Priefert®

2027 Benefits Enrollment Guide







We are... Priefert®

If you have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see pages 32 and 33 for more details.

This guide highlights the main features of many of the benefit plans sponsored by Priefert. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. Priefert reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.



BENEFITS OVERVIEW

OUR BENEFITS PROGRAM HAS YOU COVERED

Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. But sometimes things don't always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son's football game ends with a broken leg. Or even when your spouse learns he or she needs an extensive root canal. That's when Priefert's benefits are there to help.

Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. Priefert's benefit plans allow you to choose the options that work best for your own needs — and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

Benefits You Pay For (All or Portion)	Benefits Provided at No Cost to You
Medical and Prescription Drug	Basic Life and AD&D Insurance
Dental Plan	Employee Assistance Program
Vision Plan	Priefert's 401(k) Match
Optional Life and AD&D Insurance	
Short-Term & Long-Term Disability	
Accident Insurance	
Critical Illness	
Hospital Indemnity	
Identity Theft Protection	
Pet Insurance	
Your 401(k) Contributions	

You are eligible to enroll in Priefert's benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on your 90th day of employment.

DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse (for medical and dental plans, your spouse must not be eligible for medical and/or dental plans through their employer)
- Your eligible children up to age 26
- "Children" are defined as your natural children, stepchildren, legally adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If you wish to cover your dependents under the medical and/or dental plans, you will be required to submit documentation as proof of eligibility prior to their effective date.

Spouse	Dependent
• Marriage Certificate	• Birth Certificate or Valid Court Order of adoption or Custody Papers (Court Papers or Legal Entity)
• SSN Card or Federal Tax Return (Current 1st page)	• SSN Card or Federal Tax Return (Current 1st page)
• Priefert Affidavit of Working Spouse	



WHEN COVERAGE BEGINS

INITIAL ENROLLMENT

If you enroll on time, coverage begins on your 90th day of employment. If you do not enroll within 30 days of becoming eligible, you will automatically be enrolled in company-paid benefits, such as Basic Life and Accidental Death & Dismemberment (AD&D) Insurance and the Employee Assistance Program (EAP), but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

ANNUAL OPEN ENROLLMENT

During annual Open Enrollment, coverage takes effect on January 1, 2027.

MAKING CHANGES TO COVERAGE

Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.

If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event by completing a Benefit Changes/Enrollment form and returning it to Human Resources. If you do not return your form within 31 days, you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent's eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage
- Loss of other coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

SPECIAL ENROLLMENT RULES

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children's Health Insurance Program ("CHIP") coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the "Special Enrollment Rules" above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated "for cause" (including failure to pay the required premiums on time).

In addition to the changes described previously, you may enroll yourself and your spouse (with or without the new dependent) in a Priefert health plan following marriage or adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, contact Benefits at 903-572-1741 ext 1137 or Benefits@priefert.com.

CHOOSING A MEDICAL PLAN

Priefert's medical option provides coverage for expenses, such as doctor's office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

When it comes to medical coverage, Priefert offers you this choice:

- PPO Plan

Preferred Provider Organizations (PPO)

The PPO plan offers in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.



Providers in the UMR network may change. To find out if your doctor participates in the network, go to www.umr.com and click on Find a Provider.

Tobacco User Surcharge

Quitting tobacco is the single most important step you can take to improve your health. Tobacco use is a leading preventable cause of disease, disability, and death in the United States. Our tobacco user surcharge is meant to encourage current users to take steps to get healthier. The tobacco user surcharge is $75 per person per month (employee and/or covered spouse) and will apply to the company's medical plan premiums in 2027 unless you complete one of the cessation programs.

MEDICAL PLAN DETAILS

Medical Plan Design	In-Network	Out-of-Network
Deductible – Individual / Family	$2,000 / $4,000	$9,000 / $27,000
Out of Pocket Max Individual / Family	$6,000 / $12,000	$12,000 / $36,000
Lifetime Max Benefit	Unlimited	Unlimited
Preventive Care	Covered 100%	Not Covered
Primary Care Physician (PCP)	$45 Copay	Covered 50% after deductible
PCP at Christus Health (Titus County Locations)	$25 Copay	N/A
Inpatient/Outpatient at Christus Health (Titus County Locations)	Covered 90% after deductible	N/A
Teladoc Visit	$10 Copay	N/A
Basic X-ray & Lab	Covered 75%, No deductible	Covered 50%, No deductible
Urgent Care	$75 Copay	Covered 50% after deductible
Emergency Room	Covered 75% after deductible	Covered 50% after deductible
Emergency Room (True ER)	Covered 75% after deductible	Covered 75% after deductible
Emergency Room (Non-True ER)	Covered 75% after deductible	Not Covered
Hospitalization	$150 Copay per admission Covered 75% after deductible	$500 Copay per admission Covered 50% after deductible
Specialist	$60 Copay	Covered 50% after deductible
Mental Health	$45 Copay	N/A
Outpatient Surgery	Covered 75% after deductible	Covered 50% after deductible

PRESCRIPTION DRUG COVERAGE

If you enroll in the Priefert medical plan, you will automatically receive prescription drug coverage, provided through UMR. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.



Retail Prescription Program

The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy. Prescriptions you fill at non-participating pharmacies are generally not covered.

Mail Order and Retail90 Programs

The mail order and Retail90 programs offer a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication for a more affordable amount. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you must fill out a mail order form and return it with a 90-day prescription from your doctor and your payment. Mail order forms are available from your HR Department or on the UMR website at www.umr.com. For the Retail90 program, you can pick up your 90-day supply of maintenance medications, at your convenience, for a more affordable amount.

Specialty Prescription Program

If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, UMR will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

Retail Prescriptions (up to 30-day supply)	You Pay
Tier 1 (generics and some brand name)	$10 copay
Tier 2 (preferred brand name)	40% to max $170
Tier 3 (brand name and some generics)	50% to max of $170
Mail Order Prescriptions (up to 90-day supply)	
Tier 1 (generics and some brand name)	$25 Copay
Tier 2 (preferred brand name)	35% to max of $425
Tier 3 (brand name and some generics)	45% to max of $425
Retail90 (up to 90-day supply)	
Tier 1 (generics and some brand name)	$25 Copay
Tier 2 (preferred brand name)	40% to max of $425
Tier 3 (brand name and some generics)	50% to max of $425
Specialty (up to 30-day supply)	
Tier 1 (generics and some brand name)	40% to max of $300
Tier 2 (preferred brand name)	50% to max of $300
Tier 3 (brand name and some generics)	60% to max of $300
Annual Prescription Out of Pocket Max	
Individual	$2,000
Family	$4,000

DENTAL PLAN



Priefert's Dental Plan is administered through UMR and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

Dental PPO Plan

The Dental PPO allows you the freedom to visit any dentist, without referrals, for all your dental care. If you receive care from one of UMR's preferred dentists, you'll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher, and you may need to file your own claims. For a list of UMR's preferred dentists, go to www.umr.com.

Dental Plan Design	Benefit
Annual Benefit Maximum	**$1,500/Member**
Annual Deductible	$50 for Individual / $100 for Family
Basic Services	
Restorations, Emergency Treatment, Simple Extractions, Periodontics, After-Hours Visits	You pay 20%
Diagnostic Services	
Periodic Exam	You pay 0% - Deductible Waived
Radiographs	You pay 0% - Deductible Waived
Lab and Other Diagnostic Tests	You pay 0% - Deductible Waived
Preventive Services	
Cleaning	You pay 0% - Deductible Waived
Fluoride Treatment	You pay 0% - Deductible Waived
Space Maintainer	You pay 0% - Deductible Waived
Major Services	
Major Restorative, Dentures and Removable Prosthetics, Fixed Partial Dentures (Bridges), Implants	You pay 50% after deductible
Orthodontia	
Orthodontia	You pay 50% after deductible Maximum orthodontia lifetime benefit of $2,000
Eligibility	Covers Children Only – up to Age 19

VISION PLAN

Priefert's Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through VSP.



Vision Coverage

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the VSP's network, you will receive a discount on services. To find a network provider, go to www.vsp.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You must pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Vision Plan Design	Benefit
Eye Exam	$10 Copay
Materials	$25 Copay
Frames	$25 Materials Copay; **$150 Allowance** (**$80 allowance at Costco**) 20% discount over $150
Lenses	
Single Vision	$0
Bifocal - Lined	$0
Trifocal - Lined	$0
Polycarbonate (Adults)	$0
Polycarbonate (Children)	$0
Standard Progressive	**$0**
Contact Lenses	
Contact Lens Fitting	Standard: $40 Specialty: 10% off retail
Contacts - Elective	$0 Copay; $200 Allowance
Medically Necessary	$0; covered in full
Frequency	
Exams	12 months
Lenses (In lieu of contacts)	12 months
Contacts (In lieu frames & lenses)	12 months
Frames	24 months

LIFE and AD&D INSURANCE

Priefert offers life insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through Lincoln Financial.

Basic Life and AD&D Insurance

Priefert automatically provides Basic Life Insurance for all eligible employees at no cost. Basic Life Insurance is equal to $50,000. The benefit is paid to your beneficiaries in the event of your death.

Optional Life and AD&D Insurance

In addition to Basic Life Insurance, you may also purchase Optional Life Insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Optional Life coverage for yourself. You pay for the cost of Optional Life Insurance on an after-tax basis through payroll deductions.

Optional Life and AD&D Insurance Coverage

Coverage For	Coverage Available
Employee	5 times annual salary, up to $500,000 Guaranteed Issue Amount 5 times up to $300,000 Must be in $10,000 increments
Spouse	100% of employee's benefit, up to $500,000 Guaranteed Issue Amount 100% of employee's benefit up to $30,000 Must be in $5,000 increments
Child(ren)	100% of employee's benefit up to $10,000

Beneficiary Designation

You must designate a beneficiary for Basic and Optional Life Insurance benefits when you enroll. Your "beneficiary" is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year.
If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

Benefits Reduce At Age 70 and 75

When you or a covered dependent reaches age 70 and 75, Basic Life Insurance benefits are reduced. For more information, refer to your Group Life Insurance booklet.

DISABILITY COVERAGE

Priefert offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, non-work related injury, or pregnancy. Disability benefits are administered through Lincoln Financial.

Short-Term Disability

Short-Term Disability (STD) benefits are available to all eligible employees at an added cost. Your STD benefits will replace 60% of your base pay.

- Optional, employee paid
- 60% of eligible earnings, up to $1,500/week
- Maximum benefit: 90 days
- Elimination Period: 15 calendar days

Long-Term Disability

If you remain totally disabled and unable to work for more than 90 days, you may be eligible for Long-Term Disability (LTD) benefits. Priefert makes available LTD benefits to all eligible employees. Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive.

- Optional, employee paid
- 60% of eligible earnings, up to $5,000/month
- Maximum Benefit: Social Security Normal Retirement Age
- Elimination Period: 90 days

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at Priefert, and
- You must have lost 20% or more of your pre-disability income due to your illness or injury.

VOLUNTARY BENEFITS

Voluntary Accident Insurance – Provided by Mutual of Omaha

Nobody plans to have an accident – and most people don't budget for one, either. Accident insurance can help you pay for out-of-pocket expenses that may not be covered by other benefits. Accident insurance pays a lump sum cash benefit for a variety of injuries and treatments due to off-the-job accidents. Coverage is also available for your eligible dependents.

Benefits	Amount
Physician Follow-up Office Visit	$100; Up to 6 per accident
Therapy Services	$50; Up to 6 per accident
Medical Device	$200
Prosthetic Device	$1,000; Up to 2 per accident
Transportation (Up to 3 trips per accident)	$500 per trip
Lodging (Up to 30 nights per accident)	$175 per night
Childcare (Up to 30 days per accident)	$30 per day
Outpatient Physician's Benefit	$100 per day
Principal Sum (PS)	You: $50,000 Spouse: $25,000 Child(ren): $10,000
Common Carrier Accidental Death	300% of PS
Transportation of Remains	Up to $5.000
Dismemberment & Paralysis	Up to 100% of PS
Reasonable Modifications	Up to 10% of PS
Coma	25% of PS
Emergency Room	$200
Urgent Care Center	$125
Initial Physician Office Visit	$100
Ambulance	Up to $1,500
Fractures (Surgical/Non-Surgical)	Up to $8,000 / Up to $4,000
Dislocations (Surgical/Non-Surgical)	Up to $10,000 / Up to $5,000
Lacerations	Up to $1,000
Burns	Up to $20,000
Dental	Up to $400
Admission	$1,500
Daily Confinement (Up to 365 days per accident)	$300 per day
ICU Confinement (Up to 15 days per accident)	$600 per day
Rehab Facility Confinement (Up to 30 days per accident)	$150 per day
Surgical	Up to $2,000
Diagnostic	Up to $300

Voluntary Critical Illness – Provided by Lincoln Financial

Critical Illness insurance helps pay the cost of non-medical expenses related to a covered critical illness, like a heart attack, stroke, kidney failure, or cancer. The plan provides you a lump sum benefit payment upon diagnosis of any covered critical illness or cancer to help cover expenses such as lost income, out-of-town treatments, special diets, daily living, and household upkeep costs. Coverage is also available for your eligible dependents.

A health screening benefit of $100 is payable once per calendar year for each insured person who has a health screening test performed while insurance is in effect for the insured person.

Coverage For	Low Plan	Mid Plan	High Plan	Guarantee Issue Amount
Employee	$10,000	$15,000	$20,000	$20,000
Spouse*	$5,000	$10,000	$20,000	$10,000
All Children	25% of employee benefit			All Guarantee Issue

*Spouse election cannot exceed 100% of employee benefit amount

Critical Illness	BENEFIT
Core Plan Benefits	
Heart attack	100%
Arterial / vascular disease	25%
Mitral or aortic valve disease	25%
Stroke	100%
Major organ failure	100%
Invasive cancer	100%
Non-invasive cancer/cancer in situ	25%
Skin cancer (paid once per lifetime)	$250
Supplemental Conditions	
Advanced Alzheimer's disease	100%
Advanced Multiple Sclerosis (MS)	25%
Advanced chronic obstructive pulmonary disease (COPD)	100%
Benign brain tumor	25%
Accidental Injury	
Severe traumatic brain injury	100%
Permanent paralysis	100%
Childhood Conditions	
Down Syndrome	100%
Type 1 Diabetes	100%

*A benefit for this critical illness is only payable once per insured person under the policy. This is a condensed list, please see the policy document for the full list of covered illnesses.

Voluntary Hospital Indemnity – Provided by Lincoln Financial

Hospital Indemnity insurance helps supplement your medical coverage and provides a cash benefit for hospital related fees you or an insured family member sustain as a result of being hospitalized. This benefit can be used to pay out-of-pocket medical expenses, help supplement your daily living expenses and cover unpaid time off work. As an active employee of Priefert, you have hospital indemnity coverage for yourself and your family members, and premiums can be deducted from your paycheck.

Coverage Level	Weekly Premium
Employee Only	$3.14
Employee + Spouse	$6.71
Employee + Child(ren)	$4.86
Family	$8.80

Benefits	Amount
Hospital Admission	$1,000 / day
Daily Hospital Confinement	$100 / day
ICU Admission	$2,000 /day
Daily ICU Confinement	$200 / day
Daily Newborn Nursery Care Confinement	$75 / day
Health Screening Benefit (1 time per insured per calendar year)	$50

For more detailed information about this plan, please contact Benefits at 903-572-1741 ext 1137 or Benefits@priefert.com.



401K PLAN

Smart saving and investing are the foundation for financial security during your retirement years. Our 401(k) plan is designed to help you reach your retirement goals and can be a powerful tool in your secure financial future.

How the Plan Works

Priefert offers a 401(k) plan to all eligible employees effective the first of the month following 90 days of employment. Priefert's 401(k) plan contains an automatic enrollment feature. Each employee is automatically enrolled at 6% (Roth 401(k)) of their gross salary. However, an employee may opt-out of the plan or modify their contributions online at www.americanfunds.retirementpartners.com.

Priefert gives you the option of either a Traditional 401(k) or a Roth 401(k). The Traditional 401(k) is funded by pre-tax contributions (which is before Federal taxes are calculated. Earnings are subject to FICA and Medicare taxes). Withdrawals and earnings are subject to Federal and most State income taxes. The Roth 401(k) is funded with after-tax contributions. Withdrawals of contributions and earnings are not taxed provided it's a qualified distribution:

- On account of disability
- On or after death

Company Contribution

Priefert matches $0.50 for every $1.00 up to 6% of Gross Compensation.

Vesting

Employees that have been with the company less than two years will not begin to vest in the Employer contributions made to their 401(k). Once you reach 2 years of service, you will be eligible for vesting rights. Please see chart below for the vesting schedule.

Less than 2 years – 0%
2 years to less than 3 – 25%
3 years to less than 4 – 50%
4 years to less than 5 – 75%
5 or more years – 100%

Investment Options

Employees will have access to invest their contributions and rollover balances in a set selection of Mutual Funds managed by Capital Group-American Funds. If the employee does not make an investment selection, their contributions will be defaulted into a Target Date fund based on the employee's age. Online access with daily valuations will be available. The employer match will be invested in a combined pool managed by Baker Financial. Quarterly valuations will be available online at www.americanfunds.retirementpartner.com.

OTHER BENEFITS



Employee Assistance Program (EAP)

You and your covered dependents have free access to Priefert's Employee Assistance Program (EAP). This confidential service offers free over-the-phone counseling any time, day or night, to help you with a variety of personal issues. The EAP also provides up to 5 free face-to-face counseling sessions for both you and your covered dependents.

Counselors can help with concerns about things like:

- Emotional well-being and mental health
- Relationships and parenting
- Addiction and recovery
- Marital and family problems
- Legal and financial issues

To contact the EAP, call 888-628-4824, 24 hours a day, seven days a week, to talk to a professional counselor. You can also get more information online at **GuidanceResources.com**.
Username: LFGSupport **Password:** LFGSupport1

Allstate Identity Theft Protection

Identity fraud can happen to anyone and now we offer comprehensive identity monitoring and fraud resolution designed to help protect you and your family.

This plan offers:

- Identity, financial account and credit monitoring
- Family digital safety tools to help keep kids safe
- Up to $2 million in identity theft expense reimbursement

ASPCA Pet Insurance

With ASPCA coverage, take your pet to any licensed vet, submit a claim on the app and get reimbursed 70%, 80% or 90% for eligible expenses. Choose the plan that fits your budget, with varying deductibles, maximums and reimbursement percentages. Enroll at any time and pay directly to ASPCA, not through pay deduction.

To enroll and setup direct bill, visit **aspscpetinsurance.com\priefert**

WEEKLY RATES

	Medical Rates (Tobacco Free)	
Annual Earnings	**$0-$55,000**	**$55,000+**
EE Only	$34.00	$52.25
EE + SP	$98.75	$151.00
EE + Child		
Child 1	$53.00	$82.00
Child 2+	$71.75	$110.50
EE + SP + Children		
Child 1	$116.50	$179.75
Child 2+	$135.25	$208.50

Reminder! Tobacco User Surcharge

The tobacco user surcharge is $75 per person per month (employee and/or covered spouse) and will apply to the medical plan premiums in 2027 unless you complete one of the tobacco cessation programs.

Dental Rates	
Tier:	**Contributions**
Employee Only	$6.30
Employee/Spouse	$13.10
Employee/Child(ren)	$14.30
Employee/Family	$23.70

Vision Rates	
Tier:	**Contributions**
Employee Only	$1.43
Employee/Spouse	$2.86
Employee/Child(ren)	$3.32
Employee/Family	$5.10

Accident Insurance Rates	
Tier:	**Contributions**
Employee Only	$2.89
Employee/Spouse	$4.24
Employee/Child(ren)	$5.83
Employee/Family	$7.29

Hospital Indemnity Rates	
Tier:	**Contributions**
Employee Only	$3.14
Employee/Spouse	$6.71
Employee/Child(ren)	$4.86
Employee/Family	$8.80

Critical Illness Rates*				
Age Band	Employee $10,000	Employee $20,000	Spouse $5,000	Spouse $10,000
<24	$0.72	$1.44	$0.26	$0.52
25-29	$0.88	$1.76	$0.34	$0.68
30-34	$1.08	$2.17	$0.45	$0.89
35-39	$1.45	$2.90	$0.63	$1.26
40-44	$2.04	$4.08	$0.92	$1.84
45-49	$2.83	$5.66	$1.32	$2.64
50-54	$3.94	$7.89	$1.87	$3.75
55-59	$5.21	$10.41	$2.51	$5.01
60-64	$7.33	$14.66	$3.57	$7.14
65-69	$10.27	$20.53	$5.04	$10.07
70+	$17.07	$34.14	$8.44	$16.88

**Premium is calculated with the employee's age as of the effective date of the plan and adjusted annually on the plan anniversary date that coincides with or follows the day an employee reaches the starting age of the next age band. Child insurance is automatic if plan is elected for employee, with no separate premium required.*

STD Premium Calculation		Example
		(42-year old employee earning $40,000 a year)
List your weekly earnings	$	$769.23
(Maximum is $2,500)		
Multiply by the Premium Factor		$0.0060923
Your Estimated Weekly Premium	$	$4.69

Short Term Disability	
Age	Premium Factor
0-24	$0.0042923
25-29	$0.0042923
30-34	$0.0042923
35-39	$0.0051231
40-44	$0.0060923
45-49	$0.0067846
50-54	$0.0080308
55-59	$0.0101077
60-64	$0.0124615
65-69	$0.0137077
70+	$0.0137077

LTD Premium Calculation		Example
		(42-year old employee earning $40,000 a year)
List your monthly earnings	$	$3,333.33
(Maximum is $2,500)		
Multiply by the Premium Factor		0.0025154
Your Estimated Weekly Premium	$	$8.38

Long Term Disability	
Age	Premium Factor
0-24	$0.0008077
25-29	$0.0009231
30-34	$0.0013385
35-39	$0.0019385
40-44	$0.0025154
45-49	$0.0035308
50-54	$0.0047769
55-59	$0.0062077
60-64	$0.0062769
65-69	$0.0079846
70-74	$0.0102231
75+	$0.0102231

WEEKLY VOLUNTARY LIFE INSURANCE AND AD&D RATE

Employee Premium Table for Non-Tobacco Users (52 Payroll Deductions Per Year)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0-24	$0.27	$0.53	$0.79	$1.05	$1.32	$1.58	$1.84	$2.10	$2.37	$2.63
25-29	$0.29	$0.58	$0.86	$1.14	$1.43	$1.72	$2.00	$2.29	$2.58	$2.86
30-34	$0.33	$0.67	$0.99	$1.33	$1.66	$2.00	$2.32	$2.66	$2.99	$3.33
35-39	$0.38	$0.75	$1.12	$1.49	$1.87	$2.25	$2.61	$2.99	$3.37	$3.74
40-44	$0.46	$0.93	$1.38	$1.85	$2.31	$2.77	$3.23	$3.69	$4.15	$4.62
45-49	$0.65	$1.30	$1.94	$2.59	$3.24	$3.89	$4.53	$5.18	$5.83	$6.48
50-54	$0.92	$1.83	$2.74	$3.65	$4.57	$5.49	$6.39	$7.31	$8.23	$9.14
55-59	$1.40	$2.80	$4.19	$5.59	$6.99	$8.39	$9.79	$11.19	$12.59	$13.99
60-64	$2.15	$4.30	$6.44	$8.58	$10.73	$12.88	$15.02	$17.17	$19.32	$21.46
65-69	$3.65	$7.31	$10.95	$14.60	$18.26	$21.91	$25.55	$29.20	$32.86	$36.51
70-74	$6.48	$12.96	$19.43	$25.91	$32.39	$38.87	$45.34	$51.82	$58.30	$64.78
75-79	$12.96	$25.92	$38.87	$51.83	$64.79	$77.75	$90.70	$103.66	$116.62	$129.58
80+	$12.97	$25.95	$38.91	$51.89	$64.86	$77.83	$90.80	$103.77	$116.74	$129.72

Employee Premium Table for Tobacco Users (52 Payroll Deductions Per Year)										
Age	**$10,000**	**$20,000**	**$30,000**	**$40,000**	**$50,000**	**$60,000**	**$70,000**	**$80,000**	**$90,000**	**$100,000**
0-24	$0.32	$0.64	$0.95	$1.27	$1.59	$1.91	$2.22	$2.54	$2.86	$3.18
25-29	$0.34	$0.69	$1.02	$1.37	$1.71	$2.05	$2.39	$2.73	$3.07	$3.42
30-34	$0.39	$0.79	$1.17	$1.57	$1.96	$2.36	$2.74	$3.14	$3.53	$3.93
35-39	$0.51	$1.03	$1.53	$2.05	$2.56	$3.08	$3.58	$4.10	$4.61	$5.13
40-44	$0.70	$1.41	$2.10	$2.81	$3.51	$4.21	$4.91	$5.61	$6.31	$7.02
45-49	$1.02	$2.05	$3.06	$4.09	$5.11	$6.14	$7.15	$8.18	$9.20	$10.23
50-54	$1.63	$3.25	$4.87	$6.50	$8.12	$9.75	$11.37	$13.00	$14.62	$16.25
55-59	$2.23	$4.46	$6.68	$8.91	$11.14	$13.37	$15.59	$17.82	$20.05	$22.28
60-64	$3.26	$6.52	$9.77	$13.03	$16.29	$19.55	$22.80	$26.06	$29.32	$32.58
65-69	$5.35	$10.70	$16.04	$21.39	$26.74	$32.09	$37.43	$42.78	$48.13	$53.48
70-74	$9.30	$18.59	$27.88	$37.17	$46.47	$55.76	$65.05	$74.34	$83.64	$92.93
75-79	$16.68	$33.36	$50.03	$66.71	$83.39	$100.07	$116.74	$133.42	$150.10	$166.78
80+	$16.69	$33.37	$50.05	$66.74	$83.42	$100.11	$116.79	$133.48	$150.16	$166.85

Spouse Premium Table (52 Payroll Deductions Per Year)										
Age	**$5,000**	**$10,000**	**$15,000**	**$20,000**	**$25,000**	**$30,000**	**$35,000**	**$40,000**	**$45,000**	**$50,000**
0-24	$0.11	$0.22	$0.33	$0.44	$0.55	$0.66	$0.75	$0.86	$0.97	$1.08
25-29	$0.12	$0.24	$0.36	$0.47	$0.59	$0.71	$0.82	$0.94	$1.06	$1.17
30-34	$0.14	$0.28	$0.42	$0.56	$0.70	$0.84	$0.96	$1.10	$1.24	$1.38
35-39	$0.18	$0.37	$0.55	$0.73	$0.92	$1.10	$1.27	$1.45	$1.64	$1.82
40-44	$0.25	$0.49	$0.74	$0.98	$1.23	$1.47	$1.71	$1.95	$2.20	$2.44
45-49	$0.36	$0.72	$1.08	$1.44	$1.80	$2.16	$2.52	$2.88	$3.24	$3.60
50-54	$0.54	$1.08	$1.62	$2.15	$2.69	$3.23	$3.76	$4.30	$4.84	$5.37
55-59	$0.80	$1.61	$2.41	$3.22	$4.02	$4.82	$5.62	$6.42	$7.22	$8.03
60-64	$1.35	$2.69	$4.04	$5.38	$6.73	$8.08	$9.41	$10.76	$12.11	$13.45
65-69	$2.27	$4.54	$6.81	$9.08	$11.35	$13.62	$15.88	$18.15	$20.42	$22.69

Child Life Premium Table
(52 Payroll Deductions Per Year)
$10,000
$0.17

WEEKLY ALLSTATE ID THEFT RATES

Allstate ID Theft Rates	
Tier:	**Contributions**
Employee Only	$1.60
Employee/Family	$2.99

IMPORTANT CONTACTS

Benefit	Contact	Phone Number
Medical	UMR	800-826-9781
Dental	UMR	800-826-9781
Tobacco Cessation	UMR	800-207-7680
Prescription Coverage	UMR	800-826-9781
COBRA	Chard Snyder	888-993-4646
Vision	VSP	800-877-7195
401(k) Savings Plan	American Funds	800-204-3731
Life, Disability, Critical Illness & Hospital Indemnity	Lincoln Financial	800-423-2765
Accident Coverage	Mutual of Omaha	800-877-5176
Employee Assistance Program (EAP)	Lincoln Financial	888-628-4824 GuideResources.com Username: LFGSupport Password: LFGSupport1
Identity Theft Protection	Allstate	800-789-2720
Pet Insurance	ASPCA	aspcapetinsurance.com/priefert Priority Code: EB24Priefert
Benefits Department	Stephanie Busby	903-572-1741 ext 1137

Health Coverage Notices

For Your Files

This guide contains legal notices for participants in group health plan(s) sponsored by Priefert. The notices included in this guide are:

- ***Health Insurance Marketplace Coverage Options and Your Health Coverage*** *that describes the Health Insurance Marketplace and eligibility and tax credit information.*
- ***Notice of Privacy Practices*** *that explains how the health care plan(s) protect your personal medical information.*
- ***Medicare Part D Notice*** *that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.*
- ***COBRA Rights Notice*** *that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.*
- ***Wellness Program and Reasonable Alternatives Notice*** *that informs employees of what information will be collected, how it will be used, who will receive it, and what will be done to keep it confidential, as well as options for those who have a medical condition that makes wellness program participation difficult.*
- ***60-Day Special Enrollment Period*** *that describes a special 60-day timeframe to elect or discontinue coverage*
- ***Notice of Special Enrollment Rights*** *that explains when you can enroll in the health care plan(s) due to special circumstances.*
- ***Newborn & Mothers Health Protection Notice*** *that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.*
- ***Women's Health and Cancer Rights Act*** *that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.*

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see pages 33 and 34 for more details.

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace's annual Open Enrollment period or if you experience a qualifying life event.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.96% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Priefert Benefits Department at 903-572-1741 ext 1137.

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

PART B: Information About Health Coverage Offered by Your Employer

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

1. Employer name: Priefert Mfg. Co., Inc.	**2. Employer Identification Number (EIN):** 75-1236931	
3. Employer address: 2630 South Jefferson Ave	**4. Employer phone number:** 903-572-1741 ext 1137	
5. City: Mount Pleasant	**6. State:** TX	**7. Zip code:** 75455
8. Who can we contact about employee health coverage at this job? Benefits Department		
9. Phone number: 903-572-1741 ext 1137	**10. E-mail address:** Benefits@priefert.com	

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

As your employer, we offer a health plan to [some/all] employees. Eligible employees are:

- Active, full-time employees regularly working 30 or more hours per week. Employees become eligible on their 90th day of employment.

With respect to dependents, we [do/do not] offer coverage. Eligible dependents are:

- Legal spouse or domestic partner
- Eligible children up to age 26
- Physically or mentally disabled children of any age

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

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

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

Priefert Notice of Privacy Practices

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

Our Company's Pledge to You

This notice is intended to inform you of the privacy practices followed by Priefert (the Plan) and the Plan's legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on *1/1/2027*.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. Priefert requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

Protected Health Information

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

How We May Use Your Protected Health Information

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

Payment. We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

Health Care Operations. We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.

Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as *permitted* by law. We are *permitted* by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when *required* by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of Priefert for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information. If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

Right to an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

Right to Request Restrictions. You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

Right to Request Confidential Communications. You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

Right to Receive a Paper Copy of this Notice. If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

Our Legal Responsibilities

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.

If you have any questions or complaints, please contact:
Priefert's Benefits Department
2630 South Jefferson Ave
Mount Pleasant, Texas 75455
903-572-1741 ext 1137 & Benefits@priefert.com

Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

Important Notice from Priefert About Your Prescription Drug Coverage and Medicare

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

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

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

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

When Can You Join A Medicare Drug Plan?

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

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

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

If you decide to join a Medicare drug plan, your current Priefert coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current Priefert coverage, be aware that you and your dependents may not be able to get this coverage back.

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

You should also know that if you drop or lose your current coverage with Priefert and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice Or Your Current Prescription Drug Coverage...
Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Priefert changes. You also may request a copy of this notice at any time.
For More Information About Your Options Under Medicare Prescription Drug Coverage...
More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.
For more information about Medicare Prescription drug coverage:

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

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).
Remember: Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: 1/1/2027
Name of Entity/Sender: Priefert
Contact/Office: Priefert Benefits Department
Address: 2630 South Jefferson Ave, Mount Pleasant, Texas 75455
Phone Number: 903-572-1741 ext 1137

COBRA Rights Notice

You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.**
When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.
The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.
You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group

health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to Chard Snyder.

How Is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are There Other Coverage Options Besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit

www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

Date: 1/1/2027
Name of Entity/Sender: Priefert
Contact/Office: Priefert Benefits Department
Address: 2630 South Jefferson Ave, Mount Pleasant, Texas 75455
Phone Number: 903-572-1741 ext 1137

Other Notices

Wellness Program and Reasonable Alternatives Notice

Tobacco Cessation is a voluntary wellness program available to all employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the program you will be asked to complete a tobacco cessation program for current tobacco users. You are not required to participate in the tobacco cessation program.

However, employees and covered spouses who choose to participate in the program will avoid the surcharge for each completed portion of the program. Although you are not required to participate, only employees and covered spouses who do so will avoid the surcharge. Please note: If you do not use tobacco, you will avoid the surcharge.

If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting The Priefert Benefits Department at 903-572-1741 ext 1137.

Patient Protection Disclosure

Priefert generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Priefert Benefits Department at 903-572-1741 ext 1137.

For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from Priefert or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Priefert Benefits Department at 903-572-1741 ext 1137.

Reasonable Alternatives

Your health plan is committed to helping you achieve your best health. Rewards for participating in a tobacco cessation program are available to all eligible employees. If you think you might be unable to meet a standard for a reward under the Priefert tobacco cessation program, you might qualify for an opportunity to earn the same reward by different means. Contact The Priefert Benefits Department at 903-572-1741 ext 1137 and we will work with you (and if you wish, with your doctor) to find a tobacco cessation program with the same reward that is right for you in light of your health status.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact The Priefert Benefits Department at 903-572-1741 ext 1137.

60-Day Special Enrollment Period

In addition to the qualifying events listed in the enrollment guide and this document, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

Notice of Special Enrollment Rights

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in Priefert medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment no more than 30 days after your or your dependent's other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in Priefert

medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact The Priefert Benefits Department at 903-572-1741 ext 1137.

Newborn & Mothers Health Protection Notice

For maternity hospital stays, in accordance with federal law, the Plan does not 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 delivery.

However, federal law generally does not prevent the mother's or newborn's attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

Women's Health and Cancer Rights Act of 1998

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

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact The Priefert Benefits Department at 903-572-1741 ext 1137 or your medical plan administrator.