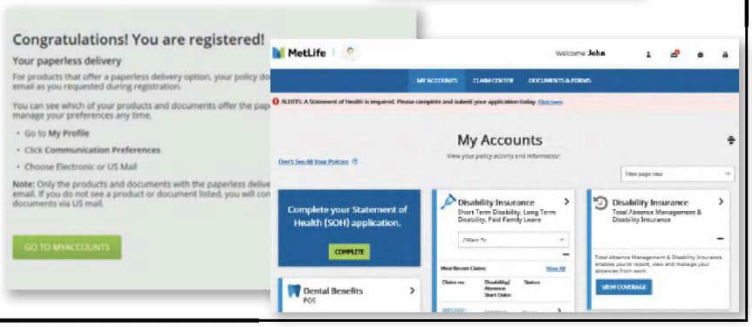
You will then be prompted to create a unique username and password for future access to MyBenefits, as well as choose and answer three identity verifications questions that will be used in the event you forget your password.

In addition to reading and agreeing to the Terms of Use, you will be asked to opt into electronic consent.



STEP 5 – Registration Is Complete

Once you have completed the process a 'congratulations' message window will display. You are now registered on MyBenefits! A registration confirmation email will be sent to the email address provided for your registration. You can immediately access your account information by selecting the 'Go To My Account' button within the congratulations window.



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MetLife Online Services capabilities may vary by product and may not be available to all customers. Please contact your MetLife representative for more information.

Life and AD&D

Employer Paid Life and AD&D

JANTRAN provides each employee with Basic Life and Accidental Death & Dismemberment (AD&D) insurance through Mutual of Omaha and pays for the full cost of coverage. Eligible employees receive $30,000 in coverage. Benefits reduce by 35% at age 65, and 50% of the original amount at age 70. Spouse benefit will terminate when employee reaches age 70.

Ensuring your beneficiary information is correct at enrollment and throughout the year is essential. Speak to a benefit counselor during open enrollment or contact HR to update your information anytime throughout the year.

Voluntary Life and AD&D

JANTRAN employees may supplement their company-paid Basic Life Insurance by purchasing additional coverage through Mutual of Omaha. In addition, after electing coverage for yourself, you may purchase coverage for a spouse and child(ren). You may purchase the following amounts for yourself and your dependents. Speak to a benefit counselor to calculate your coverage cost.

EMPLOYEE	SPOUSE	CHILD(REN)
Increments of $10,000 to $500,000 maximum, not to exceed 5x annual salary amount. **Guarantee Issue:** $200,000	Increments of $5,000 up to $250,000 maximum. **Guarantee Issue:** $50,000	Flat amount: $10,000 **Guarantee Issue:** All amounts

Guarantee Issue

The Guarantee Issue (GI) amount is the highest coverage you or your dependents may elect without completing an Evidence of Insurability (EOI) form. Suppose you elect an amount above the GI limit or wish to increase your benefit amount at a future date. In that case, the coverage amount over the GI level will not go into effect until your EOI has been reviewed and approved, and payroll deductions have begun.
For full details, refer to the Certificate of Coverage.

Lifetime Life Insurance

Be sure to reach out to a benefit counselor to review this new life insurance benefit offered by Voya. It is permanent life insurance that includes a Long-Term Care benefit.

EMPLOYEE	SPOUSE	CHILD(REN)
$5,000 to a maximum of $125,000 in $5,000 increments	$5,000 to a maximum of $75,000 in $5,000 increments (not to exceed the employee's life insurance amount)	Choice of $5,000, $10,000, $15,000, $20,000 or $25,000

Disability Benefits

Whether you are disabled and unable to work due to an accident or illness, JANTRAN offers Short- and Long-Term Disability coverage options through Mutual of Omaha. Disability is insurance for your paycheck should you become disabled due to an off-the-job injury or illness. This coverage will provide a percentage of your salary once you satisfy the waiting period. Refer to the Plan Summaries for details.

Voluntary Short-Term Disability

JANTRAN offers all full-time employees working a minimum of 30 hours per week the option to purchase Short-Term Disability (STD) insurance coverage. After a 14-day waiting period, the benefit pays 60% of your weekly pre-disability earnings to a maximum of $1,150 per week up to 24 weeks or until you no longer meet the definition of disability, whichever occurs first.

Voluntary Long-Term Disability

JANTRAN offers all full-time employees working a minimum of 30 hours per week the option to purchase Long-Term Disability (LTD). The benefit would pay 60% of your monthly pre-disability earnings to a maximum of $10,000 per month until you no longer meet the definition of disability or reach the Social Security Normal Retirement Age (SSNRA) after a 180-day waiting period. Your cost for LTD coverage can be calculated when you make your benefits elections.

PLAN HIGHLIGHTS	SHORT-TERM DISABILITY	LONG-TERM DISABILITY
Benefits Begin	Accident / Illness: 14 days	180 days
% of Salary Replaced	60% of weekly earnings	60% of monthly earnings
Benefit Maximum	$1,150 per week	$10,000 per month
Benefit Duration	24 weeks	End of disability or SSNRA
Pre-existing Condition	3/6	12/12

See plan details for exclusions, including pre-existing limitations.

Accident Insurance

Where most medical plans only pay a portion of the bills, Accident insurance can provide a cash benefit if you or a covered dependent experiences an eligible event and offers an annual health screening benefit. Covered services include:

- Hospital/ICU admission
- Inpatient surgical
- Emergency transportation and care
- Fractures, burns, lacerations, dislocations
- Accidental death benefit

Wellness Benefit

This plan also offers a wellness benefit of $75 for each employee, their spouse, and children, once per calendar year, payable when certain wellness tests are performed as the result of a preventive care visit.

Organized Sports Activity Injury Benefit Rider

If a covered person has an accident that is due to organized sports activity, we will pay an extra 25% of eligible benefits, subject to limitations described in the certificate, under the following benefit categories: Accidental Injury, Accident Medical Treatment and Services, Hospital benefits. *The Organized Sports Activity Injury Benefit Rider is pending regulatory approval in some states.*

Benefit Costs	Weekly	Semi-Monthly	Monthly
Employee Only	$2.60	$5.64	$11.28
Employee + Spouse	$5.12	$11.09	$22.18
Employee + Child(ren)	$6.14	$13.30	$26.59
Employee + Family	$7.25	$15.71	$31.42

Accident Plan Summary	Base Plan
Accidental Death Benefit Employee Spouse Child	 $50,000 $25,000 $12,500
Accidental Death on Common Carrier Employee Spouse Child	 $150,000 $75,000 $37,500
Loss of hearing	up to $25,000
Loss of sight	up to $50,000
Loss of limbs	up to $50,000
Fractures	up to $5,000
Dislocations	up to $5,000
Burns	up to $15,000
Skin Grafts	50% of Burn Benefit
Concussion	$500
Coma	$10,000
Rupture Disc	$650
Knee Cartilage	$650
Laceration	up to $800
Prosthetic Device Benefit	$2,000 One device per covered accident
Hospital Admission	$1,500
Intensive Care Admission	$3,000
Hospital Confinement	$300/day – up to 365 days
Intensive Care Confinement	$600/day – up to 30 days
Prosthetic Device or Artificial Limb	$2,000 One device per covered accident
Chiropractic Visit	$50 per visit up to 10 times
Therapy Services Benefit (including physical therapy)	$50 per visit up to 10 times
Blood, Plasma, Platelets	$500
Ambulance Benefit Ground	$400
Lodging Benefit	$200 – up to 30 nights

Critical Illness Insurance

Critical Illness insurance pays a lump sum cash benefit when you or a covered family member is diagnosed with a serious illness, such as a heart attack, stroke, major organ failure, or cancer.

You may use this benefit any way you choose to pay for non-medical expenses that have occurred due to the diagnosis, such as lost wages, family care, rehabilitation, or transportation. The plan also offers an annual health screening benefit. Benefits are paid to you regardless of any additional coverage you have.

You may purchase the following amounts for you and your family:

- **Employee Amount:** Choice of $10,000, $20,000 or $30,000
- **Spouse Amount:** 50% of employee amount
- **Child(ren) Amount:** 50% of employee amount

Wellness Benefit

This plan also offers a wellness benefit of $75 for each employee, their spouse, and children, once per calendar year, payable when certain wellness tests are performed as the result of a preventive care visit.

Covered Critical Illnesses	Benefit
• Invasive Cancer • Heart Attack • Major Organ Failure • End-Stage Renal Failure • Sudden Cardiac Arrest • Occupational HIV • Functional Loss • Paralysis • Severe Burn • Stroke • ALS/Other Motor Neuron Disease • Advanced Alzheimer's • Parkinson's Disease • Advanced Multiple Sclerosis • Coma • Benign Brain Tumor • Major Congenital Structural Anomaly • Congenital Metabolic Disorder • Congenital Chromosomal Abnormality	100%
• Coronary Artery Disease (needing surgery or angioplasty) • Minor Cancer	50%
• Infectious Disease (Minimum Hospital Stay: 5 days)	25%

Critical Illness Insurance Premiums

Employee Weekly Premium $10,000 Benefit Amount				
Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$1.10	$1.81	$1.60	$2.33
25-29	$1.18	$1.99	$1.70	$2.49
30-34	$1.37	$2.26	$1.87	$2.76
35-39	$1.62	$2.66	$2.14	$3.16
40-44	$2.10	$3.36	$2.60	$3.86
45-49	$2.82	$4.44	$3.32	$4.94
50-54	$4.11	$6.19	$4.61	$6.69
55-59	$5.86	$8.52	$6.38	$9.01
60-64	$8.27	$11.76	$8.76	$12.25
65-69	$11.65	$16.28	$12.15	$16.78
70-74	$15.45	$21.68	$15.95	$22.18
75+	$20.67	$29.51	$21.16	$30.01

Employee Semi-Monthly Premium $10,000 Benefit Amount				
Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$2.39	$3.92	$3.47	$5.04
25-29	$2.57	$4.32	$3.69	$5.40
30-34	$2.97	$4.91	$4.05	$5.99
35-39	$3.51	$5.76	$4.64	$6.84
40-44	$4.55	$7.29	$5.63	$8.37
45-49	$6.12	$9.63	$7.20	$10.71
50-54	$8.91	$13.41	$9.99	$14.49
55-59	$12.69	$18.45	$13.82	$19.53
60-64	$17.91	$25.47	$18.99	$26.55
65-69	$25.25	$35.28	$26.33	$36.36
70-74	$33.48	$46.98	$34.56	$48.06
75+	$44.78	$63.95	$45.86	$65.03

Employee Weekly Premium $20,000 Benefit Amount				
Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$1.41	$2.33	$2.04	$2.95
25-29	$1.62	$2.66	$2.24	$3.28
30-34	$1.99	$3.20	$2.62	$3.86
35-39	$2.49	$3.99	$3.12	$4.65
40-44	$3.41	$5.40	$4.07	$6.02
45-49	$4.90	$7.56	$5.52	$8.18
50-54	$7.44	$11.05	$8.10	$11.67
55-59	$10.97	$15.74	$11.59	$16.37
60-64	$15.78	$22.18	$16.41	$22.80
65-69	$22.51	$31.24	$23.14	$31.86
70-74	$30.12	$42.04	$30.74	$42.70
75+	$40.54	$57.70	$41.21	$58.32

Employee Semi-Monthly Premium $20,000 Benefit Amount				
Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$3.06	$5.04	$4.41	$6.39
25-29	$3.51	$5.76	$4.86	$7.11
30-34	$4.32	$6.93	$5.67	$8.37
35-39	$5.40	$8.64	$6.75	$10.08
40-44	$7.38	$11.70	$8.82	$13.05
45-49	$10.62	$16.38	$11.97	$17.73
50-54	$16.11	$23.94	$17.55	$25.29
55-59	$23.76	$34.11	$25.11	$35.46
60-64	$34.20	$48.06	$35.55	$49.41
65-69	$48.78	$67.68	$50.13	$69.03
70-74	$65.25	$91.08	$66.60	$92.52
75+	$87.84	$125.01	$89.28	$126.36

Employee Weekly Premium $30,000 Benefit Amount				
Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$1.74	$2.80	$2.49	$3.61
25-29	$2.06	$3.30	$2.80	$4.11
30-34	$2.62	$4.17	$3.36	$4.92
35-39	$3.36	$5.36	$4.11	$6.11
40-44	$4.74	$7.48	$5.48	$8.22
45-49	$6.98	$10.72	$7.73	$11.46
50-54	$10.78	$15.95	$11.59	$16.70
55-59	$16.08	$22.93	$16.82	$23.68
60-64	$23.30	$32.65	$24.05	$33.40
65-69	$33.40	$46.23	$34.14	$46.98
70-74	$44.80	$62.43	$45.55	$63.18
75+	$60.44	$85.92	$61.25	$86.67

Employee Semi-Monthly Premium $30,000 Benefit Amount				
Attained Age	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
<25	$3.78	$6.08	$5.40	$7.83
25-29	$4.46	$7.16	$6.08	$8.91
30-34	$5.67	$9.05	$7.29	$10.67
35-39	$7.29	$11.61	$8.91	$13.23
40-44	$10.26	$16.20	$11.88	$17.82
45-49	$15.12	$23.22	$16.74	$24.84
50-54	$23.36	$34.56	$25.11	$36.18
55-59	$34.83	$49.68	$36.45	$51.30
60-64	$50.49	$70.74	$52.11	$72.36
65-69	$72.36	$100.17	$73.98	$101.79
70-74	$97.07	$135.27	$98.69	$136.89
75+	$130.95	$186.17	$132.71	$187.79

Hospital Indemnity Insurance

A hospital admission can result in significant financial hardship. You may have a large deductible to meet in addition to other hospital-related charges for surgery, anesthesia, radiology, and more. A Hospital Indemnity policy provides a lump sum cash benefit paid directly to you to help offset those expenses not covered by your major medical insurance. You may elect coverage for yourself, your spouse, and children. Reimbursement increases with the number of days you are hospitalized. Refer to the Certificate of Coverage for more information about pre-existing condition limitations, covered services, and other limitations and exclusions.

Hospital Indemnity Summary	Benefit
Hospital Admission	$1,000 per admission
Hospital ICU Admission	$1,000 per admission
Hospital Confinement	After first day, $200 per day up to 365 days
Hospital ICU Confinement	After first day, $800 per day up to 30 days
Substance Abuse/Mental Health Facility	$100 per day up to 30 days

Benefit Costs

	Weekly	Semi-Monthly	Monthly
Employee Only	$3.59	$7.78	$15.56
Employee + Spouse	$10.81	$23.42	$46.84
Employee + Child(ren)	$6.51	$14.11	$28.21
Family	$13.73	$29.75	$59.50

Lifetime Life Insurance Benefits

Lifetime Life Insurance may be a great supplement to any term life insurance you may already have because it protects your loved ones for your entire life, not just while you're working. Lifetime Life Insurance is permanent coverage you own; as long as the premiums are paid it can never be cancelled, even if your health changes.[1]

Employee must elect coverage in order for spouse and children to be eligible to enroll. Available coverage is subject to certain minimums and maximums summarized in the Lifetime Coverage Limits table below.

PLAN HIGHLIGHTS	Age	Defined Benefit Certificates (Min/Max)
Employee	Up to age 75	$5,000 / $125,000

See plan details for exclusions, including pre-existing limitations.

PLAN HIGHLIGHTS	Age	Defined Benefit Riders (Min/Max)
Spouse	Up to age 65	$5,000 / $75,000 Not to exceed employee's benefit amount
Children	Up to age 26	$5,000 / $25,000

Guaranteed Issue maximums are available in the employee's initial period of eligibility by answering "Yes" to the question ("Are you at work on a full-time basis, performing your usual duties?"). After the initial enrollment period guaranteed issue maximums are subject to change. *Guaranteed issue available for children at $5,000 - $10,000 Face Amount Value Only.*

Benefit reduction schedule – 50% at the latter of age 70 or after 25 years of paying premium. Long-term care benefits are paid based on the original death benefit.

Lifetime Life Insurance Benefits

Additional Benefits and Riders

Some or all of these benefits may be available during the enrollment period. Riders may have terms under which they may be continued in force or discontinued. Refer to the riders for complete provisions, limitations and exclusions.

Spouse Lifetime Life Insurance Rider

Employees may enroll for spouse term life insurance coverage, as long as the Employee also has Lifetime Life coverage on him/herself. Spouse face amount may not exceed the Employee's face amount.

Spouse Term Life Insurance Rider Form #GLL-SPR-23. May vary by state.

Children's Term Life Insurance Rider

An Employee may enroll for term life insurance coverage on all of their eligible children not to exceed the amount of Employee Lifetime Life insurance. The benefit options for this rider are listed in this proposal. The Children's Term Life Insurance Rider covers all children for the same benefit amount (defined benefit). The premium for this rider is a single rate per unit of face amount, regardless of the number of children.

Children's Term Life Insurance Rider Form #GLL-CHR-23. May vary by state.

Accelerated Death Benefit Rider for Terminal Illness

An insured may collect a portion of their benefit amount if the insured has a qualifying event as defined in the rider. An Accelerated Death Benefit payment will reduce the insured's death benefit. Any remaining death benefit will be payable to the beneficiary upon the insured's death.

Accelerated Death Benefit Rider Form #GLL-ABR-TI-23. May vary by state.

Accelerated Death Benefit Rider for Long Term Care

If the insured is chronically ill and receiving qualified long-term care services, they may collect a portion or all of their death benefit amount after meeting the elimination period of 90 days. A chronic illness is an inability to perform two or more Activities of Daily Living (ADLs) or Severe Cognitive Impairment. See rider for complete definition. The Long-Term Care Accelerated Rider will pay a percentage of your face amount each month, which can help with the growing cost of care. An Accelerated Death Benefit payment will reduce the insured's death benefit.

The Accelerated Death Benefit Rider for Long Term Care also includes two optional benefits – Extension of Benefits and Restoration of benefits.

* Extension of Benefits: Once Accelerated Death Benefit payments have been exhausted under the Accelerated Death Benefit Rider for Long Term Care, the Extension of Benefits allows for one additional extension of the accelerated payments.

* Restoration of Benefits: The restoration of benefits option "restores" the death benefit after each accelerated payment, this feature restores the death benefit to 90% of the original death benefit.

Once an Accelerated Death Benefit Rider for Long Term Care is approved, premium is waived automatically for the duration of the claim. There is no additional premium for this feature.

Accelerated Death Benefit Rider for Long Term Care Form #GLL-ABRLTC-23. May vary by state.

EMPLOYEE ASSISTANCE PROGRAM

Available Services When You Need Help the Most

JANTRAN, Inc
G000BZQ5

Life isn't always easy. Sometimes a personal or professional issue can affect your work, health and general well-being. During these tough times, it's important to have someone to talk with to let you know you're not alone.

With Mutual of Omaha's Employee Assistance Program, you can get the help you need so you spend less time worrying about the challenges in your life and can get back to being the productive worker your employer counts on to get the job done.

Learn more about the Employee Assistance Program services available to you.

We are here for you

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral and mental health topics.

mutualofomaha.com/eap
or call us: 1-800-316-2796

Comprehensive EAP Services

Features	Value to Company and Employees
Employee Family Clinical Services	• An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments • Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters • Access to subject matter experts in the field of EAP service delivery
Counseling Options	• Six sessions per year (per issue) conducted by face-to-face* counseling or telehealth (text, chat, phone, or video) via a secure, HIPAA compliant portal
Exclusive Provider Network	• National network of more than 10,000 licensed clinical providers for face-to-face counseling • National network of more than 30,000 licensed clinical providers for telehealth counseling • Network continually expanding to meet customer needs • Flexibility to meet individual client/member needs

Continued on back.

*California Residents: Knox-Keene Statute limits no more than three face-to-face sessions in a six-month period per person.

Mutual of Omaha

Comprehensive EAP Services *(continued)*

Features	Value to Company and Employees
Access	• 1-800 hotline with direct access to a Master's level EAP professional • 24/7/365 services available • Telephone support available in more than 120 languages • Online submission form available for EAP service requests • EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	• Valuable resources – legal libraries, tools and forms – available on EAP website • 25% discount for ongoing legal services for same issue
Employee Family Financial Services	• Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health
Employee Family Work/Life Services	• Childcare resources and referrals • Elder care resources and referrals

Online Services	• An inclusive website with resources and links for additional assistance, including:
	  • Current events and resources
	  • Family and relationships
	  • Emotional well-being
	  • Financial wellness
	  • Substance abuse and addiction
	  • Legal assistance
	  • Physical well-being
	  • Work and career
	• Bilingual article library

Employee Communication	• All materials available in English and Spanish
Eligibility	• Full-time employees and their immediate family members; including the employee, spouse and dependent children (unmarried and under 26) who reside with the employee
Coordination with Health Plan(s)	• EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible

Insurance products and services are offered by Mutual of Omaha Insurance Company or one of its affiliates. Mutual of Omaha Insurance Company is licensed nationwide. United of Omaha Life Insurance Company is licensed nationwide, except in New York. Companion Life Insurance Company is licensed in New York. Each underwriting company is solely responsible for its own contractual and financial obligations. Some exclusions or limitations may apply. Not all services available in New York.

Your retirement plan— one great benefit, lots of *advantages*

Your retirement plan can be a great way to help you build your financial future. Be sure you're not missing out on the many ways you can benefit.

Tax savings now

When your contributions are taken out of your paycheck before federal income taxes, you may be able to lower your taxable income and find yourself in a lower tax bracket.

Tax savings later

Your retirement plan savings grow tax deferred, so your money and any earnings aren't taxed until withdrawal, ideally at retirement, when your tax rate may be lower.

Flexibility

You contribute as much as you want (subject to plan and IRS limits) to your plan. Plus, you have the flexibility to change your contribution rate at any time (subject to plan limits).

Join your retirement plan today!

Register your account at myplan.johnhancock.com or download John Hancock's retirement app.

Be sure to provide an email address and mobile number to stay connected and get important plan updates and transaction details.

Get started today!

Get started on building your financial future, today!

It's yours!

Even if you change jobs, your contributions and earnings belong to you. You'll typically have several distribution options to help you keep your retirement savings invested and growing on a tax-deferred basis.[1]

Convenience

Your contributions are deducted from your paycheck automatically, so the money you're saving goes right from your paycheck to your plan account. And with regular contributions, your retirement account has a chance to add up.

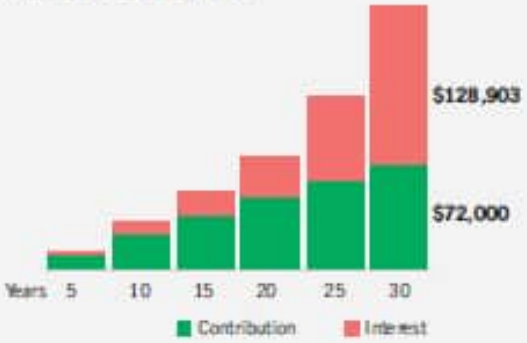
Power of compounding

Compounding is the growth on your original contributions and the earnings. With time on your side, compounding can go a long way toward giving your savings an opportunity to keep growing.

When you save through your retirement plan, your deposits generate earnings. Those earnings are reinvested and generate their own earnings. The earlier you start saving, the more powerful the effect of compounding can be. Start small and incrementally increase your contributions to help meet your savings need. See below how putting away $200 each month in your retirement plan ($50 each week) can grow over time.

$72,000 + **$128,903** → **$200,903**

Total deposits (Principal + contributions) | **Total interest** | **Final balance**



This chart is for illustrative purposes only and assumes a $0 starting balance, $200 per month in contributions, and a 6% annual rate of return.

There is no guarantee that the results shown will be achieved or maintained over any time period. This example assumes no withdrawals; does not take into account fees associated with investing, which, if included, would reduce the account balance; and assumes reinvestment of earnings. Taxes are due at withdrawal.

John Hancock

1 Certain restrictions and conditions may apply. There are advantages and disadvantages to all rollover options; you are encouraged to review your options to determine if staying in a retirement plan, rolling over to an IRA, or another option is best for you.

The content of this document is for general information only and is believed to be accurate and reliable as of the posting date, but may be subject to change. It is not intended to provide investment, tax, or legal advice (unless otherwise indicated). Please consult your own independent advisor as to any investment, tax, or legal statements made herein.

John Hancock Retirement Plan Services LLC provides administrative and/or recordkeeping services to sponsors or administrators of retirement plans through an open-architecture platform. John Hancock Trust Company LLC provides trust and custodial services to such plans.

Group annuity contracts and recordkeeping agreements are issued by John Hancock Life Insurance Company (U.S.A.), Boston, MA (not licensed in New York), and John Hancock Life Insurance Company of New York, Valhalla, New York. Product features and availability may differ by state. All entities do business under certain instances using the John Hancock brand name.

Each entity makes available a platform of investment alternatives to sponsors or administrators of retirement plans without regard to the individualized needs of any plan. Unless otherwise specifically stated in writing, each such company does not, and is not undertaking to, provide impartial investment advice or give advice in a fiduciary capacity. Securities are offered through John Hancock Distributors LLC, member FINRA, SIPC.

NOT FDIC INSURED. MAY LOSE VALUE. NOT BANK GUARANTEED.

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FREQUENTLY ASKED Q&A

General

If I am already enrolled and not making any changes, do I have to complete the Open Enrollment process?
No. However, you are encouraged to review your benefits each year to make sure what you are enrolled in is still what is best for you. It's also a good time to review your beneficiary information.

If I want to decline coverage, must I still complete the Open enrollment process?
Yes. It is important that Human Resources has a record of your decision. Please keep in mind that if you decline coverage, you won't be able to elect coverage during the year unless you have a special qualifying event such as a marriage, divorce, birth or adoption of a child, or loss of other coverage.

Can I enroll my spouse or dependent on one plan and myself on another?
No. All covered dependents, including spouse, must be on the same plan as the employee.

Can I drop or change plans during the plan year?
Changes can only be made if there has been a qualifying event or personal life change. Examples include marriage, divorce, birth of a child, or change in employment status.

What is the difference between a calendar year and a contract year?
A plan on a calendar year runs from January 1–December 31. Items like deductible, maximum out- of-pocket expense, etc. will reset every January 1. All Individual and Family plans are on a calendar year. A plan on a contract year (also called benefit year) runs for any 12-month period within the year. Items like deductible, maximum out-of-pocket expense, etc. will reset at the plan's renewal date. For example, ABC Company renews on July 1 every year. Your deductible would start July 1 and end on June 30. The deductible would reset every July 1 for JANTRAN Company members.

What happens if I sign up for insurance but find later on in the year that I cannot afford the premiums?
If the reason for your change in affordability is due to a life-changing event such as the loss of a job, death of a spouse, or birth of a child, you would be eligible for special enrollment within 30 days of the event. If you do not enroll during this period, you will not be assured a health plan will cover you either through the Health Insurance Marketplace or in the private market. If you do not pay your premium, you could lose coverage and will not be able to enroll again until the next open enrollment period.

Benefit Payments

For benefits received in the Network, you are responsible only for your co-payment, deductible and coinsurance amounts. Your provider will file the claim.

Medical

Should I notify my pharmacy and physician of my benefits plan with BlueCross BlueShield of Arkansas?
Yes. On your next visit to the pharmacy or doctor, simply present your BCBS ID card. This will allow the provider to correctly bill BCBS for the services you have received. It's important to inform your physician of the requirement to utilize an BCBS facility as a medical plan participant.

Required Notices

This document outlines important annual, required legal notices for JANTRAN. If you have any questions about these notices, contact the Human Resources at 662-759-6841.

Women's Health and Cancer Rights Act (WHCRA) 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 (WHCRA) of 1998. 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; and
- 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.

If you have questions about your benefits under HKS medical plans, please call the member services number on your medical plan ID card or contact Payroll & Benefits.

Newborns' and Mothers' Health Protection Act

Federal law (Newborns' and Mothers' Health Protection Act of 1996) prohibits the plan from limiting a mother's or newborn's length of hospital stay to less than 48 hours for a vaginal delivery or 96 hours for a Cesarean delivery or from requiring the provider to obtain pre- authorization for a stay of 48 or 96 hours, as appropriate. However, federal law generally does not prohibit the attending provider, after consultation with the mother, from discharging the mother or her newborn earlier than 48 hours for normal delivery or 96 hours as applicable.

Notice of Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 31 days" after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

Further, if you decline enrollment for yourself or eligible dependents (including your spouse) while Medicaid coverage or coverage under a State CHIP program is in effect, you may be able to enroll yourself and your dependents in this plan if:

- Coverage is lost under Medicaid or a State CHIP program; or
- You or your dependents become eligible for a premium assistance subsidy from the State.

In either case, you must request enrollment within 60 days from the loss of coverage or the date you become eligible for premium assistance.

To request special enrollment or obtain more information, contact person listed at the end of this summary.

Important Notice from JANTRAN 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 BlueCross BlueShield 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. JANTRAN has determined that the prescription drug coverage offered by BlueCross BlueShield 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.

Required Notices

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 during Open Enrollment.

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 JANTRAN coverage will not be affected.

If you do decide to join a Medicare drug plan and drop your current JANTRAN coverage, be aware that you and your dependents will be able to get this coverage back (during open enrollment or in the case of a special enrollment opportunity).

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 JANTRAN 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.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

Contact the person listed on the next page 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 JANTRAN 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: January 1, 2027
Name of Entity/Sender: JANTRAN Corporation
Contract-Position/Office: Human Resources
Address: 3400 Gribble St, North Little Rock, AR 72114
Phone Number: 662-759-6841

Statement of ERISA Rights

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, the Plan and Plan documents, including the insurance contract and copies of all documents filed by the Plan with the U.S. Department of Labor, if any, such as annual reports and Plan descriptions.
- Obtain copies of the Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if required to be furnished under ERISA. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if any.

Required Notices

Continue Group Health Plan Coverage

If applicable, you may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You and your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the Plan for the rules on COBRA continuation of coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to operate the Plan prudently and in the interest of you and other Plan participants.

No one, including the Company or any other person, may fire you or discriminate against you in any way to prevent you from obtaining welfare benefits or exercising your rights under ERISA.

Enforce your Rights

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have a right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce these rights. For instance, if you request materials from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $149 per day (up to a $1,496 cap per request), until you receive the materials, unless the materials were not sent due to reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the available claims procedures under the Plan, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose (for example, if the court finds your claim is frivolous) the court may order you to pay these costs and fees.

Assistance with your Questions

If you have any questions about your Plan, this statement, or your rights under ERISA, you should contact the nearest office of the Employee Benefits and Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits and Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

Contact Information

Questions regarding any of this information can be directed to:
JANTRAN Corporation - HR
3400 Gribble St, North Little Rock, AR 72114
662-759-6841

Notice of Privacy Practices Regarding Your Medical Information

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

We understand that your medical information is private, and we are committed to maintaining the privacy of your medical information.

This notice describes the ways in which the component plans that are considered group health plans under the Health Benefit Plan of JANTRAN (hereafter the "Plan") sponsored by JANTRAN (the "Company") may use and disclose medical information about you. This notice also describes your rights regarding the use and disclosure of your medical information.

The Plan is required by law to maintain the privacy of medical information about you, provide you with certain rights with respect to your medical information, to provide you with this notice about the Plan's legal duties and privacy practices with respect to medical information about you, to maintain the privacy of medical information about you, and to abide by the terms of this notice as it is currently in effect.

Each time you submit a claim to the Plan for reimbursement, and each time you see a health care provider who is paid by the Plan, a record is created. The record may contain your medical information. In general, the Plan will only use or disclose your medical information without your authorization for the specific reasons detailed below. Except in limited circumstances, the amount of information used or disclosed will be limited to the minimum necessary to accomplish the intent of the use or disclosure. The Plan does not operate by itself but rather is operated and administered by the Company acting on the Plan's behalf. As a result, medical information used or disclosed by the Plan (as discussed below) necessarily means that the Company is using or disclosing the medical information on behalf of the Plan. As a result, references to the Plan in this Notice of Privacy Practices should also be construed as references to the Company to the extent necessary to carry out the actions of the Plan.

Required Notices

The health plans identified above may share your medical information with each other to carry out treatment, payment, and health care operations.

PERMITTED USES AND DISCLOSURES

The following categories describe different ways that the Plan may use or disclose your medical information. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Primary Uses and Disclosures of Your Medical Information

Treatment. The Plan may use or disclose your medical information to facilitate medical treatment or services by providers. The Plan may disclose your medical information to providers, including doctors, nurses, technicians, pharmacists, medical students, or other hospital personnel who are involved in your care. For example, the Plan might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative of prior prescriptions.

Payment. The Plan may use and disclose your medical information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. The Plan may also share medical information with a utilization review or precertification service provider. Likewise, the Plan may share medical information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

Health Care Operations. The Plan may use and disclose your medical information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with: conducting quality assessment and improvement activities; underwriting (with respect to medical information other than medical information which is genetic information), premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Family Members, Relatives, Close Personal Friends. The Plan may disclose your health information to your family members, relatives, or close personal friends if the information is directly relevant to the family or friend's involvement with your care or payment for your care and you have either agreed to the disclosure or have been given an opportunity to object and have not objected. The Plan may also disclose your health information if you are not able to agree or object or are not present if it has determined that the disclosure is in your best interests.

The Company. The Plan may disclose medical information about you to the Company for Plan administration purposes.

Business Associates. The Plan contracts with individuals and entities ("business associates") to perform various functions on behalf of the Plan or provide services to the Plan. These business associates may receive, create, maintain, use, or disclose your medical information, but only after they agree in writing to safeguard your medical information. For example, the Plan may disclose your medical information to a business associate to administer claims, perform utilization review management, or review the Plan's financial records.

Covered Entities. The Plan may use and disclose your medical information to assist health care providers with their treatment or payment activities, or to assist other health plans or health care clearing houses with payment activities and certain health care operations. For example, the Plan may disclose your medical information to a health care provider to conduct health care operations in the areas of quality assurance, accreditation, licensing, etc. This also means that the Plan may disclose your medical information to other health plans and/or insurance carriers to coordinate benefits, if you have coverage through another health plan or insurance carrier.

Other Possible Uses and Disclosures of Your Medical Information

Requirement by Law. The Plan will disclose your medical information when required to do so by federal, state, or local law. For example, the Plan may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action.

Aversion of a Serious Threat to Health or Safety. Consistent with applicable federal and state laws, the Plan may use or disclose your medical information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your medical information in a proceeding regarding the licensure of a physician.

Required Notices

Organ and Tissue Donation. If you are an organ donor, the Plan may release your medical information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your medical information as required by military command authorities. The Plan may also release medical information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your medical information for workers' compensation or similar programs. These programs provide benefits for work related injuries or illness.

Organ and Tissue Donation. The Plan may disclose your medical information for public health activities. These activities generally include the following: prevention/ control of disease, injury, or disability; reporting births and deaths; reporting child abuse or neglect; reporting reactions to medications or problems with products; notifying people of recalls of products they may be using; notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; notifying the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. The Plan may disclose medical information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure proceedings. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, the Plan may disclose your medical information in response to a court or administrative order. The Plan may also disclose your medical information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may release your medical information if asked to do so by a law enforcement official: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; if you are, or are suspected to be, the victim of a crime, under certain limited circumstances, and the Plan Administrator is unable to obtain your agreement; about a death the Plan Administrator believes may be the result of criminal conduct; about criminal conduct on the Company's premises; or in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

Department of Health and Human Services. The Plan will disclose your medical information to the U.S. Department of Health and Human Services when requested for purposes of determining the Plan's compliance with applicable regulations.

Coroners, Medical Examiners, and Funeral Directors. The Plan may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your medical information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, the Plan may release your medical information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Other Benefits. The Plan may contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you. For example, if you are suffering from a complex illness, the Plan may contact you to discuss an alternate form of care or an alternate treatment facility.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION

Right to Access and Copy. The Plan will make your medical information available to you for inspection and copying upon your written request. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork. The Plan may charge a fee for the costs of copying, mailing or other supplies associated with your request. If the Plan maintains any of your medical information in an electronic health record, you can get a copy of that information in electronic format.

Required Notices

The Plan may deny your request to inspect and copy in certain limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed in certain circumstances.

Right to Request an Amendment. If you feel that medical information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You must provide a reason that supports your request. You have the right to request an amendment for as long as the information is kept by or for the Plan. Any request to amend your medical information must be made in writing. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork.

The Plan may deny your request for an amendment in certain circumstances, including your failure to request the amendment in writing or to include a reason to support the request, or, for example, if the information to be amended was not created by the Plan or is accurate and complete.

Right to an Accounting of Disclosures. If you wish to know to whom medical information about you has been disclosed, you may make a written request to the Plan. Please contact the individual listed below under the section titled "For More Information" to request the necessary paperwork.
Your request must state the time period for which you would like the accounting, and cannot include dates prior to the six-year period ending on the date of your request (in other words, if your request is dated January 1, 2012, you cannot request an accounting of disclosures for time periods prior to January 1, 2006). Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, the Plan may charge you for the costs of providing the accounting. The Plan will notify you of the cost involved, and you may choose to withdraw or modify your request at that time before any costs are incurred.

The accounting will not include disclosures for the purposes of treatment, payment, or health care operations (provided, that, to the extent required by law, if the Plan maintains an electronic health record, the accounting will include such disclosures made through an electronic health record). In addition, the accounting will not include disclosures, which you have authorized in writing or for certain other purposes.

Right to Request Restrictions. You may request that the Plan restrict or limit the medical information the Plan uses or discloses about you for treatment, payment, or health care operations. In addition, you may request that the Plan limit the medical information disclosed about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery you had.

To request a restriction or limitation, please contact the individual listed below under the section titled "For More Information." Your request must be in writing. In your request, you must specify (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Please note that the Plan is not required to agree to your request, unless your request is to restrict disclosures to another health plan for payment or plan operations purposes and the health information pertains solely to a health care item or service for which you have already paid a health care provider out-of-pocket in full.

Right to Request Confidential Communications. If the disclosure of your medical information could endanger you, you may request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you may request that the Plan only contact you at work or by mail. To request confidential communications, please contact the individual listed below under the section titled "For More Information." Your request must specify how or where you wish to be contacted. The Plan will only accommodate requests for confidential communications if the disclosure of the information would endanger you.

Right to Be Notified of a Breach. You have the right to be notified in the event the Plan (or a Business Associate) discovers a breach of your medical information.

Right to a Paper Copy of this Notice. You may ask the Plan for a copy of this notice at any time by contacting the individual listed below under the section titled "For More Information." Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy.

CHANGES TO THIS NOTICE

The Plan reserves the right to modify this notice at any time. The Plan also reserves the right to make the revised or changed notice effective for medical information it already has about you, as well as any information received in the future.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To register a complaint with the Plan, please contact the individual listed below under the section titled "For More Information." All complaints must be submitted in writing.

You will not be retaliated against for filing a complaint.

Required Notices

OTHER USES OF MEDICAL INFORMATION

Any uses and disclosures of medical information other than those listed above will be made only with your written authorization. If you provide the Plan authorization to use or disclose medical information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer use or disclose medical information about you for the reasons covered by your written authorization. Please note that the Plan is unable to take back any disclosures it has already made with your authorization, and that the Plan is required to retain records of the care provided to you.

FOR MORE INFORMATION

If you have any questions about this notice, please contact:
JANTRAN Corporation - HR
3400 Gribble St, North Little Rock, AR 72114
662-759-6841
EFFECTIVE DATE: January 1, 2027

Evaluating Your Health Insurance Options What You Need to Know

This letter has been created to help you understand your health insurance options. The health care reform law (called the Patient Protection & Affordable Care Act) requires most Americans to carry health insurance coverage or pay a penalty.

You can:

- Elect employer-provided health insurance (if offered).
- Purchase health insurance through the Marketplace.

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

You may be able to save money on premiums if your employer does not offer coverage, or offers coverage that does not meet government standards. Your potential savings on health insurance premiums would be dependent on household size and income. If you are offered employer-provided health insurance that meets those government standards, you may not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. If the cost of your employer's plan to cover yourself only (and not other members of your family) is more than 9.5% of your annual household income, you may be eligible for a tax credit.

Open enrollment for health insurance coverage through the Marketplace generally begins in October each year for coverage starting as early as the following January. Visit www.healthcare.gov to learn more about your options, or to request assistance.

Want to Buy on the Marketplace? Start with This Information

STEP 1: Visit www.healthcare.gov and begin the application process

STEP 2: You will need the information below to apply (Numbers correspond directly to numbers on actual application.)

3s	Employer Name:	JANTRAN, Incorporated
4	Employer Identification Number (EIN):	64-0749179
5	Employer Address:	3400 Gribble St
6	Employer Phone Number:	501-320-8449
7	Employer City:	North Little Rock
8	Employer State:	AR
9	Employer Zip Code:	72114
10	Who can we contact about employee health coverage at this job?	Leslie Jenkins
11	Employer Contact Phone Number (if different from above):	662-759-6841
12	Employer Email:	leslie@JANTRAN.com

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of- network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you think you've been wrongly billed, contact the No Surprises Helpdesk, operated by the U.S. Department of Health and Human Services, at 1.800.985.3059.

Visit *www.cms.gov/nosurprises/consumers* for more information about your rights under federal law.

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 Marketpla 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 eligi for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labo 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 January 31, . 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.flmedicaidtplrecovery.com/flmedicaidtplrecover y.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: 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: https://www.ldh.la.gov/healthy-louisiana Medicaid Customer Service Line: 1-888-342-6207 Louisiana Medicaid email: healthy@la.gov Louisiana Health Insurance Premium Program (LaHIPP) Website: https://www.ldh.la.gov/lahipp LaHIPP phone: 1-877-697-6703 LaHIPP email: La.HIPP@la.gov LaHIPP fax: 1-888-716-9787 LaHIPP mailing address: 100 Crescent Centre Parkway, Suite 1000 Tucker, GA 30084
MAINE – Medicaid	**MASSACHUSETTS – Medicaid and CHIP**
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	**MISSOURI – Medicaid**
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.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 RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059

TEXAS – Medicaid	UTAH – Medicaid and CHIP
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	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-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

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

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 4/30/)

The information in this Benefits Summary is presented for illustrative purposes and is based on information provided by your employer. The text contained in this Summary was taken from various summary plan descriptions and benefits information. While every effort was taken to report your benefits, discrepancies or errors are always possible. In case of a discrepancy between the Benefits Summary and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this Summary, contact Human Resources.

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