



CRETE CARRIER CORPORATION

WELFARE BENEFITS PLAN

and

SUMMARY PLAN DESCRIPTION

(2024)

Introduction

Crete Carrier Corporation (the “Sponsoring Company”) sponsors Crete Carrier Corporation Welfare Benefits Plan (the “Plan”). This document (this “Summary”) sets forth the terms of the amended and restated Plan as of January 1, 2024, except as otherwise indicated. The Plan provides benefits through each of the separate plans listed in the Appendix (the “Component Benefit Programs”). Applicable written plan documents, insurance contracts, and/or other governing documents contain the actual terms of each Component Benefit Program. The Plan incorporates these documents by reference. Together, this Summary and the written plan documents, insurance contracts, and other governing documents of each Component Benefit Program constitute the written plan document for the Plan, as required by the Employee Retirement Income Security Act of 1974 (“ERISA”).

Separate summary plan descriptions, insurance booklets, and other similar documents summarize the terms of each Component Benefit Program. This Summary incorporates those applicable summary plan descriptions, insurance booklets, and/or other documents by reference. The Sponsoring Company intends this document, together with those summaries, booklets, and similar documents, to constitute the Plan’s Summary Plan Description.

If anything in this Summary is different than the actual terms of the Component Benefit Programs, the Component Benefit Programs control. The Sponsoring Company may change the Plan and any Component Benefit Program from time to time.

You should keep this Summary with the summary plan descriptions, insurance booklets and other documents you received regarding the Component Benefit Programs. Please contact the Crete Carrier Corporation Benefits Department at (800) 998-9100 if you have any questions.

1. General Information. The Sponsoring Company is the Plan Sponsor. Its legal name, address, and federal Company identification number are:

Crete Carrier Corporation
400 NW 56th Street
Lincoln, Nebraska 68528
EIN: 47-0496288

The “Company” means the Sponsoring Company together with any Participating Company. Section 6 contains more information about Participating Companies.

2. Identification of Plan. The Plan is known as the:

Crete Carrier Corporation Welfare Benefits Plan

The Company has assigned Plan Number 501 to this Plan. The Plan keeps its records on a 12-month period from January 1 through December 31. It calls this period the “Plan Year.”

3. Type of Plan. The Plan is a welfare benefits plan that provides benefits through several Component Benefit Programs. The Plan incorporates the Component Benefit Programs listed in the Appendix. The Company may include other plans as a Component Benefit Program from time to

time. All of the Component Benefit Programs are treated as one Plan for Form 5500 and other ERISA compliance purposes.

4. Plan Administrator. The Company is the Plan Administrator. The Company may delegate its responsibilities as Plan Administrator to a committee or other person or persons in writing. The Company's telephone number is (800) 998-9100. The Plan Administrator provides information about your rights and benefits under the Plan. It has the primary authority to file various reports, forms, and returns with the U.S. Department of Labor and the Internal Revenue Service. The summary plan descriptions, insurance policies, or plan documents identify the plan administrator of each Component Benefit Program. The plan administrator of each Component Benefit Program also makes decisions regarding eligibility of individuals to participate and receive benefits from the program. If a Component Benefit Program does not identify a plan administrator, the Plan Administrator of this Plan shall be the plan administrator for the Component Benefit Program.

The Plan must designate an agent for service of legal process. The agent for service of legal process is –

General Counsel
Crete Carrier Corporation
400 N.W. 56th St.
Lincoln, Nebraska 68528

Legal process may also be served on the Plan Administrator.

The Plan Administrator has full power to interpret and apply the terms of the Plan. The Plan Administrator's decisions are final and binding. The Plan Administrator also makes decisions regarding eligibility of individuals to participate and receive benefits from the Plan. The Plan Administrator may make and enforce rules to help it administer the plan. The Plan Administrator has all other powers necessary and appropriate to carry out its obligation to administer the Plan.

The Company agrees to indemnify and defend, to the fullest extent permitted by law, any employee serving as the Plan Administrator or as a member of a committee designated as the Plan Administrator, with respect to liabilities, damages, costs and expenses including attorneys' fees, and settlements approved by the Company, that occur because of a good faith act or omission in connection with the Plan.

5. Named Fiduciary. The law requires the Plan to identify a named fiduciary with authority to control and manage plan operation and administration. For Insured Benefits, the insurance company issuing the applicable policy constitutes the named fiduciary with the full power to interpret and apply the terms of the applicable Component Benefit Program as those terms relate to benefits under the applicable insurance contract, and to determine the eligibility of participants based on information provided by the Company. For Component Benefit Programs that are Self-Insured Benefits, the plan administrator of the applicable Component Benefit Program constitutes the named fiduciary for purposes of determining the amount of, and entitlement to, benefits under the Appendix. If the Component Benefit Program does not identify a plan administrator, the Plan Administrator of this Plan shall be the plan administrator for the Component Benefit Program. The respective plan administrator has full power and authority to make factual determinations, to interpret, and to apply the terms of the Plan.

6. Participating Companies. A “Participating Company” means a Company affiliated with the Sponsoring Company that adopts the Plan with the Sponsoring Company’s consent. Currently, Hunt Transportation, Inc. is a Participating Company in this Plan and the Component Benefit Programs listed in the Appendix.

The Sponsoring Company may add other Participating Companies from time to time. A Company is affiliated with the Sponsoring Company if it is a trade or business under Common Control with the Company. A trade or business entity (whether a corporation, partnership, sole proprietorship or otherwise) is under “Common Control” with another trade or business entity if (a) both entities are corporations that are members of a controlled group of corporations as defined in Internal Revenue Code (the “Code”) Section 414(b), or (b) both entities are trades or businesses (whether or not incorporated) which are under common control as defined in Code Section 414(c), or (c) both entities are members of an “affiliated service group” as defined in Code Section 414(m), or (d) both entities are required to be aggregated pursuant to regulations under Code Section 414(o).

An employee who transfers employment directly between the Sponsoring Company and a Participating Company, or who transfers employment directly among Participating Companies, does not experience a separation from service for purposes of the Plan. Accordingly, if the employee meets the eligibility requirements for participation in the Plan, he or she remains a participant.

An affiliated Company becomes a Participating Company by having one of its officers file formal notice with the Plan Administrator. The Sponsoring Company’s Board of Directors must approve the affiliated Company’s adoption for the affiliated Company to become a Participating Company. A Participating Company has all the duties and responsibilities of a Company under the Plan, unless the Sponsoring Company delegates duties differently in a written agreement. However, the Sponsoring Company reserves to itself the responsibility to determine the terms of the Plan including eligibility and benefits; to appoint, remove, or replace the Plan Administrator; to exercise all administrative functions and powers related to the Plan, unless delegated to the Plan Administrator; to amend or terminate the Plan; and to establish and maintain the Plan.

The Sponsoring Company may terminate an affiliated Company’s adoption of the Plan upon 90 days notice to the affiliated Company. An affiliated Company may terminate its adoption of the Plan upon 90 days notice to the Sponsoring Company.

7. Eligibility to Participate. You are eligible to participate in this Plan if you are eligible to receive benefits under one or more Component Benefit Programs. The terms and conditions of the Component Benefit Programs will tell you whether you participate in this Plan. You become a participant in this Plan automatically when you become a participant in a Component Benefit Program. In general, the Company must treat you as an employee for you to be eligible, or you must be an Eligible Independent Contractor or Director. The Company treats you as its employee if it withholds taxes from compensation it pays to you. Except as provided in the Appendix, an Eligible Independent Contractor means an owner-operator of an over-the-road tractor leased to the Company and any employee(s) of such owner operator. Agents or independent contractors of Eligible Independent Contractors are not eligible. A Director means a member of the Board of Directors of the Sponsoring Company who is not an employee, but who is eligible to participate in one or more of the Component Benefit Plans.

For more information about eligibility, please read the eligibility conditions that are part of each summary plan description, insurance booklet, or other governing document of the Component Benefit Programs. The summary plan description for each Component Benefit Program is available at www.cretecarrierbenefits.com. You may need to sign a salary contribution agreement before you can participate in some of the Component Benefit Programs.

8. Funding. Some Component Benefit Programs are funded through contracts or policies of insurance purchased from one or more insurance carriers. The Plan refers to these benefits as Insured Benefits. Other Component Benefit Programs are funded through a trust or through the general assets of the Company. The Plan refers to these benefits as Self-Insured Benefits. Nothing in this Plan provides a right to any fund, account, or asset of the Company from which a payment under the Plan may be made. Unless required to do so by law, the Company generally will not segregate any amount for benefits under the Plan in a separate trust or fund. If an insurance carrier pays a rebate, refund, dividend, or other distribution, the terms of the insurance contract, policy, or Component Benefit Program govern ownership of the payment. If the terms of the insurance contract, policy, or Component Benefit Program are silent or ambiguous, the Company owns the payment unless applicable law requires a different result. The Appendix has more information about the benefits provided by the Component Benefit Programs, and which Component Benefit Programs are Insured Benefits and Self-Insured Benefits. The Company will pay the incidental costs of administering this Plan.

The Plan Administrator will provide a schedule of the applicable premiums and/or premium equivalents to eligible employees and Eligible Independent Contractors during the initial and subsequent open enrollment periods and upon request for each of the Component Benefit Programs. The Appendix explains the Component Benefit Programs funded by Company contributions, participant contributions, or both. The Company decides how much it will contribute to the Plan. It will contribute enough money to pay for the benefits or portion of the benefits that it has agreed to pay for. You must contribute the remaining cost of any benefits you elect. For the Insured Benefits, the Company will pay its contributions and your contributions to the insurer. For Self-Insured Benefits, the Company will use its contributions and your contributions to pay benefits from the Company's general assets. The Company may also deposit your contributions for a Component Benefit Program in a trust and pay premiums or benefits from the trust. The Plan will use all of your contributions toward the cost of a benefit before it uses Company contributions to pay for the cost of such benefit.

9. Summary of Plan Benefits. If you meet the eligibility conditions stated above, the Plan provides you an opportunity to participate in the Component Benefit Programs. Each program has its own applicable summary plan description, insurance booklet, and/or other governing document. These documents contain more information about the benefits provided by the Component Benefit Programs. The summary plan description for each Component Benefit Program is available at www.cretecarrierbenefits.com. You can also obtain these documents free upon request by contacting the Plan Administrator. The Company may add or remove any Component Benefit Program at any time.

10. Limits on Benefits, Circumstances that May Cause a Loss of Benefits. The Plan contains restrictions on the type, amount, and circumstances under which it will pay benefits. You should read the applicable summary plan description, insurance booklet, and/or other governing document of each Component Benefit Program for more information. You may lose coverage under the Plan if the

Company terminates the Plan. You may also lose coverage if the Company amends the Plan to reduce or eliminate your coverage. Your coverage under this Plan generally terminates when you terminate employment or service with the Company. Coverage will also terminate if you are no longer eligible for benefits under all Component Benefit Programs. Eligibility for some benefits may terminate if you are not actively at work, or if you switch from full-time to part-time employment status.

11. Termination of Participation. Your participation in the Plan will end when you stop receiving benefits under all Component Benefit Programs. The same rule applies for participation of your spouse and dependents. Some Component Benefit Programs may also terminate coverage if you fail to pay your share of the applicable premiums. Your coverage may end if you fail to work the number of hours required for participation. Sections 12 and 13 describe circumstances in which you may be eligible to continue coverage under some of the Component Benefit Programs.

Please read the applicable summary plan description, insurance booklet, and/or other governing document for each Component Benefit Program for more information regarding events that terminate your participation. You may also contact the Plan Administrator.

12. Coverage under the Consolidated Omnibus Budget Reconciliation Act (“COBRA”). Some Component Benefit Programs provide continuation coverage required by COBRA. The following COBRA procedures apply to the extent that COBRA applies to a Component Benefit Program and COBRA rights are not set forth in the summary plan description or plan documents for the Component Benefit Programs. If you have any questions, please refer to the appropriate, applicable summary plan descriptions, insurance booklets and/or other documents. You may also contact the Plan Administrator.

Qualifying Events. Certain individuals may be eligible for COBRA if coverage is lost for any of the following reasons, called Qualifying Events. A loss of coverage occurs when coverage ceases to be available under the same terms and conditions that applied immediately before the Qualifying Event. Qualifying events occur when:

- Your employment with the Company ends for any reason (including retirement and layoffs) other than gross misconduct;
- Your scheduled hours of work are reduced;
- You die while employed and your dependents are covered by one or more of the Component Benefit Programs;
- You and your spouse legally separate or divorce, causing your spouse and/or children to lose coverage under one or more of the Component Benefit Programs;
- You become entitled to Medicare (determined by the date of enrollment in Part A or Part B, whichever occurs earlier). This allows eligible dependents to elect COBRA coverage for up to 36 months from the date you enroll in Medicare.
- Your dependent children no longer meet one or more of the Component Benefit Programs’ eligibility requirements.

If one of the above events occurs, eligible individuals may continue the same coverage they had when the event occurred, subject to any future changes to one or more of the Component Benefit Programs.

Qualified Beneficiaries. Only Qualified Beneficiaries may elect continued coverage. Qualified Beneficiaries include you (for termination of employment and reduction of hours), your spouse and any dependent children who are enrolled in one or more of the Component Benefit Programs at the time of the Qualifying Event in addition to any children who are born to or placed for adoption with you if you are participating in COBRA during the COBRA continuation period, provided they are enrolled within 60 days of the date of birth or date of placement.

A domestic partner is not eligible to elect COBRA as a Qualified Beneficiary unless the Component Benefit Program provides for domestic partner coverage, and the domestic partner qualifies as a tax dependent within the meaning of Internal Revenue Code Section 152 (determined without regard to Sections 152(b)(1), (b)(2), or (d)(1)(B)). However, if you and a domestic partner have coverage under a group health plan and together lose coverage due to a Qualifying Event, you may elect COBRA for yourself and the domestic partner.

Qualified Beneficiaries have the same right as active employees to change coverage under any Component Benefit Program for which coverage has been continued and add or drop dependents.

COBRA Coverage – Time Limits. For the Component Benefit Programs subject to COBRA, continued coverage is limited to the following specific periods of time:

- You and your dependents may continue coverage for up to 18 months, if:
 - Your employment with the Company is terminated (including retirement and layoff); or
 - Your regularly scheduled work hours are reduced.
- A spouse and dependent children may continue coverage for up to 36 months, if they lose coverage:
 - Because of your death, divorce or legal separation or because you become entitled to Medicare; or
 - Because a dependent child no longer meets the Component Benefit Programs' eligibility requirements.

If you become entitled to Medicare before retirement, your entitlement to Medicare is not a Qualifying Event unless your spouse or dependent child loses coverage as a result. If no such loss of coverage occurs (before retirement), at retirement, the maximum COBRA coverage period for your spouse and dependent children ends on the later of these two dates:

- 18 months from your date of retirement
- 36 months from the date you became covered by Medicare.

For Qualified Beneficiaries who are determined to be disabled by the Social Security Administration or who are dependents of a disabled Qualified Beneficiary at the time employment ends (or hours are reduced), or become disabled during the first 60 days of continuation of coverage, coverage may continue for up to 29 months. Each Qualified Beneficiary may separately elect the additional continuation coverage for up to 29 months. You must notify the Company of a Social Security award or appeal notice within 60 days of the Social Security determination but no later than the end of the 18th month of COBRA coverage. If you or your family member received a determination of disability before COBRA continuation coverage began and did not receive a

subsequent determination that you are no longer disabled, a copy of the determination of disability must be furnished within 60 days of the loss of coverage.

A Qualified Beneficiary may experience more than one Qualifying Event. For example, subsequent Qualifying Events may occur as the result of death, divorce, legal separation, or a child losing eligibility under a Component Benefit Program. A second Qualifying Event may extend coverage for your dependents to a maximum of 36 months from the date of the original Qualifying Event.

A Qualified Beneficiary's COBRA continuation coverage will end before the maximum time period is reached if:

- Payments are not made on a timely basis (within the 30-day grace period);
- The Qualified Beneficiary becomes entitled to Medicare after COBRA continuation coverage is elected;
- In the case of an 11-month extension (up to a total of 29 months) due to certain disabilities, a final determination is made that the individual is no longer disabled (after the first 18 months);
- After the COBRA continuation coverage is elected, the Qualified Beneficiary who elects COBRA coverage under the Component Benefit Program becomes covered under another group health plan, unless the other plan contains a pre-existing condition exclusion or limitation applicable to the Qualified Beneficiary. COBRA coverage will not terminate unless or until the individual is not or is no longer affected by the pre-existing condition exclusion or limitation under the other plan (for example, if the new plan gives credit for prior coverage, it may eliminate all or part of the pre-existing condition exclusion period and COBRA coverage may be terminated);
- The Company ends the applicable Component Benefit Programs for all active employees;
- Coverage ceases for any other generally applicable reason under the applicable Component Benefit Program.

For the Flexible Spending Account Plan, the COBRA continuation coverage period will extend only until the end of the plan year in which the Qualifying Event occurs.

COBRA Notification/Cost. The Company will provide enrollment information for COBRA continuation coverage at the time of a Qualifying Event. It is the enrolled participant's responsibility to provide an accurate address for mailing purposes.

It is the enrolled participant's responsibility to notify the Company or the Plan Administrator of a loss of health coverage as a result of a divorce, legal separation, or child's loss of dependent status under a health plan. This notice **must be in writing and must be provided within 60 days of the date of the event** (or, if later, the date the dependent would lose coverage because of the event). If your qualifying event is a divorce or legal separation, your notice must include a copy of the divorce decree or legal separation agreement. The Company or the Plan Administrator must also be notified if:

- A dependent has a second Qualifying Event that would allow coverage to be extended to a total maximum of 36 months. This notice must be provided within 60 days of the second

Qualifying Event (or the date it would have resulted in a loss of coverage if it had been the first Qualifying Event).

- An enrolled participant is determined by the Social Security Administration to have a disability that would allow the extension of coverage from 18 months to a total maximum of 29 months. This notice must include a copy of the Social Security Administration's determination letter and be provided within 60 days of that determination and no later than the end of the original 18-month of COBRA continuation coverage.
- The Social Security Administration has determined that an enrolled individual is no longer disabled, ending entitlement to continue coverage. This notice must be provided within 30 days of the Social Security Administration's determination.

All of the notices provided under COBRA must include: the name of the participant, the name of each affected dependent, the Qualifying Event, and the date of the Qualifying Event.

Notices must be directed to:

Benefits Department
Crete Carrier Corporation
400 NW 56th Street
Lincoln, Nebraska 68528

If an individual fails to provide an appropriate notice on time, the right to COBRA continuation coverage will be lost.

The cost of continued coverage is 102% of the total cost for the coverage, including the Company and participant contributions. For disabled Qualified Beneficiaries and their family members who have elected COBRA who are continuing coverage beyond 18 months, the monthly cost will be increased to 150% of the cost for the remaining 11 months. The cost will be adjusted annually each January 1 to reflect any changes in the total cost.

To elect COBRA continuation coverage, Qualified Beneficiaries are given 60 days after they receive the election form or, if later, 60 days after coverage under the applicable Component Benefit Program would otherwise end if COBRA coverage is not elected. Each Qualified Beneficiary is entitled to make his or her own coverage election. When coverage is elected, there is 45 days from the date of election to make the initial payment. After that, payments must be made monthly and there is a 30-day grace period.

13. Coverage under the Uniformed Services Employment and Reemployment Rights Act ("USERRA") and the Family and Medical Leave Act ("FMLA"). Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services under USERRA or leave under the FMLA. Please review the applicable summary plan description, insurance booklet, and/or other document for each Component Benefit Program for more information about coverage under USERRA or the FMLA. The Company will provide you with information about paying for coverage under the Component Benefit Programs during leave, at the time of your leave. You may also contact the Plan Administrator.

14. Qualified Medical Child Support Orders. The Plan will provide benefits under the Component Benefit Programs that provide health benefits as required by any qualified medical child support order (“QMCSO”). A QMCSO has to satisfy certain specific conditions to be qualified. The Plan Administrator will notify you if it receives a QMCSO that applies to you. It will then provide you with a copy of the Plan’s procedures for determining whether the medical child support order is qualified. You or your beneficiary can obtain a copy of these procedures from the Plan Administrator at no charge. The Plan will also provide benefits to dependent children placed with participants or beneficiaries for adoption. The Plan will provide these benefits under the same terms and conditions as apply in the case of dependent children who are biological children of participants or beneficiaries.

15. Claims Procedure for Benefits. This Section applies if you have not received benefits under the Plan that you believe the Plan should pay. All claim and appeal opportunities available must be exhausted before any lawsuit may be filed with respect to a claim.

(a) **Claims for Insured Benefits**. The applicable insurance contracts, booklets and/or other documents explain how to make a claim for an Insured Benefit. To obtain benefits from the insurer, you must follow the insurer’s claims procedure. That procedure may require you to complete, sign, and submit a written claim on the insurer’s form. You may obtain a copy of the form from the insurer or the Plan Administrator.

The insurer will decide your claim according to its reasonable claims procedures. These procedures may be subject to ERISA. The insurer may request independent medical advice and such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim, in whole or in part, you will receive written notification of the reason(s) for the denial. If your claim is denied, you may appeal to the insurer for further review. The insurer will decide your appeal in accordance with its reasonable claims procedures. These procedures may be subject to ERISA. If a lawsuit with respect to a claim denial is filed, it generally must be filed no later than three years after the date of the final Insured Benefit decision (including all appeals) regarding the claim. However, if the documents governing an Insured Benefit expressly provide for a longer period to file a lawsuit, the longer period controls. If you do not appeal on time, you may lose your right to file suit in federal or state court. The court may find that you failed to exhaust your administrative appeal rights. You can find more information about the claims procedure for each Insured Benefit in its applicable insurance contract, booklet, and/or other document, or by contacting the Plan Administrator. This Plan incorporates the insurer’s claims procedure by reference.

(b) **Claims for Self-Insured Benefits**. The applicable summary plan descriptions and/or plan documents explain how to make a claim for a Self-Insured Benefit. The following procedures apply to the extent the Component Benefit Program that is a Self-Insured Benefit does not have its own claims procedure. These claims procedures are established in accordance with ERISA. If there are any inconsistencies between the information set forth below and the claims procedures set forth in the appropriate provider’s information or the summary plan description for the Component Benefit Program, the provider’s claims procedure or the procedure in the summary plan description will control.

Filing an Initial Claim. To file an initial claim under the applicable Component Benefit Program, a claimant should submit his or her claim as set forth in the summary plan description.

Initial Claim Determinations. Claims will be evaluated and processed within a time frame that depends upon the nature of the claim. Different time frames for determining claims will apply depending on whether the claim is urgent, pre-service but not urgent, or post-service. With the exception of the subsection labeled “Disability Claim,” all of the descriptions below relate to claims for health benefits. Determinations will be made in accordance with the terms of the Component Benefit Program and applicable law.

Urgent Care Claim. A health benefit claim is considered an urgent care claim if delaying the decision of the claim beyond the urgent time frames could seriously jeopardize life or health or the ability to regain maximum function, or in the opinion of the claimant’s physician, would subject the claimant to severe pain that could not be adequately managed without the care that is the subject of the claim. Urgent care claim determinations will be made as soon as possible. Notice of the determination will be provided within 72 hours of the claim unless more information is required to process the claim. If more information is required, notification will be provided within 24 hours and the claimant will have 48 hours to make a submission. The claimant will be notified of the decision within 48 hours of that submission. If a claim is improperly filed, the notification of the proper filing procedure will be provided within 24 hours. This notice will be provided only if the claim identified the name of the claimant, the specific medical condition or symptom, and the treatment, service, or product for which approval is sought and only if the claim was submitted to a person or unit customarily responsible for handling benefit matters relating to the option elected.

Concurrent Care. If the health benefit claimant has been approved for an ongoing course of treatment and the Component Benefit Program reduces the treatment before the end of the pre-approved period of time or number of treatments, the reduction will be considered an adverse benefit determination. Notification of the reduction or termination will be provided sufficiently in advance in order to allow the claimant to appeal the determination and obtain a review of the claim before treatment is disrupted. If the claimant requests to extend a course of treatment for an urgent care claim at least 24 hours before approval for treatment will lapse, the claimant will be notified whether the extension is granted or denied as soon as possible, but in any event, within 24 hours after receipt of the request.

Pre-Service Claim. A pre-service claim is a claim that must be filed before receiving medical care (other than an urgent care claim) to be eligible for full benefits under the Component Benefit Program. In the case of a pre-service claim, notification of the Component Benefit Program’s benefit determination will be provided within a reasonable period of time, but no later than 15 days after the Component Benefit Program receives the claim. This period may be extended by the Component Benefit Program for an additional 15 days, provided that the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and provides timely notification of the circumstances requiring the extension of time and the date by which a decision can be expected. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information. If a claim is improperly filed, notification will be provided within five days.

Post-Service Claim. A post-service health benefit claim is a claim under the Component Benefit Program that is not a pre-service or urgent care claim and can be filed after medical care is received. For a post-service claim, notification of an adverse benefit determination will be provided within a reasonable period of time, but no later than 30 days after the Component Benefit Program receives the claim. This period may be extended by the Component Benefit Program for an additional 15 days,

provided the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and the Plan Administrator provides timely notification of the circumstances that require the extension of time and the date by which a decision can be expected. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information.

Disability Claim. For a disability benefits claim, notification of an adverse benefit determination will be provided within a reasonable period of time, but no later than 45 days after the Component Benefit Program receives the claim. This period may be extended for an additional 30 days (up to two times), provided that the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Component Benefit Program, and the Plan Administrator provides timely notification of the circumstances requiring the extension and the date by which a decision can be expected. The notice will also explain the standards for being entitled to a benefit and issues that need to be resolved before a decision can be made. If an extension is necessary because of a failure to submit information necessary to decide the claim, the notice of extension will specifically describe the required information. The claimant will have 45 days to provide that information.

Notification. Written or electronic notification of any adverse health or disability benefit determination will be provided. If a claim is denied, in whole or in part, the notice will set forth:

- The specific reason or reasons for the denial;
- If the claim is for a disability benefit, the notice will explain the basis for disagreeing with the views presented by the claimant of health care professionals who treated the claimant and of vocational professionals who evaluated the claimant, the views of medical or vocational experts whose advice was obtained by the Plan, or a disability determination presented by the claimant made by the Social Security Administration;
- A reference to the specific Component Benefit Program provisions on which the denial is based;
- A description of any additional material or information necessary for the benefit to be paid and an explanation of why such material or information is necessary;
- An explanation of the Component Benefit Program's review procedures and time limits (including expedited review procedures in the case of an urgent care claim and voluntary appeal procedures in the case of a disability claim) and a statement of the right to bring a civil action following the claim denial on review;
- In the case of a claim denial by a Component Benefit Program providing disability benefits, a description of any applicable contractual limitation period that applies to the claimant's right to bring a civil action following denial upon review, and the calendar date on which the limitations period expires for the claim;
- In the case of a claim denial by a Component Benefit Program providing health or disability benefits:
 - For a health benefit, if the decision relied on a claims administrator's internal rules, a copy of the applicable rule or a statement that the rule will be provided free of charge upon request;
 - For a disability benefit, the specific internal rules, guidelines, protocols, standards, or other similar criteria relied upon in making the determination, or a statement that the foregoing do not exist;

- If the decision is based on a limit or exclusion for medical necessity or experimental treatment or a similar exclusion or limit, an explanation of the clinical or scientific judgment for the determination. For health benefits, the notice may include statement that such explanation will be provided free of charge upon request; and
- If the claim pertains to disability benefits, a discussion that explains the reasons for disagreeing with the views of health care professionals and vocational professionals who treated or evaluated the claimant, and the views of medical or vocational experts whose advice the claims administrator obtained in connection with the decision. The notice will include this information whether or not the claims administrator relied on those views. It will also explain the reasons for disagreeing with any determination made by the Social Security Administration.
- In the case of a claim denial by a plan involving urgent care, the information described above may be provided orally within the prescribed time frames, with written confirmation within three days.
- In the case of a disability claim denial, a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

Appeal of Adverse Benefit Determinations. If a claim is denied, the claimant is entitled to a full and fair internal review. The claimant will have 180 days after receiving a claim denial notice to file an appeal. The request for review must be written and should include an explanation of why the claimant believes he or she is entitled to benefits and any supporting evidence or documentation, including testimony. The claimant has the right to request, free of charge, reasonable access to and copies of documents, records, and other information relevant to the claim, including the claim file. The Plan Administrator will not charge or otherwise unduly inhibit or hamper submission or processing of an appeal. Subject to reasonable verification procedures, a personal representative may act on a claimant's behalf in filing or pursuing an appeal. The review of a denied claim will be conducted by a fiduciary of the Component Benefit Program who is not the individual who made the initial claim decision and is not a subordinate of such individual. Appropriate medical experts will be consulted where medical judgment is required.

For group health plans that are not excepted benefits and for disability benefits, the Plan or applicable insurer must provide any new or additional evidence considered, relied upon, or generated by the Plan or insurer (or at the direction of the Plan or insurer) in connection with a claim. This evidence must be provided as soon as possible, and sufficiently in advance of the due date for the notice of final internal adverse benefit determination so that the claimant has a reasonable opportunity to respond prior to the due date. If the final internal adverse benefit determination will be based on new or additional rationale, the Plan or insurer must provide the claimant, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the due date for the notice of final internal adverse benefit determination to provide the claimant a reasonable opportunity to respond prior to the due date.

The Plan or insurer must ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. This means that (a) the named fiduciary deciding an appeal be different from (and not subordinate to) the individual who decided the initial claim; (b) any medical expert, and, for disability claims, vocational experts, consulted regarding an appeal be different from (and not subordinate to) the expert

consulted in connection with the initial claim; and (c) decisions involving hiring, compensation, termination, promotion, or related matters regarding any individual (e.g., a claims adjudicator, medical expert, or vocational expert) must not be based on the likelihood that the individual will support the benefits denial.

The various providers maintain their own procedures for appeals of adverse benefit determinations. Claimants should contact the provider for information about the applicable provider's appeal procedures. If there are any inconsistencies between the information set forth above and the claims procedure in the appropriate provider's information, the provider's procedure will control.

Assistance Regarding a Claim or Appeal. Some states have established an office of health insurance customer assistance or ombudsman under PHS Act Section 2793 to assist individuals with internal claims and appeals and external review process. Please contact the Plan Administrator for a current list of states that offer this assistance.

Timing of Decisions. The chart below sets forth the timing of decisions on appeal. The decision on appeal will be final and binding.

Procedure	Health Benefits			Disability Benefits	Other Benefits
	Urgent	Pre-Service Non-Urgent	Post-Service		
Notice of Improper Filing	24 hours	5 days	N/A	N/A	N/A
Notice of Incompleteness	24 hours	N/A	N/A	N/A	N/A
Notice of Initial Determination or Need for Extension (Measured from Filing)	72 hours (no extensions)	15 days	30 days	45 days	90 days
Claimant's Provision of Additional Information (where required) ¹	48 hours	45 days	45 days	45 days	Not Specified
Notice of Initial Determination after Commencement of Extension or Receipt of Additional Information, as applicable	48 hours	15 days ²	15 days	30 days (may be repeated once)	90 days
Request by Claimant for Review after Claim Denial	180 days	180 days	180 days	180 days	60 days
Notice of Determination of Appeal (or Need for Extension, if applicable)	72 hours	30 days	60 days	45 days	60 days

¹ Measured from the notice of incompleteness for urgent health claim or the notice of a need for extension where more information is required.

² May be increased by unused time from period for providing notice of extension or need for additional information. May be delayed to extent the plan waits for claimant to provide information.

External Review Procedure. The external review procedures apply to group health plans that are not excepted benefits. If a claim is denied following a full and fair internal review, the claimant is entitled to a full and fair external review, except that a denial, reduction, termination or failure to provide payment based on a determination that the participant or beneficiary fails to meet the requirements for eligibility under the terms of the group health plan is not eligible for external review. Generally, this means that external review only applies to claims involving the following: (a) medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment), as determined by the external reviewer; or (b) rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time). The claimant will have four months after receiving the final internal claim denial notice to file an appeal.

Within five business days after receipt of a request for external review, the Plan Administrator or its designee will determine whether the claim is eligible for review under the external review procedure. This determination is based on whether:

- The claimant is or was covered under the Component Benefit Program at the time the claim was made or incurred;
- The denial relates to the claimant's failure to meet the Component Benefit Program's eligibility requirements;
- The claimant has exhausted the Component Benefit Program's internal claims and appeal procedures; and
- The claimant has provided all the information required to process an external review.

Within one business day after completion of this preliminary review, the Plan Administrator or its designee will provide written notification to the claimant of whether the claim is eligible for external review.

If the request for review is complete but the claim is not eligible for external review, the Plan Administrator or its designee will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the United States Department of Labor Employee Benefits Security Administration at its toll free number 866.444.3272. If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the four month filing period, whichever is later, to submit the additional information.

If the request is eligible for external review, the Component Benefit Program will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for external review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Component Benefit Program within one business day. The Component Benefit Program may consider this information and decide to reverse its denial of the claim. If the denial is reversed, the Component Benefit Program will notify the claimant in writing and the external review process will end.

If the Component Benefit Program does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Component Benefit Program or issuer, claimant, or the claimant's treating provider;
- The terms of the Component Benefit Program;
- Appropriate practice guidelines, which must include applied evidence-based standards;
- Any applicable clinical review criteria developed and used by the Component Benefit Program; and
- The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Component Benefit Program and the claimant of its final decision within 45 days after the IRO receives the request for the external review. The IRO's decision notice must contain:

- A general description of the reason for the external review, including information sufficient to identify the claim;
- The date the IRO received the assignment to conduct the review, the date the external review was conducted, and the date of the IRO's decision;
- References to the evidence or documentation, including the evidence-based standards, the IRO considered in reaching its decision;
- A discussion of the principal reason(s) for the IRO's decision, including what applicable, if any, evidence-based standards were a basis for its decision;
- The rationale for the IRO's decision;
- A statement that the determination is binding and that judicial review may be available to the claimant; and
- Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act.

The decision of the IRO is binding on the Component Benefit Program, as well as the claimant, except to the extent other remedies are available under state or federal law. The Component Benefit Program will provide any benefits (including making payment on the claim) pursuant to the final external review decision without delay, regardless of whether the Component Benefit Program intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Generally, a claimant must exhaust the Component Benefit Program's claims and appeal procedures in order to be eligible for the external review process. However, in some cases the Component Benefit Program provides for an expedited external review if:

- The claimant receives an adverse benefit determination that involves a medical condition for which the time for completion of the Component Benefit Program's internal claims and appeal procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or
- The claimant receives a final adverse benefit determination that involves a medical condition where the time for completion of a standard external review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care,

continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited external review, the Component Benefit Program must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for external review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Component Benefit Program.

16. Legal Action. This Section applies to a Component Benefit Program that does not impose its own limitation on the filing of lawsuits. If a lawsuit with respect to a claim denial is filed, it must be filed no later than three years after the date of the final Component Benefit Program decision (including all appeals) regarding the claim.

17. Amendment and Termination. The Company hopes to continue the Plan indefinitely but, as with all of the Component Benefit Programs, the Company may change or discontinue the Plan at any time. The Company may amend or terminate the Plan by a written instrument adopted by the Company or by a person authorized by the Company. The Company may make changes to all or any class of eligible individuals, at any time and for any reason, without notice. The Company further authorizes its President, Chief Executive Officer, Chief Operating Officer, Vice President Risk Management, or General Counsel of the Company to execute amendments to the Plan (a) which counsel to the Company recommends be adopted to comply with applicable law or which facilitate Plan administration; and (b) which do not materially increase the cost to the Company of sponsoring and administering the Plan.

If the Company amends, alters, discontinues, or terminates the Plan, the Plan will only be liable for previously incurred claims that are filed within the time period set forth in the applicable Component Benefit Program. If the Company discontinues or terminates the Plan, benefits under the Component Benefit Programs will be governed by the applicable plan document, insurance contract, or other governing document. Unless otherwise specified in the Component Benefit Program, any remaining assets of a Component Benefit Program will be distributed to the Company and participants pro rata according to their respective contributions to the Component Benefit Program.

18. HIPAA Privacy and Security. This Section applies to Component Benefit Programs that are group health plans and that are Self-Insured Benefits, or that are Insured Benefits that provide the Plan or Component Benefit Program with access to Protected Health Information (as defined below) (collectively, the "HIPAA Component Benefit Programs"). The terms of this Section apply to the extent a HIPAA Component Benefit Program does not contain its own HIPAA Privacy and Security provisions.

Purpose: The Sponsoring Company adopts this Section to allow the HIPAA Component Benefit Programs offered under the Plan to disclose Protected Health Information to the Company in certain situations, as permitted by HIPAA. References in this Section to disclosures from the Component

Benefit Programs made to the Company include disclosures to employees of the Company, as described below.

Definitions. The following definitions apply for purposes of this Section:

- “Health Information” means any information, including genetic information, whether oral or recorded in any form or medium, that: is created or received by a health care provider, health plan, public health authority, Company, life insurer, school or university, or health care clearing house; and relates to the past, present or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual.
- “Health Plan” means an individual or group plan that provides or pays the cost of medical care (as defined in Section 2791(a)(2) of the Public Health Service Act, 42 U.S.C. § 300gg--91(a)(2)).
- “HIPAA” means the Health Information Portability and Accountability Act of 1996, as amended, HITECH, and including final regulations promulgated pursuant thereto.
- “HIPAA Component Benefit Program” means any Component Benefit Program that is a group health benefit program to which HIPAA applies. Generally, this means the Component Benefit Programs that provide medical care coverage and are maintained by the Company.
- “HITECH” means the Health Information Technology for Economic and Clinical Health Act enacted as part of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 (Feb. 17, 2009).
- “Individually Identifiable Health Information” means a subset of Health Information including demographic information collected from an individual, and which: is created or received by a health care provider, Health Plan, Company, or health care clearing house; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual; or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- “Plan Administration Functions” means administration functions performed by the Company on behalf of the HIPAA Component Benefit Program, excluding functions performed by the Company in connection with any other benefit or benefit plan of the Company.
- “Privacy Notice” means the notice of the HIPAA Component Benefit Program’s privacy practices distributed to HIPAA Component Benefit Program participants in accordance with 45 C.F.R. § 164.520, as amended from time to time.
- “Protected Health Information” or “PHI” means Individually Identifiable Health Information that is: transmitted by electronic media; maintained in any media described in the definition of electronic media at 42 C.F.R. § 162.103; or transmitted or maintained in any other form or medium. Protected Health Information excludes Individually Identifiable Health Information in education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. § 1232g; records described at 20 U.S.C. § 1232g(a)(4)(B)(iv); employment records held by a covered entity in its role as employer; and records regarding a person who has been deceased for more than 50 years.
- “Secretary” means the Secretary of the U.S. Department of Health and Human Services or his or her designee.

- “Summary Health Information” means information that: summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a Health Plan; and from which the information described at 42 C.F.R. § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 42 C.F.R. § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.
- “Unsecured PHI” means Protected Health Information that has not been secured through the use of technology or by a methodology specified by the Secretary in guidance issued pursuant to 42 U.S.C. § 17932(h)(2). In the absence of guidance from the Secretary, “Unsecured PHI” means Protected Health Information that is not secured by a technology standard that renders PHI unusable, unreadable, or indecipherable to unauthorized persons and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

Terms used, but not otherwise defined in this Section shall have the same meaning as those terms in HIPAA and regulations promulgated thereunder.

Conditions of Disclosure. The Company agrees that with respect to any PHI disclosed to it by the HIPAA Component Benefit Program, a health insurance issuer or an HMO, the Company shall:

- Not use or further disclose the PHI other than as permitted or required by the HIPAA Component Benefit Program documents or as required by law.
- Ensure that any agents, including a subcontractor, to whom it provides PHI received from the HIPAA Component Benefit Program, agree to the same restrictions and conditions that apply to the Company with respect to such PHI.
- Not use or disclose the PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Company.
- Report to the HIPAA Component Benefit Program any access, use or disclosure of PHI that is inconsistent with this Section or the Privacy Rule or Security Rule, including, without limitation, any access, use, or disclosure of Unsecured PHI which could reasonably require the HIPAA Component Benefit Program to undertake an analysis to determine whether a “breach” has occurred (as that term is defined in the regulations and the Secretary’s guidance promulgated with respect to HITECH and HIPAA generally), immediately upon becoming aware of an inconsistent use or disclosure. The Company agrees to provide all information reasonably requested by the HIPAA Component Benefit Program in order for the HIPAA Component Benefit Program to fully comply with its obligations under 45 C.F.R. Part 164 including breach notification and security incident obligations. The Company agrees, to the extent practicable, to mitigate the harmful effects of a breach or security incident known to the Company and to document any breach or security incident and the outcome of the same. The Company agrees to reimburse the HIPAA Component Benefit Program for all costs incurred by the HIPAA Component Benefit Program in complying with the breach notification procedures in 45 C.F.R. § 164 Subpart D, provided such costs arise out of a breach for which the Company is required to give the HIPAA Component Benefit Program notice under this Section.
- Provide individuals with access to PHI in accordance with 45 C.F.R. § 164.524 and 42 U.S.C. § 17935(e). The Company agrees to provide access to PHI in a Designated Record Set, as that term is defined in 45 C.F.R. § 164.501, to the HIPAA Component Benefit Program or, as directed by the HIPAA Component Benefit Program, to an individual at the written request of

the HIPAA Component Benefit Program within 10 calendar days to allow the HIPAA Component Benefit Program to meet the requirements of 45 C.F.R. § 164.524. If an individual requests access to PHI in a Designated Record Set in an electronic format, the Company agrees to permit such access and to direct a secure transmission of such PHI to the entity or person designated by the individual, provided that the direction from the individual is clear, conspicuous and specific.

- Make available PHI for amendment and incorporate any amendments to PHI in a Designated Record Set in accordance with 45 C.F.R. § 164.526. The Company agrees to make said amendments within 10 calendar days of a written request by the HIPAA Component Benefit Program.
- Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528 and 42 U.S.C. § 17935(c). The Company acknowledges that for purposes of 45 C.F.R. § 164.528, effective as of the applicable date set forth in 42 U.S.C. § 17935(c)(4), to the extent the Company makes a disclosure of an electronic health record containing PHI from a Designated Record Set, the Company will maintain such information as required by the Secretary in regulations promulgated pursuant to 42 U.S.C. § 17935(c)(2) notwithstanding the status of such disclosures as “treatment,” “payment,” or “health care operations” disclosures.
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the HIPAA Component Benefit Program available to the Secretary of Health and Human Services for purposes of determining compliance by the HIPAA Component Benefit Program with HIPAA.
- If feasible, return or destroy all PHI received from the HIPAA Component Benefit Program that the Company maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
- Ensure that the adequate separation between HIPAA Component Benefit Program and Company, required in 45 C.F.R. § 164.504(f)(2)(iii) and described in this Section, is established.
- Implement administrative, physical, and technical safeguards to the extent required by sections 164.308, 164.310, and 164.316 of title 45, Code of Federal Regulations and HITECH that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI or PHI the Company creates, receives, maintains or transmits on behalf of the HIPAA Component Benefit Program (other than enrollment/disenrollment information) and it will ensure that any agents or subcontractors to whom it provides such electronic PHI agrees to implement reasonable and appropriate safeguards to protect the information.
- Comply with the other provisions of HIPAA, HITECH and any implementing regulations promulgated thereunder to the extent the same apply to the Company.
- Limit its uses and disclosures of PHI to the “minimum necessary” amount of information to accomplish the intended purpose of the use, disclosure, or request for information. The Company acknowledges that for purposes of this Section, it will be deemed to meet the “minimum necessary” requirement if it discloses only such information within the definition of a “limited data set” as described in 45 C.F.R. § 164.514(e)(2), or if it discloses only such information consistent with guidance required to be provided by the Secretary under 42 U.S.C. § 17935(b)(1)(B).

- To the extent the HIPAA Component Benefit Program is required to restrict the use or disclosure of PHI pursuant to 42 U.S.C. § 17935(a), or otherwise agrees to a restriction on the disclosure of PHI, the Company agrees to abide by such requested restriction to the extent the Company is made aware of the same via written notice from the HIPAA Component Benefit Program and to immediately implement the restriction as requested.

Adequate Separation Between HIPAA Component Benefit Program and Company. In compliance with HIPAA, the Company will designate persons entitled to access PHI. The Company shall only allow those persons so identified to be given access to PHI. Those employees who have access to PHI from the HIPAA Component Benefit Program are listed in the Privacy Notice, either by name or individual position. The employees who have access to PHI listed in the Privacy Notice may only use and disclose PHI to the extent necessary to perform the Plan Administration Functions that the Company performs for the HIPAA Component Benefit Program, including but not limited to: quality assurance, claims processing, auditing, and monitoring. In the event that any of these specified persons do not comply with the provisions of this Article, that person, if an employee of the Company, shall be subject to disciplinary action by the Company for noncompliance pursuant to the Company's employee discipline and termination procedures. If that person is a non-employee, the Company shall take appropriate action with the entity involved, to ensure that appropriate discipline or sanctions are imposed and that non-compliance does not recur.

Permitted and Non-permitted Uses and Disclosure of PHI. Unless otherwise permitted by law, and subject to obtaining a written certification pursuant to subsection titled "Certification of Plan Sponsor", the HIPAA Component Benefit Program may disclose PHI to the Company, provided the Company uses or discloses such PHI only for the purpose of carrying out Plan Administration Functions that the Company performs for the HIPAA Component Benefit Program, consistent with the provisions of subsection titled "Conditions of Disclosure." Notwithstanding the provisions of this Section to the contrary, in no event shall the Company be permitted to use or disclose PHI in a manner that is inconsistent with 45 C.F.R. § 164.504(f). The HIPAA Component Benefit Program may not permit a health insurance issuer or HMO with respect to the HIPAA Component Benefit Program to disclose PHI to the Company except as permitted by 45 C.F.R. § 164.504(f). The HIPAA Component Benefit Program may not disclose PHI to the Company for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Company. The HIPAA Component Benefit Program shall not use or disclose PHI that is genetic information for underwriting purposes.

Information Regarding Participation. Notwithstanding the previous paragraph, the HIPAA Component Benefit Program, or a health insurance issuer or HMO with respect to the HIPAA Component Benefit Program, may disclose to the Company information on whether an individual is participating in the HIPAA Component Benefit Program, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the HIPAA Component Benefit Program.

Privacy and Security Official. The HIPAA Component Benefit Program shall designate a Privacy and Security Official, who will be responsible for the HIPAA Component Benefit Program's compliance with HIPAA's Privacy and Security Rules. The Privacy Official and the Security Official may be the same individual. The Privacy and Security Official is responsible for ensuring the HIPAA Component Benefit Program's compliance with HIPAA's Privacy and Security Rules. The Privacy and Security Official may contract with, or otherwise utilize, the services of attorneys, accountants, brokers,

consultants, or other third-party experts as the Privacy and Security Official deems necessary or advisable.

19. Other Required Notices.

HIPAA Special Enrollment. If you are declining group health plan 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 one or more of the Component Benefit Programs if you or your dependents lose eligibility for that other coverage (or if the Company stopped contributing towards 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 Company stops contributing toward the other coverage). If the other health coverage is provided under Medicaid or a state children's health insurance program, you must request enrollment within 60 days after your or your dependents' other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. Finally, if you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under one or more Component Benefit Programs, you may enroll yourself and your dependents in the Component Benefit Programs to which the subsidies apply. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for that premium assistance. If a Component Benefit Program or federal guidance expressly provides a longer period to request special enrollment, the longer period controls. To request special enrollment or obtain more information, contact the Plan Administrator.

Newborns' and Mothers' Health Protection Act. 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. For an individual who is receiving benefits under a Component Benefit Program that is a group health plan in connection with a mastectomy and who elects breast reconstruction, the 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; surgery/reconstruction of other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications, including lymphedemas. Please consult the summary plan description for the applicable Component Benefit Program for a description of cost-sharing for these benefits.

20. General Information.

No Guarantee of Employment. The Plan is not an employment contract. Nothing contained in this Summary or the Component Benefit Programs gives you the right to be retained in the service of the Company. This Plan does not interfere with the right of the Company to discharge you or to terminate

your service at any time. The Plan does not give any person legal or equitable rights against the Company, its officers, directors, or trustees, except as provided in the Plan.

Coordination of Benefits. Your benefits under this Plan and the Component Benefit Programs may be coordinated with other plans. This means that in some cases, your coverage may be reduced or not provided if you have coverage from another source. This prevents duplicate benefits. Please refer to the applicable summary plan descriptions, insurance booklets, and/or other governing documents for more information about coordination of benefits.

Subrogation, Reimbursement. Your benefits under this Plan and the Component Benefit Programs may be subject to subrogation. This means that you may be required to reimburse the Plan for benefits you receive as a result of an injury or illness for which a third party is, or may be, held responsible. This prevents duplicate benefits. You may also be required to repay the Plan for any overpaid or erroneously paid benefits. Please refer to the applicable summary plan description, insurance booklet, and/or other governing document for each Component Benefit Program for more information about subrogation and reimbursement.

Documents of Component Benefit Programs Control. The applicable summary plan descriptions, insurance booklets, and/or other governing documents of the Component Benefit Programs contain the terms of your right to receive benefits. If there is a conflict among the plans, the terms of the Component Benefit Programs will control the interpretation, unless otherwise required by law.

Assignment of Benefits. Your benefits under the Plan cannot be used as collateral for loans or be assigned in any other way, except as required by federal law. The Plan shall not be liable for or subject to debts, contracts, liabilities or torts of any person entitled to benefits under the Plan. To the extent permitted by law, neither the benefits nor payments under the Plan will be subject to the claim of creditors or to any legal process. Notwithstanding the above statements, you may assign benefits directly to a health care provider or facility. Otherwise, benefits will be paid according to the terms of the summary plan descriptions, insurance booklets, or other governing documents of the Component Benefit Programs.

Governing Law. This Plan shall be construed according to applicable Federal law and, to the extent otherwise applicable, the laws of the State of Nebraska.

No Guarantee of Tax Consequences. The Company does not represent or guarantee that any particular federal or state income, payroll, personal property or other tax consequence will result from participation in this Plan or any one or more of the Component Benefit Programs. You should consult with your own tax advisors if you have questions.

Payments to Minors, Etc. If an individual entitled to receive benefits under the Plan is a minor or if a court has determined that the individual is not legally capable of giving valid receipt and discharge of benefits, or if the Plan Administrator deems the individual not to have such legal capabilities, the Plan Administrator will designate a person to receive payments on behalf of the individual. The Plan treats these payments as payments to the individual, and the payments fully discharge the Plan's liability.

Severability. If a court with jurisdiction holds any portion of this Plan invalid or unenforceable, the remaining provisions continue to be fully effective.

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

RECEIVE INFORMATION ABOUT YOUR PLAN BENEFITS

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, written request to the Plan Administrator, copies of all documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review the applicable summary plan description and other documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your Company, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit of exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

In your claim for a welfare benefit is denied or ignored, in whole or in part, you have right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator

to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory of the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities by calling the publications hotline of the Employee Benefits Security Administration.

22. Conclusion. This Summary is intended to briefly highlight the provisions of the Component Benefit Programs. The Company intends this Summary to be accurate. However, the terms of a Component Benefit Program will control any conflict with this Summary. You should consult with the Plan Administrator concerning the actual Component Benefit Program provisions if you have questions.

APPENDIX: COMPONENT BENEFIT PROGRAM INFORMATION

This Appendix summarizes key features of the Component Benefit Programs of the Crete Carrier Corporation Welfare Benefits Plan and Summary Plan Description. The Sponsoring Company may add or remove Component Benefit Programs from time to time. When this Appendix refers to the Company, it means the Sponsoring Company and all Participating Companies, unless otherwise indicated. When this Appendix refers to the Welfare Benefits Plan SPD, it means the preceding portions of the Crete Carrier Corporation Welfare Benefits Plan and Summary Plan Description. If anything in this Appendix differs from the actual terms of the Component Benefit Program, the Component Benefit Program controls. More information about the Component Benefit Programs is available at www.cretecarrierbenefits.com.

General Information about the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan	
Plan Administrator:	Crete Carrier Corporation, 400 NW 56th Street, Lincoln, NE 68528, is the Plan Administrator of the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan. The Plan Administrator's telephone number is (800) 998-9100. Service of process may be made upon the Plan Administrator.
Insured Status:	The Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan are each Self-Insured Benefits. Benefits are paid from the general assets of the Company and from the trust described below.
Contributions:	Benefits under the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan are funded through Company and participant contributions. The Company will contribute an amount that it determines necessary to meet its obligations under these plans. A participant must contribute the remainder necessary to pay for benefits he or she elects.
About the Trust:	When this Appendix refers to a trust, it means the Crete Carrier Corporation Welfare Benefits Trust. As of April 1, 2024, the names and titles of the trustees of the trust are: Christopher C. Hilkemann (Vice President – Risk Management / Associate General Counsel), Kyle A. Cech (Corporate Controller), and Timothy G. Aschoff (President and Chief Operating Officer). You may obtain a list of the current trustees by contacting the Plan Administrator. The trustees' principal place of business is Crete Carrier Corporation, 400 NW 56th Street, Lincoln, Nebraska 68528. Service of process may be made upon the trustees.
Information about Benefits:	The benefit booklets provided to you by the third party claims administrators contain detailed information about benefits under these plans. You can obtain the booklets and a detailed summary of benefit payments and limitations at no charge upon request, by contacting the Plan Administrator, or at www.cretecarrierbenefits.com. This Appendix, together with the booklets provided by the applicable claims administrators, provides an overview of your benefits. It is not intended to be a complete description of every detail of these plans. Coverage and benefit determinations are governed by the applicable plan document, which consists of this Appendix, the Wrap Plan SPD, the booklet from the claims administrator, and other documents entered into between the Company and the claims administrator. These plans have a contractual right to recover any overpayment of benefits, or payments made in error.
FMLA Leave:	Employees covered under the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and/or Crete Carrier Corporation Group Vision Plan have the right to continue coverage during FMLA leave by paying the same portion of the premium or coverage payments for the benefits that applied prior to the FMLA leave, subject to overall Plan adjustments in premiums. If you elect to continue coverage during FMLA leave, you may elect to pay for your portion of coverage through pre-payment, paying as you go, or catching up upon your return. An employee

General Information about the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan	
FMLA Leave (cont'd):	may also elect to discontinue coverage for the period of FMLA leave, and upon return, be reinstated in coverage on the same basis as prior to the leave, subject to any changes in status. The Company will provide you with more information about benefits and FMLA leave when you request the leave. It will also provide you an opportunity to elect to continue or revoke your benefits during the FMLA leave. You can also obtain more information by contacting the Plan Administrator.
Military Leave under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"):	Pursuant to USERRA, the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan make continued coverage under the Plan available to employees and their dependents if coverage would otherwise be lost due to a military leave. If coverage under the Plan ends because of service in the uniformed services, an employee may elect to continue health coverage for themselves and any covered dependents, until the earlier of: (1) 24 consecutive months from the date active duty began; or (2) the day after the date on which the employee fails to apply for, or return to employment, in accordance with USERRA. An employee is responsible for payment of the required premium to continue coverage. If the leave for military service is less than 31 days, the required premium is the standard employee share of the applicable premium; for a leave in excess of 30 days, the required premium shall be no more than 102% of the total premium applicable for the membership option an employee elected. If you take military leave under USERRA, the Company will inform you of the amount and procedure for payment of premiums. Continued coverage under USERRA will end at midnight on the earliest of: (a) the day the Company ceases to provide any group health plan for its employees; (b) the day premium is due and unpaid; (c) the day a person again becomes covered under the Plan as an employee; (d) the day coverage has been continued for the period of time stated above. Following service in the uniformed services, a person may be eligible to apply for reemployment with the Company in accordance with USERRA. Such reemployment includes the right to reenroll for coverage under the Plan with no new waiting period. Please contact the Plan Administrator for more information regarding your rights under USERRA.
Other Leave:	Leaves of absence other than FMLA leave or leave under USERRA may affect your eligibility for coverage under the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan. You may have the right to continue coverage if it would otherwise be lost due to a period of leave. Contact the Plan Administrator for more information.
Amendment and Termination of a Plan:	The Sponsoring Company reserves the right to amend or terminate the Crete Carrier Corporation Group Health Plan, the Crete Carrier Corporation Group Dental Plan, and/or the Crete Carrier Corporation Group Vision Plan at any time. The Sponsoring Company will follow the procedure for amendments or termination set forth in Section 17 of the Welfare Benefits Plan SPD. If the Sponsoring Company amends, alters, discontinues, or terminates these plans, they will only be liable for previously incurred claims that are filed within the time period described in the applicable plan's booklet. You may not receive benefits if one or more of these plans are amended or terminated.

General Information about the Crete Carrier Corporation Group Health Care Plan, Crete Carrier Corporation Group Dental Plan, and Crete Carrier Corporation Group Vision Plan	
Termination of Trust:	The Sponsoring Company reserves the right to amend or terminate the trust at any time by a written instrument adopted by the Sponsoring Company or a person authorized by the Sponsoring Company. If the trust is terminated, any remaining assets will be applied to pay benefits and expenses permitted by law, and any remaining assets disposed of in a manner permitted by law and the terms of the trust.
HIPAA Privacy:	Please refer to the Notice of Privacy Practices from the Company and from the claims administrators for further details regarding HIPAA privacy practices.

Component Benefit Program: Crete Carrier Corporation Group Health Care Plan (including the trust or trusts through which the Plan benefits are funded)	
Type of Plan:	Welfare benefit plan providing hospital, medical, and surgical benefits.
Claims Administration:	HighMark Blue Cross Blue Shield administers claims payments, except for prescription drug benefits. Its address is: Highmark Blue Cross and Blue Shield, Member Claims, P.O. Box 3355, Pittsburgh, PA 15230-3355. MaxCare administers claims payments for prescription drug benefits. Its address is: MaxCare, LLC, P.O. Box 16430, Oklahoma City, OK 73113. The third-party claims administrators have discretion with respect to the processing of claims to the extent described in the booklets.
Eligibility:	The following persons are eligible to participate in the Plan: ○ An employee of the Company who regularly works at least 30 hours per week; and ○ Independent contractors who are owner operators of over-the-road tractors leased to the Company are eligible, if they work a minimum of 30 hours per week on a regular calendar year basis. However, coverage is not available with respect to owner operators who reside in: Alaska, California, Colorado (effective March 1, 2024), Connecticut (effective April 1, 2024), Delaware, the District of Columbia, Hawaii, Illinois, Louisiana, Maine, Massachusetts, Michigan, Montana, New Hampshire, New Jersey, New Mexico, Nevada, North Dakota, Oregon, Rhode Island, Vermont, Virginia, Washington, and Wisconsin. In addition, coverage is only available to owner operators in Maryland, Minnesota, and New York if they have continuously resided in the applicable state and remained continuously enrolled in coverage since December 31, 2020. The Plan determines the state of residence of an owner operator based on their commercial driver's license. <i>Important notice for owner operators: due to state law restrictions, owner operator relocations and/or ceasing coverage may affect your ability to continue coverage or re-enroll in the future.</i> Other independent contractors and individuals designated as part-time, temporary, or contract employees are not eligible. A person who is eligible for coverage under the Plan may also elect coverage for his or her dependents (generally, the person's spouse and children). Coverage for children generally ends when the eligible person dies, the child attains age 26, or otherwise ceases to meet the requirements of an eligible dependent. Please refer to the booklet from the claims administrator for more detailed information about dependent eligibility.
Enrollment:	An eligible employee or owner operator must enroll themselves and any eligible dependents within 31 days of initial eligibility or during a special enrollment period. Refer to Section 19 of the Welfare Benefits Plan SPD for information on special enrollment. Eligible persons who do not enroll for coverage during the initial enrollment period or a special enrollment period, may do so during the Plan's annual open enrollment period. Contact the Benefits Department for more information about open enrollment.

Component Benefit Program: Crete Carrier Corporation Group Health Care Plan (including the trust or trusts through which the Plan benefits are funded)	
Entry Date:	Coverage generally becomes effective on the first day of the month following completion of an eligibility (probationary) waiting period of 30 consecutive calendar days of employment or service. Different rules apply to special enrollment. Refer to Section 19 of the Welfare Benefits Plan SPD for the deadlines for special enrollment notification. If a timely request for special enrollment is received, coverage in connection with a birth of a child will take effect upon the child's date of birth. Coverage due to placement of a child for adoption generally will take effect on the date the child is placed for adoption. Coverage for other special enrollment events generally will take effect no later than the first of the month following the date of the event giving rise to special enrollment rights.
Provider Network:	You can obtain a listing of eligible network providers at no charge by calling the toll-free number on the back of your identification card. Effective January 1, 2022, benefits will be administered in a manner consistent with the applicable provisions of the Consolidated Appropriations Act, 2021, including those relating to billing for services from nonparticipating providers.
Termination of Coverage:	Coverage under the Plan will terminate for you and any dependents upon the earliest of the following: (1) the last day of the month in which you terminate employment with the Company or cease to meet the eligibility requirements; (2) for your dependent, the last day of the month during which the person ceases to meet the Plan's definition of an eligible dependent; (3) the date you die; (4) the last date for which a premium is paid; and (5) the date the Plan terminates. You may be eligible to continue coverage, as described in Section 12 of the Welfare Benefits Plan SPD. Continuation of coverage during FMLA leave and military leave is described in other provisions of this Appendix. Coverage under the Plan may be cancelled or rescinded due to a covered person's fraud or intentional misrepresentation of a material fact about a claim or eligibility for this coverage. If coverage is rescinded, the amount of premium paid will be reduced by any benefits that were paid, and will be refunded. If benefits paid exceed the premium received, the Plan may recover the difference.
Right to Reimbursement:	In addition to and separate from subrogation rights, the Plan has a contractual right to recover benefits paid under the Plan for an illness or injury for which a covered person receives full or partial proceeds from any other source. Such sources may include judgments; payments made under group auto insurance, individual or group no fault auto insurance, to another person's uninsured, underinsured, or medical payment insurance; or proceeds otherwise paid by a third party. The Plan's rights under this provision shall not be defeated by allocating proceeds in whole or in part to nonmedical damages. When the Plan recovers under this contractual right to reimbursement, amounts previously credited toward a deductible or coinsurance liability may be removed, and future claims will be subject to the reinstated deductible or coinsurance. By accepting coverage under this Plan, you agree to cooperate and assist the Plan in any way necessary to recover payments owed as a result of an illness or injury. These include notifying the Plan of a claim or lawsuit filed on your behalf or on behalf of your dependent for an injury or illness, and obtaining approval of the Plan prior to settling any claim or lawsuit to obtain an itemization of subrogation or reimbursement due to the Plan. Upon receiving proceeds subject to subrogation or reimbursement, you agree to hold them in trust until they can be transferred to the Plan. The Plan may recover costs incurred in enforcing subrogation provisions and/or the right to reimbursement, and/or in recovering any overpayment of benefits. These include but are not limited to, fees, litigation and court costs, and other expenses.

Component Benefit Program: Crete Carrier Corporation Group Dental Plan (including the trust or trusts through which the Plan benefits are funded)	
Type of Plan:	Welfare benefit plan providing dental care benefits.
Type of Administration:	Ameritas Life Insurance Corp. is the third party claims administrator. Its address is P.O. Box 82595, Lincoln, NE 68501.
Eligibility/Entry Date:	As described in the Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Vision Plan (including the trust or trusts through which the Plan benefits are funded)	
Type of Plan:	Welfare benefit plan providing vision care benefits.
Type of Administration:	Ameritas Life Insurance Corp. is the third party claims administrator. Its address is P.O. Box 82595, Lincoln, NE 68501.
Eligibility/Entry Date:	As described in the applicable Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Life Insurance Plan	
Type of Plan:	Welfare benefit plan providing life insurance.
Insured Status:	Fully Insured Benefit. United of Omaha Life Insurance Company is the Insurer. Its address is 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Contributions:	Company and participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the applicable Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Voluntary Life Insurance Plan	
Type of Plan:	Welfare benefit plan providing life insurance, including accidental death and dismemberment.
Insured Status:	Fully Insured Benefit. United of Omaha Life Insurance Company is the Insurer. Its address is 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Contributions:	Participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the applicable Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Long-Term Disability Insurance Plan	
Type of Plan:	Welfare benefit plan providing long-term disability insurance.
Insured Status:	Fully Insured Benefit. United of Omaha Life Insurance Company is the Insurer. Its address is 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Contributions:	Company contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the applicable Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Short-Term Disability Insurance Plan	
Type of Plan:	Welfare benefit plan providing short-term disability insurance.
Insured Status:	Fully Insured Benefit. United of Omaha Life Insurance Company is the Insurer. Its address is 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Contributions:	Company contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the applicable Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Voluntary Short-Term Disability Insurance Plan	
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Type of Plan:	Welfare benefit plan providing short-term disability insurance.
Insured Status:	Fully Insured Benefit. United of Omaha Life Insurance Company is the Insurer. Its address is 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Contributions:	Participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the applicable Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Employee Assistance Plan	
Type of Plan:	Welfare benefit plan providing employee assistance benefits.
Insured Status:	Fully Insured Benefit. United of Omaha Life Insurance Company is the Insurer. Its address is 3300 Mutual of Omaha Plaza, Omaha, NE 68175.
Contributions:	Company contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	All employees, and all owner operators who elect to participate in the Group Life Insurance Plan, are eligible as of the date of hire.
COBRA:	The Company makes COBRA benefits under the Employee Assistance Plan available to employees and eligible owner operators and their respective beneficiaries for the applicable coverage period, at no cost to a Qualified Beneficiary. Section 12 of the Welfare Benefits Plan Summary Plan Description explains Qualified Beneficiaries, Qualifying Events, and the coverage period. When calling the Employee Assistance Plan or the Insurer to obtain benefits, you must explain that you are receiving COBRA benefits. If you have questions about COBRA benefits under the Employee Assistance Plan, contact the Plan Administrator at (800) 998-9100.

Component Benefit Program: Crete Carrier Corporation Flexible Spending Account Plan	
Type of Plan:	Welfare benefit plan providing a medical care reimbursement benefits.
Insured Status:	Self-Insured Benefit.
Contributions:	Participant contributions.
Type of Administration:	Third-party claims administrator. Refer to the Summary Plan Description for this Component Benefit Program for more information about claims.
Eligibility/Entry Date:	As described in the Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Accident Insurance Plan	
Type of Plan:	Welfare benefit plan providing accident insurance.
Insured Status:	Fully Insured Benefit. American Heritage Life Insurance Company is the Insurer.
Contributions:	Participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Universal Life Insurance Plan	
Type of Plan:	Welfare benefit plan providing life insurance.
Insured Status:	Fully Insured Benefit. American Heritage Life Insurance Company is the Insurer.
Contributions:	Participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Critical Illness Insurance Plan	
Type of Plan:	Welfare benefit plan providing critical illness insurance.
Insured Status:	Fully Insured Benefit. American Heritage Life Insurance Company is the Insurer.
Contributions:	Participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the Summary Plan Description for this Component Benefit Program.

Component Benefit Program: Crete Carrier Corporation Group Hospital Indemnity Insurance Plan	
Type of Plan:	Welfare benefit plan providing hospital indemnity insurance.
Insured Status:	Fully Insured Benefit. American Heritage Life Insurance Company is the Insurer.
Contributions:	Participant contributions.
Type of Administration:	The Insurer administers claims.
Eligibility/Entry Date:	As described in the Summary Plan Description for this Component Benefit Program.

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