
SWIFT
Now is the time to...
Enroll in your
2022 benefits.

Current employees: Here's what's new for 2022

Good news! For this year's Annual Enrollment, there aren't many changes. Here are the highlights:

Medical and dental premiums are changing. Medical and dental premiums are increasing, but your costs for other benefits are unchanged. Premiums are listed on page 16.

NEW! New app lets you access your benefits and enroll on the go. Download the new app and get help with:

- **Finding important benefits information**—Review your current coverage.
- **Choosing your benefits**—View your options and select the best coverage for you on your desktop, tablet or smartphone.
- **Storing your benefit ID cards**—Take photos of your benefit ID cards and store them for easy access.
- **Finding a doctor or urgent care**—Find in-network providers near you based on your plan.

New Alight Mobile App

Go to the App Store or Google Play and search **Alight Mobile**. To register, enter "Swift Transportation" and then log in.

Annual Enrollment is November 18–December 2, 2021.

Your Swift Transportation Benefits

Be sure to enroll!

- **Review** your plan options and costs. Your needs may change year to year, so it's important to review the available plans and select the ones that are best for you.
- **Choose** the coverage that works best for you.
- **Enroll** by the December 2, 2021 deadline.

New Alight Mobile App

Go to the App Store or Google Play and search **Alight Mobile**. To register, enter "Swift Transportation" and then log in.

Annual Enrollment: November 18–December 2, 2021

Your enrollment checklist

Before November 18

- ☐ **Review** the information in this booklet.
- ☐ **If you need to update your mailing address, you can do that on the Transmission Portal**, so all of your important benefit information is going to the right place.
- ☐ **Opt in to text messaging and update your email on swift.benefitsnow.com**, so you can get benefits-related reminders on the go. See page 59 for details.

During Annual Enrollment (November 18–December 2)

- ☐ **Gather up** Social Security numbers and dates of birth for each eligible dependent you are adding to coverage.
- ☐ **Log on to swift.benefitsnow.com** and follow the steps to use the tools to help you select the benefits that best fit your needs and complete your enrollment. And, if you want an FSA for 2022, don't forget to make that election.
- ☐ **Make your attestations for the tobacco-free credit** of $19 per week, worth up to $988 annually.
- ☐ **Confirm if the spousal surcharge ($1,200)** applies. **IMPORTANT!** If you don't do this, you'll pay an additional $1,200 ($23.08 per week) for having your spouse on your medical plan.
- ☐ **Review** your beneficiary information.

Currently enrolled Swift employees

If you don't enroll by December 2 and are currently covered through Swift's medical, dental and/or vision plans:

- You will have the same medical, dental and vision coverage at 2022 rates.
- You won't participate in the FSAs, either Health Care or Dependent Daycare.
- You won't receive our **tobacco-free credit of up to $988** on the medical plan. Note: Use of e-cigarettes/vaping is considered tobacco usage.
- If your spouse is currently enrolled in medical, you'll pay up to $1,200 for the spousal surcharge.

It's important for you to take action during Annual Enrollment. Review the plans and costs, then select the benefits that are right for you in 2022.

4 reasons why it's smart to enroll online

1. It's the best way to see exactly which plans are available to you and how much they cost.
2. You can use tools to help you pick the best available plan, based on what matters to you.
3. You can enroll from any computer, mobile device or tablet. Or, download the Alight Mobile app and enroll that way.
4. If you have a question or get stuck, there's an online chat feature for instant help.

The right medical plan matters!

When you enroll online, **ask Sara—your virtual guide—**will ask you a few simple questions about your health care needs. Based on your responses, the tool will help you select the right medical plan for your situation.

Get help when you need it.

For questions or to enroll over the phone, call **1-844-577-4333**. Representatives are available Monday through Friday between 8:00 a.m. and 6:00 p.m. ET (except national holidays). Or use the online chat feature to speak with a trained representative.

Appointment Scheduler and automatic callback. Don't like to wait on hold? You can choose to receive an automatic callback from the next available representative. Or select the Appointment Scheduler to set a specific time for a representative to call you.

Take advantage of these ways to save

Be a savvy health care consumer. Take advantage of the ways Swift helps you manage your costs.

1. **SAVE ON YOUR SWIFT MEDICAL PREMIUMS BY PARTICIPATING IN THE SWIFT WELLNESS GPS PROGRAM.**
   Download the **Wellness at Your Side™** app, using connection code **Swift**, or visit **WebMDhealth.com/Swift** for program details.

2. **KICK TOBACCO. SAVE UP TO $988.**
   During enrollment, indicate whether you and your covered spouse use tobacco. Non-tobacco users save $19 per week ($988 annually) off their 2022 medical plan premiums. **Note:** Use of e-cigarettes/vaping is considered tobacco usage.

3. **SAVE ON TAXES WITH THE FLEXIBLE SPENDING ACCOUNTS (FSAs).**
   Use your FSAs for eligible health care or for dependent daycare expenses. You don't pay income tax on the money you contribute to these accounts, so it's like getting a discount on expenses you pay out of pocket. Remember, you need to re-elect FSAs every year. See page 17 for more information.

After you enroll

ID Cards

- ☐ Blue Cross Blue Shield of Arizona will issue new ID cards with new member ID numbers to all enrolled participants.
- ☐ All new ID cards are scheduled to arrive in January.
- ☐ MetLife does not issue ID cards for dental and vision plans as they are not needed to obtain service. Your provider can verify coverage using your Social Security number.
- ☐ **Are you adding a new dependent to your coverage?** Be on the lookout for dependent verification information in the U.S. postal mail and your email, if you've provided one to the Benefits Service Center. Don't miss the deadline! **See pages 26–28 for more information.**
- ☐ **If you made changes to your current life and disability plans OR you are enrolling for the first time in these plans,** you will be required to complete a medical questionnaire. Watch your mail for information from The Hartford regarding the medical questionnaire that must be completed within a specified time frame to be approved.

Note: You'll be billed directly if your paycheck is not enough to cover your premiums. **See page 29 for details.**

If you're a new Swift employee

You must enroll by your enrollment deadline, which appears on your New Hire Benefits Enrollment Notice.

- Benefits start the first of the month following 30 days of continuous full-time employment.

If you don't enroll by your deadline:

- You and your family will not have medical, dental or vision coverage or any supplemental benefits for 2022.
- Your next opportunity to enroll will be for 2023 coverage.

After you enroll:

- Within 30 days of enrolling, you will be issued ID cards from the medical plan you enroll in. **Please note** that MetLife does not issue ID cards for dental and/or vision as they are not needed to obtain service. Your provider can verify coverage using your Social Security number.
- Adding a dependent? Be on the lookout for dependent verification information in the U.S. postal mail and your email, if you've provided one to the Benefits Service Center. **See pages 26–28 for details.**

Note: You'll be billed directly if your paycheck is not enough to cover your premiums. **See page 29 for details.**

If you have questions

You can call to talk with representatives Monday through Friday between 8:00 a.m. and 6:00 p.m. ET (except national holidays). No waiting on hold, either! Use the Appointment Scheduler to set a specific time for a representative to call.

For questions or to enroll over the phone, call **1-844-577-4333**.

Enroll online at **swift.benefitsnow.com**

The first time you log on, you'll need to register as a new user, provide some personal information to verify your identity, and set up a user ID and password that you'll use in the future to access your benefits information online.

Medical plan options

Blue Cross Blue Shield of Arizona administers our plans nationwide (including California). Plans provided by Kaiser Permanente are only available in California. This chart gives you a quick overview of your options. Ask Sara, our virtual guide, will help you make the right choice when you enroll online.

	Blue Cross Blue Shield			Kaiser Permanente (in-network only) (available in California only)		
	VALUE (PPO)	CORE (PPO)	PREMIUM (EPO)	VALUE	CORE	PREMIUM
Annual deductible (individual/ family)	**In-network:** $2,500/$5,000 **Out-of-network:** $5,000/$10,000	**In-network:** $1,000/$2,000 **Out-of-network:** $2,000/$4,000	**In-network:** $800/$1,600 **Out-of-network:** Not covered	**In-network:** $2,500/$5,000	**In-network:** $1,000/$2,000	**In-network:** $800/$1,600
Annual out-of-pocket maximum (individual/ family)	**In-network:** $8,000/$16,000 **Out-of-network:** $16,000/$32,000	**In-network:** $6,000/$12,000 **Out-of-network:** $12,000/$24,000	**In-network:** $4,000/$8,000 **Out-of-network:** Not covered	**In-network:** $7,900/$15,800	**In-network:** $6,000/$12,000	**In-network:** $4,000/$8,000
Preventive care	**In-network:** Covered 100%, no deductible **Out-of-network:** Not covered	**In-network:** Covered 100%, no deductible **Out-of-network:** Not covered	**In-network:** Covered 100%, no deductible **Out-of-network:** Not covered	**In-network:** Covered 100%, no deductible	**In-network:** Covered 100%, no deductible	**In-network:** Covered 100%, no deductible

	Blue Cross Blue Shield (in-network*)			Kaiser Permanente (in-network only) (available in California only)		
	VALUE (PPO)	CORE (PPO)	PREMIUM (EPO)	VALUE	CORE	PREMIUM
Doctor's office visit copay (no deductible)	**PCP:** $50 **Specialist:** $100 **Telemedicine:** $50	**PCP:** $40 **Specialist:** $80 **Telemedicine:** $40	**PCP:** $30 **Specialist:** $60 **Telemedicine:** $30	**PCP:** $50 **Specialist:** $50 **Telemedicine:** $0	**PCP:** $40 **Specialist:** $40 **Telemedicine:** $0	**PCP:** $30 **Specialist:** $30 **Telemedicine:** $0
Emergency room	You pay 30% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay $100 copay, after deductible	You pay $80 copay, after deductible	You pay $60 copay, after deductible
Urgent care copay	You pay $100 copay, no deductible	You pay $80 copay, no deductible	You pay $60 copay, no deductible	You pay $50 copay, no deductible	You pay $40 copay, no deductible	You pay $30 copay, no deductible
Inpatient and outpatient care	You pay 30% after deductible	You pay 30% after deductible	You pay 25% after deductible	You pay 30% after deductible	You pay 30% after deductible	You pay 25% after deductible

* For the Blue Cross Blue Shield of Arizona plans: The Value and Core plans offer out-of-network benefits while the Premium plan offers in-network benefits only.

All plans have **"traditional"** deductibles and out-of-pocket limits. This means each family member's expenses count toward both an individual limit and the family limit. So if one family member's expenses reach that individual limit, the plan pays its share for that family member only. (This way, if one family member has a lot of expenses, the plan pays benefits sooner for that person.) Once the total family expenses reach the family limit, the plan pays its share for the whole family.

PCP: Primary Care Physician

Deductible: How much you have to pay for care before you and the plan share expenses.

Out-of-pocket maximum: Once your eligible expenses reach this limit, the plan pays 100% of eligible expenses for the rest of the year.

Are out-of-network services covered?

The Value and Core plans under Blue Cross Blue Shield of Arizona cover in-network and out-of-network services; however, their Premium plan does not cover out-of-network services. Be sure to check to see which doctors and providers are included in your plan's network.

The Kaiser Permanente plans offered in California do not cover out-of-network charges, with the exception of urgent and emergent care. You must designate a primary care physician to coordinate your care if you choose coverage from Kaiser Permanente.

Whether you live in Arizona or another state, you'll have access to a large national network of Blue Cross Blue Shield providers. To find an in-network provider, see the **Contacts** on page 59 of this guide.

Going out-of-network?

The out-of-network charges under the Value and Core plans with Blue Cross Blue Shield of Arizona will not count toward your in-network annual deductible or out-of-pocket maximum. The same goes for in-network charges—they will not count toward your out-of-network annual deductible or out-of-pocket maximum.

Defining PPO and EPO

- **A PPO** (Preferred Provider Organization) covers both in-network and out-of-network charges. However, you will pay much less when you use in-network providers.
- **An EPO** (Exclusive Provider Network) covers only in-network charges. No out-of-network benefits are offered through an EPO.

	Medical and Pharmacy Network Coverage		
	VALUE	CORE	PREMIUM
BCBS of Arizona	In-network **and** out-of-network	In-network **and** out-of-network	In-network only
CVS Caremark	In-network only	In-network only	In-network only
Kaiser Permanente	In-network only	In-network only	In-network only

Kaiser Permanente: Manage your care online

Kaiser Permanente, with plans available in California only, offers flexible options for you to get care beyond the doctor's office—and you can manage your care anytime with the Kaiser Permanente app or at the Kaiser Permanente/Swift new online site for employees at **select.kp.org/swift**.

Sign up for the Kaiser Permanente/Swift online site for employees at select.kp.org/swift

- You must be registered at **select.kp.org/swift** to access these services. Visit **select.kp.org/swift** and select **Welcome**. Then scroll to **"Already a Kaiser Permanente member?"** and either sign in or create an account. Have your medical record number and follow the instructions.

Getting care

- Talk with a Kaiser Permanente clinician by video or phone for the same high-quality care as an in-person visit.[1]
- Get 24/7 medical advice by phone or online.
- Email your doctor's office with non-urgent questions.[2]

Managing care[2]

- Schedule or cancel routine appointments.
- Refill most prescriptions.
- Check your medical records and pay bills.
- View most lab test results.

[1] When appropriate and available.

[2] Available when you get care from Kaiser Permanente facilities.

Prescription drugs

CVS Caremark is our prescription drug provider for all plans offered through Blue Cross Blue Shield of Arizona. **The plan provides in-network benefits only.** CVS Caremark's large nationwide pharmacy network includes Walgreens, Walmart, Costco and most drug and grocery store chains. CVS Caremark offers you:

- Short-term prescriptions (30-day supply or less) can be filled through any of the CVS retail stores nationwide, along with other pharmacies in the CVS Caremark network.
- Maintenance medications (those taken on an ongoing basis) can be filled through CVS Caremark's mail service (delivering your prescription to your door) or at a local CVS pharmacy. You choose what is convenient for you.

Be sure to contact CVS Caremark to see how your drugs are covered under the formulary. Kaiser Permanente provides prescription coverage for their plans.

	CVS Caremark (available nationwide)			Kaiser (available in California)		
	VALUE	CORE	PREMIUM	VALUE	CORE	PREMIUM
Retail: Your Cost						
Generic	$15	$12	$10	$15	$15	$15
Preferred	30%, max $75	$50	$40	30%, max $75	$50	$40
Non-preferred brand	30%, max $125	$70	$60	N/A	N/A	N/A
Specialty drugs	30% standard, PrudentRx member cost is $0			30%, max $75	$50	$40
90-Day Supply (Mail or Retail): Your Cost						
Generic	$40	$30	$25	$30	$30	$30
Preferred	30%, max $190	$125	$100	30%, max $75	$100	$80
Non-preferred brand	30%, max $315	$175	$150	N/A	N/A	N/A
Specialty drugs	30% standard, PrudentRx member cost is $0			N/A	N/A	N/A

Note: Pharmacy coinsurance is not subject to the medical deductible.

Dental plan options

The coverage shown below is for both in-network and out-of-network providers. However, you'll pay negotiated rates at in-network providers, which are typically lower than at out-of-network providers. Coverage is provided through MetLife.

	VALUE		CORE		PREMIUM	
	In-network	Out-of-network*	In-network	Out-of-network*	In-network	Out-of-network*
Reimbursement Preventive (e.g., routine cleanings)	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%	Plan pays 100%
Basic (e.g., root canal, gum disease treatment)	You pay 20%	You pay 20%	You pay 20%	You pay 20%	You pay 20%	You pay 20%
Major (e.g., implants, dentures)	Not covered	Not covered	You pay 40%	You pay 40%	You pay 20%	You pay 20%
Deductible Individual Family	Basic services only $100 $300		Basic and major services $100 $300		Basic and major services $50 $150	
Calendar year maximum (applies to preventive, basic and major)	$1,000	$1,000	$1,500	$1,500	$2,500	$2,500
Orthodontia Lifetime maximum	Not covered Not covered	Not covered Not covered	You pay 50% $1,500	You pay 50% $1,500	You pay 50% $2,000	You pay 50% $2,000

Note: Dental coinsurance applies after deductible, where applicable.
*Out-of-network is based on 70% of reasonable and customary fees.

Vision plan options

In-network providers offer more coverage and larger allowances. This coverage is provided through MetLife.

	VALUE – EXAM ONLY PLAN		CORE		PREMIUM	
	In-network	Out-of-network	In-network	Out-of-network	In-network	Out-of-network
Routine vision exam	Covered in full ($0 copay)	$45 allowance	Covered in full after exam $20 copay	$45 allowance	Covered in full after exam $10 copay	$45 allowance
Retinal imaging	N/A	N/A	15% discount/ $39 max	Applied to exam allowance	15% discount/ $39 max	Applied to exam allowance
Standard corrective lenses	20% discount available at private locations	Not covered	Covered in full after $20 copay	$30–$90 allowance	Covered in full after $10 copay	$30–$90 allowance
Frame allowance	20% discount available at private locations	Not covered	Covered up to a $100 allowance; Frames are covered to the allowance of $55 at Costco locations	$70 allowance	$200 allowance or $110 (Costco)	$70 allowance
Contact lenses Elective	N/A	N/A	$100 allowance (in lieu of lens and frame benefits)	$70 allowance (in lieu of lens and frame benefits)	$200 allowance (in lieu of lens and frame benefits)	$70 allowance (in lieu of lens and frame benefits)
Medically necessary	N/A	N/A	$20 copay (in lieu of lens and frame benefits)	$200 allowance (in lieu of lens and frame benefits)	$10 copay (in lieu of lens and frame benefits)	$200 allowance (in lieu of lens and frame benefits)

2022 Benefits Costs–Health Care Benefits

Medical, dental and vision

		WEEKLY PAYCHECK CONTRIBUTIONS			
		MEDICAL			
PLAN DESIGN	COVERAGE	BCBS ARIZONA (ALL EMPLOYEES)	KAISER PERMANENTE (CALIFORNIA ONLY)	METLIFE DENTAL	METLIFE VISION
Value	Employee Only	$49.36	$48.45	$3.37	$0.26
	Employee + Spouse	$97.10	$93.85	$7.07	$0.61
	Employee + Child(ren)	$67.96	$65.53	$8.42	$0.46
	Employee + Family	$102.65	$98.95	$12.13	$0.81
Core	Employee Only	$71.21	$65.60	$6.36	$0.79
	Employee + Spouse	$151.89	$135.85	$13.28	$1.89
	Employee + Child(ren)	$109.06	$97.02	$15.92	$1.41
	Employee + Family	$174.31	$154.46	$22.87	$2.52
Premium	Employee Only	$103.15	$86.67	$10.53	$1.71
	Employee + Spouse	$231.25	$187.13	$22.11	$4.10
	Employee + Child(ren)	$168.57	$135.48	$26.31	$3.08
	Employee + Family	$278.52	$222.40	$37.90	$5.47

Note: The above rates do not include the following weekly credits and surcharge:

- $19 Tobacco-Free Credit
- Swift Wellness GPS Credit
- $23.08 Spousal Surcharge

Save on taxes with Flexible Spending Accounts

Flexible spending accounts (FSAs) can help you save money on all eligible health care and dependent care expenses by using before-tax dollars.

You don't pay taxes on money you contribute to an FSA, putting extra dollars in your pocket at the same time you save for planned expenses. This means you'll save an amount equal to the taxes you would have paid on the money you set aside. Then, you use the money in your accounts to pay for eligible health care or dependent care expenses. It's that easy to save money on expenses you would usually pay out-of- pocket.

Take advantage of Swift's two FSAs and enroll during Annual Enrollment:

- The **Health Care FSA** is for eligible health care (medical, prescription drug, dental and vision) expenses you pay out-of-pocket—such as copays, deductibles and coinsurance. In 2022, you can contribute up to $2,500 to your Health Care FSA.

  The Health Care FSA is your best option for tax savings on out-of-pocket health care expenses.

- The **Dependent Daycare FSA** is for eligible expenses you pay to care for a dependent (such as daycare, after-school care or elder care) so you and your spouse (if applicable) can work, find work or attend school full time. In 2022, you can contribute up to $5,000 ($2,500 if married and filing separate tax returns) to your Dependent Daycare FSA.

You can enroll in the Health Care and Dependent Daycare FSAs for 2023 during Annual Enrollment if:

- You are hired or rehired on or before November 1, 2022.

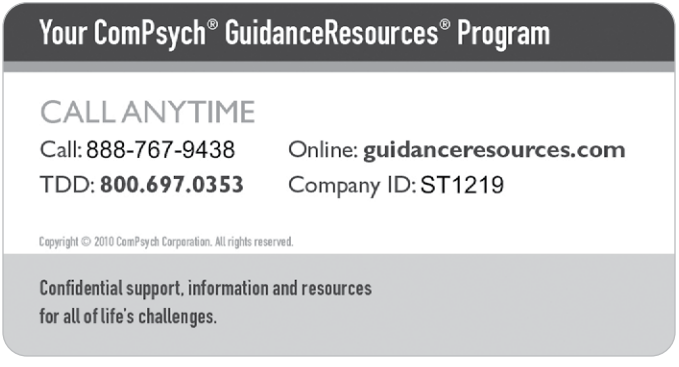
You must re-elect FSA each year during Annual Enrollment.

For more information on the rules surrounding flexible spending accounts, contact PayFlex at **1-800-284-4885**.

Employee Assistance Program

Everyone needs help now and then to deal with the stresses of everyday life. Swift's Employee Assistance Program (EAP) is provided to you at no cost and can help you or your family members deal with these issues with up to six free counseling sessions per person, per year, per issue. This confidential program provides help from counselors and other experts in the appropriate field, based on your needs.

Our EAP can also help with money management concerns through Financial Connect® or with legal concerns through Legal Connect®. Call **1-888-76-SWIFT** for more information. You can also find helpful information and tools through Guidance Resources®, simply go to **guidanceresources.com**.



Reminder:

Calls to the EAP are no cost to Swift employees and their families and are completely confidential.

Disability insurance

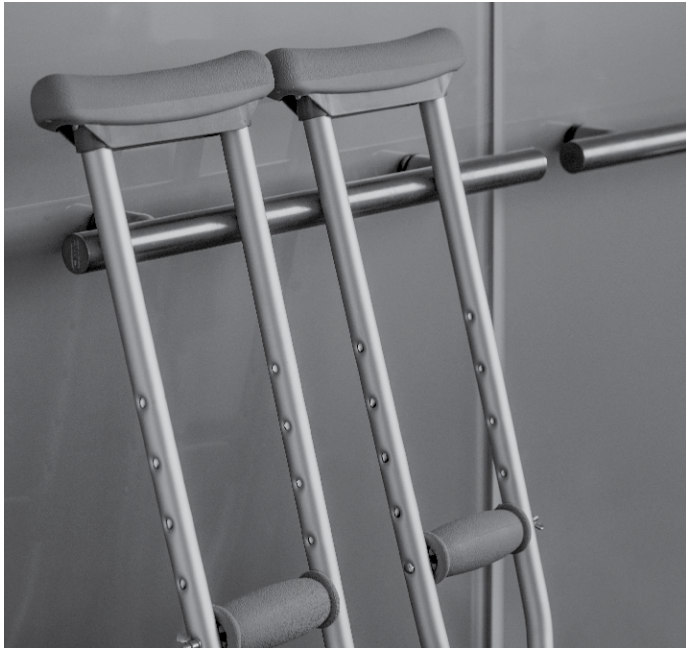
Disability insurance provides you and your family with important financial protection if you are unable to work due to an illness or non-work-related injury. This insurance covers just you, as the employee, and is provided by The Hartford.

Short-term disability starts on the eighth day of your disability and lasts for as long as you are considered disabled and unable to work, up to a maximum of 26 weeks. You can choose from a number of different weekly benefit options.

Long-term disability picks up where your short-term disability benefits end. Once you have been sick or injured (non-work related) for 26 weeks (180 days), long-term disability benefits begin. You can choose from a number of different weekly benefit options.

The disability plans will cover up to 60% of your regular pay. See page 20 for information on coverage levels and cost.

Note: Generally, this coverage does not apply to pre-existing conditions. Contact The Hartford if you have questions. Premiums for this coverage do not reflect the cost of state-mandated statutory disability benefits for employees who work in California, Hawaii, New York, New Jersey, Puerto Rico and Rhode Island. If you work in one of these states, your disability benefits will be offset by the amount you receive through the state.



2022 Benefits Costs–Disability Benefits

Short-Term Disability Options	Weekly Cost
$250 (your average weekly pay must be at least $417)	$7.33
$400 (your average weekly pay must be at least $677)	$11.90
$550 (your average weekly pay must be at least $917)	$13.28
$750 (your average weekly pay must be at least $1,250)	$14.81
$1,000 (your average weekly pay must be at least $1,667)	$17.23

Note: *A personal health application must be completed and approved by the insurance carrier for any election or increase after your new hire enrollment in STD coverage. This is a short medical questionnaire to validate your good health. This questionnaire will be sent to you after you enroll. Coverage is subject to pre-existing condition limits.**

Long-Term Disability Options	Weekly Cost
$1,100 (your average monthly pay must be at least $1,833)	$2.62
$1,800 (your average monthly pay must be at least $3,000)	$4.59
$2,500 (your average monthly pay must be at least $4,167)	$5.18
$3,500 (your average monthly pay must be at least $5,833)	$6.82
$5,000 (your average monthly pay must be at least $8,333)	$9.42
$7,500 (your average monthly pay must be at least $12,500)	$10.00
$10,000 (your average monthly pay must be at least $16,667)	$21.44

Note: *A personal health application must be completed and approved by the insurance carrier for any elections or increases of more than one level made after your new hire enrollment in LTD coverage. This is a short medical questionnaire to validate your good health. This questionnaire will be sent to you after you enroll. Coverage is subject to pre-existing condition limits.**

If you enroll during your new hire waiting period, you will not be required to complete a medical questionnaire.

* **Pre-Existing Conditions:** An illness, injury or pregnancy related condition for which you were diagnosed, treated or received medical treatment; or taken prescribed medications during the 3 month period prior to your effective date of coverage. After you have been insured for 12 consecutive months pre-existing condition clause will not apply.

Life and accident insurance

Life and accident insurance provide you and your family with important peace of mind. Swift offers you both company-paid coverage, as well as supplemental coverage you can purchase. Our life and accident insurance benefits are provided through The Hartford.

Company-paid coverage

Swift Transportation automatically provides you with a company-paid basic life insurance plan, which pays a benefit in the event of your death. Swift also provides accidental death and dismemberment (AD&D) insurance, which pays a benefit in the event of your accidental death or an accidental loss such as a hand or foot. The benefit amount of this company-paid coverage is based on your job. Be sure you name a beneficiary for these coverages—and keep it updated. To find out how much company paid life insurance you have, and assign a beneficiary, contact the Benefits Service Center at **1-844-577-4333** or log on to **swift.benefitsnow.com**.

In addition, if you enroll your family in Swift's medical plan, the company provides basic term life insurance for your spouse and dependent children ($1,000 in coverage or $100 for children under 6 months).

Supplemental coverage

You can also purchase additional life and AD&D coverage for yourself, as well as coverage for your spouse and dependent children—all at attractive group rates (which are typically less than you pay buying the same insurance on your own). See pages 23 and 24 for information on the amount of coverage available and the cost.

Keeping beneficiaries updated

A beneficiary is the person or persons you name to receive your life insurance and AD&D benefits in the event of your death.

If you're enrolling in life and AD&D coverage for the first time, be sure you name beneficiaries for the coverage. If you already have coverage through Swift, check to make sure your beneficiary designations are up to date.

Voluntary benefits

Voluntary benefits provide additional coverage for you and your family in the event of an illness or accident. These coverages are provided by The Hartford.

Accident insurance

You can purchase group accident insurance, provided by The Hartford. This coverage provides cash benefits for covered accidental injuries as well as related services and treatments such as diagnostic exams, x-rays and other emergency services, physician visits, ambulance transportation and more. You can purchase coverage for yourself, as well as your spouse and dependent children, if you wish. See page 25 for information on the amount of coverage available and the cost.

Hospital Indemnity coverage

This coverage (offered by The Hartford) provides a cash benefit in the event of an unexpected hospital stay for a covered illness or non-work-related injury. The benefits are payable in addition to any medical benefits you may receive from other plans. You can use the benefit to offset out-of-pocket medical expenses or to offset other expenses you may have. See page 25 for information on the amount of coverage available and the cost.

Critical Illness coverage

You can buy additional coverage, provided by The Hartford, that makes a lump sum payment when a covered illness is diagnosed, such as a heart attack, stroke, major organ transplant and cancer—just to name a few. You can use the lump sum payment for medical bills or day-to-day living expenses, such as groceries, utility bills and rent or mortgage payments. You can choose to cover just yourself or cover your spouse and dependent children too. See page 25 for information on the amount of coverage available and the cost.

2022 Benefits Costs–Life Insurance and Voluntary Benefits

Supplemental Life Insurance

(Available in $50,000 increments from $50,000 to $300,000)

AGE	COST PER $1,000 OF COVERAGE	AGE	COST PER $1,000 OF COVERAGE
<25	$0.02	≥ 50 < 55	$0.13
≥ 25 < 30	$0.02	≥ 55 < 60	$0.21
≥ 30 < 35	$0.02	≥ 60 < 65	$0.36
≥ 35 < 40	$0.03	≥ 65 < 70	$0.62
≥ 40 < 45	$0.05	≥ 70 < 75	$1.13
≥ 45 < 50	$0.08	≥ 75	$2.17

Note: *A personal health application must be completed and approved by the insurance carrier for any elections or increases of more than $350,000 combined basic and supplemental life insurance coverage made after your new hire election. This is a short medical questionnaire to validate your good health. This questionnaire will be sent to you after you enroll. Any elections or increases of more than one level in coverage of supplemental life insurance made after your new hire enrollment, will require a personal health application.*

Note for new hires: If you enroll during your new hire waiting period, you will generally not be required to complete a medical questionnaire.

Supplemental Accidental Death & Dismemberment Insurance

(maximum benefit cannot exceed 10x your salary)

	EMPLOYEE ONLY	EMPLOYEE + FAMILY
$100,000	$1.04	$1.34
$200,000	$2.08	$2.68
$300,000	$3.12	$4.02
$400,000	$4.15	$5.35
$500,000	$5.19	$6.69

Supplemental Spouse Life Insurance	Weekly Cost
$5,000	$0.29
$10,000	$0.59
$15,000	$0.88
$20,000	$1.17
$25,000	$1.47

Note: *A personal health application must be completed and approved by the insurance carrier for any elections or increases for coverage that exceed $10,000. This is a short medical questionnaire to validate your good health. This questionnaire will be sent to you after you enroll.*

Supplemental Child Life Insurance	Weekly Cost
$2,000	$0.07

Note: *A medical questionnaire is not required to obtain coverage for children.*

Accident Insurance**

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Enrolled	$3.75	$7.04	$7.66	$9.32

Hospital Indemnity**

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Enrolled	$6.45	$11.64	$10.72	$15.66

Critical Illness**

	EMPLOYEE ONLY	EMPLOYEE + SPOUSE	EMPLOYEE + CHILD(REN)	EMPLOYEE + FAMILY
Enrolled	$5.82	$8.67	$5.93	$8.78

**This is not an ERISA plan. It is not sponsored, maintained, endorsed nor recommended by Swift. Swift Transportation merely makes payroll deductions available to pay the premiums.

Are you adding a dependent to your coverage?

Swift Transportation requires that you verify the eligibility of all new dependents added to your benefits coverage.

You will receive a complete packet of information and instructions after you enroll. Watch your U.S. postal mail or email (if you have it on file with the Benefits Service Center) for details.

To verify a dependent, you must submit the required documentation described on the next page within 31 days of the date you enroll as a new hire, during Annual Enrollment or following a qualified life event.

If you do not submit the required documentation by the deadline, your dependents will be dropped from coverage and your next opportunity to add them will be at the next Annual Enrollment (unless you have a qualifying life event).

Important notes:

- It is your responsibility to ensure that all information is received by the Dependent Verification Center by the stated 31-day deadline.
- Send copies only.
- Black out all Social Security numbers appearing on any documents you are submitting.
- Proof of marriage must be a government-issued marriage certificate that includes the date of your marriage. If you were married within the last 12 months, then you are only required to submit the marriage certificate. If married more than 12 months, a secondary document is required as outlined on the next page.

Designate your beneficiaries

Be sure to designate beneficiaries for your supplemental life and employer paid basic life and accidental death and dismemberment insurance. You can update your beneficiaries anytime by visiting **swift.benefitsnow.com**.

You must provide required documents

Don't risk having your dependent's coverage canceled. For each dependent, provide the below required documentation within 31 days from the date you add them to your benefits.

DEPENDENT	REQUIRED DOCUMENTATION
Spouse • Legal spouse **Note:** If you're legally separated pursuant to a court order, your spouse is not eligible for coverage.	• A copy of your marriage certificate **AND one of the following**: - A copy of a household bill or account statement listing your name and your spouse's name at the same address and dated within 60 days of submission ***OR*** - A copy of page 1 of your prior year's federal tax return (as filed) listing your spouse
Child • Your children up to age 26 (includes adopted children, stepchildren and legal foster children) • Your unmarried, disabled child(ren) over the age of 26 who you claim as dependent(s) on your federal income taxes (proof of disability will be required) **Note:** Eligibility requirements may be different under the life and AD&D insurance plans for children (including disabled children) over the age of 19.	• A copy of your child's birth certificate listing you or your spouse as the parent **Note:** For your stepchildren, you must also provide proof of marriage to the biological parent. • A copy of the adoption certificate • A copy of the court order of legal guardianship, or other document evidencing placement by an authorized placement agency

Where to send documents:

You can submit your documentation online, or by fax or U.S. postal mail.

Online: Log on to **swift.benefitsnow.com** and review the verification notification in the "Action Needed" box on the homepage.

Fax: 1-855-636-0518

Mail: Swift Dependent Verification Center
PO Box 661065
Dallas, TX 75266-1065

Be sure to check ...

You'll want to call the Benefits Service Center at **1-844-577-4333** to make sure your dependent documentation was received and that your dependents have been verified.

Making qualified changes during the year

The benefits you elect this enrollment period will remain in effect for the entire plan year—January 1, 2022 through December 31, 2022—unless you have a qualified change in employment or family status. The qualified change must be reported to the Benefits Service Center within 31 days after the life event.

Qualified changes in employment or family status include:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse or dependent
- Change in spouse's employment (beginning or leaving a job if tied to eligibility)
- Change in your spouse's benefit elections through another employer
- Loss of medical coverage under another group plan
- Change in your dependent daycare situation

Benefits Direct Bill Policy

Here's a reminder about our Benefits Direct Bill Policy that was implemented in September 2011. A copy of the policy is enclosed in this packet. Please make sure you understand how this could impact your 2021 benefits.

A benefits invoice is created and sent to you in the event there is not sufficient income in your paycheck to cover the full amount of the benefits premium due. You must pay the invoice timely in order to prevent cancellation of your benefits. The invoice and the reminder notice are sent by U.S. mail and to your Swift email address. If you are a driver, alerts are also sent to you via qualcomm.

Some employees think if they miss a benefits premium payment that Swift will "make up" the missed premiums on a future paycheck. This does not happen, which is why we send you an invoice. The invoice must be paid in full within 30 days of the invoice date. Failure to timely pay the invoice in full will result in cancellation of your benefit(s) retroactively, as of the date of the invoice.

Below we have listed some sample scenarios that outline what will happen if your benefits are cancelled for non-payment as we transition into a new benefits plan year and what you need to do during the benefits Annual Enrollment period if you want to have these benefits next year.

If your 2021 benefits were cancelled with an effective date prior to October 1, 2021:

Example:

Benefits Invoice date ..... September 16
Invoice Grace Period expires (last day to pay) ..... October 17
Cancellation date if not paid in full ..... September 16

- You will need to make an affirmative benefits election during Annual Enrollment in order to obtain coverage effective January 1, 2022.
- If you do not elect benefits during Annual Enrollment, you will not have coverage in 2022 for any benefit plans that were cancelled in 2021 due to non-payment. You also will not be able to enroll in any benefit plans that were cancelled in 2021 until the next Annual Enrollment (in 2022) for 2023 benefits.

Effective September 15, 2011

All employees that participate in company sponsored benefit plans are required to make timely premium payments to retain eligibility and coverage. The Company will withhold premiums from your paycheck to the extent possible. This policy describes how premiums will be invoiced (i.e., billed) if the Company is unable to withhold from your paycheck premiums for one or more of the company sponsored benefit plans you elected. As described below, invoiced premiums must be received and processed by the Company within 30 days of the invoice date to maintain coverage. Any unpaid/underpaid invoices will result in a **retroactive** cancellation of benefits back to the invoice date.

When Will I Get An Invoice?

You'll get an invoice if:

- Your pay is not sufficient for the Company to deduct your premium from your payroll check.
- Your existing premium increases (or you have a new premium) because of a permitted midyear enrollment. For example, within 31 days of the birth of your child, you add your newborn child to your existing medical coverage (or you newly elect coverage for both yourself and your newborn). You will be invoiced for any shortfall in premium until the new premiums are withheld from your paycheck.

The invoice will list each type of coverage for which you owe premiums. However, **you will not get an invoice for premiums for supplemental coverage you elect (such as supplemental group accident, supplemental hospital/ medical, or critical illness) which must be paid directly to the insurance carrier who insures the benefit**. Rather, if you want to keep that coverage, it is your responsibility to ensure that you timely pay those premiums directly to the insurance carrier.

How Much Will I Owe?

You will owe the amount shown on the invoice which will equal the amount of premium that was unable to be withheld from your payroll check.

What Are Acceptable Methods of Payment?

Online payments via credit card or PayPal, cashier's check and money orders are acceptable forms of payment. The invoice will provide complete details and instruction.

When Will Payment Be Due?
Payment will be due on the date of the invoice, but you will be treated as having made a timely payment if payment is received and processed within 30 days after the date of the invoice. Allow 5–7 days for processing time.

Are Partial Payments of an Amount Invoiced for a Benefit Allowed?
No. Any partial payment of an amount invoiced for a benefit will be returned to you and that coverage will be cancelled as described below. Please note that an invoice may include amounts owed for more than one benefit (such as medical and dental). In that case, you can choose to pay the invoiced amount for one benefit (e.g., medical) and not pay the invoiced amount for the other benefit (e.g., dental), in which case only coverage for the benefit for which you did not pay the full invoiced amount (e.g., dental) will be cancelled. It is your responsibility to indicate on the invoice the benefit(s) to which your payment should be applied. If you fail to do so, your payment will be applied as determined by the Company in its discretion.

Will Coverage Be Cancelled If Payment Is Not Timely Made?
Yes. If you do not pay the entire amount due for a benefit within 30 days of the date of the invoice (or if your payment does not clear or is otherwise not honored by our bank), that coverage will be cancelled retroactively as of the date of the invoice. This means that you (and, if applicable, your dependents) will not have coverage on or after the date of the invoice. If your (or your and your dependents') coverage is retroactively cancelled as described above, any premiums that you paid for that coverage after the effective date of cancellation will be refunded to you. Remember, if you want to avoid cancellation of your (or your and your dependents') coverage, it is your responsibility to make sure that payment is both timely made and actually received. Allow 5–7 days for processing time.

Can I Use A Premium Refund To Reduce The Amount Owed?
No. A premium refund through payroll cannot be used to reduce the amount owed on an invoice. Rather, you must separately pay the invoiced amount.

If A Qualified Medical Child Support Order Requires Dependent Coverage, Will Coverage Still Be Cancelled Due To Nonpayment?

Yes. You are responsible for paying the cost of your dependent's coverage, even if that coverage is required by a qualified medical child support order. This means that, if you receive an invoice and you do not pay the entire amount due within 30 days of the invoice, your dependent's coverage will be cancelled, even if that coverage is required by a qualified medical child support order.

How Will A Cancellation of Coverage Affect My Flexible Spending Accounts?

If your Health Care and/or Dependent Daycare Flexible Spending Account coverage is cancelled because you do not timely pay an invoice for that coverage, any expenses you incur on or after the effective date of cancellation cannot be reimbursed from your account(s).

Will I Be Eligible for COBRA Coverage if My Coverage Is Cancelled?

No. A cancellation of coverage due to a failure to pay premiums is not a COBRA qualifying event.

Can I Re-Enroll in Regular (i.e., non-COBRA) Coverage If My Coverage Is Cancelled?

Yes, but you will not be able to re-enroll until the next Annual Enrollment period occurs for the coverage that was cancelled (unless reinstatement of coverage occurs pursuant to the Company's rehire policy or as required by law). The Company reserves the right to change its rehire policy at any time without prior notice. By law, if group health care coverage (for example, medical, dental, vision or health care spending accounts) is cancelled due to nonpayment of premiums during an approved FMLA or military leave of absence, the cancelled coverage will be reinstated when you return to work, but you still will not have coverage on or after the effective date of cancellation and prior to your return to work.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

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, such as a copayment, coinsurance and/or a deductible. You may have other 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" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay 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 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.

You are 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 the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). 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 may 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 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 care out-of-network. You can choose a provider or facility in your plan's network.

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

- You are only responsible for paying your share of the cost (like the copayments, coinsurance and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (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 deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact *U.S. Department of Health & Human Services Hubert H. Humphrey Building 200 Independence Avenue, S.W. Washington, D.C. 20201*, or call *1-877-696-6775*.

Visit **https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf** for more information about your rights under federal law.

Notice Regarding Wellness Program

Swift Wellness GPS is a voluntary wellness program available to all full-time employees and eligible spouses. Spouses can participate if they are currently enrolled in a Swift medical plan. Full-time Swift employees can participate even if you aren't planning to enroll in the medical plan next year. You can still benefit from the wide range of activities and information available.

Incentives for the wellness points commence in January 2022. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

If you choose to participate in this voluntary program you can select from a wide variety of activities. In order to earn the medical premium incentives, you must complete a health risk assessment, or "HRA," that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes or heart disease). This helps to recommend programs and activities specific to your individual needs.

Other activities that can earn incentives include:

- Completing a health screening and obtaining the following healthy ranges:
  - Total cholesterol at or under 200
  - Blood pressure at or under 120/80
  - Fasting blood glucose level at or under 100 (or 140 non-fasting)
  - Body mass index at or under 29.9
- Health coaching
- Self-guided online daily habit programs
- Financial wellness activities and education

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting WebMD at **1-888-321-1517**.

The information from your HRA and the results from your health screening will be used to provide you with information to help you understand your current health and potential risks. The information may also be used to offer you services through the wellness program, such as health coaching. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Swift Transportation may use aggregate information they collect to design a program based on identified health risks in the workplace, WebMD will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are designated representatives from WebMD, in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any employment decision. Swift Transportation will not have any of your specific results in any of our systems. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact WebMD at **1-888-321-1517**.

HIPAA Privacy Notice

This notice is effective October 1, 2015, and it describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

What is protected health information (PHI)?

Protected health information ("PHI") includes all individually identifiable health information transmitted or maintained by the health plan* ("plan"), whether electronically, in writing, or orally.

Examples of PHI include reports of diagnosis and treatment submitted with a benefit claim form and records relating to an eligibility determination by a claims administrator. PHI does not include health information created or received by an employer for employment-related purposes, such as a medical certification submitted with a request for FMLA leave.

*Health plan is defined as employer-provided group health insurance, limited scope dental/vision plans, health-related FSA accounts and most employee assistance programs (EAPs). Workers' compensation is not defined as a health plan as it pertains to PHI.

What are the plan's duties relating to your PHI?

The plan is required by law to maintain the privacy of your PHI and to provide you with this notice of its legal duties and privacy practices. The plan must abide by the terms of this notice, but it reserves the right to change the terms of this notice and apply the revised notice to all PHI that it maintains, in which case you'll be appropriately notified of the change. This notice does not apply to de-identified information, which is information that does not identify an individual and that cannot reasonably be used to identify an individual.

When can your PHI be used or disclosed?

Except as described below, the plan will not use or disclose your PHI to anyone but you without your written consent. Also, your PHI cannot be used for marketing purposes or sold without your written consent. If you authorize the plan to use or disclose your PHI, you may revoke that authorization in writing at any time. You can receive PHI on your dependent children under the age of 18 who are on the plan. No disclosure will be made to you regarding the PHI of your

dependent children age 18 or older who are on the plan unless they provide us with written authorization. Similarly, if your spouse calls, your PHI cannot be disclosed without written authorization from you.

The plan may use or disclose your PHI without your consent if the use or disclosure relates to treatment, payment or health care operations, and, in connection with these functions, your PHI may be disclosed by the plan to Swift Transportation. "Treatment" includes the provision, coordination or management of health care and related services. For example, the plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

"Payment" includes billing, claims management, and reviews for medical necessity. For example, the plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the plan. "Health care operations" includes quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, and premium rating, and periodic audits of the plan's normal business operations. For example, the plan may use information about your claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing (or other) functions. However, the plan is prohibited from using or disclosing genetic information for underwriting purposes.

The plan also may use or disclose your PHI without your consent when required by law or under certain other permitted situations. Legally required disclosures include disclosures to or relating to:

- the U.S. Department of Health and Human Services to determine the plan's compliance with this notice
- reporting abuse, neglect or domestic violence to public authorities if the plan has reason to believe you may be a victim of abuse, neglect or domestic violence, subject to prior notice to you
- judicial or administrative proceedings, such as in response to a subpoena, subject to prior notice to you
- a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law, or to funeral directors as necessary to carry out their duties with respect to the decedent
- to comply with workers' compensation or other similar programs established by law

Other permitted situations include disclosures to or relating to:

- a public health oversight agency for oversight activities authorized by law, including uses or disclosures in civil, administrative or criminal investigations
- for public health activities, such as to report product defects or stop the spread of a communicable disease
- law enforcement purposes, such as to report certain types of wounds or for the purpose of identifying or locating a suspect, fugitive, material witness or missing person
- for research, subject to certain conditions
- to prevent or lessen a serious and imminent threat to the health or safety of a person or the public

When using or disclosing PHI or when requesting PHI from another covered entity, the plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply to: disclosures to or requests by a health care provider for treatment; uses or disclosures made to you; disclosures made to the U.S. Department of Health and Human Services; uses or disclosures that are required by law; or uses or disclosures that are required for the plan's compliance with legal regulations.

What are your rights?

You have certain rights with respect to your PHI. These include the right to:

- request that the plan restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations; the plan is not required to comply with your request
- receive confidential PHI communications and request that the plan communicate with you in a certain way if you feel that the disclosure of your PHI could endanger you
- inspect and obtain a copy of your PHI and receive the copy electronically if the plan uses or maintains an electronic record of your PHI
- request a correction of your PHI if you believe that the PHI the plan has about you is inaccurate or incomplete
- request and receive a list of disclosures made by the plan of your PHI, other than those disclosures for which an accounting is not required (such as disclosures for treatment, payment or health care operations); special rules apply to disclosures made through an electronic health record which permit you to request and receive a list of disclosures made by the plan of your PHI through an electronic health record (including disclosures for treatment, payment or health care operations) during the 3-year period preceding your request

- request and receive a paper copy of this notice even if you have received this notice previously or agreed to receive this notice electronically
- receive notification from the plan in the event there is a breach of PHI that is not secured through the use of a technology or methodology specified by the U.S. Department of Health and Human Services
- file a complaint with the Privacy Officer (Mike Ruchensky, Chief Information Systems Officer) or U.S. Department of Health and Human Services if you believe that your privacy rights have been violated; the plan will not retaliate against you for filing a complaint

To exercise any of these rights, including filing a claim with the Privacy Officer, contact the Swift Transportation Benefits Department at **1-866-410-5765**. To file a claim with the U.S. Department of Health and Human Services, send your complaint to Secretary of the U.S. Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, D.C. 20201. The plan will not retaliate against you for filing a complaint.

Who can you contact for additional information?

If you have questions or need additional information, please contact the Swift Transportation Benefits Department at **1-866-410-5765**.

HIPAA Special Enrollment Notice

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

If either of the following two events occur, you will have *60 days* from the date of the event to request enrollment in your employer's plan: (1) your dependents lose Medicaid or CHIP coverage because they are no longer eligible; or (2) your dependents become eligible for a state's premium assistance program.

To take advantage of special enrollment rights, you must experience a qualifying event *and* provide the employer plan with timely notice of the event and your enrollment request.

To request special enrollment or obtain more information, contact **1-844-577-4333**. Representatives are available to assist you Monday through Friday between 8:00 a.m. and 6:00 p.m. ET (except national holidays).

Women's Health and Cancer Rights Act

The Women's Health and Cancer Rights Act stipulates that any health plan that provides medical benefits for a mastectomy must provide coverage for breast reconstruction for patients who choose to receive it.

Swift Transportation's medical plan covers mastectomy patients for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to achieve a symmetrical appearance; prostheses; and treatment of physical complications of all stages of mastectomy, including lymphedema.

Coverage under the plan will continue until the earlier of (1) the date that is one year after the first day of the medically necessary leave of absence or (2) the date that coverage would otherwise end under the plan's terms.

Newborns' Act Disclosure

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Patient Protection Notice

Swift Transportation's medical plans generally allow the designation of a primary care provider. Some plans require it, including HMO plans. You have the right to designate any primary care provider who participates in the plan's network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your insurer.

You do not need prior authorization from your insurer or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in your plan's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a preapproved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your plan.

Who can you contact for additional information?

If you have questions or need additional information, please contact **1-844-577-4333**. Representatives are available to assist you Monday through Friday between 8:00 a.m. and 6:00 p.m. ET (except national holidays).

Health Care Reform and Your Health Insurance Options

Effective January 1, 2014, the Affordable Care Act—also known as "health care reform"—requires most Americans to have health insurance.

The Health Insurance Marketplace (formerly referred to as "state exchanges") was created as an outcome of this requirement to ensure that everyone has access to affordable health insurance. **The Marketplace is an option for someone who does not have employer-provided health coverage** or for someone who chooses not to enroll in employer-provided health coverage.

Pages 47–49 contain a notice on Marketplace health insurance coverage options. Swift Transportation is required by law to send this to you. **No action is required by you.**

Why am I receiving this notice?
This notice provides you with instructions on how to access information about the Health Insurance Marketplace, which consists of health plans offered to you by either your state or the U.S. Department of Health and Human Services.

What this means for you

- **No action required.** You don't need to do anything, unless you're interested in Marketplace coverage.
- **Swift will continue to offer coverage to you and your family.** Benefits-eligible employees and their eligible dependents will have access to health care coverage through Swift Transportation.
- **Our plans offer the best value.** You'll hear about new coverage options available in the Health Insurance Marketplace, but in most cases, Swift's coverage will continue to provide the greatest value and exceed the minimum level of coverage called "essential health benefits."
- **Most Swift employees won't qualify for government subsidies.** If you want to buy insurance in an exchange but can't afford it, you may be eligible for a government subsidy if you meet certain income requirements. Only a small percentage of Swift employees will meet these requirements.
- **We'll keep you updated.** We'll continue to provide resources and support to help you understand the impact of health care reform, so that you can make smart decisions.

No action required
Swift Transportation is required to send the enclosed notice to every U.S. employee to comply with rules under the federal Patient Protection and Affordable Care Act (ACA). **No action is required by you.**

How does my Swift Transportation coverage compare to the Marketplace?
The Swift Transportation group health plan intends to provide **more coverage at a lower cost to you** than a Marketplace health plan. If you buy insurance in the Marketplace, you will **not** receive a contribution from Swift Transportation, as the company already meets government standards for providing minimum, affordable coverage.

What if I'm interested in Marketplace coverage?
- Go to **HealthCare.gov** to review the plans available in your state.
- Keep the enclosed notice because it has information you'll need to enroll in Marketplace coverage.

Questions? Call **1-800-318-2596** (TTY: 1-855-889-4325) or visit **HealthCare.gov**.

We are providing this notice only because federal law requires us to provide it to you. We can provide you with no further information about its contents. We also cannot provide you with assistance in evaluating your options for exchange coverage or the potential penalties under the law, but the government agencies will have some educational materials and sources for additional information. You can find more information to help you make your decision at ***HealthCare.gov*** *(English) or* ***https://www.cuidadodesalud.gov/es/*** *(Spanish). You can also call* ***1-800-318-2596****.*

PART A: General Information

Since key parts of the health care law took effect in 2014, there is a new way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the new Marketplace and employment-based health coverage offered by your employer.

What Is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in November 2021 for coverage starting as early as January 1, 2022.

Can I Save Money on My Health Insurance Premiums in the Marketplace?

You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings Through the Marketplace?

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

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

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description. You can also visit **swift.benefitsnow.com** or call **1-844-577-4333**.

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

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

3. Employer name: Swift Transportation	**4. Employer identification number (EIN):** 20-5589597	
5. Employer address: Swift Transportation Benefits Department P.O. Box 29243 Phoenix, AZ 85038-9243	**6. Employer phone number:** 1-866-410-5765	
7. City: Phoenix	**8. State:** AZ	**9. ZIP code:** 85038-9243
10. Who can we contact about employee health coverage at this job? Swift Transportation Benefits Department		
11. Phone number (if different from above) 1-866-410-5765	**12. Email address:** hrbenefits@swifttrans.com	

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to:
  ☐ All employees.
  ☒ Some employees. You're eligible for benefits if:
  - You are a current full-time non-driving employee working at least 30 hours per week.
  - You are a current full-time driver working at least 30 hours per week.
- With respect to dependents:
  ☒ We do offer coverage.
  Eligible family members (dependents) you can cover include:
  - Your legal spouse of the opposite or same gender. If you're legally separated pursuant to a court order, your spouse will not be eligible for coverage.
  - Your children up to age 26 (includes adopted children, stepchildren and legal foster children).
  - Your unmarried, disabled children over the age of 26 who you claim as a dependent on your federal income taxes. (Proof of disability may be required.)

  ☐ We do not offer coverage.

☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

**Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed midyear, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, **HealthCare.gov** will guide you through the process.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2021. Contact your State for more information on eligibility.

ALABAMA – MEDICAID

Website: **http://myalhipp.com**
Phone: **1-855-692-5447**

ALASKA – MEDICAID

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

ARKANSAS – MEDICAID

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

CALIFORNIA – MEDICAID

Health Insurance Premium Payment (HIPP) Program
Website: **https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx**
Phone: **1-800-541-5555**

COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)

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

FLORIDA – MEDICAID

Website: **https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/**
Phone: **1-877-357-3268**

GEORGIA – MEDICAID

Website: **https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp**
Phone: **1-678-564-1162 ext 2131**

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64:
Website: **http://www.in.gov/fssa/hip/**
Phone: **1-877-438-4479**
All other Medicaid:
Website: **https://www.in.gov/medicaid/**
Phone: **1-800-457-4584**

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website: **https://dhs.iowa.gov/ime/members**
Medicaid Phone: **1-800-338-8366**
Hawki Website: **http://dhs.iowa.gov/Hawki**
Hawki Phone: **1-800-257-8563**
HIPP Website: **https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp**
HIPP Phone: **1-888-346-9562**

KANSAS – MEDICAID

Website: **https://www.kancare.ks.gov/**
Phone: **1-800-792-4884**

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: **https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx**
Phone: **1-855-459-6328**
Email: **KIHIPP.PROGRAM@ky.gov**
KCHIP Website: **https://kidshealth.ky.gov/Pages/index.aspx**
Phone: **1-877-524-4718**
Kentucky Medicaid Website: **https://chfs.ky.gov**

LOUISIANA – MEDICAID

Website: **www.medicaid.la.gov** or **www.ldh.la.gov/lahipp**
Phone: **1-888-342-6207 (Medicaid hotline)** or **1-855-618-5488 (LaHIPP)**

MAINE – MEDICAID

Website: **http://www.maine.gov/dhhs/ofi/public-assistance/index.html**
Phone: **1-800-442-6003**
TTY: **Maine relay 771**
Private Health Insurance Premium Webpage: **https://www.maine.gov/dhhs/ofi/applications-forms**
Phone: **1-800-977-6740**
TTY: **Maine relay 711**

MASSACHUSETTS – MEDICAID AND CHIP

Website: **https://www.mass.gov/info-details/masshealth-premium-assistance-pa**
Phone: **1-800-862-4840**

MINNESOTA – MEDICAID

Website: **https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp**
Under ELIGIBILITY tab, see "what if I have other health insurance?"
Phone: **1-800-657-3739**

MISSOURI – MEDICAID

Website: **https://dss.mo.gov/mhd/participants/pages/hipp.htm**
Phone: **1-573-751-2005**

MONTANA – MEDICAID

Website: **http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP**
Phone: **1-800-694-3084**

NEBRASKA – MEDICAID

Website: **http://www.ACCESSNebraska.ne.gov**
Phone: **1-885-632-7633**
Lincoln: **(402) 473-7000**
Omaha: **(402) 595-1178**

NEVADA – MEDICAID

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

NEW HAMPSHIRE – MEDICAID

Website: **https://www.dhhs.nh.gov/oii/hipp.htm**
Phone: **603-271-5218**
Toll free number for the HIPP program: **1-800-852-3345, ext 5218**

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website: **http://www.state.nj.us/humanservices/dmahs/clients/medicaid/**
Medicaid Phone: **609-631-2392**
CHIP Website: **http://www.njfamilycare.org/index.html**
CHIP Phone: **1-800-701-0710**

NEW YORK – MEDICAID

Website: **https://www.health.ny.gov/health_care/medicaid/**
Phone: **1-800-541-2831**

NORTH CAROLINA – MEDICAID

Website: **https://medicaid.ncdhhs.gov/**
Phone: **919-855-4100**

NORTH DAKOTA – MEDICAID

Website: **http://www.nd.gov/dhs/services/medicalserv/medicaid/**
Phone: **1-844-854-4825**

OKLAHOMA – MEDICAID AND CHIP

Website: **http://www.insureoklahoma.org**
Phone: **1-888-365-3742**

OREGON – MEDICAID

Websites: **http://healthcare.oregon.gov/Pages/index.aspx**
http://www.oregonhealthcare.gov/index-es.html
Phone: **1-800-699-9075**

PENNSYLVANIA – MEDICAID

Website: **https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx**
Phone: **1-800-692-7462**

RHODE ISLAND – MEDICAID AND CHIP

Website: **http://www.eohhs.ri.gov**
Phone: **1-855-697-4347**, or **401-462-0311**
(Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: **https://www.scdhhs.gov**
Phone: **1-888-549-0820**

SOUTH DAKOTA – MEDICAID

Website: **http://dss.sd.gov**
Phone: **1-888-828-0059**

TEXAS – MEDICAID

Website: **http://gethipptexas.com/**
Phone: **1-800-440-0493**

UTAH – MEDICAID AND CHIP

Medicaid Website: **https://medicaid.utah.gov/**
CHIP Website: **http://health.utah.gov/chip**, Phone: **1-877-543-7669**

VERMONT – MEDICAID

Website: **http://www.greenmountaincare.org/**
Phone: **1-800-250-8427**

VIRGINIA – MEDICAID AND CHIP

Website: **https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp**
Medicaid Phone: **1-800-432-5924**
CHIP Phone: **1-855-242-8282**

WASHINGTON – MEDICAID

Website: **https://www.hca.wa.gov/**
Phone: **1-800-562-3022**

WEST VIRGINIA – MEDICAID

Website: **http://mywvhipp.com/**
Toll-free phone: **1-855-MyWVHIPP (1-855-699-8447)**

WISCONSIN – MEDICAID AND CHIP

Website: **https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm**
Phone: **1-800-362-3002**

WYOMING – MEDICAID

Website: **https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/**
Phone: **307-777-7531**

To see if any other states have added a premium assistance program since July 31, 2021, 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

Notes

Reminders

- **If you need to update your mailing address, you can do that on the Transmission Portal,** so all of your important benefit information is going to the right place.
- **Opt in to text messaging and update your email on swift.benefitsnow.com,** so you can get benefits-related reminders on the go. Once you log on, go to your profile and select **Personal Information**. To opt in for text, select mobile phone as preferred and check the box, **"Yes, send text message notifications to my mobile phone."** You can also update your preferred email.

Contact information

Use this information (to the right) to contact the Benefits Service Center, as well as plan carriers if you have questions about coverage and provider networks. Use the preview websites to learn about carriers before you enroll for benefits. Once enrolled, use the member website for the carriers you selected.

Contacts

	CARRIER	MEMBER SITE	PRE-ENROLLMENT PHONE NUMBER	POST ENROLLMENT PHONE NUMBER
Benefits Service Center	N/A	swift.benefitsnow.com	N/A	1-844-577-4333
Employee Assistance Plan (EAP) (Company Code: ST1219)	Guidance Resources	guidanceresources.com	N/A	1-888-767-9438
Medical	Blue Cross Blue Shield of Arizona	azblue.com	1-844-817-4117 reference Swift Transportation	1-855-845-1883
Medical (CA Only)	Kaiser Permanente	kp.org	800-464-4000 Southern California: Group number 234551 Northern California: Group number 606416	1-800-464-4000
Prescription	CVS Caremark	caremark.com	1-855-305-3016	1-855-305-3016
Dental/Vision	MetLife	metlife.com/mybenefits	1-800-438-6388	1-800-438-6388
Life, accident and disability insurance	The Hartford	mybenefits.thehartford.com/login	1-888-563-1124	1-888-563-1124
Principal 401(k)	Principal	principal.com	1-800-547-7754	1-800-547-7754
Accident, Hospital Indemnity and Critical Illness	The Hartford	mybenefits.thehartford.com/login	N/A	1-866-547-4205
Health Care & Dependent Daycare FSAs	Payflex	payflex.com	N/A	1-800-284-4885
Swift Wellness GPS	WebMD	webmdhealth.com/swift/ or Wellness at Your Side app	1-888-321-1517	1-888-321-1517

Swift Transportation Benefits Service Center
P.O. Box 1495
Lincolnshire, IL 60069-1495

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