Crete Carrier Corporation Welfare Benefits Plan
2026/2027 Annual Notice Packet

As a member in one or more of our benefits plans, you are entitled to certain annual notices. This packet contains the following notices:

- ***Medicare Part D – Creditable Coverage Notice*** *– If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the enclosed notice on the next page for more details. It is your responsibility to share this information with your Medicare eligible dependents.*

- ***Summary of Benefits and Coverage*** - As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury. Your plan offers one health coverage option. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across other options which may be available to you.

- ***Health Insurance Marketplace Coverage Options and Your Health Coverage (Affordable Care Act Notice)***

- ***Notice of Rights to Continue Group Health Coverage Under the Crete Carrier Corporation Welfare Benefits Plan (COBRA Notice)***

- ***HIPAA Notice of Privacy Practices for the Crete Carrier Corporation Welfare Benefits Plan (HIPAA Privacy Notice)***

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

- ***Mental Health Parity and Addiction Equity Act (MHPAEA Disclosure)***

- ***Newborn's and Mother's Health Protection Act Notice***

- ***Women's Health and Cancer Rights Act (WHCRA) Notices***

- ***HIPAA - Notice of Special Enrollment Rights***

- ***2025 Summary Annual Report (SAR) for the Crete Carrier Corporation Welfare Benefits Plan***

- ***Form 1095-C Tax Information Notice***

If you want a paper version of these annual notices, please request one from the Benefits Department (benefits@cretecarrier.com or via telephone at 1-800-998-9100). There is no additional charge for it. If you have any questions please contact the Benefits Department.

BENEFITS DEPARTMENT

400 N.W. 56th St. • Lincoln, NE 68528

October 1, 2026

Important Notice from Crete Carrier Corporation and Hunt Transportation, Inc. 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 Crete Carrier Corporation and Hunt Transportation, Inc. and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is contained in 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 a 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. **Crete Carrier Corporation and Hunt Transportation, Inc. have determined that the prescription drug coverage offered by the Crete Carrier Corporation Group Health Care Plan and administered by MaxCare, LLC is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

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

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Crete Carrier Corporation/Hunt Transportation, Inc. coverage will not be affected and the plan will coordinate coverage with Part D coverage.

If you do decide to join a Medicare drug plan and drop your current Crete Carrier Corporation/Hunt Transportation, Inc. coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period, except for a change in status, which would include, but not be limited to marriage, divorce, birth of a child, death of a spouse or child, or termination of employment. You must complete the appropriate benefits change form to drop your current coverage.

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 Crete Carrier Corporation and Hunt Transportation, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the office listed below for further information:

Name of Entity:	Crete Carrier Corporation / Hunt Transportation, Inc.
Contact Office:	Benefits Department
Address:	400 NW 56th Street, Lincoln, NE 68528
Phone Number:	800-998-9100

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 Crete Carrier Corporation and Hunt Transportation, Inc. changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

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

For more information about Medicare prescription drug coverage:

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

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

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

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Coverage Period: 01/01/2027 - 12/31/2027

Crete Carrier Corporation: PPO

Coverage for: Individual/Family **Plan Type: PPO**

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, please visit www.myhighmark.com or call 1.866.370.2583. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.HealthCare.gov/sbc-glossary/ or call 1.866.370.2583 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$1,350 individual/$2,700 family network. $2,700 individual/$5,400 family out-of-network. All services are credited to both network and out-of network deductibles.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your network deductible. Copayments and coinsurance amounts don't count toward the network deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	$3,800 individual/$7,600 family network out-of-pocket limit, up to a total maximum out-of-pocket of $3,800 individual/$7,600 family. $6,500 individual/$13,000 family out-of-network. All services are credited to both network and out-of-network out-of-pocket.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out–of–pocket limit?	Network: Premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn't cover do not apply to your total maximum out-of-pocket. Out-of-network: Premiums, balance-billed charges, prescription drug expenses, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit. Prescription drug expenses are subject to an independent out-of-pocket limit described elsewhere in the SBC.

Will you pay less if you use a network provider?	Yes. See www.myhighmark.com or call 1.866.370.2583 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your overall **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% coinsurance	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for. Please refer to your preventive schedule for additional information.
	Specialist visit	20% coinsurance	30% coinsurance	
	Preventive care/screening/immunization	No charge Deductible does not apply.	30% coinsurance No charge for immunizations Deductible does not apply to immunizations	
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance independent lab 30% coinsurance	Out-of-network: Independent lab subject to network deductible. Precertification may be required.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance independent lab 30% coinsurance	Out-of-network: Independent lab subject to network deductible. Precertification may be required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.mymaxcarerx.com or call 1.855.537.5843 .	**Retail:** Generic drugs	Up to $19 copayment or 20% coinsurance whichever is greater	Not covered	Prescription drugs are provided through MaxCare, LLC Prescription drugs obtained at a non-preferred pharmacy require an additional $10-15 copayment/10% coinsurance to the stated amounts. For copayment / coinsurance of Brand drugs that have a Generic alternative available, you pay the Brand copayment/coinsurance plus the cost difference between Brand drug and its Generic alternative. Specialty drugs are limited to a 30-day supply. Only maintenance drugs are allowed for 31-90-day supply. Out-of-pocket limit: $1,500 individual/$3,000 family network out-of-pocket limit. There is no out-of-pocket limit for out-of-network providers.
	Preferred Brand drugs	Up to $49 copayment or 20% coinsurance whichever is greater	Not covered	
	Non-preferred Brand drugs	Up to $86 copayment or 20% coinsurance whichever is greater	Not covered	
	Mail or Retail 90: Generic drugs	$40 copayment	Not covered	
	Preferred Brand drugs	$138 copayment	Not covered	
	Non-preferred Brand drugs	$235 copayment	Not covered	
	Speciality drugs: Generic drugs	20% coinsurance up to a $50 copayment	Not covered	
	Preferred Brand drugs	20% coinsurance up to a $80 copayment	Not covered	
	Non-preferred Brand drugs	20% coinsurance up to a $150 copayment	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Precertification may be required.
If you need immediate medical attention	Emergency room care	20% coinsurance after $250 copayment/visit	20% coinsurance after $250 copayment/visit	Copayment waived if admitted as an inpatient. Out-of-network: Subject to network deductible.
	Emergency medical transportation	20% coinsurance	20% coinsurance	Out-of-network: Subject to network deductible.
	Urgent care	20% coinsurance	30% coinsurance	----------none----------
If you have a hospital stay	Facility fees (e.g., hospital room)	20% coinsurance	30% coinsurance	Precertification may be required.
	Physician/surgeon fees	20% coinsurance	30% coinsurance	Precertification may be required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	30% coinsurance	Precertification may be required.
	Inpatient services	20% coinsurance	30% coinsurance	Precertification may be required.
If you are pregnant	Office visits	20% coinsurance	30% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services, a copayment, coinsurance, or deductible may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Network: The first visit to determine pregnancy is covered at no charge. Please refer to the Women's Health Preventive Schedule for additional information. Precertification may be required.
	Childbirth/delivery professional services	20% coinsurance	30% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	20% coinsurance	30% coinsurance	Combined network and out-of-network: 60 visits per benefit period, combined with visiting nurse. Precertification may be required.
	Rehabilitation services	20% coinsurance	30% coinsurance	Combined network and out-of-network: 60 combined physical medicine, occupational therapy, and speech therapy visits per benefit period. Combined network and out-of-network: Habilitation and rehabilitation services. Precertification may be required.
	Habilitation services	20% coinsurance	30% coinsurance	
	Skilled nursing care	20% coinsurance	30% coinsurance	Combined network and out-of-network: 60 days per benefit period. Precertification may be required.
	Durable medical equipment	20% coinsurance	30% coinsurance	Combined network and out-of-network: rental or purchase, whichever is least costly. Precertification may be required.
	Hospice services	20% coinsurance	30% coinsurance	Precertification may be required.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	----------none----------
	Children's glasses	20% coinsurance	30% coinsurance	Limited: Only covered if required because of a change in prescription as a result of surgery or injury. Must be within 12 months.
	Children's dental check-up	Not covered	Not covered	----------none----------

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture	• Long-term care	• Weight loss programs
• Cosmetic surgery	• Private-duty nursing	
• Dental care (Adult)	• Routine eye care (Adult)	
• Hearing aids	• Routine foot care	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Infertility (to treat underlying medical condition)	• Non-emergency care when traveling outside the U.S. See www.bcbsglobalcore.com

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov. Other options to continue coverage are available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit http://www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim appeal or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Your plan administrator/employer.
- The Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? **Yes**
Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet the Minimum Value Standards? **Yes**
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	$1,350
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$10
Coinsurance	$2,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,720**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

The plan's overall deductible	$1,350
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$100
Coinsurance	$800
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$2,270**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	$1,350
Specialist coinsurance	20%
Hospital (facility) coinsurance	20%
Other coinsurance	20%

This EXAMPLE event includes services like:

Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$1,350
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,950**

The plan would be responsible for the other costs of these EXAMPLE covered services.

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card (TTY: 711).

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al número en la parte posterior de su tarjeta de identificación (TTY: 711).

请注意：如果您说中文，可向您提供免费语言协助服务。

请拨打您的身份证背面的号码（TTY：711）。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số điện thoại ở mặt sau thẻ ID của quý vị (TTY: 711).

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. ID 카드 뒷면에 있는 번호로 전화하십시오 (TTY: 711).

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tawagan ang numero sa likod ng iyong ID card (TTY: 711).

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Позвоните по номеру, указанному на обороте вашей идентификационной карты (номер для текст-телефонных устройств (TTY): 711).

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل بالرقم الموجود خلف بطاقة هويتك (جهاز الاتصال لذوي صعوبات السمع والنطق: 711).

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le numéro qui est au dos de votre carte d'identité. (TTY: 711).

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez le numéro au dos de votre carte d'identité (TTY: 711).

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń pod numer podany na odwrocie karty ubezpieczenia zdrowotnego (TTY: 711).

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para o número no verso da sua identidade (TTY: 711).

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Contatti il numero riportato sul retro della sua carta d'identità (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie dazu die auf der Rückseite Ihres Versicherungsausweises (TTY: 711) aufgeführte Nummer an.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。ID カードの裏に明記されている番号に電話をおかけください (TTY: 711)。

توجه : اگر شما به زبان **فارسی** صحبت می کنید، خدمات کمک زبان، به صورت رایگان، در دسترس شماست. با شماره واقع در پشت کارت شناسایی خود (TTY: 711) تماس بگیرید.

Health Insurance Marketplace Coverage Options and Your Health Coverage

Form Approved
OMB No. 1210-0149
(expires 12-31-2026)

PART A: General Information

Even if you are offered health coverage through your employment, you may have other coverage options through the Health Insurance Marketplace ("Marketplace"). To assist you as you evaluate options for you and your family, this notice provides some basic information about the Health Insurance Marketplace and health coverage offered through your employment.

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 in your geographic area.

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

You may qualify to save money and lower your monthly premium and other out-of-pocket costs, but only if your employer does not offer coverage, or offers coverage that is not considered affordable for you and doesn't meet certain minimum value standards (discussed below). The savings that you're eligible for depends on your household income. You may also be eligible for a tax credit that lowers your costs.

Does Employment-Based Health Coverage Affect Eligibility for Premium Savings through the Marketplace?

Yes. If you have an offer of health coverage from your employer that is considered affordable for you and meets certain minimum value standards, you will not be eligible for a tax credit, or advance payment of the tax credit, for your Marketplace coverage and may wish to enroll in your employment-based health plan. However, you may be eligible for a tax credit, and advance payments of the 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 is considered affordable for you or meet minimum value standards. If your share of the premium cost of all plans offered to you through your employment is more than 9.12%[1] of your annual household income, or if the coverage through your employment does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit, and advance payment of the credit, if you do not enroll in the employment-based health coverage. For family members of the employee, coverage is considered affordable if the employee's cost of premiums for the lowest-cost plan that would cover all family members does not exceed 9.12% of the employee's household income.[1,2]

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered through your employment, then you may lose access to whatever the employer contributes to the employment-based coverage. Also, this employer contribution -as well as your employee contribution to employment-based coverage- is generally excluded from income for federal and state income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis. In addition, note that if the health coverage offered through your employment does not meet the affordability or minimum value standards, but you accept that coverage anyway, you will not be eligible for a tax credit. You should consider all of these factors in determining whether to purchase a health plan through the Marketplace.

---

[1] Indexed annually; see https://www.irs.gov/pub/irs-drop/rp-22-34.pdf for 2023.

[2] An employer-sponsored or other employment-based 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 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

When Can I Enroll in Health Insurance Coverage through the Marketplace?

You can enroll in a Marketplace health insurance plan during the annual Marketplace Open Enrollment Period. Open Enrollment varies by state but generally starts November 1 and continues through at least December 15.

Outside the annual Open Enrollment Period, you can sign up for health insurance if you qualify for a Special Enrollment Period. In general, you qualify for a Special Enrollment Period if you've had certain qualifying life events, such as getting married, having a baby, adopting a child, or losing eligibility for other health coverage. Depending on your Special Enrollment Period type, you may have 60 days before or 60 days following the qualifying life event to enroll in a Marketplace plan.

There is also a Marketplace Special Enrollment Period for individuals and their families who lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage on or after March 31, 2023, through July 31, 2024. Since the onset of the nationwide COVID-19 public health emergency, state Medicaid and CHIP agencies generally have not terminated the enrollment of any Medicaid or CHIP beneficiary who was enrolled on or after March 18, 2020, through March 31, 2023. As state Medicaid and CHIP agencies resume regular eligibility and enrollment practices, many individuals may no longer be eligible for Medicaid or CHIP coverage starting as early as March 31, 2023. The U.S. Department of Health and Human Services **is offering a temporary Marketplace Special Enrollment period to allow these individuals to enroll in Marketplace coverage.**

Marketplace-eligible individuals who live in states served by HealthCare.gov and either- submit a new application or update an existing application on HealthCare.gov between March 31, 2023 and July 31, 2024, and attest to a termination date of Medicaid or CHIP coverage within the same time period, are eligible for a 60-day Special Enrollment Period. **That means that if you lose Medicaid or CHIP coverage between March 31, 2023, and July 31, 2024, you may be able to enroll in Marketplace coverage within 60 days of when you lost Medicaid or CHIP coverage.** In addition, if you or your family members are enrolled in Medicaid or CHIP coverage, it is important to make sure that your contact information is up to date to make sure you get any information about changes to your eligibility. To learn more, visit HealthCare.gov or call the Marketplace Call Center at 1-800-318-2596. TTY users can call 1-855-889-4325.

What about Alternatives to Marketplace Health Insurance Coverage?

If you or your family are eligible for coverage in an employment-based health plan (such as an employer-sponsored health plan), you or your family may also be eligible for a Special Enrollment Period to enroll in that health plan in certain circumstances, including if you or your dependents were enrolled in Medicaid or CHIP coverage and lost that coverage. Generally, you have 60 days after the loss of Medicaid or CHIP coverage to enroll in an employment-based health plan, but if you and your family lost eligibility for Medicaid or CHIP coverage between March 31, 2023 and July 10, 2023, you can request this special enrollment in the employment-based health plan through September 8, 2023. Confirm the deadline with your employer or your employment-based health plan.

Alternatively, you can enroll in Medicaid or CHIP coverage at any time by filling out an application through the Marketplace or applying directly through your state Medicaid agency. Visit https://www.healthcare.gov/medicaid-chip/getting-medicaid-chip/ for more details.

How Can I Get More Information?

For more information about your coverage offered through your employment, please check your health plan's summary plan description or contact:

Benefits Department: 1-800-998-9100 or visit: www.cretecarrierbenefits.com

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 Crete Carrier Corporation, including Hunt Transportation, Inc.		4. Employer Identification Number (EIN) 47-0496288
5. Employer address 400 NW56th Street		6. Employer phone number 1-800-998-9100
7. City Lincoln	8. State NE	9. ZIP code 68528
10. Who can we contact about employee health coverage at this job? Benefits Department or visit www.cretecarrierbenefits.com		
11. Phone number (if different from above)	12. Email address benefits@cretecarrier.com	

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

- As your employer, we offer a health plan to:

☐ All employees. Eligible employees are:

☒ Some employees. Eligible employees are:

(i) Employees or (ii) owner operator contractors of the company residing in eligible states - (subscribers) - working a minimum of 30 hours per week on a regular calendar year basis are eligible for coverage. Coverage will be effective the first of the month following completion of an eligibility waiting period of 30 consecutive calendar days of employment or service, provided that the employee or contractor enrolls within 31 days.

- With respect to dependents:

☒ We do offer coverage. Eligible dependents are:

- Your spouse under a legally valid existing marriage, unless ended by a legal, effective decree of dissolution, divorce, or separation.

- Your children under 26 years of age, unless otherwise extended pursuant to applicable state or federal law, including:

  - Biological children
  - Stepchildren (the son or daughter of the subscriber's current spouse)
  - Legally adopted children and children from whom the subscriber is the child's legal guardian, but does not Include foster children
  - Otherwise eligible children awarded coverage pursuant to a Qualified Medical Child Support Order

- Unmarried children age 26 or over who are not able to support themselves due to intellectual disability, physical disability, mental illness, or developmental disability that started before age 26, and who depend on the subscriber for support and maintenance. Proof of disability must be received from the subscriber within 31 days of the child's reaching age 26 and after that, as 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 mid-year, 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. Here's the employer information you'll enter when you visit **HealthCare.gov** to find out if you can get a tax credit to lower your monthly premiums.

The information below corresponds to the Marketplace Employer Coverage Tool. Completing this section is optional for employers, but will help ensure employees understand their coverage choices.

13. **Is the employee currently eligible for coverage offered by this employer, or will the employee be eligible in the next 3 months?**

☐ **Yes** (Continue)
13a. If the employee is not eligible today, including as a result of a waiting or probationary period, when is the employee eligible for coverage?_____ (mm/dd/yyyy) (Continue)
☐ **No** (STOP and return this form to employee)

14. Does the employer offer a health plan that meets the minimum value standard*?
☐ Yes (Go to question 15) ☐ No (STOP and return form to employee)

15. For the lowest-cost plan that meets the minimum value standard* **offered only to the employee** (don't include family plans): If the employer has wellness programs, provide the premium that the employee would pay if he/ she received the maximum discount for any tobacco cessation programs, and didn't receive any other discounts based on wellness programs.
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

If the plan year will end soon and you know that the health plans offered will change, go to question 16. If you don't know, STOP and return form to employee.

16. What change will the employer make for the new plan year?_____
☐ Employer won't offer health coverage
☐ Employer will start offering health coverage to employees or change the premium for the lowest-cost plan available only to the employee that meets the minimum value standard.* (Premium should reflect the discount for wellness programs. See question 15.)
a. How much would the employee have to pay in premiums for this plan? $_____
b. How often? ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Quarterly ☐ Yearly

• 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 percent of such costs (Section 36B(c)(2)(C)(ii) of the Internal Revenue Code of 1986)

NOTICE OF RIGHTS TO CONTINUE GROUP HEALTH COVERAGE UNDER THE CRETE CARRIER CORPORATION WELFARE BENEFITS PLAN

Federal law requires most employers sponsoring group health plans to offer employees and their families the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or COBRA coverage) in certain instances when coverage under a group health plan would otherwise end. A group health plan includes any major medical plan, dental plan, vision plan, health FSA, or other plan that employers may maintain and that provides health care. For simplicity, any such group health plan is referred to in this Notice as a "Plan." Any person entitled to COBRA coverage is called a "qualified beneficiary." This Notice provides a brief overview of your rights and obligations under current law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and this Notice should be construed accordingly. More complete information is available from the Plan Administrator and contained in the applicable Summary Plan Descriptions. ***Both you and your spouse and/or other dependents should read this summary carefully and keep it with your records!***

For purposes of this Notice, Crete Carrier Corporation and its affiliate Hunt Transportation are called the "Company." You are considered to be a "Plan Participant" for purposes of this Notice if you meet two conditions. First, you must be employed by the Company, a non-employee Director of the Company, an independent contractor owner-operator of an over-the-road tractor leased to the Company, or an employee of an independent contractor owner-operator of an over-the-road tractor leased to the Company. Second, you must have elected or purchased coverage under a Plan sponsored by the Company.

Qualifying Events

If you are a Plan Participant, you have the right to elect continuation coverage if you lose coverage under the Plan because of any one of the following "qualifying events":

1. Termination of employment or operating agreement (for reasons other than gross misconduct).
2. Reduction in the hours of your employment.

If you are the **spouse** of Plan Participant, you have the right to elect continuation coverage if you lose coverage under the Plan because of any of the following "qualifying events":

1. The death of your spouse.
2. A termination of your spouse's employment or operating agreement (for reasons other than gross misconduct) or reduction in your spouse's hours of employment.
3. Divorce or legal separation from your spouse.
4. Your spouse becomes entitled to Medicare benefits.

In the case of a **dependent child** of a Plan Participant, the dependent child has the right to elect continuation coverage if group health coverage under the Plan is lost because of any of the following "qualifying events":

1. The death of the Plan Participant-parent.
2. The termination of the Plan Participant-parent's employment or operating agreement (for reasons other than gross misconduct) or reduction in the Plan Participants-parent's hours of employment.
3. Parent's divorce or legal separation.
4. The Plan Participant-parent becomes entitled to Medicare benefits.
5. The dependent ceases to be a "dependent child" under the Plan.

Your IMPORTANT Notice Obligations

If your spouse or dependent child loses coverage under the Plan because of divorce, legal separation or the child's losing dependent status under the Plan, then you (the Plan Participant) or your spouse or dependent has the responsibility to notify the Plan Administrator in writing of the divorce, legal separation, or the child's losing dependent status. (The contact information for the Plan Administrator is set forth in the PLAN ADMINISTRATOR paragraph below.) You or your spouse or dependent *must* provide this written notice within 60 days after the later of the event or the date on which coverage would end under the Plan because of the event. The written notice to the Plan Administrator must include sufficient information to enable the Plan Administrator to identify the Plan, the qualified beneficiaries, the qualifying event, and the date the qualifying event occurred. *If you or your spouse or dependent child fails to provide this notice to the Plan Administrator during this 60-day notice period,*

any spouse or dependent child who loses coverage will NOT be offered to elect continuation coverage. Furthermore, if you or your spouse or dependent child fails to provide this notice to the Plan Administrator, and if any claims are mistakenly paid for expenses after the date coverage terminate upon the divorce, legal separation, or a child's losing dependent status, then you, your spouse, and your dependent children will be required to reimburse the Plan for any claims so paid.

If the Plan Administrator is timely provided with the written notice of a divorce, legal separation, or a child's losing dependent status that caused a loss of coverage, then the Plan Administrator will notify the affected beneficiaries of the right to elect continuation coverage (but only to the extent that the Plan Administrator has been notified in writing of the affected beneficiary's current mailing address - See the YOU MUST NOTIFY US paragraph below).

Your Employer's Notice Obligations

Your employer must notify the Plan Administrator if you are a Plan Participant and you die, your employment or operating agreement terminates (for reasons other than gross misconduct), or you become entitled to Medicare benefits. Generally, your employer must provide this notice to the Plan administrator within 30 days of the date of the event. The Plan Administrator will notify you (the Plan Participant), your spouse and dependent children of the right to elect continuation coverage after it receives this notice and determines that the event results in a loss of coverage. Similar rights may apply to certain retirees, spouse, and dependent children if the Plan Participant's employer commences a bankruptcy proceeding and these individuals lose coverage as a result.

Election Procedures

Within 14 days after notice of a qualifying event is received by the Plan Administrator, you and/or your spouse and dependent children will be sent a written notice of the right to continue coverage and an election form. You (the Plan Participant) and/or your spouse and dependent children must elect continuation coverage within 60-days after Plan coverage ends, or, if later, 60 days after the Plan Administrator provides you, your spouse, or your dependent children with notice of the right to elect continuation coverage. *If you or your spouse and dependent children do not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* A COBRA election mailed to the Plan Administrator is considered to be mailed on the date of mailing.

You (the Plan Participant) and/or your spouse and dependent children may elect continuation coverage for all qualifying family members. You, your spouse and dependent children each have an independent right to elect continuation coverage. Thus, a spouse or dependent child may elect continuation coverage even if the covered Plan Participant does not (or is not deemed to) elect it. You (the Plan Participant) and/or your spouse and dependent children may elect continuation coverage even if covered under another employer-sponsored group health plan or entitled to Medicare.

You do not have to show that you are insurable to elect continuation coverage; however, you will have to pay the applicable premium for your continuation coverage. At the end of the maximum coverage period (described below), you will be allowed to enroll in an individual conversion health plan, if available, subject to the requirement to pay the premiums required by the individual conversion health plan.

Type of Coverage

Ordinarily, the continuation coverage that is offered will be the same coverage that you, your spouse or dependent children had on the day before the qualifying event. Therefore, an employee, independent contractor (owner operator), spouse or dependent child who is not covered under the Plan on the day before the qualifying event generally is not entitled to COBRA coverage. If the coverage is modified for similarly-situated Plan Participants or their spouses or dependent children, then COBRA coverage will be modified in the same way.

If the Company maintains more than one group health plan (or offers a choice of separate benefit packages under a single plan), you (or your spouse or dependent children) may elect COBRA coverage under one or more of those plans (or separate benefit packages) in which you have coverage. For example, if you are covered under three separate Plans (*e.g.*, a medical plan, a dental plan, and a vision plan), you could elect COBRA coverage under the medical plan and decline coverage under either or both of the dental and vision plans. But if the Company maintains one consolidated group health plan (for example, one that provides medical, dental, and vision benefits under a single plan), you must elect or decline COBRA coverage for the plan as a whole.

If the Company maintains a health flexible spending arrangement (health FSA) under which you are reimbursed for medical expenses, you (or your spouse or dependent children) may elect to continue the health FSA coverage under COBRA, but only

if the Plan Participant has not overspent the amounts in his or her account. This means that the annual limit elected by the Plan Participant, reduced by the reimbursable claims submitted up to the time of the qualifying event, is equal to or more than the amount of premiums for COBRA coverage under the health FSA for the remainder of the Plan Year. Generally, COBRA coverage under the health FSA will continue only for the remainder of the Plan Year in which the qualifying event occurred. If the Company has elected to maintain a grace period for the health FSA, and if you (or your spouse or dependent children) pay the applicable COBRA premiums through the end of the Plan Year, you will be permitted to submit claims during the grace period. If you (or your spouse or dependent children) elect this coverage under COBRA, you may submit claims up to your elected annual maximum reduced by the reimbursable claims submitted up to the time of the qualifying event. Any unused amounts will be forfeited at the end of the Plan Year or applicable grace period, and COBRA coverage will terminate at the end of the Plan Year or applicable grace period. If the health FSA is overspent, then no qualified beneficiary may elect COBRA coverage under the health FSA. If you are participating in the health FSA under COBRA, you may not enroll in the health FSA during open election. Please contact the Plan Administrator for more information.

COBRA Premiums That You Must Pay

The premium payments for the "initial premium months" must be paid for you (the Plan Participant) and for any spouse or dependent children by the 45th day after electing continuation coverage. The initial premium months are the months that end on or before the 45th day after the election of continuation coverage is made.

Once continuation coverage is elected, the right to continue coverage is subject to timely payment of the required COBRA premiums. Coverage will not be effective for any initial premium month until the month's premium is paid within the 45-day period after the election of continuation coverage is made.

All other premiums are due on the 1st of the month for which the premium is paid, subject to a 30-day grace period. A premium payment that is mailed is considered to be made on the date it is sent. If you don't make the full premium payment by the due date or within the 30-day grace period, then COBRA coverage will be terminated as of the last day of the previous month, with no possibility of reinstatement.

Maximum Coverage Periods

The maximum duration for COBRA coverage is described below. COBRA coverage terminates before the maximum coverage period in certain situations described later under the heading "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

36 Months. If you (the spouse or dependent child) lose group health coverage because of the Plan Participant's death, divorce, legal separation, or the Plan Participant's becoming entitled to Medicare, or because you lose your status as a dependent child under the Plan, then the maximum coverage period (for spouse and dependent child) is three years from the date of the qualifying event.

18 Months. If you (the Plan Participant, spouse or dependent child) lose group health coverage because of the Plan Participant's termination of employment or operating agreement (other than for gross misconduct) or reduction in hours of employment, then the maximum continuation coverage is 18 months for the date of termination or reduction in hours. There are three exceptions:

1. If a Plan Participant or a Plan Participant's spouse or dependent is disabled at any time during the first 60 days after the date of termination of employment or operating agreement or reduction in hours of employment, then the continuation coverage period for all qualified beneficiaries under the qualifying event is 29 months from the date of termination or reduction in hours. The Social Security Administration must formally determine under Title II (Old Age, Survivors, and Disability Insurance) of the Social Security Act that the disability exists and when it began. For the 29- month continuation coverage period to apply, written notice of the determination of disability under Social Security Act must be provided to the Plan Administrator within both the 18-month coverage period and 60 days after the date of the determination or the qualifying event, whichever is later.
2. If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child (for example, the Plan Participant dies or becomes divorced) occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes three years from the date of the initial termination or reduction in hours. For the 36-month maximum coverage period to apply, written notice of the second qualifying event must be provided to the Plan Administrator

within 60 days after the date of the event. If no notice is given within the required 60-day period, no extension of COBRA coverage will occur.

3. If the qualifying event occurs within 18 months after the Plan Participant becomes entitled to Medicare, then the maximum coverage period (for the spouse and the dependent child) is three years from the date the Plan Participant became entitled to Medicare.

Shorter Maximum for Health FSAs

The maximum COBRA period for a health flexible spending arrangement (health FSA) maintained by the Company (if the Health FSA is not overspent, as explained above) ends on the last day of the Plan year in which the qualifying event occurred, subject to any grace period offered under the health FSA. If the Health FSA is overspent, as of the date of the qualifying event, no COBRA coverage will be offered.

Termination of COBRA Coverage Before the End of Maximum Coverage Period

Continuation coverage of the Plan Participant, spouse and/or dependent child will automatically terminate (before the end of the maximum coverage period) when any one of the following events occurs:

1. The Company no longer provides group health coverage to any of its employees or to or through its independent contractors (owner operators).
2. The premium for the qualified beneficiary's COBRA coverage is not timely paid.
3. After electing COBRA, you (the Plan Participant, spouse or dependent child) become covered under another group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any preexisting condition that you have. If the other plan has applicable exclusions or limitations, then your COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month preexisting condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another group health plan. (Note that under HIPAA, an exclusion or limitation of the group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
4. After electing COBRA coverage, you (the Plan Participant, spouse or dependent child) become entitled to Medicare benefits. This will apply only to the person who becomes entitled to Medicare.
5. You (the Plan Participant, spouse or dependent child) became entitled to a 29-month maximum coverage period due to disability of qualified beneficiary, but then there is a final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than the 30 days after the determination).
6. Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered Plan Participants or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

You Must Notify Us About Address Changes, Marital Status Changes, Dependent Status Changes, Disability Status Changes and Subsequent Qualifying Events

If you or your spouse's address changes, you *must* promptly notify the Plan Administrator in writing (the Plan Administrator needs up-to-date addresses in order to mail important COBRA notices and other information). Also, if your marital status changes or if a dependent ceases to be a dependent eligible for coverage under the Plan terms, you or your spouse or your dependent *must* promptly notify the Plan Administrator in writing (such notification is necessary to protect COBRA right for your spouse and dependent children). In addition, you must notify us if a disabled Plan Participant or a Plan Participant's spouse or dependent child is determined to be no longer disabled or if a qualified beneficiary suffers a subsequent qualifying event. Your notice must contain sufficient information to enable the Plan Administrator to identify the Plan, the qualified beneficiary(ies) (the Plan Participant, spouse or dependent child), the qualifying event, and the date the qualifying event occurred. Failure to provide timely and proper written notice may result in the loss of the right to COBRA coverage.

Automatic Continuation of Employee Assistance Plan Benefits

The Company makes COBRA benefits under its Employee Assistance Plan available for the applicable coverage period following the date coverage would otherwise be lost due to a Qualifying Event. The Company makes this coverage available at no cost to you or your Qualified Beneficiaries.

Plan Administrator

Crete Carrier Corporation is the Plan Administrator. All notices and other communications regarding the Plan and regarding COBRA must be directed to the Plan Administrator at the following addresses:

Crete Carrier Corporation
400 NW 56th Street
Lincoln, NE 68528

Other Options

You may have other options available to you when you lose group health coverage. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, Children's Health Insurance Program ("CHIP") or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. For example, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. Additionally, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. You can learn more about many of these options at www.healthcare.gov.

COBRA and Medicare

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of:

1. The month after your employment ends; or
2. The month after group health plan coverage through the Company based on current employment ends.

If you don't enroll in Medicare Part B and elect COBRA coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA coverage and later enroll in Medicare Part A or B before the COBRA coverage ends, the Plan may terminate your COBRA coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information, visit https://www.medicare.gov/medicare-and-you.

For More Information

If you, your spouse or dependent children have any questions about this notice or COBRA or if you wish to receive the most recent copy of the Plan's Summary Plan Description which contains important information about Plan benefits, eligibility, exclusions and limitations, please contact your Plan Administrator at the above address. You may also contact your Plan Administrator by telephone at 1-800-998-9100. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

4836-1923-0004, v. 7

HIPAA - Notice of Privacy Practices

Plan/Plan Sponsor:
Plan: Crete Carrier Corporation Welfare Benefits Plan and other associated Group Health Plans
Plan Sponsor: Crete Carrier Corporation
400 NW 56th Street
Lincoln, NE 68528
Telephone: 1-800-998-9100

Privacy Official:
Crete Carrier Corporation
Attn: Compliance Counsel (Privacy Officer)
400 NW 56th Street
Lincoln, NE 68528
Telephone: 1-800-998-9100

Effective Date: 2/16/2026

Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues

- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

To the extent that we have your substance use disorder patient records, subject to 42 CFR part 2, we will not share that information for investigations or legal proceedings against you without (1) your written consent or (2) a court order and a subpoena.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home, office, or mobile phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say "yes" if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no," for example, if it could affect your care. If we agree to your request, we may still share this information in the event that you need emergency treatment.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If someone has authority to act as your personal representative, such as if someone has your medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us at:
  Crete Carrier Corporation
  Attn: Compliance Counsel (Privacy Officer)
  400 NW 56th Street
  Lincoln, NE 68528
  Telephone 1-800-998-9100
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **https://www.hhs.gov/hipaa/filing-a-complaint/index.html**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- **We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.** This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. And **in all cases**, if we have substance use disorder patient records about you, subject to 42 CFR part 2, we cannot use or share information in those records in civil, criminal, administrative, or legislative investigations or proceedings against you without (1) your consent or (2) a court order and a subpoena.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described in this notice unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you, to the extent required by law.

Other Information

Protected health information may be disclosed to the plan sponsor of the Crete Carrier Corporation Welfare Benefits Plan or other Group Health Plans for the purposes of plan administration or pursuant to an authorization or request signed by you. Unless otherwise authorized by you, disclosure will be limited to those individuals responsible for plan administration and/or documentation storage/retention, including staff members in the following areas: payroll/benefits, plan and trust accounting, plan trustees, and information technology.

The HIPAA Privacy Regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of protected health information concerning HIV or AIDS, mental health, substance abuse/chemical dependence, genetic testing, reproductive rights, etc.

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

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2026. 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/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**ILLINOIS - 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	Illinois Medicaid Premium Assistance Information Medicaid application website: https://abe.illinois.gov HIPP Hotline Number: 217-524-8268 HIPP Email: hfs.boc.hipp@illinois.gov
INDIANA – Medicaid	**IOWA – Medicaid and CHIP (Hawki)**
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	Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562
KANSAS – Medicaid	**KENTUCKY – Medicaid**
Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660	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	MAINE – Medicaid
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	Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP	**MINNESOTA – Medicaid**
Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com	Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672
MISSOURI – Medicaid	**MONTANA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid	**NEVADA – Medicaid**
Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
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	Medicaid Website: https://www.nj.gov/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid	**NORTH CAROLINA – Medicaid**
Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100

NORTH DAKOTA – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
OREGON – Medicaid	**PENNSYLVANIA – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075	Website: https://www.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)
RHODE ISLAND – Medicaid and CHIP	**SOUTH CAROLINA – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
SOUTH DAKOTA - Medicaid	**TEXAS – Medicaid**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP	**VERMONT– Medicaid**
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/	Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427
VIRGINIA – Medicaid and CHIP	**WASHINGTON – Medicaid**
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	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022

WEST VIRGINIA – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
WYOMING – Medicaid	
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269	

To see if any other states have added a premium assistance program since July 31, 2026, 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 5/31/2029)

Mental Health Parity and Addiction Equity Act (MHPAEA) Disclosure

The Mental Health Parity and Addiction Equity Act of 2008 generally requires group health plans and health insurance issuers to ensure that financial requirements (such as co-pays and deductibles) and treatment limitations (such as annual visit limits) applicable to mental health or substance use disorder benefits are no more restrictive than the predominant requirements or limitations applied to substantially all medical/surgical benefits. For information regarding the criteria for medical necessity determinations made under the plan with respect to mental health or substance use disorder benefits, please contact your plan administrator at 1-800-998-9100.

Newborns' and Mothers' Health Protection Act Notice

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).

Women's Health and Cancer Rights Act (WHCRA) Notices

Enrollment Notice

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

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; 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. Therefore, the following deductibles and coinsurance apply: $1,350 deductible (in-network) and 20% coinsurance (in-network) and $2,700 deductible (out-of-network) and 30% coinsurance (out-of-network). If you would like more information on WHCRA benefits, call your plan administrator at 1-800-998-9100.

Annual Notice

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call your plan administrator at 1-800-998-9100 for more information.

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).

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.

If you or your dependent(s) lose coverage under a state Children's Health Insurance Program (CHIP) or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the loss of CHIP or Medicaid coverage.

If you or your dependent(s) become eligible to receive premium assistance under a state CHIP or Medicaid, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days of the determination of eligibility for premium assistance from state CHIP or Medicaid.

To request special enrollment or obtain more information, contact Crete Carrier Corporation's Benefits Department by mail at 400 NW 56th Street, Lincoln, Nebraska 68528 or by telephone at 1-800-998-9100.

SUMMARY ANNUAL REPORT

For the Crete Carrier Corporation Welfare Benefits Plan

This is a summary of the annual report of the Crete Carrier Corporation Welfare Benefits Plan, EIN 47-0496288, Plan No. 501, for period 01/01/2025 through 12/31/2025. The annual report has been filed with the Employee Benefits Security Administration, U.S. Department of Labor, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Crete Carrier Corporation has committed itself to pay certain self-insured Medical, Dental, and Vision claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with HM Life Insurance Company, United of Omaha Life Insurance Company, and American Heritage Life Insurance Company to pay Stop Loss, Life Insurance, Short-term Disability, Long-term Disability, Employee Assistance Program, Accidental Death and Dismemberment, Critical Illness, Accident, and Hospital Indemnity claims incurred under the terms of the plan. The total premiums paid for the plan year ending 12/31/2025 were $10,189,326.

Basic Financial Statement

The value of plan assets, after subtracting liabilities of the plan, was $-1,415,175 as of 12/31/2025, compared to $-2,037,679 as of 01/01/2025. During the plan year the plan experienced an increase in its net assets of $622,504. This increase includes unrealized appreciation and depreciation in the value of plan assets; that is, the difference between the value of the plan's assets at the end of the year and the value of the assets at the beginning of the year or the cost of assets acquired during the year. During the plan year, the plan had total income of $72,864,675 including employer contributions of $46,846,611, participant contributions of $25,667,143, other contributions of $236,450, and other interest income of $114,471. Plan expenses were $72,242,171. These expenses included $3,511,978 in administrative expenses and $68,730,193 in benefits paid to participants and beneficiaries and payments to insurance carriers for the provision of benefits.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

- an accountant's report;
- financial information and information on payments to service providers;
- assets held for investment;
- transactions in excess of 5 percent of the plan assets; and
- insurance information, including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of Crete Carrier Corporation at 400 NW 56th Street, Lincoln, NE, 68528 or by telephone at (800) 998-9100.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (Crete Carrier Corporation, 400 NW 56th Street, Lincoln, NE, 68528) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, Room N1513, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Or you may access a copy on the DOL's web site www.efast.dol.gov.

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 (0MB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by 0MB under the PRA, and displays a currently valid 0MB control number, and the public is not required to respond to a collection of information unless it displays a currently valid 0MB 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 0MB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average less than one minute per notice (approximately 3 hours and 11 minutes per plan). 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, Office of the Chief Information Officer, Attention: Departmental Clearance Officer, 200 Constitution Avenue, N.W., Room N-1301, Washington, DC 20210 or email DOL_PRA_PUBLIC@dol.gov and reference the OMB Control Number 1210-0040.

OMB Control Number 1210-0040 (expires 03/31/2026)

IMPORTANT HEALTH COVERAGE TAX DOCUMENTS
FORM 1095-C TAX INFORMATION

You can obtain a copy of Form 1095-C for your health care coverage upon request at no charge by:

Calling:	(800) 998-9100
Emailing:	benefits@cretecarrier.com
Writing:	Crete Carrier Corporation Attn: Benefits Department 400 NW 56th Street Lincoln, NE 68528

Questions? Call the Benefits Department at (800) 998-9100 or email benefits@cretecarrier.com.

4896-6556-8526, v. 2