OMAHA TRACK

Employee Benefits Presentation

January 1 – December 31, 2026

2026

WELCOME

We are pleased to offer a comprehensive array of valuable benefits to protect your health, family and way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

Eligibility

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your biological children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage. Your children are eligible for medical, dental, and vision coverage until the end of he month in which they turn 26. Life insurance will end when your child reaches age 26 unless the child is disabled and meets certain requirements.

Coverage Begins

- **New Hires:** You must complete enrollment within 30 days of your date of hire. If you enroll on time, coverage is effective first of the month following 60 days of employment. If you fail to enroll on time, you will NOT have benefits coverage (except for company-paid benefits) until you enroll during our next annual Open Enrollment period.
- **Open Enrollment:** Changes made during Open Enrollment are effective January 1, 2026.

Coverage Ends

Medical, dental, and vision coverage for you and your family will end on the last day of the month in which your employment with the Company ends or you lose full-time eligibility status.

Choose Carefully

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualifying life event during the year. Following are examples of the most common qualifying life events:

- Marriage or divorce
- Birth or adoption of a child
- Death of a spouse or child
- Lost coverage under your spouse's plan
- You gain access to state coverage under Medicaid or The Children's Health Insurance Program

Making Changes

To change your benefit elections, you must contact Human Resources within 30 days of the qualifying life event. Be prepared to show documentation of the event, such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to change your elections.

INSIDE

ENROLLMENT

Go to www.omahatrack.com/benefits. There you will find detailed information about the plans available to you and instructions for enrolling.

Required Information—You will be required to enter a Social Security number (SSN) for all covered dependents when you enroll. The Affordable Care Act (ACA) requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.

TAKE A LOOK INSIDE

Health

Medical
Dental
Vision

Wealth

Health Savings Account (HSA)
Health Reimbursement Account (HRA)
401(k)
Life Insurance
Disability Insurance
Voluntary Benefits

Wellbeing

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Perks

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Resources

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WELCOME!

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits.

Benefits At-a-Glance

Coverage	Carrier
Medical	Blue Cross Blue Shield of Nebraska
Dental	Ameritas
Vision	Ameritas/VSP
Health Savings Account (HSA)	Fidelity
Health Reimbursement Account (HRA)	PointC
401(k)	Fidelity
Basic Life/AD&D	Mutual of Omaha
Supplemental Life/AD&D	Mutual of Omaha
Short-Term Disability	Mutual of Omaha
Long-Term Disability	Mutual of Omaha
Accident Insurance, Critical Illness, Hospital Indemnity	Mutual of Omaha
Identity Theft	Allstate Identity Protection
Employee Assistance Program (EAP)	CuraLinc
Telehealth	NewBenefits and Telescope

OPEN ENROLLMENT DETAILS

Remember, Open Enrollment is an opportunity to make changes to your benefits without a qualifying life event. During this time, you can:

- Add, cancel or change your coverage
- Add or remove eligible family members
- Elect your 2026 HSA contributions

MARK YOUR CALENDARS

Open Enrollment Begins:

November 17, 2025

Deadline to Enroll:

November 30, 2025

Benefits in Effect:

January 1, 2026

Click here to watch a video about Open Enrollment.

Important Changes

Each year the Company reviews our benefits program to ensure our partners provide comprehensive and affordable coverage. This year, we're pleased to announce new offerings for our employees to help you better manage your health and well-being in the new year.

2026 Updates At-a-Glance

- Unless you take action, your current benefit elections will roll over.
- You will see a slight increase to your premiums.
- We have improved our vision coverage to include a frames and contact lenses allowance of $150, was $130 in 2025, and you are now able to use that allowance every 12 months instead of every 24 months.
- You will have the option to enroll in Identity Theft Protection at your own cost.

HOW TO ENROLL

Enroll Through ADP

Enrolling in benefits is easy. ADP is available 24 hours a day, seven days a week, so you can visit the site anytime and anywhere you have computer access.

Step 1:

Access the Employee Self Service Web site.

Note: If this is your first time logging in, or you need help getting started, click the appropriate link for instructions and assistance.

Step 2:

Click User **Login**.

Enter your **User ID** and **Password**.

Note: To retrieve a lost User ID or Password, click the appropriate link for online Help.

Step 3:

Click **Log In**.

Step 4:

Click **Start Enrollment** on Enrollment Splash Page or navigate to Enrollment screen by clicking on **Myself > Benefits > Enrollments.**

After You Enroll

Save or print a copy of your Enrollment Summary after making your coverage selections. Review it thoroughly to ensure that your benefit elections have been recorded correctly.

If there are any errors, contact the HR Department immediately at dulce@omahatrack.com so the necessary corrections can be made. Errors that are not reported by the communicated deadline cannot be corrected. Your next opportunity to correct any errors will be during the next annual Open Enrollment or within 30 days of experiencing a Qualifying Life Event.

Benefits Website

Our benefits website www.omahatrack.com/benefits can be accessed anytime you want additional information on our benefit programs.

QUESTIONS?

For questions about any of your benefits, contact Dulce Cortes at 402-932-4794 or dulce@omahatrack.com.

HEALTH

MEDICAL COVERAGE

HDHP + HSA

The HDHP + HSA (High-Deductible Health Plan + Health Savings Account), provided through Blue Cross Blue Shield of Nebraska, is an insurance plan that typically offers lower premiums and higher deductibles. The highlight of this plan is that it allows you to open an HSA, which is a tax-advantaged personal savings account that lets you save pre-tax dollars to pay for any qualified health-related expenses (state taxation rules may apply). This includes most medical care and services, prescriptions, dental, vision and expenses related to meeting the plan's deductible. For a complete list of qualified health-related expenses, visit Publication 502.

Individuals with HDHPs normally pay a lower amount each month but pay more on their yearly medical expenses before their insurance policy begins paying. You can visit any doctor, hospital or other health care provider you want, with greater cost savings in-network.

How You Pay for Services

- You pay the full cost of non-preventive health care services and prescription drugs until you meet the annual deductible. The deductible is waived for in-network routine preventive care services and medications on the preventive drug list.
- The HDHP includes copays for prescription drugs only. You must meet the annual deductible before prescription copays apply.
- Once you meet the annual deductible, you pay a percentage of your health care expenses (coinsurance), and the plan pays the rest.
- Once your deductible and coinsurance add up to the out-of-pocket maximum, this plan pays the full cost of all qualified health care services for the rest of the year.

MEDICAL COVERAGE

Following is a high-level overview of your medical plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductible and out-of-pocket maximum are per plan year.

To locate an in-network provider, visit: myNebraskablue.com

Key Benefits	HDHP + HSA	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family)	$6,350/$12,700	$10,000/$20,000
Out-of-Pocket Max (Individual/Family)	$6,350/$12,700	$12,700/$25,400
Office Visits (physician/specialist)	100% after deductible is met	30% after deductible is met
Routine Preventive Care	Plan pays 100%	30% after deductible is met
Diagnostics (lab/X-ray)	100% after deductible is met	30% after deductible is met
Complex Imaging	100% after deductible is met	30% after deductible is met
Chiropractic	100% after deductible is met	30% after deductible is met
Ambulance	100% after deductible is met	30% after deductible is met
Emergency Room	100% after deductible is met	100% after deductible is met
Urgent Care Facility	100% after deductible is met	30% after deductible is met
Inpatient Hospital Stay	100% after deductible is met	30% after deductible is met
Outpatient Surgery	100% after deductible is met	30% after deductible is met

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. The deductible is embedded. This means that once a family member meets their individual deductible, the plan will begin to pay coinsurance for that family member.
3. The out-of-pocket maximum is embedded. This means that, once an individual family member meets their out-of-pocket maximum, that individual's expenses are covered at 100%.

HEALTH REIMBURSEMENT ACCOUNT (HRA)

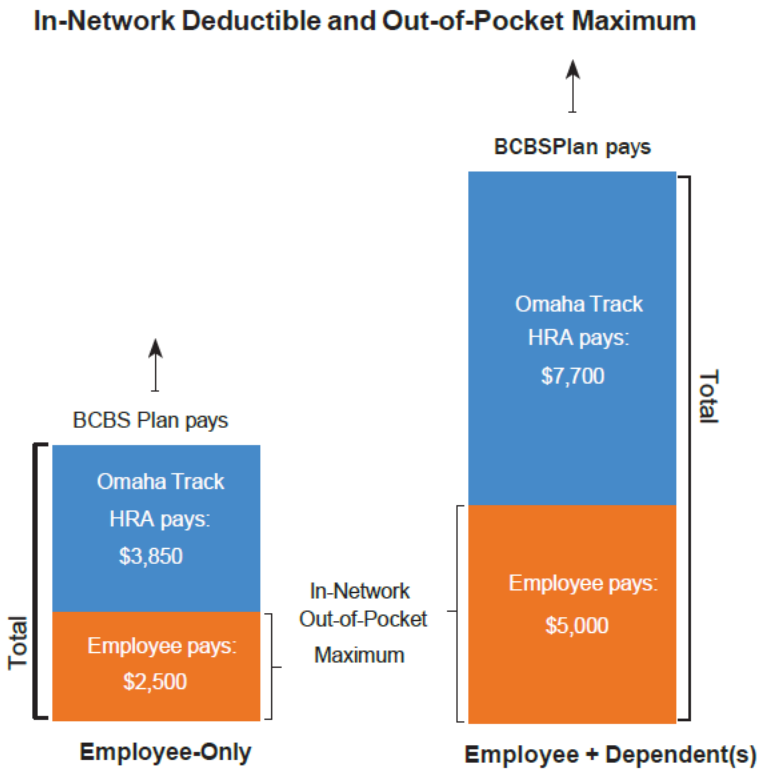
We provide a health reimbursement account (HRA) through PointC. An HRA is an employer-funded account from which you are reimbursed tax-free for qualified medical expenses, up to a fixed dollar amount per year. The Company funds and owns the arrangement.

How the HRA Works

- When you enroll in the HRA, the Company contributes to your account based on the coverage level you elect.
- You may use these funds to pay for qualified out-of-pocket health care expenses, such as doctor's visits and prescription drugs.
- When you incur a qualified health care expense, you may submit a claim for reimbursement. The Company will then reimburse you using funds from your account.

HRA Contributions

Coverage Tier	2026 Company Contribution to your HRA
Individual	$3,850
Family	$7,700



Click here to watch a video about how an HRA works.

PREVENTIVE CARE

What is Preventive Care?

Regular preventive care can help you stay well, catch problems early on and may be potentially lifesaving. The ACA requires that certain preventive care services are provided for no cost, copayment or coinsurance. All medical plans cover preventive care services like screenings, immunizations and exams. When you visit in-network providers, you don't have to worry about any out-of-pocket costs for preventive care services. If you use an out-of-network provider, a deductible and out-of-network expenses may apply.

Preventive vs. Diagnostic Care

Preventive care is generally precautionary. For example, if your doctor recommends having a colonoscopy because of your age or family history, this would be considered preventive care. But if your doctor recommends a colonoscopy to investigate symptoms you're having, this would be considered diagnostic care, and your plan cost share will apply.

Click here to watch a video about preventive care.

TELESCOPE - TELEHEALTH

Quality care when you need it, where you need it.

With your Blue Cross Blue Shield of Nebraska health care coverage, you can access telehealth services anytime, day or night. A simple video chat or phone call connects you to their innovative telehealth service, where board-certified physicians are ready to assist with unexpected health issues or guide you on treating sudden injuries.

What do sinus infections, earaches and twisted ankles have in common? They generally don't conveniently happen during regular office hours. Consider using your telehealth benefit for situations like:

- A toddler who comes home from daycare with a rash and sudden fever
- Your teenaged track runner is worried they've pulled a hamstring
- You've been fighting off a cold, but you're concerned it's becoming something more serious
- You are not feeling like yourself – maybe anxious or depressed

MORE INFORMATION LINKED HERE

To view your Telescope offerings, scan the code or visit myNebraskaBlue.com, or call the telehealth number on the back of your ID card.

Getting started with online mental health care: Your guide to success.

Taking the first step towards mental health care is a significant and courageous decision. You have access to mental health care through secure video appointments, so you can get professional mental health support from the comfort of your home. It includes consultations, therapy sessions, medication management and follow-up care.

MORE INFORMATION LINKED HERE

24/7 Nurse Navigation: Helping you navigate the complex world of healthcare.

Access the Blue Cross nurse navigation team, from the comfort of your home. The 24/7 Nurse Line helps patients:

- **Over-the-Counter Medication Guidance:** Get advice on proper use, dosage and interactions
- **Health Education:** Learn about chronic conditions, prevention and wellness
- **Medication:** Get help with side effects, interactions and symptoms
- **Viral Illness Support:** Manage symptoms and home care recommendations
- **Primary Care Referrals:** Offer a list of trusted providers to choose from for establishing primary care
- **Urgency Evaluation:** Determine if urgent care, primary care, or virtual care is needed
- **Home Care Advice:** Offer practical guidance for minor injuries and illnesses
- **Work and School Excuse:** Assist with obtaining necessary documentation

MORE INFORMATION LINKED HERE

You must be enrolled in the Blue Cross Blue Shield of NE medical plan to utilize the Telescope benefit offerings.

Click here to watch a video about how telehealth works.

NEWBENEFITS - TELEHEALTH

Enjoy On-Demand Health Care with 24/7 Access to Doctors by Phone or Video.

General Medical

- Doctors offer a diagnosis, treatment options, and prescription, **if medically necessary for a $15 visit fee**
- Treatment for common medical issues such as colds, flu, poison ivy, respiratory infections, bronchitis, pink eye, sinus problems, allergies, UTI, and ear infections
- Includes spouse and dependents – from children to seniors
- U.S. board-certified doctors with an average 20 years practice experience
- If you are caring for an aging parent or loved one, **you can provide them access to $49 visits**

Nutrition

- Registered dieticians help you develop a personalized eating plan or manage health conditions like diabetes or high blood pressure
- **$59 per consultation**

Dermatology

- Upload images for a quick, convenient, and discreet treatment plan within two business days for skin conditions such as rash, acne, psoriasis, suspicious moles, and more
- $75 per consultation, plus one follow-up question

To utilize this benefit, you must be enrolled in at least ONE of the following lines of coverage through Omaha Track: Medical, Dental, and/or vision.

Download the **My Benefits Work Mobile App**
800.800.7616 | **MyBenefitsWork.com**

PRESCRIPTION COVERAGE

Retail Pharmacy

When you fill a prescription at a participating retail pharmacy, you may purchase up to a 30-day supply. At the participating pharmacy, you will need to present your ID card and an applicable payment. Most major pharmacies are in our plan's pharmacy network. To find a participating pharmacy near you, visit www.nebraskablue.com.

Specialty Program

With a rare or complex medical condition (e.g., cancer, hepatitis, hemophilia, rheumatoid arthritis or HIV), the appropriate use of specialty medications can be critical to maintaining or improving a patient's health and quality of life. We use the Prime program to make these medications accessible and cost effective for plan members. It provides focused, specialized support to individuals with complex medical conditions that often require multiple specialty medication therapies.

Save Money on Medications

Ask for Generic Drugs

You can save money by asking for generic drugs. The FDA requires that generic drugs have the same high quality, strength, purity and stability as brand-name drugs. The next time you need a prescription, ask your doctor to prescribe a generic drug if it is available and appropriate.

Use Mail Order

If you require regular medication for a long-term or chronic condition, such as arthritis or diabetes, you can save money by using your plan's mail-order service.

Key Benefits	HDHP + HSA	
	In-Network	Out-of-Network
Retail Pharmacy		
Generic	100% after deductible is met	50% after deductible is met
Preferred Brand	100% after deductible is met	50% after deductible is met
Non-Preferred Brand	100% after deductible is met	50% after deductible is met
Specialty	100% after deductible is met	Not covered

Click here to watch a video about prescription drug coverage.

DENTAL COVERAGE

PPO

The dental Preferred Provider Organization (PPO) plan, provided through Ameritas, offers you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a dentist who participates in the Ameritas network. **Employees on the medical plan receive dental coverage at no employee cost. Employees who waive medical can still elect dental benefits.**

Dental Rollover Option

Your dental plan offers a dental rollover option which allows you to carry forward up to $250 annually of your unused annual dental plan with a maximum of $1,000 by submitting at least one claim for dental expenses during the benefit year, if benefits do not exceed $500 in the calendar year. You can continue to carry forward unused funds year to year, up to a fixed limit. See your dental plan summary for more information.

To find an in-network provider, visit www.ameritas.com

Following is a high-level overview of your dental plan options. For complete coverage details, please refer to the Summary Plan Description (SPD). **Note:** The deductibles and annual benefit maximums are per calendar year.

Key Benefits	PPO	
	In-Network	Out-of-Network[1]
Deductible (Individual/Family) (waived Type 1)	$25	$50
Annual Benefit Maximum (per person)	$1,500	$1,500
Preventive Services	No charge	No charge
Basic Services	No charge	20%
Major Services	40%	50%
Orthodontic Services (Child & Adult)	50%	50%

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
*Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.

VISION COVERAGE

Vision Plan

Your eyesight is an integral part of your overall health and a key component of safety. This plan, provided through Ameritas, gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and lower your out-of-pocket costs if you choose a provider who participates in the VSP network. If you decide to use an out-of-network provider, you will pay the provider in full at the time of your appointment and submit a claim form for reimbursement up to the amount allowed by the plan.

Receiving benefits from a network provider is as easy as making an appointment with the provider of your choice from the list of providers. The provider will coordinate all necessary authorizations you supply in your membership information.

Special discounts are offered on non-covered services, such as an additional pair of glasses, special lens options and LASIK.

To find an in-network provider, visit www.ameritas.com

Following is a high-level overview of your vision plan options. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Benefits	VSP Choice Network	
	In-Network	Out-of-Network Reimbursement
Deductible	$10 exam	$10 exam
Exam (once every 12 months)	$10 exam copay then covered in full	$10 exam copay then an additional copay up to $45
Materials Copay	$25	$25
Frames (once every 12 months)	$150 allowance	Up to $70
Lenses (once every 12 months)		
Single Vision	Covered in full	Up to $30
Bifocal		Up to $50
Trifocal		Up to $65
Contact Lenses (in lieu of glasses; once every 12 months)		
Medically Necessary	Covered in full	Up to $210
Elective	Up to $150	Up to $105

WEALTH

HEALTH SAVINGS ACCOUNT (HSA)

The HDHP features an HSA provided through Blue Cross Blue Shield of Nebraska. The HSA lets you set aside pre-tax dollars to help offset your annual deductible and pay for qualified health care expenses.

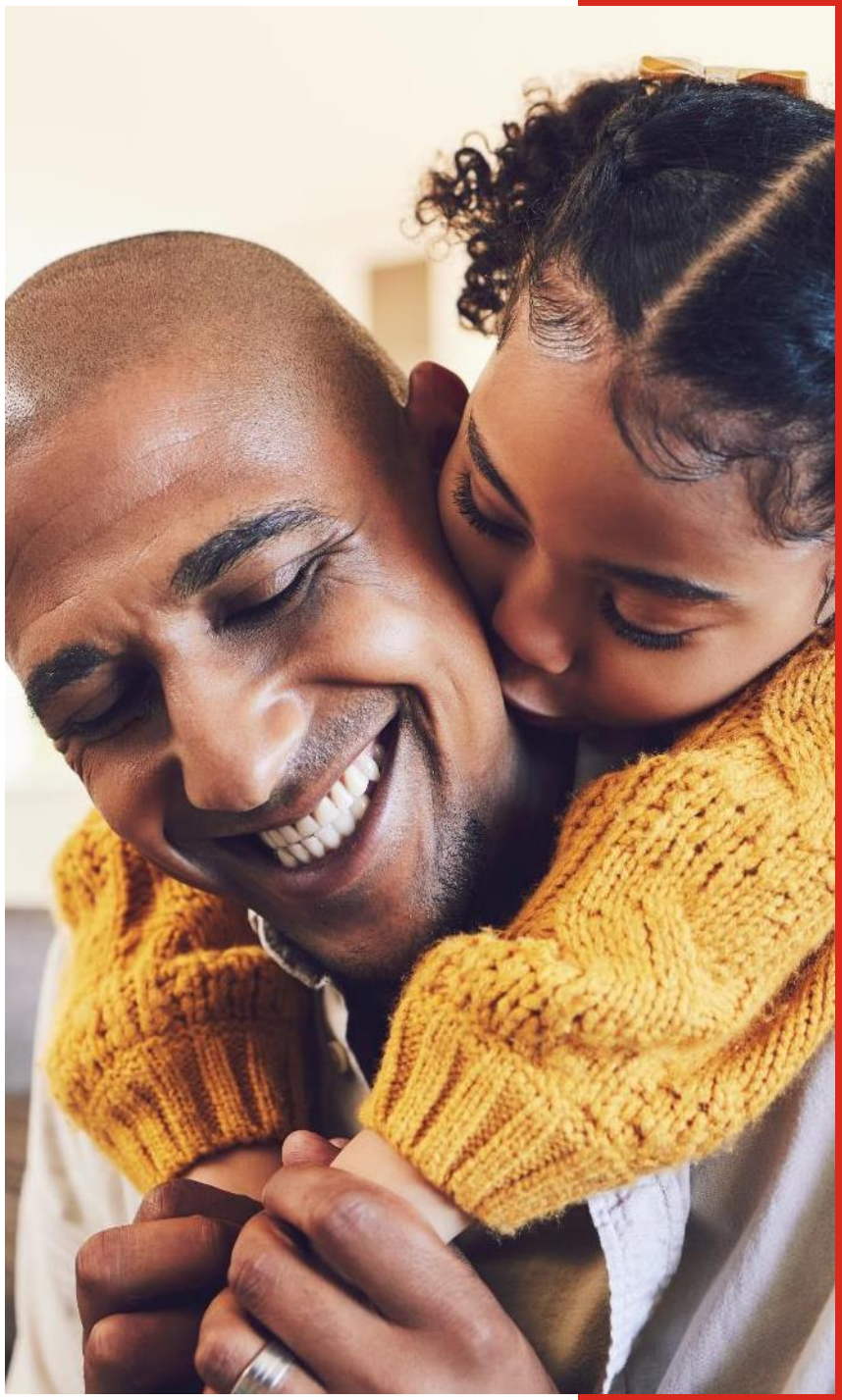
How the HSA Works

- You contribute pre-tax dollars through automatic payroll deductions or make after-tax contributions that are deductible when you file your taxes.
- The Company contributes the following amounts annually to your HSA account to help it grow:
  - **Employee only coverage: $100 when the account is first opened + up to $300 employer match each year**
  - **Employee + dependent(s) coverage: $150 when the account is first opened + up to $600 employer match each year**
- You may change your contributions at any time throughout the year.
- You can withdraw HSA funds tax free to pay for current qualified health care expenses, or save them for the future, also tax free. Unused funds roll over from year to year and are yours to keep, even if you change medical plans or leave your employer.

Contribution Limits

Coverage Tier	2025	2026
Individual	$4,300	$4,400
Family	$8,550	$8,750
Catch-up Contributions	$1,000	$1,000

Click here to watch a video about HSA limits. *(ER cont.)*



HEALTH SAVINGS ACCOUNT (HSA)

Key Features of the HSA

Triple-Tax Advantage

- You contribute funds pre-tax through convenient payroll deductions. This means the money comes out of your paycheck before income tax is calculated. So, you get to keep a bigger portion of your paycheck.
- HSA funds grow tax free, and unused funds roll over year to year. So, the more you save, the more your account will grow—just like a bank savings account.
- If you need to use your HSA funds, you can withdraw them tax free to pay for qualified health care expenses now and in the future—even in retirement.

Control

You own and control the money in your HSA. You decide how or whether you want to spend it. You can use it to pay for doctor's visits, prescriptions, braces, glasses—even laser vision correction surgery.

Investment Opportunities

Once you reach and maintain a minimum threshold, you can make investments to help your money grow tax free.

Savings Potential

Your HSA is like a "health care 401(k)." There is no "use it or lose it" rule. Your account grows over time as you continue to roll over unused dollars from year to year.

Portability

Your HSA is yours for life. The money is yours to spend or save, even if you change health plans,[1] retire or leave the organization.

Preventive Medications List

If you are enrolled in an HSA-compatible medical plan, you may be able to access a range of preventive medications for a copay or coinsurance before meeting your deductible. These medications are contained in the HSA Preventive Drug List provided by your employer.

Qualified Health Care Expenses

- Qualified medical, dental and vision expenses not covered by the plans, as defined by the IRS in Publication 502
- COBRA premiums
- Qualified long-term care insurance and expenses
- Health insurance premiums when receiving unemployment compensation
- Medicare and retiree health insurance premiums (not Medicare Supplement premiums)
- Medigap insurance premiums

Important Notes

- You must meet certain eligibility requirements to have an HSA: You a) must be at least 18 years old, b) must be covered under a qualified HDHP, c) must not be enrolled in Medicare and d) cannot be claimed as a dependent on another person's tax return. For more information, please refer to IRS Publication 969.
- Adult children must be claimed as dependents on your tax return for their medical expenses to qualify for payment or reimbursement from your HSA.

1. You must be enrolled in an IRS-qualified high-deductible health plan to contribute to an HSA.

Click here to watch a video about how an HSA works.

401(K) RETIREMENT SAVINGS ACCOUNT

According to experts, you should aim to have 70–80% of your pre-retirement income saved by the time you retire. With help from the 401(k) provided through Fidelity, you can help secure your financial future.

The Basics

- The 401(k) is a tax-advantaged savings account that lets you save money for retirement.
- You can contribute either pre-tax or after-tax tax funds through automatic payroll deductions.

Plan Eligibility

- All regular full-time employees are eligible to participate in the Omaha Track, Inc. 401(k) Plan as of the first of the month following 60 days of employment. Regular part-time employees are eligible once they have met the service and hours requirement under the Plan.

Employer Match and Vesting

The Omaha Track, Inc. 401(k) Plan contains an auto-enrollment provision, which means unless you actively elect to participate in the Plan or "waive "participation, you will automatically default to participation with a 4% pre-tax contribution level.

Employees may contribute up to the maximum amount allowed by law under Code Section 402(g) and 415, which for 2026 is $23,500 (the 2026 IRS contribution limits have not been released). Employee contributions up to 18% of compensation will be eligible for employer match. Omaha Track matches employee contributions (excluding incentives and bonuses) with pre-tax dollars as shown below.

- 100% of the first 1% of your contribution, plus
- 50% of the next 9% of your contribution, plus
- 25% of the next 8% of your contribution

Employees age 50 and older are also eligible to elect catch-up contributions to the Plan up to a maximum of $7,500 (the 2026 IRS contribution limits have not been released). per year for 2025, and not exceed the maximum contribution allowed by law under Code 402(g) and 415. Catch-up contributions are not eligible for employer match.

Roth 401(k) Option

In addition to the traditional 401(k), the Company also offers a Roth 401(k) option. Unlike a traditional 401(k), you contribute after-tax funds, which means the money you put into the account has already been taxed. Once you retire, any withdrawals you make from your account are tax free, provided:

- The withdrawal is a qualified distribution.
- You've held the account for at least five years.
- The withdrawal is made due to a disability, on or after your death or once you turn age 59 ½.

Click here to watch a video about how a retirement plan works.

LIFE INSURANCE

Life insurance, provided through Mutual of Omaha, provides your named beneficiaries with a benefit following your death, while accidental death and dismemberment (AD&D) insurance provides a benefit to you following a covered accident that leads to dismemberment (such as the loss of a hand, foot or eye). Should your death occur due to a covered accident, both the life benefit and the AD&D benefit would be payable.

Basic Life and AD&D (employer-paid)

Term life insurance, provided through Mutual of Omaha, offers temporary coverage for a period of 10, 20 or 30 years—hence its name. Your designated beneficiaries will then receive a death benefit if you die within the term of your policy. However, your beneficiaries will not receive the benefit if you live past the policy term. Because term life insurance doesn't build cash value that you can borrow against, it is a lower cost alternative to permanent or whole life insurance.

Coverage Tier	Benefit Amount
Employee	$50,000

Supplemental Life and AD&D (employee-paid)

If you determine you need more than the basic coverage, you may purchase additional insurance for yourself and your eligible family members.

Coverage Tier	Benefit Amount	Guaranteed Issue Amount
Employee	5x annual salary, up to $150,000	$150,000
Spouse	100% of employee's benefit, up to $30,000	$30,000
Child(ren)	100% of employee's benefit, up to $10,000	

Note: During your initial eligibility period, you can secure coverage up to the Guaranteed Issue limits without the need for Evidence of Insurability (EOI, or information about your health). Please note that coverage amounts requiring EOI will only go into effect once the insurance carrier approves them.

Click here to watch a video about how life insurance works.

DISABILITY INSURANCE

Disability insurance, provided through Mutual of Omaha, provides benefits that replace part of your lost income when you cannot work due to a covered illness or injury.

Short-Term Disability

Provided at NO COST to you.	
Benefit	60% of weekly salary
Maximum weekly benefit	$1,500
When benefit begins	After 14th day of disability
When benefit ends	11 weeks

Long-Term Disability

Provided at NO COST to you.	
Benefit	60% of monthly salary
Maximum monthly benefit	$10,000
When benefit begins	After 90th day of disability
When benefit ends	Social Security Normal Retirement Age (SSNRA)

Click here to watch a video about how disability insurance works.

VOLUNTARY BENEFITS

Accident Insurance

Accident insurance, provided through Mutual of Omaha, can soften the financial impact of an accidental injury by paying a benefit to you to help cover the unexpected out-of-pocket costs related to treating your injuries. Some accidents, like breaking your leg, may seem straightforward: you visit the doctor, take an X-ray, put on a cast and rest up until you're healed. But treating a broken leg can cost thousands of dollars. When your medical bill arrives, you'll be relieved you have accident insurance on your side.

Accident insurance pays a fixed cash benefit directly to you when you have a covered accident-related injury, on or off-the-job, like a sprain or bone fracture. Examples of covered expenses include:

- Doctor's office visits
- Diagnostic exams
- Broken leg rehab treatment
- Physical therapy sessions

The Accident plan includes a $50 health screening benefit payable once per covered person per calendar year for approved preventive visits. Examples include immunizations, annual routine physicals, serum cholesterol test, and many more.

Accident Insurance in Practice

Situation	Abed broke his leg in a bike accident.
Covered Benefits	• Emergency Care Treatment……..…..….. $300 • X-ray……..…….. $75 • Closed Leg Fracture Diagnosis…..…..….$2,250 • Physical therapy sessions (6 visits)…..…...$450 • Follow-up Physician Visits (6)……..…….$900
Total Benefit Paid Directly to Employee	**$3,975**

Click here to watch a video about how an accident plan works.

VOLUNTARY BENEFITS

Critical Illness Insurance

About half of U.S. adults report being unable to pay an unexpected medical bill of $500 without going into debt.[1] With Critical Illness insurance provided through Mutual of Omaha, you won't have to. This benefit provides a fixed, lump-sum cash benefit directly to you when you are diagnosed with a covered health condition such as a heart attack or stroke. You can use this benefit however you like, including to help pay for: increased living expenses, prescriptions, travel expenses, treatments, etc.

- Benefits are eligible for payment if an insured person is diagnosed with a covered illness after the effective date of the policy.
- Coverage reduces to 50% of your original elected amount at the age of 70 for both you and your spouse.
- If you or your covered dependent has a covered health screening test performed, you may receive a $50 benefit, once per insured per calendar year up to a maximum of 6 per family. To file the claim, call Mutual of Omaha or email documentation.

Your Plan's Benefits

	Employee	Spouse	Dependent Children
Guaranteed Issue	$50,000	$50,000	50% of employee's sum, up to $5,000
Max. Coverage Amount	$50,000	100% of employee's sum, up to $50,000	
Min. Coverage Amount	$5,000	$5,000	

Click here to watch a video about how a critical illness plan works.

1. Kaiser Family Foundation. "Americans' Challenges with Health Care Costs." Kaiser Family Foundation, kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs.

VOLUNTARY BENEFITS

Hospital Indemnity Insurance

When you or a dependent need to be hospitalized, your family deserves to focus on their well-being, not the stress of a stint at the hospital, which can cost an average of $3,025 per inpatient day. Hospital Indemnity, provided by Mutual of Omaha, pays a fixed cash benefit directly to you when you experience:

- Hospital admissions
- Hospital stays
- Intensive care unit stays

Your Plan's Benefits

	Hospital	ICU
Admission (Total of 2 payable per year)	$1,000	$2,000
Daily Confinement (Total of 30 days per year)	$100	$200
Newborn Nursery Care Confinement (Up to 2 days per year)	$75	N/A*

*If a newborn dependent child is confined in a hospital for treatment of an injury or sickness, the hospital or ICU confinement benefit will be payable.

Click here to watch a video about how a Hospital Indemnity plan works.

VOLUNTARY BENEFITS

Allstate Identity Protection Pro+ Cyber Plan

Your identity is made up of more than your Social Security number and credit score. It includes the trail of data you leave behind from financial transactions, as well as what you share on social media. That's why we offer identity theft protection, provided through Allstate Identity Protection for you and your family members.

Features

- Up to $5 million financial protection coverage
    - ID theft, stolen funds, 401(k)/HSA fraud, home title, fraud & more
- Dark web monitoring
- High-risk transaction monitoring
- Social media monitoring
- IP address monitoring
- Lost wallet protection
- Credit monitoring and alerts
- Data breach notifications
- Full-service restoration support
- Stolen 401(k) and HSA funds reimbursement

Click here to watch a video about how an Identity Theft plan works.

WELLBEING

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Life is full of challenges, and sometimes balancing them all can be difficult. We are proud to provide a confidential program dedicated to supporting the emotional health and well-being of our employees and their families. The Employee Assistance Program (EAP) is provided at NO COST to you through CuraLinc.

The EAP can help with the following issues, among many others:

- Mental health
- Relationships
- Substance use
- Child and eldercare
- Grief and loss
- Legal or financial issues

EAP Benefits

- Assistance for you and your household members
- 5 free sessions of counseling, coaching, or 5 weeks of text therapy. Omaha Track employees receive 5 free sessions per issue within the year, issues unlimited.
- Unlimited toll-free phone access and online resources

QUESTIONS?

To learn more, visit www.curalinc.com

Group Code: omahatrack

For questions, contact CuraLinc EAP at 800-490-1585 or email at info@curalinc.com.

Click here to watch a video about how an EAP works.

PERKS

EMPLOYEE DISCOUNTS

BenefitHub

BenefitHub is an exclusive employee discount program that can help you save big on thousands of items daily such as travel, apparel, tickets, auto, electronics, insurance, education, restaurants and so much more! To get started:

- Go to https://mypathperks.benefithub.com/
- Not registered? Click on link for "Don't have an account? Signup"
- Complete registration using referral code **K7WEWL**

Questions? Call 866-664-4621 or email customercare@benefithub.com.

MEDICARE GUIDANCE

HUB Medicare Advocacy

The HUB Senior and Individual Team Medicare advocacy service is available at no cost to you and your family members who are approaching Medicare eligibility and/or who are already Medicare eligible. HUB can:

- Answer basic questions about Medicare coverage and enrollment
- Provide guidance on how to avoid late enrollment penalties and coverage gap pitfalls, including COBRA
- Compare current coverage to Medicare and explain the differences between the two
- Provide retiree benefits counseling
- Help individuals shopping for Medicare Supplement Plans, Advantage Plans and Part D

For more information or to get started, call 833-482-7471 or email Senior.IFP@hubinternational.com.

RESOURCES

PLAN CONTRIBUTIONS

Your contributions toward the cost of benefits are automatically deducted from your paycheck. The amount will depend on the plan you select and if you choose to cover eligible family members.

Medical

Coverage	Weekly Contributions
	Plan 1
Employee Only	$25.23
Employee + Spouse	$132.46
Employee + Child(ren)	$69.11
Employee + Family	$181.01

Dental

Coverage	Weekly Contributions
	Plan 1
Employee Only	$1.03
Employee + Spouse	$4.87
Employee + Child(ren)	$4.98
Employee + Family	$8.82

Vision

Coverage	Weekly Contributions
	Plan 1
Employee Only	$0.51
Employee + Spouse	$2.44
Employee + Child(ren)	$2.63
Employee + Family	$4.58

PLAN CONTRIBUTIONS

Your contributions toward the cost of voluntary benefits are automatically deducted from your paycheck after taxes. The amounts will depend upon the plan you select, your age (in some cases) and if you choose to cover eligible family members.

Supplemental Life and AD&D

Age	Weekly Contributions	
	Employee & Spouse Rate (Per $1,000 of Insurance)	Child Rate (Per $1,000 of Insurance)
0 – 24	$0.02	$0.05
25 – 29	$0.02	
30 – 34	$0.02	
35 – 39	$0.03	
40 – 44	$0.05	
45 – 49	$0.07	
50 – 54	$0.10	
55 – 59	$0.17	
60 – 64	$0.27	
65 – 69	$0.44	
70 – 74	$0.88	
75+	$0.88	
Optional AD&D Rate	$0.008	

PLAN CONTRIBUTIONS

Your contributions toward the cost of voluntary benefits are automatically deducted from your paycheck after taxes. The amounts will depend upon the plan you select, your age (in some cases) and if you choose to cover eligible family members.

Accident

Coverage	Accident Weekly Contributions
Employee Only	$2.31
Employee + Spouse	$3.81
Employee + Child(ren)	$5.52
Employee + Family	$7.28

Hospital Indemnity

Coverage	Hospital Indemnity Weekly Contributions
Employee Only	$3.78
Employee + Spouse	$8.69
Employee + Child(ren)	$5.21
Employee + Family	$10.42

Critical Illness

Weekly coverage rates are available in your SyncHR benefit wizard or can be found by going to www.omahatrack.com/benefits, clicking on Health & Welfare Benefit Plan Documents & Resources, then Mutual of Omaha – Critical Illness – Rates.

Identity Theft

Coverage	Identity Theft Weekly Contributions
Employee Only	$2.31
Family	$3.92

IMPORTANT CONTACTS

Benefit	Carrier	Phone Number	Website/Email
Medical	Blue Cross Blue Shield of Nebraska		www.nebraskablue.com
Dental	Ameritas	800-487-5553	www.ameritas.com
Vision	Ameritas/VSP	800-877-7195	www.ameritas.com www.vsp.com
Health Savings Account (HSA)	Fidelity	800-544-3716	Netbenefits.com
401k	Fidelity	800-544-3716	Netbenefits.com
Life Insurance	Mutual of Omaha	800-775-8805	www.mutualofomaha.com
Disability Insurance	Mutual of Omaha	800-877-5176	www.mutualofomaha.com
Accident/Critical Illness/Hospital Indemnity	Mutual of Omaha	Lisa Hartman: 605-444-5103 Jamie Turner: 402-964-5428	Lisa.Hartman@hubinternational.com jaime.turner@hubinternational.com
Allstate Identity Protection	Allstate Identity Protection	800-789-2720	Myaip.com
Employee Assistance Program (EAP)	CuraLinc	800-490-1585	Curalinc.com Group Code: omahatrack
Telehealth	NewBenefits	800-800-7616	Mybenefitswork.com
Telehealth	Telescope Health	Number on the back of your BCBS ID card	www.nebraskablue.com

ANNUAL NOTICES

Click here for annual notices.

BENEFIT SUMMARIES

Click here for benefit summaries.

BENEFIT TERMINOLOGY

Allowed amount

This is the amount agreed upon between the provider and the insurance company for the service provided. It is almost always less than the billed amount, which is why enrollees see different amounts on their Explanation of Benefit statements (EOBs). For example, a provider may charge $120 per hour of psychotherapy, but the insurance company pays them $95—the allowed amount for that service.

Balance billing

When an out-of-network provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. An in-network provider cannot balance bill you for the covered services.

Beneficiary

A person who is designated as the recipient of proceeds from an insurance policy.

Coinsurance

Your share of the costs of a covered medical service calculated as a percent of the allowed amount for the service. You pay coinsurance plus any deductibles you owe. Consider an example in which the medical plan's allowed amount for a medical service is $100 and you've met your deductible. If your plan pays 70%, then you are responsible for the remaining 30%, which is $30.

Copayment

Oftentimes referred to as a "copay," this is the amount you are responsible for paying when seeing a doctor, picking up a prescription, or visiting an urgent care facility or emergency room.

Deductible

The amount you must pay for eligible expenses before the plan begins to pay benefits. A deductible may be per service, per visit, per supply or per coverage year. For example, if your individual deductible is $1,500, your plan will not pay anything for certain medical services until you have paid $1,500. The deductible may not apply to all services, such as services that are covered by a copay.

Dependent

Dependents are usually an immediate relative, such as a spouse or child (up to age 26, as per the ACA), who is eligible to be included on your health insurance policy. The Company also allows domestic/civil union partners to be listed as dependents.

Diagnostic test

Medical tests designed to establish the presence (or absence) of disease as a basis for treatment decisions in symptomatic or screen positive individuals. Note that diagnostic tests are different than screening tests. Screenings are primarily designed to detect early disease or risk factors for disease in apparently healthy individuals.

Durable medical equipment (DME)

Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include oxygen equipment, wheelchairs or crutches.

Eligible expense

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "negotiated rate." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference. See balance billing.

BENEFIT TERMINOLOGY

Embedded deductible

Once a person covered under a family plan reaches the individual embedded deductible, all covered expenses for that individual will be paid at the coinsurance amount even when the family deductible may not have been satisfied. For example, the HDHP features an in-network family deductible of $12,700. If one member of the family satisfies the individual $6,350 deductible, the medical carrier will pay 100% of the remaining in-network expenses. Once another person or a combination of persons meet the remaining amount, the embedded family deductible is considered satisfied.

Embedded out-of-pocket maximum

Once a person covered under a family plan reaches the individual embedded out-of-pocket maximum, all covered expenses for that individual will be paid at 100% even when the family out-of-pocket maximum may not have been satisfied. For example, the HDHP features a family out-of-pocket maximum of $12,700. If one member of the family satisfies the individual out-of-pocket maximum of $6,350 the medical carrier will pay 100% of remaining in-network expenses for that individual. Once another person or a combination of persons meet the remaining portion, the embedded family out-of-pocket maximum is considered satisfied.

Employee contribution

The amount an employee contributes through payroll deductions for their medical and other insurance and savings program benefits.

Excluded services

Medical services that your medical plan doesn't pay for or cover.

Explanation of benefits

Every time you use your health insurance, your health plan sends you a record called an "explanation of benefits" (EOB) or "member health statement" that explains how much you may owe. The EOB also shows the total cost of care, how much your plan paid, and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount"). An EOB is generated for every single health claim, including prescriptions. It is not a bill, but rather a tool members can use to make sure they're not paying more than their insurer expects them to for services rendered.

Generic drugs

Medications that are comparable to brand-name drugs in dosage form, strength, quality, performance characteristics and intended use, per the FDA. Generic drugs are almost always priced more attractively than their brand-name counterparts. (These are typically "Tier 1" drugs in the Company's medical plans.)

High-Deductible health plan (HDHP)

A HDHP is a type of health insurance plan that typically offer lower premiums in exchange for higher deductibles. The deductible, which is the amount you must pay out of pocket for covered medical expenses before your insurance begins to pay, is higher for HDHPs compared to traditional PPO plans. These plans allow individuals to pay a lower monthly premium and instead cover more of their medical expenses through out-of-pocket deductibles.

Health savings account (HSA)

An employer- and employee-funded savings plan that reimburses you for qualified out-of-pocket medical expenses. Funded through pre-tax payroll deductions by the employer and employee, HSAs are only available to people enrolled in a qualified high-deductible health plan. Unspent balances aren't forfeited; they roll over and accumulate over time.

BENEFIT TERMINOLOGY

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In-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who contract with your health insurance carrier. In-network coinsurance costs you less than out-of-network coinsurance payments.

In-network provider

The facilities, providers and suppliers our health insurance carrier has contracted with to provide medical services. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Mail order Rx

The Company's medical carrier offers this method of delivery for prescription drug orders to assist in delivering drugs more conveniently and at a lower cost. Through mail order, members can obtain a 90-day supply at one time versus a 30-day supply at a traditional pharmacy. Most suitable for maintenance medications or any drug taken daily, such as contraceptives or blood pressure medications, your copay is cheaper through mail order.

Medically necessary

Medical services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms, and that meet accepted standards of medicine.

Member health statement

Every time you use your health insurance, your health plan sends you a record called a "member health statement" or an "explanation of benefits" (EOB) that explains how much you may owe. The member health statement also shows the total cost of care, how much your plan paid and the amount an in-network doctor or other health care professional is allowed to charge a plan member (called the "allowed amount").

BENEFIT TERMINOLOGY

Negotiated rate

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "payment allowance" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

Network

The facilities, providers and suppliers a health insurance carrier has contracted with to provide medical services at a pre-negotiated discount. Your out-of-pocket expenses will be lower, and you will not be responsible for filing claims if you visit a participating in-network provider.

Non-preferred brand-name drugs

Generally, these are higher-cost medications that have recently come on the market. In most cases, an alternative preferred medication is available, be it a preferred brand-name drug or a generic. (These are typically ["Tier 3"] drugs in the Company's medical plans.)

Non-preferred provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider.

Open Enrollment

A period during which a health insurance company is required to accept applicants without regard to health history.

Out-of-network coinsurance

The percentage you pay of the allowed amount for covered medical services to providers who do not contract with your health insurance carrier. Out-of-network coinsurance costs you more than in-network coinsurance. An out-of-network provider can balance bill you for charges over the allowed amount.

Out-of-network provider

A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see an out-of-network provider.

Out-of-pocket maximum

The most you pay during a policy period (a calendar year) before your plan begins to pay 100% of the allowed amount. This limit does not include your premium or balance-billed charges.

Over-the-counter drug

A drug that you can buy without a prescription from a drugstore or most general or grocery stores. For example, Benadryl, Tylenol, and Ibuprofen are sold over-the-counter. The opposite of a prescription drug.

Payment allowance

Amount on which payment is based for covered medical services. This may be called "allowed amount maximum," "negotiated rate" or "eligible expense." If an out-of-network provider charges more than the allowed amount, you may have to pay the difference.

BENEFIT TERMINOLOGY

Preauthorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or prior approval, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Preferred/brand-name drug

These are medications for which generic equivalents are not available. They have been on the market for some time and are widely accepted. They cost more than generic drugs, but less than non-preferred brand-name drugs. (These are typically ["Tier 2"] drugs in the Company's medical plans.)

Preferred provider

A provider who has a contract with your health insurer or plan to provide services to you at a pre-negotiated discount.

Prescription drugs

Medications you can only obtain with a prescription from your doctor. Prescriptions must be taken to a pharmacy (or sent to a mail-order facility) where a licensed pharmacist will fill it for you. For example, Lipitor, Vicodin and Albuterol can only be obtained with a prescription. The opposite of an over-the-counter drug.

Prescription drug coverage

Coverage that helps pay for prescription drugs and medications covered under a health insurance carrier's formulary. A formulary is the list of FDA-approved drugs covered under a medical plan. Each drug is classified into a tier and each tier determines the copayment you will pay for the drug. These tiers typically, but not always, are: Generic (Tier 1), Preferred Brand (Tier 2), Non-Preferred Brand (Tier 3), and Specialty.

Your cost will depend on the level of drug specified by your doctor. A generic drug is a medication whose active ingredients, safety, dosage, quality and strength are identical to that of its brand-name counterpart. Preferred brand-name drugs generally do not have a generic equivalent, while those listed as non-preferred brand-name drugs generally do have a generic or preferred brand-name equivalent.

Your copay for preferred brand-name drugs is less than the copay for non-preferred brand-name drugs because you don't have the generic option available to you.

Premium (Insurance)

The fees paid to an insurance carrier to provide coverage. These fees are usually shared between you and the Company, though there are insurance benefits the Company pays for entirely, while there are others that you pay for yourself.

Premium (Medical)

The amount that is paid for your medical coverage. You and the Company share this cost, which is paid monthly to the insurance carrier.

Pre-tax deduction

Payments deducted from your gross pay before Medicare, federal, and state taxes are calculated, thus reducing your taxable wages and tax liability.

BENEFIT TERMINOLOGY

Prior approval/authorization

A medically necessary determination by a health insurance carrier for a medical service, treatment plan, prescription drug, medical or prosthetic device or certain types of durable medical equipment. Sometimes called preauthorization, prior authorization or precertification, many plans require preauthorization for certain services before you can receive them, except in cases of emergency. Preauthorization isn't a promise your medical plan will cover the cost.

Post-tax deduction

Payments deducted from your net pay after Medicare, federal and state taxes are calculated, thereby having no impact on your taxable wages and tax liability.

Preventive care

Medical treatments performed with the intention of preventing a health issue. For example, vaccinations and age-appropriate screenings are almost always considered to be preventive.

Primary care physician (PCP)

A physician who directly provides or coordinates a wide range of medical services for a patient. Primary care physicians include medical doctors, doctors of osteopathic medicine, internists, family practitioners, general practitioners, OB/GYNs and pediatricians. The opposite of a specialist.

Provider

A physician, health care professional or health care facility, certified or accredited as required by state law.

Qualifying life event (QLE)

QLEs are major events in an enrollee's life that allow them to make specific changes to their insurance policy outside of an annual Open Enrollment period. This usually includes the birth or adoption of a child, marriage, divorce, death of a spouse or change in the spouse's employment or insurance status. These changes must typically be made within 31 days of the QLE.

Special enrollment period

Special enrollment periods allow you to make changes to your insurance plan or sign up for a new policy outside of Open Enrollment. They're almost always triggered by QLEs.

Specialist

A physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat for certain types of symptoms and conditions. The opposite of a primary care physician. For example, a dermatologist is considered a specialist.

Specialty drugs

Prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia.

Telehealth

Telehealth is the use of telecommunication technologies through which you and your personal physician, who is treating you and knows your health history, can talk live over the phone or video chat, by appointment, during regular office hours. Services such as medication management, regular visits and online counseling are particularly well suited to Telehealth, since consistent and regular visits with your physician typically improve outcomes.

BENEFIT TERMINOLOGY

Telemedicine

Telemedicine is the use of telecommunication technologies where you and an on-call physician can talk live (24/7/365) over the phone or video chat. Services that are particularly well-suited to telemedicine include the discussion of symptoms, receiving a diagnosis, learning your treatment options and minor health issues such as pink eye or sore throat. Prescription can also be facilitated through telemedicine. Please note that each time you reach out for telemedicine services, you might speak with a different physician.

Urgent care

An illness or injury serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Wellness

Wellness refers to a healthy state of being.

Click here to watch a video about benefits terms.