



2026 **Benefit Enrollment**
It's Time To Talk
About Your Benefits



ENROLL FOR 2026 BENEFITS

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Timpte Industries, Inc. is proud to offer a comprehensive benefits package to eligible, full-time employees who work 30 hours per week. This booklet is a summary of the benefits offered. You will receive plan booklets, which give you more detailed information about each of these benefits.

You share the costs of some benefits (medical, dental, vision and voluntary life) and Timpte Industries, Inc. provides other benefits at no cost to you such as life, accidental death & dismemberment, STD and EAP. In addition, there are voluntary benefits with reasonable group rates that you can purchase through payroll deductions.

BENEFITS OFFERED

- Medical
- Dental
- Vision
- Life Insurance
- Accidental Death & Dismemberment (AD&D) Insurance
- Voluntary Life and AD&D
- Short Term Disability
- Voluntary Accident, Critical Illness, Hospital Indemnity
- Voluntary Universal Life with Long Term Care
- Employee Assistance Program
- Health Savings Account (HSA)
- Flexible Spending Accounts (FSA)

ELIGIBILITY

You and your dependents are eligible for Timpte Industries, Inc. benefits on the first of the month following 60 days of employment.

Eligible dependents are your spouse, children under age 26, disabled dependents of any age, or Timpte Industries, Inc. eligible dependents.

Elections made now will remain until the next open enrollment unless you or your family members experience a qualifying event. If you experience a qualifying event, you must contact HR within 30 days of the event.

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 37-39 for more details.

This document is an outline of the coverage provided under your employer's benefit plans based on information provided by your company. It does not include all the terms, coverage, exclusions, limitations, and conditions contained in the official Plan Document, applicable insurance policies and contracts (collectively, the "plan documents"). The plan documents themselves must be read for those details. The intent of this document is to provide you with general information about your employer's benefit plans. It does not necessarily address all the specific issues which may be applicable to you. It should not be construed as, nor is it intended to provide, legal advice. To the extent that any of the information contained in this document is inconsistent with the plan documents, the provisions set forth in the plan documents will govern in all cases. If you wish to review the plan documents or you have questions regarding specific issues or plan provisions, you should contact your Human Resources/Benefits Department.



CONTACT INFORMATION

If you have specific questions about a benefit plan, please contact the administrator listed below, or your local human resources department.

Benefit	Administrator	Phone	Website/Email
Medical	EBMS	866-326-7631	www.miBenefits.ebms.com
Voluntary Dental	Ameritas	800-487-5553	www.ameritas.com
Voluntary Vision	Ameritas	800-659-2223	www.vsp.com
Life, Voluntary Life, Critical Illness, Accident, Hospital Indemnity, EAP	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Short Term Disability	Timpte Human Resources	402-367-6318	hr@timpte.com
Voluntary Universal Life with LTC	Trustmark	800-918-8877	www.TrustmarkVB.com
Human Resources	Laura Sobota/Heather Funkhouser	402-367-6318	hr@timpte.com
Online Enrollment Platform	SMBO	Contact Human Resources	www.timptebenefits.com





EMPLOYEE CONTRIBUTIONS

EMPLOYEE CONTRIBUTIONS FOR BENEFITS

MEDICAL PLAN WELLNESS	MONTHLY
PPO - Platinum Plan	
Employee	\$300.00
Employee + Spouse	\$500.00
Employee + Child(ren)	\$430.00
Family	\$520.00
HDHP – Gold Plan	
Employee	\$40.00
Employee + Spouse	\$170.00
Employee + Child(ren)	\$145.00
Family	\$215.00
PPO – Silver Plan	
Employee	\$50.00
Employee + Spouse	\$200.00
Employee + Child(ren)	\$175.00
Family	\$260.00

MEDICAL PLAN NON-WELLNESS	MONTHLY
PPO - Platinum Plan	
Employee	\$344.00
Employee + Spouse	\$588.00
Employee + Child(ren)	\$474.00
Family	\$608.00
HDHP – Gold Plan	
Employee	\$84.00
Employee + Spouse	\$258.00
Employee + Child(ren)	\$189.00
Family	\$303.00
PPO – Silver Plan	
Employee	\$94.00
Employee + Spouse	\$288.00
Employee + Child(ren)	\$219.00
Family	\$348.00

Wellness Exam Incentive Program

You and your covered spouse will need to complete your wellness exam by **10/31/2025** to continue to receive the wellness discounted rates for **2026**

BENEFIT PLAN	MONTHLY
Dental Rates	
Employee	\$6.06
Employee + Spouse	\$12.18
Employee + Child(ren)	\$16.64
Family	\$22.78
Vision Rates	
Employee	\$5.58
Employee + Spouse	\$11.08
Employee + Child(ren)	\$10.36
Family	\$15.84



MEDICAL & PHARMACY

Administered by EBMS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventing screenings provide a no-cost review of your health if you use an in-network provider. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	PPO – Platinum Plan	HDHP – Gold Plan
	In-Network	In-Network
Lifetime Benefit Maximum	Unlimited	Unlimited
Calendar Year Deductible	\$1,500 single / \$3,000 family	\$3,400 single / \$6,800 family
Calendar Year Out-of-Pocket Maximum	\$5,000 single / \$10,000 family	\$6,000 single / \$12,000 family
Coinsurance	25%	50%
DOCTOR'S OFFICE		
Primary Care Office Visit	\$20 copay	Deductible & Coinsurance
Specialist Office Visit	Deductible & Coinsurance	Deductible & Coinsurance
Preventive Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	Paid at 100%	Paid at 100%
Telehealth	\$10 Copay	Paid at 100%
PRESCRIPTION DRUGS		
Retail—Generic Drug (30-day supply)	\$10 copay	Deductible & Coinsurance
Retail—Formulary Drug (30-day supply)	25% coinsurance; \$70 maximum	Deductible & Coinsurance
Retail—Non-formulary Drug (30-day supply)	25% coinsurance; \$100 maximum	Deductible & Coinsurance
Specialty	25% coinsurance; \$150 maximum	Deductible & Coinsurance
Mail Order—Generic Drug (90-day supply)	\$20 copay	Deductible & Coinsurance
Mail Order—Formulary Drug (90-day supply)	25% coinsurance; \$140 maximum	Deductible & Coinsurance
Mail Order—Nonformulary Drug (90-day supply)	25% coinsurance; \$200 maximum	Deductible & Coinsurance
HOSPITAL SERVICES		
Emergency Room	\$500 copay; waived if admitted	\$500 copay after deductible; copay waived if admitted
Inpatient	Deductible & Coinsurance	Deductible & Coinsurance
Outpatient Surgery	\$100 copay per visit; then Coinsurance; Deductible is waived	Deductible & Coinsurance
Chiropractic Care	\$30 copay	Deductible & Coinsurance



MEDICAL & PHARMACY

Administered by EBMS

Comprehensive and preventive healthcare coverage is important in protecting you and your family from the financial risks of unexpected illness and injury. A little prevention usually goes a long way—especially in healthcare. Routine exams and regular preventing screenings provide a no-cost review of your health if you use an in-network provider. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

	PPO – Silver Plan
	In-Network
Lifetime Benefit Maximum	Unlimited
Calendar Year Deductible	\$4,000 single / \$8,000 family
Calendar Year Out-of-Pocket Maximum	\$8,000 single / \$16,000 family
Coinsurance	25%
DOCTOR'S OFFICE	
Primary Care Office Visit	Paid at 100%
Specialist Office Visit	Deductible & Coinsurance
Preventive Care (routine exams, x-rays/tests, immunizations, well baby care and mammograms)	Paid at 100%
Telehealth	Paid at 100%
PRESCRIPTION DRUGS	
Retail—Generic Drug (30-day supply)	\$0 copay
Retail—Formulary Drug (30-day supply)	25% coinsurance; \$40 maximum
Retail—Non-formulary Drug (30-day supply)	25% coinsurance; \$70 maximum
Specialty	25% coinsurance; \$150 maximum
Mail Order—Generic Drug (90-day supply)	\$20 copay
Mail Order—Formulary Drug (90-day supply)	25% coinsurance; \$140 maximum
Mail Order—Nonformulary Drug (90-day supply)	25% coinsurance; \$200 maximum
HOSPITAL SERVICES	
Emergency Room	\$500 copay; waived if admitted
Inpatient	Deductible & Coinsurance
Outpatient Surgery	\$100 copay per visit; then Coinsurance; Deductible is waived
Chiropractic Care	\$30 copay

miChoice can work for you!

miChoice lets you know before you go:

Know the hospital's quality prior to your scheduled procedure.

Know what the charges will be.

Know that you can avoid potential harm by choosing a hospital and provider based on quality and costs.

and...receive enhanced benefits when you use miChoice

STEPS FOR YOU

STEP 1 >

Connect with EBMS and tell us you want miChoice if you have an expected inpatient surgical procedure or outpatient orthopedic surgery.

STEP 2 >

A miChoice Concierge will walk you through your options for quality, costs, and benefits associated with each possible hospital.

STEP 3 >

Your miChoice Concierge will coordinate with your provider of choice. If travel is necessary, they will handle your travel arrangements.

STEP 4 >

Your Clinical Coordinator, a registered nurse, will also support your medical journey both before and after your procedure.

2000

100,000 Preventable Deaths in Hospitals

TODAY

250,000 Preventable Deaths in Hospitals

John T. James, JournalPatientSafety.com, Lippincott Williams & Wilkins, 2013

Please call us at **866.677.8745** to find the best provider for your healthcare needs.

www.ebms.com

JOIN THE MOVEMENT TOWARD SMARTER HEALTHCARE



miChoice

Most patients do not search for the best surgical facility or provider because they are referred from other doctors or patients via word of mouth. DON'T BE A STATISTIC! miChoice allows a member to see how many times this facility has performed their specific surgery and what the success rate was nationally and compared to others in the area! FIND THE BEST QUALITY FOR YOU!

Understanding miChoice

miChoice is a simple and powerful provider transparency tool and medical concierge service that helps patients select planned inpatient or outpatient services, resulting in better outcomes and lower costs to the patient and plan. While utilizing the miChoice program, you can experience relief and assurance that you are fully informed and able to utilize your medical benefit plan to its maximum potential, while keeping out-of-pocket expenses low. By choosing miChoice, a friendly and knowledgeable EBMS miChoice concierge will provide you with health plan travel benefit details and even help arrange your travel and lodging!

866.677.8745

Choosing a High-Value Medical Provider

We strive to help you find a low-cost, high-quality solution so you can have the best value at your fingertips. Below is an example of a report that your miChoice concierge will deliver to you in order to help you make the best medical provider selection.

Hospital Name	miChoice Cost-Quality Ranking	COST		QUALITY		Clinical Category: Cardiac Surgery (major)
		Targeted Payment	Medicare	State Percentile	National Percentile	
Swedish Covenant Hospital • Chicago, IL	A+	\$51,432	\$33,955	86%	88%	DRG Description: 234 - Coronary Bypass w/ Cardiac Cath. w/o MCC Average Length of Stay: Nine Days
Northwestern Memorial Hospital • Chicago, IL	A	\$55,549	\$37,032	79%	80%	
Saints Mary and Elizabeth Medical • Chicago, IL	A	\$52,278	\$34,852	69%	70%	
Resurrection Hospital Chicago, IL	B	\$53,067	\$35,378	45%	50%	
Rush University Medical Center • Chicago, IL	B	\$67,376	\$44,917	87%	83%	
Advocate Illinois Masonic Medical • Chicago, IL	C	\$62,071	\$41,381	44%	47%	
The University of Chicago Medical • Chicago, IL	C	\$67,683	\$45,122	50%	53%	
University of Illinois Medical Center • Chicago, IL	D	\$75,439	\$50,293	48%	52%	
Mercy Hospital & Medical Center • Chicago, IL	D	\$59,108	\$39,405	23%	27%	
Mount Sinai Hospital Chicago, IL (Out Of Network)	E	\$62,022	\$41,348	15%	17%	

DID YOU KNOW?

An average person has 9.2 medical procedures in his/her lifetime. In 25% of these, he/she will be harmed by hospital medical errors.



New England Journal of Medicine, Mary Maki, Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care

Save with miChoice

TRAVEL REIMBURSEMENT
Travel for you and a companion will be covered!



Call us at 866.677.8745 to find out more about how you can save by using miChoice.

OUT-PATIENT ARTHROSCOPIC SURGERY FOR LATERAL AND MEDIAL MENISCUS TEAR

PHYSICIAN RECOMMENDED FACILITY In Network

- Rated as a "D" Facility by miChoice
- The bottom 13% ranked nationally
- Patient Responsibility (Plus Applicable Deductible) **\$15,500**



UTILIZATION OF MICHoice In or Out of Network

- Rated as an "A" Facility by miChoice
- The top 93% ranked nationally
- Patient Responsibility (Deductible Waived) **\$4,892**

ADDITIONAL BENEFITS

How the Plans Work

All plans use the Aetna network and cover 100% of the cost for preventive care services like annual physicals and routine immunizations. The way you pay for care is different with each plan.

With the HDHP, you pay the full negotiated cost for medical services and prescription drugs until you meet your annual deductible. If you meet the deductible, you and the plan share the costs (coinsurance) until you reach the annual out-of-pocket maximum. After that, the plan pays for 100% of your claims for the rest of the year. Your paycheck deductions for this plan are lower than the PPO plan.

The PPO plan has set copays for some services and a deductible and coinsurance for others. Copays do not apply toward your deductible, so you will pay copays until you reach your annual out-of-pocket maximum. This plan has higher paycheck deductions than the HDHP.

	HDHP	PPO Plan
Per-paycheck Cost for Coverage	\$	\$\$
Annual Deductible	\$\$	\$
Annual Out-of-pocket Maximum	\$\$	\$
Using the Plan	Pay less with each paycheck and more when you need care	Pay more with each paycheck and less when you need care
Spending Account Options	Health savings account (HSA) Dependent care FSA	Health care FSA Dependent care FSA

Paying For Health Care

Timpte offers several ways to set aside pre-tax dollars to pay for medical, prescription drug, dental and vision care expenses. The health care accounts available to you depend on the medical plan you choose.

	HSA	FSA
What medical plan can I choose?	HDHP	PPO plan
What expenses are eligible?	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)	Medical, prescription, dental & vision care (See IRS publication 502 for a full list)
When can I use the funds?	Funds are available as you contribute to the account	All of the funds you elect for the year are available on January 1
Can I roll over funds each year?	Yes, funds roll over from year-to-year and are yours to keep (even if you change jobs)	You may carry over up to \$680 of unused funds at the end of 2026. This will occur automatically unless you choose otherwise.
How do I pay for eligible expenses?	With your Optum debit card (You can also submit claims for reimbursement online at www.optumbank.com)	Claim forms are located in ADP or you may contact Human Resources
How much can I contribute each year?	You can contribute \$4,400 for individual coverage or \$8,750 for family coverage (this total includes company funding) in 2026	You can contribute \$3,400 in 2026
Can I change my contributions throughout the year?	Yes, you can log on to www.optumbank.com to change your HSA contributions at any time	No, unless you have a qualifying life event.

HSA and FSA ADDITIONAL BENEFITS

Everyday Savings & Support

Health Savings Account | Optum

A smart way to manage your medical expenses.

An HSA lets you save tax-free for qualified medical expenses like doctor visits, prescriptions, and lab work—especially before meeting your deductible under the HDHP PPO 3300 plan.

Your 2026 IRS Maximum Contribution Limits	
Employee Only	\$4,400
Employee + Family	\$8,750
Catch Up (Age 55 & Older)	\$1,000

Unused funds roll over year to year and are always yours to keep. You can even invest your balance to save for future healthcare costs—even in retirement. Contributions, earnings, and withdrawals (for eligible expenses) are all tax-free.

HSA Eligibility

To be eligible, you must:

- Be enrolled in the HDHP PPO 3300 plan
- Have no other health coverage (including a spouse's FSA)
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return

Manage, Spend, and Grow Your HSA with Optum Bank

Optum Bank makes it easy to use and grow your HSA. You'll get a debit card, a mobile app to track expenses, and investment options once your balance hits \$2,000.

Need help? Access tools, support, and more at optumbank.com/health-accounts/hsa or scan the QR code to download the app.



Scan here to
download
Optum Bank
app.

Flexible Spending Accounts (FSAs) | Optum

Save on everyday expenses.

FSAs, administered by Optum, let you set aside pre-tax dollars to pay for eligible expenses, reducing your taxable income. You must re-enroll each year during Open Enrollment.

Types of FSAs:

- **Health Care FSA** – For medical, dental, and vision expenses if you're in the PPO 1500 plan. Contribute up to \$3,300 in 2026. Full amount available at the start of the year. Up to \$660 can roll over.
- **Limited Purpose FSA** – For dental and vision only if you have an HSA. Same limits and rollover as the Health Care FSA.
- **Dependent Care FSA** – For childcare or elder care. Contribute up to \$5,000 per household (\$2,500 if married filing separately). Funds available as contributed, no rollover.

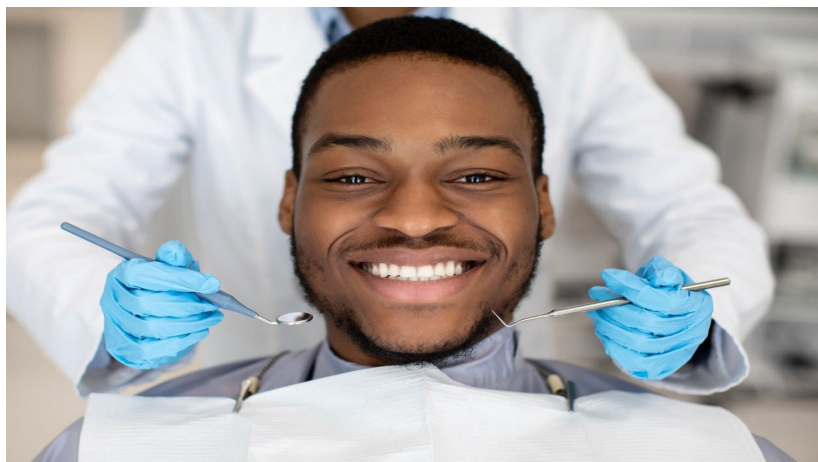


DENTAL BENEFITS

Administered by Ameritas

Good oral care enhances overall physical health, appearance and mental well-being. Problems with the teeth and gums are common and easily treated health problems. Keep your teeth healthy and your smile bright with the Timpte Industries, Inc. dental benefit plan.

SERVICES	IN-NETWORK AND OUT-OF-NETWORK PPO
Calendar Year Deductible	\$50 per person; no family maximum
Calendar Year Benefit Maximum	\$1,500 per calendar year
Preventive Dental Services (cleanings, exams, x-rays)	100%
Basic Dental Services (fillings, root canal therapy, oral surgery)	80%
Major Dental Services (extractions, crowns, inlays, onlays, bridges, dentures, repairs)	50%
Orthodontia Services (covered to age 19)	50% to \$1,500 lifetime maximum
Ameritas Classic Dental Provider Network	www.Ameritas.com/employee-benefits/find-a-provider





VISION BENEFITS

Administered by Ameritas

Regular eye examinations can not only determine your need for corrective eyewear but also may detect general health problems in their earliest stages. Protection for the eyes should be a major concern to everyone.

SERVICE	IN-NETWORK (ANY VSP PROVIDER)	OUT-OF-NETWORK (ANY QUALIFIED NON-NETWORK PROVIDER OF YOUR CHOICE)
Eye Exam — once every 12 months	\$10 copay; covered in full	\$10 copay; up to \$45
LENSES — ONCE EVERY 12 MONTHS		
Single Vision Lenses	Covered in full	Up to \$30
Lined Bifocal Lenses	Covered in full	Up to \$50
Lined Trifocal Lenses	Covered in full	Up to \$65
Lenticular Lenses	Covered in full	Up to \$100
Frames — once every 12 months	Up to \$180	Up to \$90
Contact Lenses — once every 12 months if you elect contacts instead of lenses/frames	Elective Up to \$180 Medically Necessary Covered in full	Elective Up to \$144 Medically Necessary Up to \$210
Laser Vision Care	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. A VSP provider must coordinate the procedure	



VSP Vision Network Provider
www.Ameritas.com/employee-benefits/find-a-provider

Walmart and Sam's Club are out of network

No need for an ID card. To take advantage of your Ameritas vision benefit, simply contact a VSP provider and let them know you have VSP coverage— they handle the paperwork for you.



LIFE & DISABILITY INSURANCE

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Administered by Mutual of Omaha

Life Insurance

Life insurance provides financial security for the people who depend on you. Your beneficiaries will receive a lump sum payment if you die while employed by Timpte Industries, Inc. The company provides basic life insurance at no cost to you. View information in your packet for further details on coverage amounts. In addition, it is very important that you have your beneficiary named.

Accidental Death and Dismemberment (AD&D) Insurance

Accidental Death and Dismemberment (AD&D) insurance provides payment to you or your beneficiaries if you lose a limb or die in an accident. Timpte Industries, Inc. provides AD&D coverage at no cost to you. This coverage is in addition to your company-paid life insurance described above.

Voluntary Life Insurance and AD&D

Insured by Mutual of Omaha

In addition to the company-provided Life coverage Timpte provides you with the opportunity to purchase Supplemental Life and AD&D insurance coverage at group rates. You may purchase insurance for your spouse and dependent children if you purchase additional coverage for yourself. You are guaranteed coverage (up to \$100,000, and up to \$25,000 for your spouse) without answering medical questions if you enroll when you are first eligible.

Employee— Multiples of \$10,000 up to \$300,000

Spouse— Multiples of \$5,000 up to \$300,000; elected amount cannot exceed 100% of Employee elected amount

Children— Multiples of \$2,500 up to \$10,000; elected amount cannot exceed 100% of Employee elected amount

DISABILITY INSURANCE

Timpte Industries, Inc. also provides disability insurance. This benefit replaces a portion of your income if you are unable to work as a result of a non-job illness or injury.

	HOW IT WORKS	WHO PAYS FOR THE BENEFIT
Short-term Disability	You receive 66 2/3% of your income up to \$800 per week. Benefits begin after 8 calendar days of absence from work and continue for up to 26 weeks.	Company

ACCIDENT VOLUNTARY BENEFIT



If you broke a leg, would it break your bank account too?

Don't let an accident catch you off guard. Protect your family's finances with Accident Insurance from United of Omaha Life Insurance Company.

An accident insurance policy supplements your medical coverage and provides a cash benefit for injuries you or an insured family member sustain from an accident. 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 TimpTE Industries, Inc., you may purchase this coverage for yourself and your family members, and premiums can be deducted from your paycheck. It's a simple and affordable way for your family to receive added financial protection.

Coverage guidelines and benefits are outlined below.



This insurance offers financial protection by paying a cash benefit if you or an insured dependent are injured as a result of a covered accident. Unless otherwise stated, the benefit amount payable is the same for you and your insured dependent(s).

ELIGIBILITY - VACC ALL ELIGIBLE EMPLOYEES (MONTHLY)

Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.
PLAN INFORMATION	INFORMATION / AMOUNT(S)
Coverage Type	Non-occupational (Off-job only)
Express Benefit	\$175
Annual Benefit Maximum (ABM)	Not Included

ACCIDENT VOLUNTARY BENEFIT

BENEFITS		AMOUNTS
Initial Care & Emergency¹ – Most treatment / service required within 72 hours of accident; Once per accident per insured person		
Emergency Room		\$400
Urgent Care Center		\$325
Initial Physician Office Visit		\$175
Ambulance		Up to \$2,000
Specified Injuries^{1,2}		
Fractures (Surgical / Non-surgical)		Up to \$12,000/Up to \$6,000
Dislocations (Surgical / Non-surgical)		Up to \$12,000/Up to \$6,000
Lacerations		Up to \$1,500
Burns		Up to \$25,000
Dental		Up to \$400
Hospital, Surgical & Diagnostic^{1,3}		
Admission		\$2,000
Daily Confinement (Up to 365 days per accident)		\$400 per day
ICU Confinement (Up to 15 days per accident)		\$800 per day
Rehab. Facility Confinement (Up to 30 days per accident)		\$300 per day
Surgical		Up to \$5,000
Diagnostic		Up to \$400
Follow-Up Care¹ – Treatment / service required within 365 days of accident; Medical device is once per accident per insured person		
Physician Follow-Up Office Visit		\$150; Up to 6 per accident
Therapy Services		\$75; Up to 6 per accident
Medical Device		\$300
Prosthetic Device(s)		\$1,250; Up to 2 per accident
Additional Benefits¹ – Benefits are payable within 365 days of accident		
Transportation (Up to 3 trips per accident)		\$400 per trip
Lodging (Up to 30 nights per accident)		\$200 per night
Catastrophic Benefits^{1,4} – Benefits are payable within 365 days of accident; Once per accident per insured person		
Principal Sum (PS)		You: \$50,000 Spouse: \$25,000 Child(ren): \$10,000
Common Carrier Accidental Death		300% of PS
Dismemberment & Paralysis		Up to 100% of PS
Reasonable Modifications		Up to 10% of PS
Coma		50% of PS
SERVICES		
Hearing Discount Program	The Hearing Discount program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.	

¹Additional limitations apply as described in the certificate.

²Fractures and dislocations require treatment within 90 days of accident, burns and lacerations within 72 hours of an accident, and dental care within 30 days. If an insured person sustains both a fracture and dislocation as the result of the same accident, the maximum amount payable is up to 200% of the amount payable for the injury with the highest applicable benefit amount.

³Daily confinement must begin within 90 days of accident and ICU confinement within 30 days. Surgical treatment timeframes vary. If applicable, diagnostic services must be received within 90 days of accident. Except for confinement benefits, most benefits are payable once per accident per insured person. If any surgery occurs concurrently with an open reduction for a fracture or dislocation of the same bone or joint as a result of the same accident, only the highest applicable benefit is payable.

⁴The principal sum for you and your spouse reduces by 50% when you reach the age of 70.

ACCIDENT VOLUNTARY BENEFIT

> How Accident Insurance Works

(For Illustration Purposes Only)



Accident Coverage

This insurance pays a benefit for each injury, treatment or service included in the policy that occurs as the result of a covered accident.

For example, Jeff's son, Jake, was playing soccer during recess at school. He was tripped and falls hard, injures his shoulder, and is transported by ambulance to the ER due to concerns of head trauma. The ER doctor orders a CT scan to check for any facial or head injuries and a shoulder X-ray.

Jake was diagnosed with a concussion and a broken collarbone. His arm was set in a sling, and he was released to his pediatrician for follow-up care. Jake visits his pediatrician at two weeks and one month after the accident to make sure he's healing well.

In the meantime, Jeff starts receiving bills for the care Jake received. The ambulance bill alone was \$556. He's a pretty healthy kid, so a health insurance deductible of \$1,500 had to be met before Jeff's health insurance would begin covering Jake's care, and after that, there's a 20% copay.

Accident benefits pay in addition to other insurance, and can be used to help cover gaps in health insurance or other expenses if the unexpected happens.

BENEFITS	AMOUNT
Ambulance	\$200
ER Visit	\$150
CT Scan	\$200
X-ray	\$50
Concussion	\$150
Broken Collarbone	\$300
Follow-Up Visit 1	\$75
Follow-Up Visit 2	\$75
Total Benefit	\$1,200

Note: The benefits shown in this example are for a sample design and may vary from the benefits that are available to you.

Voluntary Accident Premium Rates

The amounts shown below are **MONTHLY** amounts (12 payments / deductions per year). You may elect insurance for you only, or for your family. Premiums will be automatically deducted from your paychecks as authorized by you during the enrollment process. Premiums must be paid by you to the policyholder.

COVERAGE TIER	PREMIUM AMOUNT
Employee/Member	\$8.35 (\$0.27 per day)
Employee/Member + Spouse	\$12.46 (\$0.41 per day)
Employee/Member + Child(ren)	\$18.08 (\$0.59 per day)
Employee/Member + Family	\$23.75 (\$0.78 per day)

Note: The amount(s) above may vary due to rounding and are subject to change based on the final terms of the policy.

ACCIDENT VOLUNTARY BENEFIT

> Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 30 hours per week and be under age 80
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital / care facility) and any child(ren) must be under age 26

Can I insure my domestic partner or civil union partner?

Any reference to “spouse” includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the country, city or local government in your jurisdiction of residence.

What is the “Express Benefit”?

This benefit is payable upon notification of an accident in which an insured person is injured. It can be paid in a short time frame with minimal information (compared to a typical claim).

When does this insurance end?

Insurance will end on the last day of the month in which an insured person no longer satisfies the applicable eligibility conditions, or when you reach the age of 80. Additional circumstances under which insurance will end are described in the certificate.

Are there any exclusions or limitations?

The benefits payable are based on the insurance in effect on the date of the covered accident, subject to the definitions, limitations, exclusions and other provisions of the policy. The exclusions and limitations are summarized in the outline of coverage and detailed in the certificate. Please contact your benefits administrator for a copy of the outline of coverage or if you have questions prior to enrolling.

CRITICAL ILLNESS VOLUNTARY BENEFIT



An unexpected critical illness can have a lasting impact on you and your family – physically, emotionally and financially.

As an active employee of Timppte Industries, Inc., you can give your family the extra security they need to lessen the financial impact of a serious illness by purchasing Critical Illness insurance through United of Omaha Life Insurance Company.

A critical illness insurance policy provides a lump-sum cash benefit upon diagnosis of a critical illness like a heart attack, stroke or cancer. The benefit can be used to pay out-of-pocket expenses or to supplement your daily cost of living.

How much insurance is enough?

Even if you have the best health insurance plan, it will not cover 100 percent of medical expenses. You also need to consider other expenses associated with the recovery process – time off work, travel to treatment centers, home modifications – that may quickly deplete your savings.

Coverage guidelines and benefits are outlined in the chart below.



ELIGIBILITY - ALL ELIGIBLE EMPLOYEES

Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or children to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you. Child insurance is automatic. A separate premium is not required.

CRITICAL ILLNESS VOLUNTARY BENEFIT

CONDITIONS ¹		% OF CI PRINCIPAL SUM	
Heart Attack		100%	
Stroke		100%	
Coronary Artery Bypass		25%	
Major Organ Transplant/Placement on UNOS List		100%	
End-Stage Renal Failure		100%	
Cancer (Invasive)		100%	
Carcinoma in Situ		25%	
COVERAGE GUIDELINES ²			
	MINIMUM	MAXIMUM	GUARANTEE ISSUE ³
For You Elect in \$10,000 increments	\$10,000	\$30,000	\$30,000
Spouse Elect in \$10,000 increments	\$10,000	100% of employee's CI Principal Sum, up to \$30,000	\$30,000
Child(ren) *benefit for each child	25% of employee's CI Principal Sum, up to \$5,000		\$5,000
ADDITIONAL BENEFITS			
Policy Benefit Maximum	The maximum payout amount is 200% of the CI Principal Sum amount for each insured person. If the policy benefit maximum is reached for an insured person, the coverage will terminate. Dependents will remain insured if you continue to satisfy the eligibility requirements of the policy.		
Health Screening Benefit	Pays a flat, annual benefit of \$50 for a health screening test.		
Reoccurrence Benefit	The reoccurrence benefit is equal to 100% of the Critical Illness principal sum.		
CONDITIONS & LIMITATIONS			
Benefit Waiting Period	There is no benefit waiting period.		
SERVICES			
Hearing Discount Program	The Hearing Discount Program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.		
Advocacy	Advocacy services give an employee who has been diagnosed with a medical condition access to skilled clinicians and nurses for personalized, problem-solving assistance in a one-on-one setting. Call 1-866-372-5577 Monday – Friday 7 A.M. to 7 P.M. CST or email careadvocates@gilsbar.com for assistance.		

¹Payment of a partial benefit reduces the remaining amount payable.

²The amount of insurance for your spouse and child(ren) will be rounded to the next higher multiple of \$1,000, if not already an even multiple of \$1,000.

³Guarantee Issue is available to new hires. Amounts over the Guarantee Issue will require a health application/evidence of insurability. For late entrants, all amounts will require a health application/evidence of insurability. Amounts over the Guarantee Issue and/or not meeting minimum participation levels will require a health application/evidence of insurability.

CRITICAL ILLNESS VOLUNTARY BENEFIT

Voluntary Critical Illness Coverage Selection and Premium Calculation

Please note that the premium amounts presented below may vary slightly from the amounts provided on your enrollment form, due to rounding.

The premium rates for employees under this plan are contingent upon tobacco use. If you have used tobacco in any form (cigarettes, chewing tobacco, forms of nicotine replacement, etc.) during the last 12 months, you must refer to the tobacco premium table. If not, refer to the non-tobacco premium table.

To select your benefit amount and calculate your premium, do the following:

- 1) Locate the benefit amount you want from the top row of the employee premium table (tobacco or non-tobacco). Your benefit amount must be in an increment of \$10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

- 2) Find your age bracket in the far left column.
- 3) Your premium amount is found in the box where the row (your age) and the column (benefit amount) intersect.
- 4) Enter the benefit and premium amounts into their respective areas in the Voluntary Critical Illness section of your enrollment form.

If the benefit amount you want to select is greater than any amount in the table below, select the benefit amount from the top row that when multiplied by another number results in the benefit amount you want to select. For example, if you want \$20,000 in coverage, you obtain your premium amount by multiplying the rate for \$10,000 times 2.

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE PREMIUM RATES FOR NON-TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)

Age	\$10,000	\$20,000	\$30,000
0 - 29	\$1.00	\$2.00	\$3.00
30 - 39	\$2.05	\$4.10	\$6.15
40 - 49	\$5.05	\$10.10	\$15.15
50 - 59	\$10.85	\$21.70	\$32.55
60 - 69	\$22.25	\$44.50	\$66.75
70 - 79	\$42.70	\$85.40	\$128.10
80+	\$59.95	\$119.90	\$179.85

VOLUNTARY CRITICAL ILLNESS EMPLOYEE OR SPOUSE PREMIUM RATES FOR TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)

Age	\$10,000	\$20,000	\$30,000
0 - 29	\$1.05	\$2.10	\$3.15
30 - 39	\$2.55	\$5.10	\$7.65
40 - 49	\$7.75	\$15.50	\$23.25
50 - 59	\$19.95	\$39.90	\$59.85
60 - 69	\$46.75	\$93.50	\$140.25
70 - 79	\$84.30	\$168.60	\$252.90
80+	\$107.30	\$214.60	\$321.90

Child dependent coverage is offered at no additional cost.

Follow the method described above to select a benefit amount and calculate premiums for optional dependent spouse coverage. **Your spouse's rate is based on your age**, so find your age bracket in the far left column of the Spouse Premium Table. Your spouse's premium amount is found in the box where the row (the age) and the column (benefit amount) intersect. Your spouse's benefit amount must be in an increment of \$10,000. Refer to the Coverage Guidelines section for minimums and maximums, if needed.

CRITICAL ILLNESS VOLUNTARY BENEFIT

SPOUSE PREMIUM RATES FOR NON-TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)			
Age	\$10,000	\$20,000	\$30,000
0 - 29	\$1.00	\$2.00	\$3.00
30 - 39	\$2.05	\$4.10	\$6.15
40 - 49	\$5.05	\$10.10	\$15.15
50 - 59	\$10.85	\$21.70	\$32.55
60 - 69	\$22.25	\$44.50	\$66.75
70 - 79	\$42.70	\$85.40	\$128.10
80+	\$59.95	\$119.90	\$179.85

SPOUSE PREMIUM RATES FOR TOBACCO USERS (24 PAYROLL DEDUCTIONS PER YEAR)			
Age	\$10,000	\$20,000	\$30,000
0 - 29	\$1.05	\$2.10	\$3.15
30 - 39	\$2.55	\$5.10	\$7.65
40 - 49	\$7.75	\$15.50	\$23.25
50 - 59	\$19.95	\$39.90	\$59.85
60 - 69	\$46.75	\$93.50	\$140.25
70 - 79	\$84.30	\$168.60	\$252.90
80+	\$107.30	\$214.60	\$321.90

CRITICAL ILLNESS VOLUNTARY BENEFIT

> Frequently Asked Questions

Who is eligible for this insurance?

- You must be actively working (performing all normal duties of your job) at least 30 hours per week
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital / care facility) and any child(ren) must be under age 26

Can I insure my domestic partner or civil union partner?

Any reference to “spouse” includes your domestic partner, civil union partner or equivalent, as recognized and allowed by applicable federal law, state law, or law of the country, city or local government in your jurisdiction of residence.

What is the reoccurrence benefit?

Once benefits have been paid for a Critical Illness, a reoccurrence benefit is payable one time for a subsequent diagnosis of the same Critical Illness, subject to certain conditions. The reoccurrence benefit is equal to 100% of the Critical Illness principal sum.

Are there any limitations or exclusions?

Benefits are not payable for any Critical Illness that:

- Is diagnosed prior to the effective date of insurance under the Policy for the Insured Person
- Results, whether the insured person is sane or insane, from an intentionally self-inflicted injury or illness, suicide, or attempted suicide
- Results from an act of declared or undeclared war or armed aggression
- Is incurred while the insured person is on active duty or training in the Armed Forces, National Guard or Reserves of any state or country and for which any governmental body or its agencies are liable
- Results from illegal activities, including participation in an illegal occupation
- Is the result of the voluntary use of illegal drugs by an insured person; the intentional misuse of over the counter medication or prescription drugs by an insured person that is not in accordance with recommended dosage and/or warning instruction(s); or the excessive or harmful use of alcohol and/or alcoholic drinks by an insured person
- Is diagnosed outside of the United States

All exclusions may not be applicable, or may be adjusted, as required by state regulations.

HOSPITAL INDEMNITY VOLUNTARY BENEFIT



When you're hospitalized, expenses can add up quickly.

Hospital stays can be stressful and having to worry about the high costs of hospitalization should not be part of the recovery plan. Hospital Indemnity insurance helps to ease your mind about handling hospitalization costs – even if they are not hospital bills.

A hospital indemnity insurance policy supplements 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 TimpTe Industries, Inc., you have hospital indemnity coverage for yourself and your family members, and premiums can be deducted from your paycheck. Hospital indemnity supplements your existing health insurance coverage by helping pay for out-of-pocket expenses incurred due to an injury or illness that may not be covered under other insurance plans.



Coverage guidelines and benefits are outlined below.

This insurance offers financial protection by paying a cash benefit if you or an insured dependent are hospitalized. The benefit amount payable is the same for you and your insured dependent(s).

ELIGIBILITY - ALL ELIGIBLE EMPLOYEES

Eligibility Requirement	You must be actively working a minimum of 30 hours per week to be eligible for coverage.
Dependent Eligibility Requirement	To be eligible for coverage, your dependents must be able to perform normal activities, and not be confined (at home, in a hospital, or in any other care facility), and any child(ren) must be under age 26. In order for your spouse and/or child(ren) to be eligible for coverage, you must elect coverage for yourself.
Premium Payment	The premiums for this insurance are paid in full by you.

HOSPITAL INDEMNITY VOLUNTARY BENEFIT

BENEFITS		AMOUNTS
Hospital Admission & Confinement - Admission benefits are payable up to a combined total of 2 days per policy year and are not payable on the same day; Confinement benefits are payable up to a combined total of 30 days per policy year unless otherwise noted and are not payable on the same day as Hospital/ICU admission benefits.		
Hospital Admission		\$1,000 per admission
Daily Hospital Confinement		\$100 per day
ICU Admission		\$2,000 per admission
Daily ICU Confinement		\$200 per day
Daily Newborn Nursery Care Confinement (Up to 2 days per policy year)		\$75 per day
SERVICES		
Hearing Discount Program	The Hearing Discount program provides you and your family discounted hearing products, including hearing aids and batteries. Call 1-888-534-1747 or visit www.amplifonusa.com/mutualofomaha to learn more.	

VOLUNTARY HOSPITAL INDEMNITY PREMIUM RATES

The amounts shown below are **MONTHLY** amounts (12 payments/deductions per year). You may elect insurance for you only, or for your family. Premiums will be automatically deducted from your paychecks as authorized by you during the enrollment process.

COVERAGE TIER	PREMIUM AMOUNT
Employee/Member	\$21.37 (\$0.70 per day)
Employee/Member + Spouse	\$49.16 (\$1.62 per day)
Employee/Member + Child(ren)	\$29.50 (\$0.97 per day)
Employee/Member + Family	\$58.99 (\$1.94 per day)

Note: The amount(s) above may vary due to rounding and are subject to change based on the final terms of the policy.

HOSPITAL INDEMNITY VOLUNTARY BENEFIT

Frequently Asked Questions

Who is eligible for this insurance?

To be eligible for this insurance:

- You must be actively working (performing all normal duties of your job) at least 30 hours per week and be under age 80
- Your dependent(s) must be performing normal activities and not be confined (at home or in a hospital/care facility) and any child(ren) must be under age 26

Is hospitalization due to childbirth covered?

Yes, maternity is covered under this policy.

What are “Express Benefits”?

This benefit is payable upon notification of an insured person’s hospital or ICU admission. It can be paid in a short time frame with minimal information (compared to a typical hospital or ICU admission claim).

In the event this insurance ends due to a change in your employment / membership status with the group, or for certain other reasons, you or your insured spouse have the right to continue this insurance under the Portability provision, subject to certain conditions.

When does this insurance end?

Insurance will end when an insured person no longer satisfies the applicable eligibility conditions, or when you reach the age of 80. Additional circumstances under which insurance will end are described in the certificate.

Are there any exclusions or limitations?

The benefits payable are subject to the following:

- Treatment for injury or sickness must occur on or after the insured person’s coverage effective date and while the policy is in force. The benefit amounts payable are based on the type and amount of insurance in effect on the date treatment of injury or sickness occurs, subject to the definitions, limitations, exclusions and other provisions of the policy.
- The exclusions and additional limitations are summarized in the outline of coverage and detailed in the certificate.

All exclusions may not be applicable, or may be adjusted, as required by state regulations. Please contact your benefits administrator for a copy of the outline of coverage or if you have questions prior to enrolling.

UNIVERSAL LIFE WITH LTC VOLUNTARY BENEFIT

Trustmark Universal Life

Trustmark's fully portable Universal Life solutions address differing needs for permanent life insurance and provide peace of mind for a lifetime. These options include the industry's most comprehensive Living Benefits package, with benefits for long-term care services. Our plans are available for you and your dependents. You can choose face amounts from \$5,000 up to \$300,000*.

Plan Features

Trustmark Universal Life

Universal Life provides flexible benefits, allowing you to adjust your death benefit, cash value and premiums as your financial needs change. In addition, this two-in-one coverage includes benefits for long-term care services that you can access during your lifetimes to help pay for the high cost of LTC.

Trustmark Universal LifeEvents®

Benefits Designed for a Lifetime

An innovative concept in life insurance, Universal LifeEvents is uniquely designed to match your needs throughout your lifetime. Universal LifeEvents pays a higher death benefit during your working years, when expenses are high and families need maximum protection. At age 70 (or the 15th policy anniversary, whichever is later), when financial needs are typically lower, the death benefit reduces to one third. However, higher benefits for LTC never reduce — they continue for the life of the policy, to help meet one's greater need for LTC in retirement.

How LifeEvents Works

Example: Universal LifeEvents with LTC benefit, 35-year-old nonsmoker, \$8/week premium

	LifeEvents	Traditional UL
Face Amount	\$57,376	\$36,820
Ages 35 to 70		
Death Benefit	\$57,376	\$36,820
Living Benefit	\$57,376	\$36,820
Age 70+		
Living Benefit	\$57,376	\$36,820
Death Benefit 1/3 of face amount	\$19,125	\$36,820

UNIVERSAL LIFE WITH LTC VOLUNTARY BENEFIT

Long-Term Care (LTC): Built-in

- Designed to accelerate Death Benefit at 4% per month for up to 25 months to pay for long-term care in an assisted living or long-term care facility, or home health care or adult day care.
 - In most states, no benefit will be paid for any condition during the six (6) months immediately prior to the Effective Date of this rider or pay benefits for loss due to a pre-existing condition that starts during the first six (6) months after the application date for this rider.
- Payments proportionately reduce the death benefit
With a death benefit of \$100,000, \$4,000 per month is available for up to 25 months to help pay for long-term care.

Death Benefit Restoration: Built-in

- Fully restores the death benefit reduced by LTC each time a benefit is paid.
- Allows beneficiaries to receive the full death benefit.
For a policy valued at \$100,000, the policy will have doubled in value – \$100,000 paid in LTC benefits if all 25 months of LTC are paid, plus \$100,000 in restored death benefit.

Extension of LTC: Built-in

- Extends LTC benefits up to 25 months, allowing the insured to receive LTC benefits for a total of up to 50 months.
For a policy valued at \$100,000, the benefit period and benefit amount double: up to \$200,000 which is paid over a period of up to 50 months.

Combination Restoration/Extension

Combining Benefit Restoration and LTC Extension of Benefits can as much as **triple the policy value.**

When offering one or both of our Universal Life products, the above riders are available to employees and spouses through age 70 and children through age 22 for Universal Life and to employees and spouses through age 64 for Universal LifeEvents.

Terminal Illness Benefit

Accelerates 75% of death benefit amount when life expectancy is 24 months or less, as compared with 50% and 6- or 12-month life expectancies commonly seen in the industry.

Interim Coverage

Trustmark's Universal Life coverage begins as soon as an eligible employee applies for the approved coverage amount. No need to wait until the effective date for coverage to begin.

UNIVERSAL LIFE WITH LTC VOLUNTARY BENEFIT

Eligibility

	Universal Life	Universal LifeEvents
Employees, actively at work Full-time (37+ hours per week) employed at least	Ages 18 to 75 60 days	Ages 18 to 64* 60 days
Spouses	Ages 18 to 70	Ages 18 to 64

- Children – Through the age of 22, who are biological, adopted, stepchildren, or children under legal guardianship. ±
- Grandchildren - Grandchildren through the age of 18 are eligible for standalone coverage but are not eligible for the child term rider.±

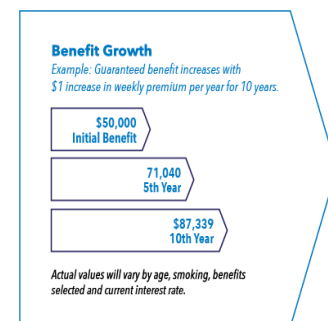
±Only eligible for the standard Universal Life Insurance plan.

*If offering our Universal LifeEvents insurance plan, an alternative plan will be offered to employees age 65 to 75.

Additional Benefits

EZ Value Plan: Employee Built-In Opt Out

- Inflation-fighting options for employees and spouses, underwritten at time of application same as base plan.
- Guaranteed increases to both LTC and death benefits – without underwriting, at time of increase.
- Automated change process is convenient for employers.
- Employees and spouses through age 60 – additional premium of \$1 per week on each of the first 10 anniversaries.
(LifeEvents - All death benefit increases resulting from EZ Value increases will reduce to one-third upon the later of the insured reaching age 70 or policy year 15.)



UNIVERSAL LIFE WITH LTC VOLUNTARY BENEFIT

Rates

Monthly Rates

Trustmark Universal LifeEvents®

Long Term Care, Benefit Restoration, Extension of Benefits

Non-Smoker Rates - Defined Benefit							
Issue Age	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000
	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium
35	20.92	24.09	36.79	52.67	68.54	84.42	100.29
45	32.71	38.21	60.21	87.71	115.21	142.71	170.21
55	54.69	64.59	104.17	153.65	203.13	252.61	302.09

Smoker Rates - Defined Benefit							
Issue Age	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000
	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium
35	28.50	33.19	51.96	75.42	98.88	122.34	145.79
45	49.26	58.06	93.30	137.34	181.38	225.42	269.46
55	95.76	113.86	186.30	276.84	367.38	457.92	548.46

Rates

Monthly Rates

Trustmark Universal Life

Long Term Care, Benefit Restoration, Extension of Benefits

Non-Smoker Rates - Defined Benefit							
Issue Age	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000
	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium
35	29.44	34.32	53.84	78.23	102.63	127.02	151.42
45	47.01	55.36	88.80	130.59	172.38	214.17	255.96
55	78.42	93.06	151.63	224.84	298.05	371.26	444.46

Non-Smoker Rates - Defined Benefit							
Issue Age	\$25,000	\$30,000	\$50,000	\$75,000	\$100,000	\$125,000	\$150,000
	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium	Monthly Premium
35	29.44	34.32	53.84	78.23	102.63	127.02	151.42
45	47.01	55.36	88.80	130.59	172.38	214.17	255.96
55	78.42	93.06	151.63	224.84	298.05	371.26	444.46

EMPLOYEE ASSISTANCE PROGRAM

Employee Assistance Program (EAP)

Available Services When You Help The Most

Timpte Industries, Inc. - G000C6VJ



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

Visit the Employee Assistance Program website to view timely articles and resources on a variety of financial, well-being, behavioral, and mental health topics. MutualofOmaha.com/EAP or call 800-316-2796

FREE AND CONFIDENTIAL to ALL Timpte Employees, Spouses, and Children (up to age 25)

Enhanced EAP Services:

Features	Value to Company and Employees
Employee Family Clinical Services	- An in-house team of Master's level EAP professionals who are available 24/7/365 to provide individual assessments - Outstanding customer service from a team dedicated to ongoing training and education in employee assistance matters - Access to subject matter experts in the field of EAP service delivery
Counseling Options	Three sessions per year (per household) conducted by either face-to-face* counseling or video telehealth via a secure, HIPAA compliant portal
Exclusive Provider Network	- National network of more than 10,000 licensed clinical providers - Network continually expanding to meet customer needs - Flexibility to meet individual client/member needs
Access	1-800 hotline with direct access to a Master's level EAP professional 24/7/365 services available - Telephone support available in more than 120 languages - Online submission form available for EAP service requests - EAP professionals will help members develop a plan and identify resources to meet their individual needs
Employee Family Legal Services	- Valuable resources – legal libraries, tools and forms – available on EAP website - A counseling session may be substituted for one legal consultation (up to 30 minutes) with an attorney 25% discount for ongoing legal services for same issue
Employee Family Financial Services	- Inclusive financial platform powered by Enrich that includes financial assessment tools, personalized courses, articles and resources, and ongoing progress reports to help members monitor their financial health - A counseling session may be substituted for one financial consultation (up to 30 minutes) with an attorney 25% discount for ongoing financial services for same issue
Employee Family Work/Life Services	- Child care resources and referrals - Elder care resources and referrals
Online Services	- An inclusive website with resources and links for additional assistance, including: - Current events and resources - Family and relationships - Emotional well-being - Financial wellness - Substance abuse and addiction - Bilingual article library - Legal assistance - Physical well-being - Work and career
Employee Communication	All materials available in English and Spanish
Coordination with Health Plan(s)	EAP professionals will coordinate services with treatment resources/providers within the employee's health insurance network to provide counseling services covered by health insurance benefits, whenever possible



Since 1884

RETIREMENT SAVINGS PLAN

RETIREMENT SAVINGS PLAN

The most convenient way to save for your future is through payroll deductions deposited into your 401(k) account!

Employee Contributions

Contributions are made up to the IRS annual limit. If applicable, you can elect to make catch-up contributions in addition to the IRS annual limit. Employees are eligible to make contributions at the first of the month, following 120 days of service.

- Traditional 401(k) (Pre-Tax): Elections are deducted from your paycheck before taxes. Your investment grows tax-deferred and will be taxed upon a distribution.
- Roth 401(k): Elections are taken out after calculating income taxes. Earnings are generally tax free at distribution.

Matching Program

As part of TimpTe's company mission of rewarding and recognizing employees, after a year of service employees will receive a company match. TimpTe contribution 100% of your election up to 4%.

Vesting Schedule

Employees are fully vested with contributions put in by themselves. Employer contributions follow the vesting schedule of 50% after 2 years of employment and 100% after 3 years.

Planning

Log on to the Principal website or call 800-547-7754 to update your contributions, view your balance, and change your investments. Any changes made to contributions will be made at the first of the following month.

If you need assistance with a rollover from a previous company, contact Principal.

GET STARTED



Visit principal.com/welcome.

NAVIGATE



See your account anytime, anywhere with the Principal® app.
Visit principal.com/onthego (disponible en español).

SEEK OUT



Call us at **800-547-7754**. Retirement specialists are available to help Monday through Friday, 7 a.m. to 9 p.m. CT.

See your account
anytime, anywhere



Download the Principal® app
Available in both English & Spanish

principal.com/onthego



ANNUAL NOTICES

WOMEN'S HEALTH & CANCER RIGHTS ACT

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

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

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the plan. Therefore, the following deductibles and coinsurance apply:

Plan 1: PPO Plan (Individual: 25% coinsurance and \$1,500 deductible; Family: 25% coinsurance and \$3,000 deductible)

Plan 2: HDHP Plan (Individual: 50% coinsurance and \$3,300 deductible; Family: 50% coinsurance and \$6,000 deductible)

Plan 3: PPO Plan (Individual: 25% coinsurance and \$4,000 deductible; Family: 25% coinsurance and \$8,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 402-367-6318 or JSobota@timppte.com.

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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

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

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

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

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

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2025. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	CALIFORNIA – Medicaid
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	FLORIDA – Medicaid
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtprecovery.com/flmedicaidtprecovery.com/hipp/index.html Phone: 1-877-357-3268

GEORGIA – Medicaid	INDIANA – Medicaid
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 678-564-1162, Press 2	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	LOUISIANA – Medicaid
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPPPROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/la hipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
MAINE – Medicaid	MASSACHUSETTS – Medicaid and CHIP
Enrollment Website: https://www.mymaineconnection.gov/benefits/s/?language=en_US Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid	MISSOURI – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	NEBRASKA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178

NEVADA – Medicaid Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	NEW HAMPSHIRE – Medicaid Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPPA program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	NEW YORK – Medicaid Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	NORTH DAKOTA – Medicaid Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	OREGON – Medicaid and CHIP Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP Website: https://www.pa.gov/en/services/dhs/apply-for-medicare-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	RHODE ISLAND – Medicaid and CHIP Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct Rite Share Line)
SOUTH CAROLINA – Medicaid Website: https://www.scdhhs.gov Phone: 1-888-549-0820	SOUTH DAKOTA - Medicaid Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid Website: Health Insurance Premium Payment (HIPPA) Program Texas Health and Human Services Phone: 1-800-440-0493	UTAH – Medicaid and CHIP Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid Website: Health Insurance Premium Payment (HIPPA) Program Department of Vermont Health Access Phone: 1-800-250-8427	VIRGINIA – Medicaid and CHIP Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	WEST VIRGINIA – Medicaid and CHIP Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPPA (1-855-699-8447)
WISCONSIN – Medicaid and CHIP Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	WYOMING – Medicaid Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2025, or for more information on special enrollment rights, contact either:

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

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

Paperwork Reduction Act Statement

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

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

OMB Control Number 1210-0137 (expires 1/31/2026)

HIPAA NOTICE OF PRIVACY PRACTICES REMINDER

Protecting Your Health Information Privacy Rights

Timpte Industries, Inc. is committed to the privacy of your health information. The administrators of the Timpte Industries, Inc. Health Plan (the “Plan”) use strict privacy standards to protect your health information from unauthorized use or disclosure.

The Plan’s policies protecting your privacy rights and your rights under the law are described in the Plan’s Notice of Privacy Practices. You may receive a copy of the Notice of Privacy Practices by contacting Laura Sobota - Payroll and Benefits Manager at 402-367-6318 or LSobota@timpte.com.

HIPAA SPECIAL ENROLLMENT RIGHTS

Timpte Industries, Inc. Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Timpte Industries, Inc. Health Plan (to actually participate, you must complete an enrollment form and pay part of the premium through payroll deduction).

A federal law called HIPAA requires that we notify you about an important provision in the plan - your right to enroll in the plan under its “special enrollment provision” if you acquire a new dependent, or if you decline coverage under this plan for yourself or an eligible dependent while other coverage is in effect and later lose that other coverage for certain qualifying reasons.

Loss of Other Coverage (Excluding Medicaid or a State Children’s Health Insurance Program).

If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment within 30 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage).

Loss of Coverage for Medicaid or a State Children’s Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children’s health insurance program is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents’ coverage ends under Medicaid or a state children’s health insurance program.

New Dependent by Marriage, Birth, Adoption, or Placement for Adoption. 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 new dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Eligibility for Premium Assistance Under Medicaid or a State Children's Health Insurance Program – 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 this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance.

To request special enrollment or to obtain more information about the plan's special enrollment provisions, contact Laura Sobota - Payroll and Benefits Manager at 402-367-6318 or LSobota@timplte.com.

Important Warning

If you decline enrollment for yourself or for an eligible dependent, you must complete our form to decline coverage. On the form, you are required to state that coverage under another group health plan or other health insurance coverage (including Medicaid or a state children's health insurance program) is the reason for declining enrollment, and you are asked to identify that coverage. If you do not complete the form, you and your dependents will not be entitled to special enrollment rights upon a loss of other coverage as described above, but you will still have special enrollment rights when you have a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan, as described above. If you do not gain special enrollment rights upon a loss of other coverage, you cannot enroll yourself or your dependents in the plan at any time other than the plan's annual open enrollment period, unless special enrollment rights apply because of a new dependent by marriage, birth, adoption, or placement for adoption, or by virtue of gaining eligibility for a state premium assistance subsidy from Medicaid or through a state children's health insurance program with respect to coverage under this plan.

NOTICE OF CREDITABLE COVERAGE

Important Notice from TimpTE Industries, Inc.

About Your Prescription Drug Coverage and Medicare

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

If you do decide to join a Medicare drug plan and drop your current Group 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 TimpTE Industries, Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

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

For More Information About This Notice or Your Current Prescription Drug Coverage...

Contact the 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 TimpTE Industries, Inc. changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

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

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

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

Date:	January 01, 2026
Name of Entity/Sender:	Timpte Industries, Inc.
Contact—Position/Office:	Laura Sobota - Payroll and Benefits Manager
Office Address:	100 Timpte Parkway, PO Box 347 David City, Nebraska 68632 United States
Phone Number:	402-367-6318

MARKETPLACE NOTICE

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options in your geographic area.

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

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

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

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

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

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

² An employer-sponsored or other employment-based health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs. For purposes of eligibility for the premium tax credit, to meet the "minimum value standard," the health plan must also provide substantial coverage of both inpatient hospital services and physician services.

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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

PART B: Information About Health Coverage Offered by Your Employer

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

3. Employer name TimpTE Industries, Inc.		4. Employer Identification Number (EIN) 22-1696742	
5. Employer address 100 TimpTE Parkway, PO Box 347		6. Employer phone number 402-367-6318	
7. City David City		8. State Nebraska	9. ZIP code 68632
10. Who can we contact about employee health coverage at this job? Laura Sobota			
11. Phone number (if different from above)		12. Email address LSobota@timpTE.com	

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

- As your employer, we offer a health plan to:
 - ☒ All employees. Eligible employees are: Full time working at least 30 hours per week
 - ☐ Some employees. Eligible employees are:
- With respect to dependents:
 - ☒ We do offer coverage. Eligible dependents are: Spouse and dependent children
 - ☐ We do not offer coverage.
- ☒ If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.
 - ** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, [HealthCare.gov](https://www.healthcare.gov) will guide you through the process.

Disclaimer

The amount the plan pays for covered services provided by non-network providers is based on a maximum allowable amount for the specific service rendered. Although your plan stipulates an out-of-pocket maximum for out-of-network services, please note the maximum allowed amount for an eligible procedure may not be equal to the amount charged by your out-of-network provider. Your out-of-network provider may bill you for the difference between the amount charged and the maximum allowed amount. This is called balance billing and the amount billed to you can be substantial. The out-of-pocket maximum outlined in your policy will not include amounts in excess of the allowable charge and other non-covered expenses as defined by your plan. The maximum reimbursable amount for non-network providers can be based on a number of schedules such as a percentage of reasonable and customary or a percentage of Medicare. The plan document or carrier's master policy is the controlling document, and this Benefit Highlight does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual plan language. Contact your claims payer or insurer for more information.

This document is an outline of the coverage proposed by the carrier(s), based on information provided by your company. It does not include all of the terms, coverage, exclusions, limitations, and conditions of the actual contract language. The policies and contracts themselves must be read for those details. Policy forms for your reference will be made available upon request.

The intent of this document is to provide you with general information regarding the status of, and/or potential concerns related to, your current employee benefits environment. It does not necessarily fully address all of your specific issues. It should not be construed as, nor is it intended to provide, legal advice. Questions regarding specific issues should be addressed by your general counsel or an attorney who specializes in this practice area.



Gallagher

Insurance | Risk Management | Consulting



This benefit summary prepared by



Insurance | Risk Management | Consulting