GORMAN
& COMPANY

Integrity. Innovation. Community.

BENEFITS GUIDE 2024

If you have any questions, please contact:

HR@gormanusa.com

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Table of Contents

Eligibility and Elections

Gorman & Company is proud to offer a comprehensive benefits package to eligible team members who work 30 or more hours per week. The benefits package is briefly summarized in this booklet. You share the cost of some benefits (medical and dental), the company provides other benefits at no cost to you (life, accidental death & dismemberment, short-term disability and long-term disability), and you have the option of purchasing other voluntary benefits (vision, accident, critical illness and pet insurance). Benefits are subject to change at any time.

Benefit Elections and Changes

You and your dependents are eligible for the company benefits on the first of the month following 30 days of employment.

** You are eligible to participate in the Gorman 401K Plan on the first of the month following 60 days of employment.

Eligible dependents are your spouse, domestic partner (DP), children under age 26, or disabled dependents of any age.

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

Qualified life events include:

- Marriage, divorce or legal separation
- Birth, adoption or placement for adoption
- Death of your spouse, domestic partner or dependent
- Significant change in your spouse's or domestic partner's coverage

If you have a life event, you must make changes to your benefits within 30 days of the event. The change to your benefits must be consistent with the life event.

Contact Human Resources with questions! HR@gormanusa.com

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Employee Premiums

2024 Employee Contributions (Bi-Weekly)

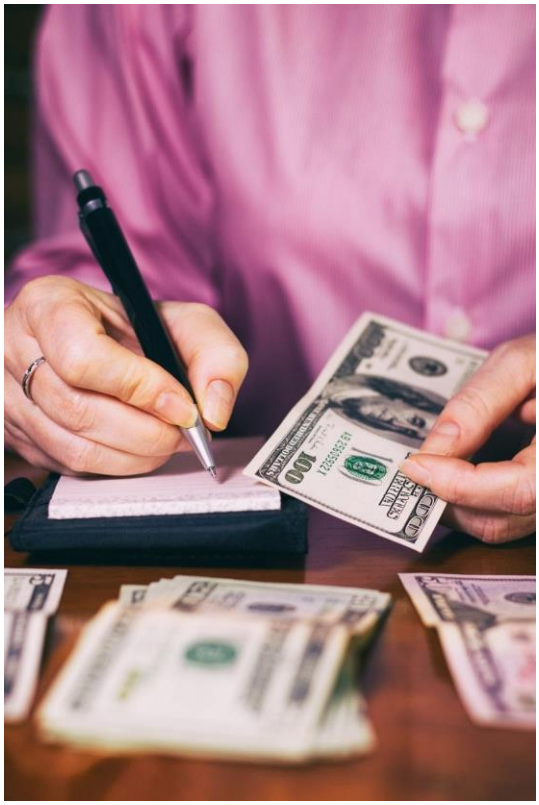
MEDICAL — UHC			
	***UHC 1000**	***UHC 3000**	***UHC HDHP**
Employee	$60.42	$53.18	$42.06
Employee + Spouse/DP	$265.85	$234.00	$185.08
Employee +Child(ren)	$217.52	$191.45	$151.43
Family	$388.27	$341.74	$270.30

MEDICAL — QUARTZ						
	HMO 1000	**POS 1000**	**HMO 3000**	**POS 3000**	**HMO—HDHP**	**POS—HDHP**
Employee	$66.78	$70.44	$56.56	$61.78	$46.94	$49.30
Employee + Spouse/DP	$244.85	$258.29	$207.39	$226.52	$172.11	$180.78
Employee + Child(ren)	$200.33	$211.33	$169.68	$185.33	$140.82	$147.90
Family	$357.59	$377.22	$302.88	$330.82	$251.36	$264.01

*UnitedHealthcare coverage is available for team members who are outside of the Quartz service area. Quartz HMO is for team members within the Quartz service area. Quartz POS is available to team members within the Quartz service area, and also provides out-of-network provider options and a Health Reimbursement Account (HRA).

DENTAL	
Employee	$3.00
Employee + Spouse/DP	$12.02
Employee + Child(ren)	$14.40
Family	$22.61

VISION	
Employee	$4.32
Employee + Spouse/DP	$8.64
Employee + Child(ren)	$8.82
Family	$13.14



Employee Premiums

2024 Employee Contributions (Monthly)

Voluntary Life Insurance		
Monthly Rate per $1,000 of coverage		
Age	Employee	Spouse/DP
<20	$0.060	$0.060
20-24	$0.060	$0.060
25-29	$0.060	$0.060
30-34	$0.070	$0.070
35-39	$0.099	$0.099
40-44	$0.170	$0.170
45-49	$0.260	$0.260
50-54	$0.399	$0.399
55-59	$0.699	$0.699
60-64	$0.992	$0.992
65-69	$1.840	$1.840
70+	$2.850	$2.850
AD&D	$0.026	$0.026
Dependent Child	$0.221	

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Medical Benefits - UHC

Administered by UnitedHealthcare www.uhc.com

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 preventive care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost.

The Summary of Benefits and Coverage can be found on the Gorman HR Hub.

Comprehensive healthcare also provides peace of mind. In case of an illness or injury, you and your family are covered with the option to choose between three excellent medical plans.

These plans use the **UnitedHealthcare Choice Plus Network.** To find a doctor, please set up your member account at myuhc.com.

	UHC 1000		UHC 3000	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Calendar year deductible (embedded)**				
Individual	$1,000	$2,000	$3,000	$6,000
Family	$2,000	$4,000	$6,000	$12,000
Plan year out-of-pocket maximum (embedded)** - Includes deductible				
Individual	$4,000	$8,000	$6,000	$8,000
Family	$8,000	$16,000	$10,000	$16,000
Your costs for covered care				
Preventive Services	$0	40% after deductible	$0	40% after deductible
Virtual Visit	$0 with a Designated Virtual Network Provider	40% after deductible	$0 with a Designated Virtual Network Provider	40% after deductible
Office Visits Primary	$20 copay, no ded ($0 >age 19)	40% after deductible	$20 copay, no ded ($0 >age 19)	40% after deductible
Office Visits Specialty	$60 copay, no ded	40% after deductible	$60 copay, no ded	40% after deductible
Emergency Room	$350 copay, no ded	$350 copay, no ded	$350 copay, no ded	$350 copay, no ded
Urgent Care	$80 copay, no ded	40% after deductible	$80 copay, no ded	40% after deductible
Hospital & Surgical	20% after deductible	40% after deductible	20% after deductible	40% after deductible
Lab Testing Designated Network / Network[1]	$0 / 50% after deductible	40% after deductible	20% after deductible/ 50% after deductible	40% after deductible
X-Ray/Diagnostics	$0	40% after deductible	20% after deductible	40% after deductible
Imaging (CT/PET Scans, MRI) Designated Network / Network[1]	20% after deductible / $500 POD, 50% after ded	40% after deductible	20% after deductible / $500 POD, 50% after ded	40% after deductible
Prescription Drugs				
Tier 1 - Retail / Mail Order	$10 / $25	$10 / Not covered	$10 / $25	$10 / Not covered
Tier 2 - Retail / Mail Order	$35 / $87.50	$35 / Not covered	$35 / $87.50	$35 / Not covered
Tier 3 - Retail / Mail Order	$70 / $175	$70 / Not covered	$70 / $175	$70 / Not covered

[1]Save on your copay by seeking care at a "Premium Designated" physician and save on services by seeking care at a "Designated Diagnostic Provider". Either can be located at www.myuhc.com.

***embedded means that if family coverage is selected, an individual within that family is not responsible for more than the embedded individual amount.*

Medical Benefits — UHC

High Deductible Health Plan (HDHP)

This plan uses the **UnitedHealthcare Choice Plus Network.** To find a doctor, please set up your member account at myuhc.com.

What is a HDHP (High Deductible Health Plan)?

A HDHP plan features lower premiums and higher out-of-pocket costs with deductibles before the plan begins covering costs. A HDHP plan is offered in conjunction with a Health Savings Account (HSA).

The plan includes 100 percent coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider. Additional preventive screenings and services may also be covered, depending on factors such as your age, gender and certain chronic conditions.

UHC—HDHP	In-network	Out-of-network
Calendar year deductible (embedded)		
Individual	$5,000	$10,000
Family	$10,000	$20,000
Plan year out-of-pocket maximum (embedded) - Includes deductible		
Individual	$5,000	$20,000
Family	$10,000	$40,000
Your costs for covered care		
Preventive Services	$0	30% after deductible
Virtual Visit	0% after deductible	30% after deductible
Office Visits Primary	0% after deductible	30% after deductible
Office Visits Specialty	0% after deductible	30% after deductible
Emergency Room	0%, no deductible	0% after network deductible
Urgent Care	0% after deductible	30% after deductible
Hospital & Surgical	0% after deductible	30% after deductible
Lab Testing Designated Network / Network[1]	0% after deductible / 50% after deductible	30% after deductible
X-Ray/Diagnostics	0% after deductible	30% after deductible
Imaging (CT/PET Scans, MRI) Designated Network / Network[1]	0% after deductible / $500 POD, then Ded, 50%	30% after deductible
Prescription Drugs		
Tier 1 - Retail / Mail Order	$0 / $0	$0 / Not covered
Tier 2 - Retail / Mail Order	$0 / $0	$0 / Not covered
Tier 3 - Retail / Mail Order	$0 / $0	$0 / Not covered

[1]Save on your copay by seeking care at a "Premium Designated" physician and save on services by seeking care at a "Designated Diagnostic Provider". Either can be located at www.myuhc.com.

You pay out of pocket until you reach the deductible.

When you have an eligible expense, such as a doctor visit when you're sick, you will pay the full cost of your health expenses until you meet your deductible. You can choose to pay from your HSA or pay with cash or credit card.

Your plan covers cost of covered services.

Once the deductible is paid, your medical plan has 0% coinsurance. This means once you have met your deductible the plan begins to pay 100% and your out-of-pocket maximum has also been satisfied.

You are protected from major expenses.

An out-of-pocket maximum protects you from major expenses. The out-of-pocket maximum is the most you will have to pay in the plan year for covered health care. Your deductible, coinsurance, medical services and prescription drugs apply toward the out-of-pocket maximum.

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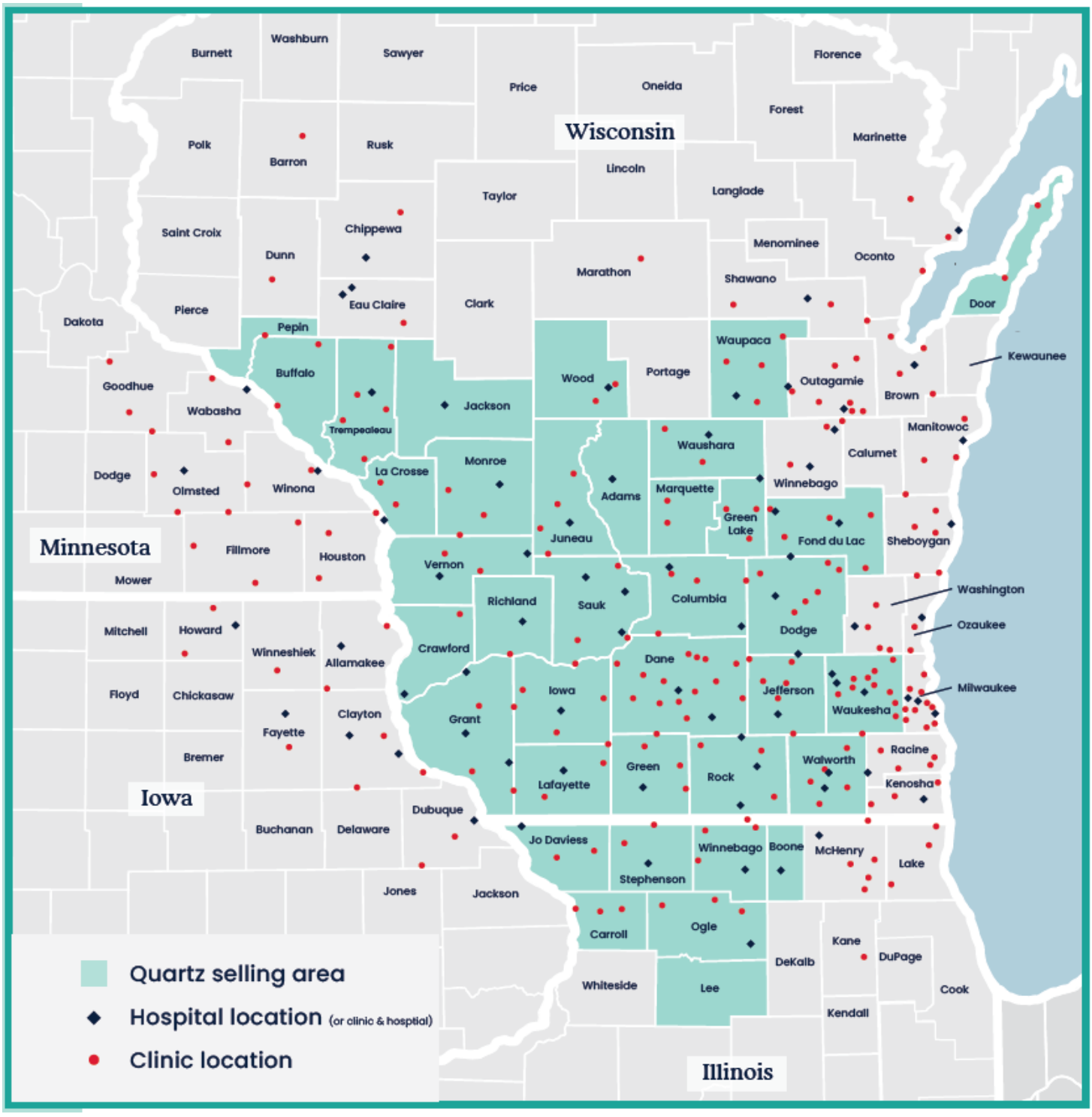
Medical Benefits - Quartz

Quartz Service Area

Quartz HMO is for team members within the Quartz service area.
Quartz POS is available to team members within the Quartz service area, and also provides out-of-network provider options and a Health Reimbursement Account (HRA).



Medical Benefits - Quartz

Administered by Quartz www.quartzbenefits.com

Comprehensive and preventative 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 preventative care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. The Summary of Benefits and Coverage can be found on the Gorman HR Hub.

	POS—Quartz Network 1000 *Health Reimbursement Arrangement available		HMO—Quartz Network 1000 Affiliated with UW Health	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Calendar year deductible (embedded)				
Individual	$1,000	$2,000/$1,000*	$1,000	N/A
Family	$2,000	$4,000/$2,000*	$2,000	N/A
Plan year out-of-pocket maximum (embedded)- Includes deductible				
Individual	$2,000	$4,000	$2,000	N/A
Family	$4,000	$8,000	$4,000	N/A
Your costs for covered care				
Preventive Services	$0	40% after deductible	$0	N/A
Office Visits Primary	$30 copay	40% after deductible	$30 copay	N/A
Office Visits Specialty	$60 copay	40% after deductible	$60 copay	N/A
Emergency Room	$100 copay per visit		$100 copay per visit	
Urgent Care	$60 copay per visit	40% after deductible	$60 copay per visit	
Hospital/Surgical	20% after deductible	40% after deductible	20% after deductible	N/A
Diagnostic Lab & X-Ray	20% after deductible	40% after deductible	20% after deductible	N/A
Prescription Drugs				
Prescription Drug Out-of-pocket maximum	$2,350 single $4,700 family	N/A	$2,350 single $4,700 family	N/A
Tier one	$10 copay	N/A	$10 copay	N/A
Tier two	$35 copay	N/A	$35 copay	N/A
Tier three	$60 copay	N/A	$60 copay	N/A
Tier four	$200 copay	N/A	$200 copay	N/A
Value Tier	$5 Rx Outcomes	N/A	$5 Rx Outcomes	N/A

** Health Reimbursement Arrangement on the Quartz POS plan reimburse expenses up to $1,000 single/$2,000 family, keeping the deductibles at $1,000 single/$2,000 family. (Gorman pays for the last $1,000 of the deductible for single coverage, and the last $2,000 of the deductible for family coverage.)*

Medical Benefits - Quartz

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Comprehensive and preventative 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 preventative care provide an inexpensive review of your health. Small problems can potentially develop into large expenses. By identifying the problems early, often they can be treated at little cost. The Summary of Benefits and Coverage can be found on the Gorman HR Hub.

	POS—Quartz Network 3000 *Health Reimbursement Arrangement available		HMO—Quartz Network 3000 Affiliated with UW Health	
	In-network	Out-of-network	In-network	Out-of-network
Calendar year deductible (embedded)				
Individual	$3,000	$6,000	$3,000	N/A
Family	$6,000	$12,000	$6,000	N/A
Plan year out-of-pocket maximum (embedded)- Includes deductible				
Individual	$5,550	$11,100	$5,550	N/A
Family	$11,100	$22,200	$11,100	N/A
Your costs for covered care				
Preventive Services	$0	40% after deductible	$0	N/A
Office Visits Primary	$30 copay	40% after deductible	$30 copay	N/A
Office Visits Specialty	$60 copay	40% after deductible	$60 copay	N/A
Emergency Room	$100 copay per visit		$100 copay per visit	
Urgent Care	$60 copay per visit	40% after deductible	$60 copay per visit	
Hospital/Surgical	20% after deductible	40% after deductible	20% after deductible	N/A
Diagnostic Lab & X-Ray	20% after deductible	40% after deductible	20% after deductible	N/A
Prescription Drugs				
Prescription Drug Out-of-pocket maximum	$2,350 single $4,700 family	N/A	$2,350 single $4,700 family	N/A
Tier one	$10 copay	N/A	$10 copay	N/A
Tier two	$35 copay	N/A	$35 copay	N/A
Tier three	$60 copay	N/A	$60 copay	N/A
Tier four	$200 copay	N/A	$200 copay	N/A
Value Tier	$5 Rx Outcomes	N/A	$5 Rx Outcomes	N/A

** Health Reimbursement Arrangement on the Quartz POS plan reimburse expenses up to $1,000 single/$2,000 family, keeping the deductibles at $1,000 single/$2,000 family. (Gorman pays for the last $1,000 of the deductible for single coverage, and the last $2,000 of the deductible for family coverage.)*

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Medical Benefits — Quartz

High Deductible Health Plan (HDHP)

Administered by Quartz www.quartzbenefits.com

What is a HDHP (High Deductible Health Plan)?

A HDHP plan features lower premiums and higher out-of-pocket costs with deductibles before the plan begins covering costs. A HDHP plan is offered in conjunction with a Health Savings Account (HSA).

The plan includes 100 percent coverage with no deductible for certain preventive care services as specified by the Affordable Care Act when you see a network provider. Additional preventive screenings and services may also be covered, depending on factors such as your age, gender and certain chronic conditions.

	POS—Quartz HDHP Network		HMO—Quartz HDHP Network Affiliated with UW Health	
	In-network	**Out-of-network**	**In-network**	**Out-of-network**
Calendar year deductible (embedded)				
Individual	$5,000	$10,000	$5,000	N/A
Family	$10,000	$20,000	$10,000	N/A
Plan year out-of-pocket maximum (embedded)- Includes deductible				
Individual	$5,000	$20,000	$5,000	N/A
Family	$10,000	$40,000	$10,000	N/A
Your costs for covered care				
Preventive Services	$0	20% after deductible	$0	N/A
Office Visits Primary	0% after deductible	20% after deductible	0% after deductible	N/A
Office Visits Specialty	0% after deductible	20% after deductible	0% after deductible	N/A
Emergency Room	0% after deductible		0% after deductible	
Urgent Care	0% after deductible	20% after deductible	0% after deductible	
Hospital & Surgical	0% after deductible	20% after deductible	0% after deductible	N/A
Diagnostic Lab & X-Ray	0% after deductible	20% after deductible	0% after deductible	N/A
Prescription Drugs				
	0% after deductible	N/A	0% after deductible	N/A

You pay out of pocket until you reach the deductible.

When you have an eligible expense, such as a doctor visit when you're sick, you will pay the full cost of your health expenses until you meet your deductible. You can choose to pay from your HSA or pay with cash or credit card.

Your plan covers cost of covered services.

Once the deductible is paid, your medical plan has 0% coinsurance. This means once you have met your deductible the plan begins to pay 100% and your out-of-pocket maximum has also been satisfied.

You are protected from major expenses.

An out-of-pocket maximum protects you from major expenses. The out-of-pocket maximum is the most you will have to pay in the plan year for covered health care. Your deductible, coinsurance, medical services and prescription drugs apply toward the out-of-pocket maximum.

Health Savings Account

A Health Savings Account (HSA) is like a bank account you use to pay for eligible health care expenses - such as office visits, prescription drugs and lab tests. The money you put into your HSA will reduce your taxable income for the year. Unused funds rollover at the end of the year and you take the money with you if you change health plans, change your employer, or retire.

Gorman & Company will make an annual company contribution on your behalf: $500 single/$1,000 family. The total amount will be divided by 26 and deposited each pay period.

Some key advantages to a HSA:

- **Tax Savings:** Your contributions to the HSA are made with pre-tax dollars, so you'll pay less in income taxes. The money in your account can earn tax-free interest and any money withdrawn from your HSA for qualified expenses can be used on a tax-free basis. HSAs provide a triple-tax advantage!

- **Control:** You can use the HSA to pay for any qualified medical expenses, as defined by the IRS. Common expenses include deductibles, copays, prescription drugs, dental and vision needs. See the full list at www.irs.gov.

- **Savings and Investments:** Unused HSA dollars roll over year to year. At age 65, you will have the ability to use your HSA funds for any purpose on a taxable basis.

Annual Company Contribution

Employee Only	$500
EE +1	$1,000
Family	$1,000

- **Portability:** The account is yours; you can take your HSA with you if employment changes.

- **Contributions and Investment Earnings:** They are tax free, as are disbursements from the account to pay for qualified expenses.

In order for a dependent under age 26 to use HSA money, they must qualify as your IRS Dependent. Additional rules apply if your spouse or tax-eligible dependent also has a HSA.

Are you eligible for a HSA?

- If you enroll in a HDHP, you are eligible to open a HSA account.
- You cannot be covered by any other non-HSA-compatible health plan, including Medicare Parts A or B.
- You cannot be enrolled in a general purpose Healthcare Flexible Spending Account (FSA).

2024 IRS Annual Contribution Limits

Employee Only	$4,150
EE +1 and Family	$8,300
Catch up	$1,000

If you enroll in the HSA-eligible medical plan option, you may contribute to a HSA through EBC and WealthCare Saver

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Flexible Spending Accounts

Administered by Employee Benefits Corporation - www.ebcflex.com

You can save money on your healthcare and/or dependent daycare expenses with a Flexible Spending Account (FSA). The FSA allows you to set aside funds each pay period on a pre-tax basis and use them tax-free for qualified expenses. Your FSA contributions are deducted from your paycheck before taxes are withheld, so you save on income taxes and have more disposable income.

Your contribution to the FSA is deducted from 26 paychecks in equal amounts throughout the benefit plan year. If you enroll after the plan year starts due to your initial enrollment period or a life event, your FSA election will be deducted equally from the remaining paychecks in the plan year.

Managing your FSA

EBC offers a full-featured online experience. EBC My Account Assistant allows you to file claims, track balances, review plan details and download forms. EBC also offers a mobile app that lets you access the best features of the website using your mobile device.

Healthcare FSA

Use your Healthcare FSA to pay for eligible medical, dental, and vision care expenses such as copays, coinsurance and deductibles for yourself and your dependents. New participants will receive an EBC Benefits MasterCard debit card to use for healthcare services. Up to $640 of Healthcare FSA funds can be carried over from one benefit plan year to the next.

See https://fsastore.com/FSA-Eligibility-List.aspx for a list of healthcare FSA eligible expenses

Please note: Enrolling in the Healthcare FSA will make you and/or your tax-eligible dependents unable to contribute or accept contributions to a Health Savings Account (HSA).

Dependent Care FSA

You can reimburse your personal funds with money from the Dependent Care FSA for eligible expenses such as care at a licensed daycare provider, day camp, and before and after-school programs for eligible dependents. Eligible dependents include children under the age of 13 and dependents who are physically or mentally disabled and incapable of caring for themselves. You (and your spouse, if you are married or tax-eligible domestic partner) must be working, looking for work, or be a full-time student to use this account.

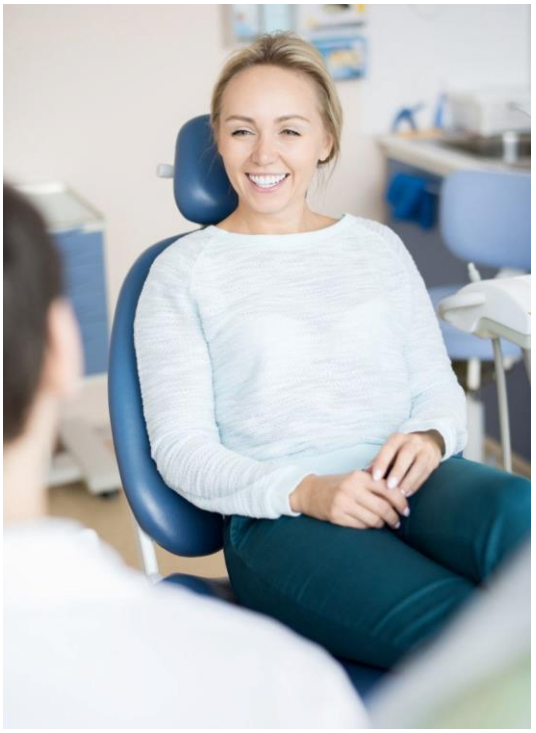
Feature	Healthcare FSA	Dependent Care FSA
Maximum contribution per year	$3,200	$5,000
Can be used for eligible…	Medical, dental and vision expenses for you and your dependents	Daycare expenses for eligible dependents
Carryout or runout period	Up to $640 of unused funds can be carried over to the next benefit plan year	You may continue to incur and submit Dependent Care expenses for an additional 90 days after the plan year ends

Dental

Administered by Delta Dental of Wisconsin - www.deltadentalwi.com

Delta Dental Summary	
Annual deductible	$25 single, $75 family
Annual benefit maximum	$1,500
Diagnostic & Preventive Services (no deductible)	
Exams	100%
Cleanings	100%
X-rays	100%
Fluoride treatments & sealants	100%
EBICP	Members with certain health conditions may be eligible for additional preventive care services.
Basic Services (deductible applies)	
Emergency treatment	Deductible, then 20% after
Fillings	Deductible, then 20% after
Endodontics & periodontics	Deductible, then 20% after
Extractions	Deductible, then 20% after
Major Services (deductible applies)	
Crowns, inlays, onlays	Deductible, then 50% after
Bridges & dentures	Deductible, then 50% after
Implants	Deductible, then 50% after
Orthodontic Services (no deductible)	
Dependents	50% to $1,000 lifetime maximum
Adult orthodontic	50% to $1,000 lifetime maximum

Helpful Tip: Minimize your out-of- pocket expense for dental care by asking your dentist for a pre-treatment estimate from Delta Dental before you agree to receive any prescribed major treatment.



Dental Provider Networks

As a Delta Dental member, you have the flexibility to choose any dentist with your Delta Dental plan – PPO, Premier or non-network. Your out-of-pocket costs will vary depending on the dentist you choose.

Here is an example of the potential costs depending on your choice of provider:

	Out-of-pocket costs with a Delta Dental PPO Dentist	Out-of-pocket costs with a Delta Dental Premier Dentist
Dentist's billed fee	$1074	
Allowed fee	$605	$901
Delta Dental pays 50% of allowed fee	$302.50	$450.50
You pay	$302.50	$450.50

Note: Non-network dentists have not agreed to accept the PPO or Premier allowed amounts and can balance bill you.

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Vision Plan

Delta Vision w/EyeMed Vision Network

www.deltadentalwi.com
www.eyemed.com

Vision insurance is a benefit that helps with the costs of eye exams, eyewear and other vision services. You can receive care from any licensed eye care professional but you'll save money by using network providers.

DeltaVision®

Service	In-Network	Out-of-Network
Services/Frequency		
Exam—Once every 12 months	Covered in full	Up to $35
Frames—Once every 12 months	$150 allowance, then 20% off balance	Up to $75
Lenses*	1 pair every 12 months	
Single Vision Lenses	Covered in full	Up to $25
Lined Bifocal Lenses	Covered in full	Up to $40
Lined Trifocal Lenses	Covered in full	Up to $55
Contact Lenses**	Once every 12 months	
Contact Lenses	$150 allowance, then 15% off balance	Up to $120
Disposable	$150 allowance	Up to $120
Medically necessary	Covered in full	Up to $200

*additional tints and coatings may incur additional out of pocket costs

**contact lens benefit in lieu of eyeglass benefits

eyeMed

Life and Disability Coverage

Administered by Reliance Standard

www.reliancematrix.com

Gorman & Company provides basic life and accidental death and dismemberment (AD&D) insurance through Reliance Standard at no cost to eligible employees. You will automatically be enrolled for this coverage.

If you want additional coverage for yourself, your spouse, domestic partner, or your children you can purchase voluntary coverage at your group rates. You must enroll to obtain additional coverage. You will need to submit a Statement of Health form for any requested amount over the Guarantee Issue amount: Click here to start your request: Gorman & Co-Electronic Statement of Health (EOI) Form

	How it Works	Basic Life and AD&D (Company-paid benefit)	Supplemental Life and AD&D (Employee-paid benefit)
Life	Your beneficiaries receive this benefit if you pass away	$50,000 at no cost to you	**You:** Increments of $10,000 up to $500,000 $150,000 Guarantee Issue **Your spouse/DP:** Increments of $5,000 up to $250,000 (not to exceed 50% of your optional life coverage amount) $20,000 Guarantee Issue **Your child(ren):** $1,000 to $10,000, not to exceed 50% of your optional life amount. $10,000 Guarantee Issue
AD&D	You (or your beneficiaries) receive this benefit if you pass away or are seriously injured in an accident	$50,000 at no cost to you	**You:** Increments of $10,000 up to $500,000 **Your spouse/DP:** Increments of $5,000 up to $250,000 (not to exceed 50% of your optional life coverage amount) **Your child(ren):** $1,000 to $10,000, not to exceed 50% of your optional life amount.

Gorman & Company also provides disability insurance through Reliance Standard. This benefit replaces a portion of your income if you become disabled and are unable to work.

IMPORTANT—You will automatically be enrolled for short term disability and long term disability coverage.

	How it Works	Who Pays for the Benefit
Short-term Disability	You receive 60% of your weekly income up to $2,000 per week. Benefits begin after 7 calendar days of absence.	Gorman & Company
Long-term Disability	You receive 60% of your monthly income up to $5,000 per month. Benefits begin following 90 days of disability.	Gorman & Company

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Employee Assistance Program

Administered by Reliance Standard

rsli.mylifeexpert.com/

EAP
employee assistance

ACI SPECIALTY BENEFITS

ACI's Employee Assistance Program (EAP) provides professional and confidential services to help employees and family members address a variety of personal, family, life, and work-related issues.

Confidential and professional assessment and referral services for employees and their family members

EAP and Work-Life Benefits:

From the stress of everyday life to relationship issues or even work-related concerns, the EAP can help with any issue affecting overall health, well-being and life management.

- Unlimited Telephonic Clinical Assessment and Referral
- Up to 3 Sessions of Professional Assessment for Employees and Family Members
- Unlimited Child Care and Elder Care Referrals
- Legal Consultation for Unlimited Number of Issues per Year
- Financial Consultation for Unlimited Number of Issues per Year
- Unlimited Pet Care Consultation
- Unlimited Education Referrals and Resources
- Unlimited Referrals and Resources for any Personal Service
- Unlimited Community-based Resource Referrals
- Online Legal Resource Center
- *Affinity*™ Online Work-Life Website
- myACI App for Mobile Access
- Multicultural and Multilingual Providers Available Nationwide

EAP benefits are free of charge, 100% confidential, available to all family members regardless of location, and easily accessible through ACI's 24/7, live-answer, toll-free number.

EAP services are provided by ACI Specialty Benefits, under agreement with Reliance Standard Life Insurance Company.

Reliance Standard Life Insurance Company is licensed in all states (except New York), the District of Columbia, Puerto Rico, the U.S. Virgin Islands and Guam. In New York, insurance products and services are provided through First Reliance Standard Life Insurance Company, Home Office: New York, NY. Product availability and features may vary by state.

Additional Questions?

Contact Human Resources or contact ACI Specialty Benefits toll-free at

855-RSL-HELP
(855-775-4357)
rsli@acieap.com
http://rsli.acieap.com

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

RS-2506 (07/2016)

GORMAN & COMPANY

Accident Insurance

Administered by Reliance Standard

www.reliancematrix.com

Gorman & Company offers voluntary Accident insurance through Reliance Standard that is 100% employee paid. Voluntary accident insurance provides a range of fixed, lump-sum benefits for injuries resulting from a covered accident, or for accidental death and dismemberment (if included). These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and childcare.

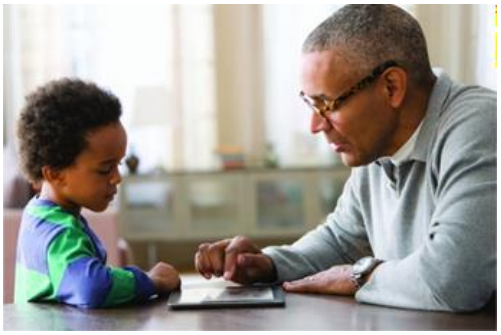
Benefits	Amount
Ambulance	$200 Ground, $1,000 Air
Blood, Plasma and Platelets	$200
Burns	To $800 for 2nd degree burns; To $6,400 for 3rd degree burns; Skin Graft - 25% of benefit payable for Burns
Chiropractic Services (per Visit)	$50 per session, 6 sessions maximum
Coma	$10,000
Concussion	$100
Dental Injury	$150 for Crown; $50 for Extraction
Diagnostic Exams	$200 per CT/MRI scan
Dislocation	To $1,880 for Non-surgical; To $3,760 for Surgical; Partial - 25% of full dislocation; Multiple - 100% of highest dislocation benefit
Emergency Treatment	$201
Epidural Anesthesia Injection (per Injection)	$100, 2 maximum
Eye Injury	$100 for removal of foreign object, $200 for surgical repair
Fractures	To $4,000 for Non-surgical; To $8,000 for Surgical repair; Chip fracture: 25% of non-surgical benefit; Multiple fractures: 100% of highest sustained fracture
Initial Hospital Admission	$500
Initial Intensive Care Unit (ICU) Hospital Admission	$1,000
Hospital Confinement (per Day)	$200, 365 days maximum
Intensive Care Unit (ICU) Confinement (per Day)	$400, 30 days maximum
Lacerations	To $400
Lodging (per Day)	$100 per day up to 30 days if more than 100 miles from residence
Medical Appliances	$100
Organized Youth Sports Benefit	25% of the benefit amount
Paralysis	$10,000 quadriplegia; $5,000 paraplegia/hemiplegia
Physical Therapy (per Session)	$50, 6 sessions maximum
Physician Visit	$50 Initial, $50 Follow-up
Prosthesis	$500 for one, $1,000 for two or more
Rehabilitation Facility Confinement (per Day)	$50, 30 days maximum
Surgery	$100 for Exploratory; $300 for Knee Cartilage; $1,000 for Abdominal or Thoracic; $500 for Ruptured Disc; to $600 Tendon, Ligament, or Rotator cuff
Transportation	$300, if more than 100 miles from residence
X-Rays	$50
Accidental Death Benefits	**Amount**
Employee AD&D	$25,000
Spouse AD&D	$12,500
Child AD&D	$5,000
Common Carrier	100%
Accidental Dismemberment Benefits	**% of AD Benefit Amount**
Single Loss	50%
Multiple Loss (Catastrophic)	100%
Thumb / Finger / Toe	1%
2+ Thumb / Finger / Toe	3%
Speech	100%
Wellness (Health Screening) Benefit	**Amount**
Wellness (Health Screening)	$50

Accident Rates (Bi-Weekly)	
Employee	$4.15
Employee + Spouse/DP	$6.92
Employee + Child(ren)	$8.77
Family	$11.54

Critical Illness Insurance

Administered by Reliance Standard

www.reliancematrix.com/



Voluntary critical illness insurance provides a fixed, lump-sum benefit upon diagnosis of a critical illness, which can include heart attack, stroke, paralysis and more. These benefits are paid directly to the insured and may be used for any reason, from deductibles and prescriptions to transportation and child care. This benefit is 100% employee paid.

Voluntary Critical Illness (Employee-paid benefit)
You: Increments of $5,000 up to $20,000 $20,000 Guarantee Issue
Your spouse/DP: Increments of $5,000 up to $20,000 (not to exceed 100% of your coverage amount) $20,000 Guarantee Issue
Your child(ren): 25% of approved employee amount up to a maximum of $5,000. $5,000 Guarantee Issue

FEATURES

DIAGNOSIS ADULT	BENEFIT
Alzheimer's Disease	100%
Carcinoma In Situ	50%
Coma	100%
Coronary Disease	50%
Heart Attack	100%
Life Threatening Cancer	100%
Major Organ Failure	100%
Motor Neuron Disease (ALS)	100%
Multiple Sclerosis	100%
Parkinson's Disease	100%
Ruptured Cerebral, Carotid or Aortic Aneurysm	100%
Skin Cancer	5%
Stroke	100%
DIAGNOSIS CHILD	**BENEFIT**
Cerebral Palsy	100%
Cleft Lip or Palate	100%
Cystic Fibrosis	100%
Downs' Syndrome	100%
Muscular Dystrophy	100%
Spina Bifida	100%
Type 1 Diabetes	100%

Employee and Spouse Bi-Weekly Premiums

Benefit Amount	Age 0-29	Age 30-39	Age 40-49	Age 50-59	Age 60-69	Age 70+
$5,000	$0.60	$1.20	$2.58	$5.45	$11.08	$30.00
$10,000	$1.20	$2.40	$5.17	$10.89	$22.15	$60.00
$15,000	$1.80	$3.60	$7.75	$16.34	$33.23	$90.00
$20,000	$2.40	$4.80	$10.34	$21.78	$44.31	$132.00

Dependent Child(ren):
Your dependent child(ren) is eligible for a benefit amount of 25% of your Critical Illness benefit election, limited to a maximum of $5,000

To calculate Dependent Child(ren) Benefit:
Employee Benefit Amount x 25% = Dependent Child(ren) Benefit. No rounding needed.

To calculate Monthly Dependent Child(ren) Premium:
Dependent Child(ren) Benefit/1000 x 0.50

Please Note: One rate and benefit amount for all eligible children in family, regardless of number.

Travel Assistance

GORMAN & COMPANY

Administered by Reliance Standard

www.reliancematrix.com/

Sure, we all expect our trips to go off without a hitch, and most times they do. However, if you experience an emergency when traveling–no matter how big or how small–you have **around- the-clock access** to On Call International's 24-hour, toll-free travel assistance services. Whether you need help with an illness or injury, lost passport, missing luggage or even a prescription refill, you can rest assured you (and your covered dependents!) have access to a personal travel emergency companion anytime you're more than 100 miles away from home.

How Your Travel Assistance Services Work

Using your travel emergency services is a cinch! Just contact On Call International directly at (603) 328-1966 anytime you need assistance while traveling. On Call's Global Response Center is open **24** hours a day, **365** days a year and can provide the following services through your group coverage with Reliance Standard.

The following is an outline of the On Call emergency travel assistance service program. For a complete description of all services and the program terms and limitations, please request a Description of Covered Services from your employer.

Covered Services

When traveling more than 100 miles from home or in a foreign country, On Call offers you and your dependents the following services:

Pre-Trip Assistance

- Inoculation requirements information
- Passport/visa requirements
- Currency exchange rates
- Consulate/embassy referral
- Health hazard advisory
- Weather information

Emergency Medical Transportation*

- Emergency evacuation
- Medically necessary repatriation
- Visit by family member or friend
- Return of traveling companion
- Return of dependent children
- Return of vehicle
- Return of mortal remains

Emergency Personal Assistance Services

- Urgent message relay
- Interpretation/translation services
- Emergency travel arrangements
- Recovery of lost or stolen luggage/personal possessions
- Legal assistance and/or bail bond

Medical Assistance Services Include

- Medical referrals for local physicians/dentists
- Medical case monitoring
- Prescription assistance and eyeglasses replacement
- Convalescence arrangements

* The services listed above are subject to a maximum combined single limit of $250,000. Return of vehicle is subject to $2,500 maximum.

Provided with your benefits coverage through

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Administered By

ON CALL INTERNATIONAL

24-Hour Travel Assistance

On Call International provided through Reliance Standard

In the U.S., toll free
(800) 456-3893

Worldwide, collect
(603) 328-1966

GORMAN & COMPANY

Identity Theft Protection

Administered by Reliance Standard

www.reliancematrix.com/

your digital life is unique. so is your identity theft benefit.

Get the only comprehensive monitoring of its kind to help you protect yourself from digital fraud

Identity theft and fraud impacted 1 in 6 people last year.[1] When fraud occurs, unraveling it can be overwhelming and costly. That's why Reliance Standard Life and your employer are providing you with InfoArmor Identity Protection. Should you experience fraud, InfoArmor's comprehensive recovery services will go the extra mile to help you resolve your case and restore your identity, saving you time, money, and stress. Plus you can rely on up to $25K in identity fraud expense reimbursement to cover related out-of-pocket costs.[1]

Nobody thinks identity theft will happen to them until it does. That's when you need a trusted expert by your side to help pick up the pieces. InfoArmor's unique combination of proprietary technology and remediation expertise provides peace of mind every step of the way — so you can live confidently online.

Powerful monitoring and security tools, plus full-service remediation and reimbursement

Dark web monitoring

In-depth monitoring goes beyond just looking out for a participant's Social Security number. Bots and human intelligence scour closed hacker forums for compromised credentials and other personal information. Then we alert you if your information is compromised.

Lost wallet assistance

Losing your wallet isn't fun. This security feature allows you to easily access and replace wallet contents. InfoArmor's encrypted vault stores:

- User IDs & passwords
- ATM/credit cards
- Checking accounts
- Driver's licenses
- Health insurance cards

$25K fraud-related loss reimbursement

Should fraud occur, we have your back. You'll receive full-service remediation and up to $25K in identity fraud expense reimbursement for out-of-pocket costs.[1]

What members are saying:

99%
are satisfied with their customer care experience[2]

98%
are satisfied with how their problem was resolved on their first call[2]

99%
are satisfied with their recovery in cases of identity theft[2]

InfoArmor IDENTITY PROTECTION

RELIANCE STANDARD
A MEMBER OF THE TOKIO MARINE GROUP

Pet Insurance

GORMAN & COMPANY

Administered by Nationwide

www.petinsurance.com/gormanusa

Nationwide® pet insurance

My Pet Protection® plan summary

Nationwide pet insurance helps you cover veterinary expenses so you can provide your pets with the best care possible **without worrying about the cost**.

My Pet Protection coverage highlights

We offer a choice of reimbursement options so you can find coverage that fits your budget. All plans have a $250 annual deductible and $7,500 maximum annual benefit. Coverage includes*:

- Accidents
- Illnesses
- Hereditary and congenital conditions
- Cancer
- Dental diseases
- Behavioral treatments
- Rx therapeutic diets and supplements
- And more

Plus, every My Pet Protection policy includes these additional benefits to maximize your value:

- Lost pet advertising and reward expense
- Emergency boarding
- Loss due to theft
- Mortality benefit

Included with every policy

vethelpline®

- 24/7 access to veterinary experts ($110 value)
- Available via phone, chat and email
- Unlimited help for everything from general pet questions to identifying urgent care needs

PetRxExpress℠

- Save time and money by filling pet prescriptions at participating in-store retail pharmacies across the U.S.
- Rx claims submitted directly to Nationwide
- More than 4,700 pharmacy locations

Additional highlights

- Exclusive product for employer groups only
- Preferred pricing for employees
- Multiple-pet discounts
- Guaranteed issuance

Get a fast, no-obligation quote today.

PetsNationwide.com • 877-738-7874

Nationwide®

401K Retirement Plan

Administered by Empower Retirement
www.empower.com/

Gorman & Company has a 401K plan which you may be eligible to participate in through pre-tax payroll deductions, or after-tax payroll deductions for Roth contributions. You are allowed to rollover existing qualified plan contributions into this plan. The entry date for participation in the employer match is the first of the month following 60 days of employment. You must be 21 years of age to participate in the Gorman 401K plan. The current discretionary employer match is 100% (dollar for dollar) of up to 6% of your annual pay. The employer match contributions are deposited on per pay period basis. There is a 6-year vesting schedule for the 401K plan.

Gorman & Company's 401K plan is set up for Auto Enrollment. This means that when you become eligible to participate in the plan, you will be **automatically enrolled** in the plan at 6%. You will receive a notice from Empower Retirement one month prior to your eligibility date explaining this and giving you the opportunity to go online and "opt out" or edit your contribution percentage.

GORMAN & COMPANY

Earned Time / Paid Holidays

EARNED TIME ACCRUAL

Earned Time is paid time off that can be used for vacation, sick, and/or personal days. Earned Time is available to full-time and full-time 75 regular and temporary team members. These team members will accrue Earned Time according to the schedules below. Part-time team members working 29 or fewer hours per week do not accrue Earned Time (unless otherwise required by law). Accrual of Earned Time commences on your start date and accrues on a per pay period basis. Team members cannot use more Earned Time than what has accrued on the date of the requested day(s) off.

FULL-TIME ACCRUAL SCHEDULE

Length of Employment	Accrual per Pay Period	Maximum Days Accrued per Year	Number of Carryover Days Allowed
0 - 5 years	5.5385 hours	18 days/144 hours	15 days/120 hours
5+ years	7.0769 hours	23 days/184 hours	35 days/280 hours

FULL-TIME 75 ACCRUAL SCHEDULE

Length of Employment	Accrual per Pay Period	Maximum Days Accrued per Year	Number of Carryover Days Allowed
0 - 5 years	4.1538 hours	14.5 days/116 hours	11.25 days/90 hours
5+ years	5.308 hours	17.25 days/138 hours	26.25 days/210 hours

PAID HOLIDAYS

Team members who are scheduled to work more than 20 hours per week may be eligible for the following paid holidays. ***** Property and Corporate team members are not eligible for the Easter holiday. ** Hotel team members are not eligible for the Day after Thanksgiving holiday or the Good Friday holiday. See the Hotel Holiday Pay policy below for more information.

- New Year's Day
- MLK Jr. Day
- Good Friday (1/2-day) **
- Easter *
- Memorial Day
- Juneteenth
- Independence Day
- Labor Day
- Thanksgiving Day
- Day after Thanksgiving **
- Christmas Eve Day (1/2-day)
- Christmas Day
- New Year's Eve Day (1/2-day)

Hotel Holiday Pay: Due to the nature of the hotel industry operating 365 days per year, paid holidays are handled differently for hotel team members at the Company. Hotel hourly team members will be paid at the rate of one and a half times their regular rate of pay for any hours worked on an eligible holiday. For the Christmas Eve and Christmas Day holidays, and the New Year's Eve and New Year's Day holidays, hourly hotel team members will be eligible for Hotel Holiday Pay when working between the hours of 3:00 p.m. on the eve of the holiday through 11:00 p.m. on the day of the holiday. Hotel salaried team members who are scheduled to work on an eligible holiday may take the holiday on a different day within the same pay period. The Company reserves the right to change paid holiday dates depending on how the holiday falls within the week of the calendar year.

Contact Information

Benefit	Vendor	Phone	Website or Email
Human Resources	Gorman & Company	608-835-5534	HR@gormanusa.com
Medical	UnitedHealthcare or Quartz	Call the number on your ID Card	www.myuhc.com www.quartzbenefits.com
Dental	Delta Dental of Wisconsin	800-236-3712	www.deltadentalwi.com
Vision	Eye Med	844-848-7090	www.eyemed.com
Health Savings Account (HSA)	EBC	800-346-2126	www.ebcflex.com
Flexible Spending Account (FSA)	EBC	800-346-2126	www.ebcflex.com
Life and AD&D	Reliance Standard	800-351-7500	www.reliancematrix.com
Disability	Reliance Standard	800-351-7500	www.reliancematrix.com
Employee Assistance Program	Reliance Standard	800-351-7500	rsli.mylifeexpert.com/
Accident	Reliance Standard	800-351-7500	www.reliancematrix.com
Critical Illness	Reliance Standard	800-351-7500	www.reliancematrix.com
Hospital Indemnity	Reliance Standard	800-351-7500	www.reliancematrix.com
Pet Insurance	Nationwide	877-738-7874	www.petinsurance.com/gormanusa
Gorman 401K Plan	Empower Retirement	800-338-4015	www.empower-retirement.com/participant
ALEX Benefits Counselor	https://www.myalex.com/gorman/2024		
Connect2MyBenefits – Gorman HR Hub	https://c2mb.ajg.com/gorman/home/		

GORMAN & COMPANY

Legal Notices

Patient Protections disclosure

The Gorman & Company Health Plan generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. Until you make this designation, UnitedHealthcare and Quartz designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the UnitedHealthcare and Quartz at 866-314-0335 and 800-362-3310 or www.myuhc.com and www.quartzbenefits.com.

For children, you may designate a pediatrician as the primary care provider.
You do not need prior authorization from UnitedHealthcare and Quartz or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the UnitedHealthcare and Quartz at 866-314-0335 and 800-362-3310 or www.myuhc.com and www.quartzbenefits.com.

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:

UnitedHealthcare:
Plan 1: UHC 1000 (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)
Plan 2: UHC 3000 (Individual: 20% coinsurance and $3,000 deductible; Family: 20% coinsurance and $6,000 deductible)
Plan 3: UHC HDHP (Individual: 0% coinsurance and $5,000 deductible; Family: 0% coinsurance and $10,000 deductible)

Quartz:
Plan 1: POS-Quartz Network (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)
Plan 2: HMO-Quartz Network (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)
Plan 3: POS-Quartz Network (Individual: 20% coinsurance and $3,000 deductible; Family: 20% coinsurance and $6,000 deductible)
Plan 4: HMO-Quartz Network (Individual: 20% coinsurance and $3,000 deductible; Family: 20% coinsurance and $6,000 deductible)
Plan 5: POS-Quartz HDHP Network (Individual: 0% coinsurance and $5,000 deductible; Family: 0% coinsurance and $10,000 deductible)
Plan 6: HMO-Quartz HDHP Network (Individual: 0% coinsurance and $5,000 deductible; Family: 0% coinsurance and $10,000 deductible)

If you would like more information on WHCRA benefits, please call your Plan Administrator at 608- 835-7004 or lhalzel@gormanusa.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, 2023. Contact your State for more information on eligibility –

ALABAMA – Medicaid	ALASKA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx
ARKANSAS – Medicaid	**CALIFORNIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Health Insurance Premium Payment (HIPP) Program Website: http://dhcs.ca.gov/hipp Phone: 916-445-8322 Fax: 916-440-5676 Email: hipp@dhcs.ca.gov
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**FLORIDA – Medicaid**
Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/State Relay 711 CHP+: https://hcpf.colorado.gov/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.mycohibi.com/ HIBI Customer Service: 1-855-692-6442	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – Medicaid	**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	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone: 1-800-457-4584

GORMAN & COMPANY

Legal Notices

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp 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: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp 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/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	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: HHSHIPPProgram@mt.gov	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
NEVADA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext. 5218
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100	Website: https://www.hhs.nd.gov/healthcare Phone: 1-844-854-4825

Legal Notices

OKLAHOMA – Medicaid and CHIP	OREGON – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://healthcare.oregon.gov/Pages/index.aspx Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP	**RHODE ISLAND – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP)(pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid	**SOUTH DAKOTA - Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://dss.sd.gov Phone: 1-888-828-0059
TEXAS – Medicaid	**UTAH – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
VERMONT– Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427	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	**WEST VIRGINIA – Medicaid and CHIP**
Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022	Website: https://dhhr.wv.gov/bms/ http://mywvhipp.com/ Medicaid Phone: 304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP	**WYOMING – Medicaid**
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002	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, 2023, 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)

GORMAN & COMPANY

Legal Notices

Notice of Privacy Practices Reminder

Protecting Your Health Information Privacy Rights
Gorman & Company is committed to the privacy of your health information. The administrators of the Gorman & Company 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 Laurie Halzel - Director of Human Resources at 608-835-7004 or lhalzel@gormanusa.com.

HIPAA Special Enrollment Rights

Gorman & Company Health Plan Notice of Your HIPAA Special Enrollment Rights

Our records show that you are eligible to participate in the Gorman & Company 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 Laurie Halzel - Director of Human Resources at 608-835-7004 or lhalzel@gormanusa.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 Gorman & Company

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 Gorman & Company 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. **Gorman & Company 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 Gorman & Company coverage may be affected. You may reference your current Quartz Health Plan & UnitedHealthcare Summary Plan Description for benefits in place at the current time. Or you may request a copy of the Summary Plan Description from Human Resources or Quartz Health Plan & UnitedHealthcare if you need to review or clarify the level of benefits currently being administered.

If you do decide to join a Medicare drug plan and drop your current Gorman & Company 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 Gorman & Company 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 Gorman & Company changes. You also may request a copy of this notice at any time.

GORMAN & COMPANY

Legal Notices

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, 2024**
Name of Entity/Sender:	**Gorman & Company**
Contact—Position/Office:	**Laurie Halzel - Director of Human Resources**
Office Address:	**200 N Main St** **Oregon, Wisconsin 53575-1447** **United States**
Phone Number:	**608-835-7004**

Marketplace Notice

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2013 for coverage starting as early as January 1, 2014.

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

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

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

Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer's health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.[1]

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

How Can I Get More Information?

For more information about your coverage offered by your employer, please check your summary plan description or contact Laurie Halzel.

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

[1]An employer-sponsored health plan meets the "minimum value standard" if the plan's share of the total allowed benefit costs covered by the plan is no less than 60 percent of such costs.

Michelle's Law

Dependent students who take a physician-certified medically necessary leave of absence from a postsecondary educational institution (college, university or vocational school) due to a serious illness or injury, will be eligible for continued group health plan coverage until the earlier of one (1) year from the first day of such a leave of absence or the date on which the coverage otherwise would terminate.

UnitedHealthcare

Gorman and Company
Policy Number: 922902
Renewal Date: 1/1/2024

REQUIRED UNIFORM MODIFICATION NOTICE FOR LARGE GROUP EMPLOYERS

Important: Legal Notice Regarding Changes to Your Group Health Plan to Take Effect at Your Next Renewal

Your group health insurance coverage is coming up for renewal. The following changes, which may also include language clarifications, are required and will be implemented at your next renewal:

- Your plan includes UnitedHealthcare Rewards. With UnitedHealthcare Rewards eligible members can earn dollars for taking small steps towards creating a healthier lifestyle. Members can choose from a variety of reward activities including: track sleep, fitness, completing biometrics and/or a health survey, going paperless and more. UHC Rewards is accessible through the UnitedHealthcare® app and myuhc.com. If a member was eligible for UnitedHealthcare Motion® or SimplyEngaged, these programs will no longer be available.
- All mental health care and substance-related and addictive disorders services must be provided by or under the direction of a behavioral health provider who is properly licensed and qualified by law and acting within the scope of their licensure.
- Provider-based case management services are no longer included under Mental Health Care and Substance-Related and Addictive Disorders Services.
- Elective fertility preservation is not a covered benefit.
- If infertility services are covered, eligibility for benefits no longer requires the member be a female under age 44.
- Benefits are provided for certain over-the-counter hearing aids for covered persons age 18 and older who have mild to moderate hearing loss.
- Specialized enteral formulas administered either orally or by tube feeding are covered for certain conditions under the direction of a physician.
- External catheters are covered health care services.
- Individual and group nutritional counseling exclusion does not apply to behavioral/mental health-related nutritional education services that are provided as part of treatment.
- The following exclusions are removed under gender dysphoria: breast enlargement, including augmentation mammoplasty and breast implants; thyroid cartilage reduction; reduction thyroid chondroplasty; trachea shave; voice modification surgery; voice lessons and voice therapy.

Uniform Modification Notice

- The routine foot care exclusion does not apply to preventive foot care due to conditions associated with metabolic, neurologic, or peripheral vascular disease.
- Reconstructive jaw surgery is covered when there is a facial skeletal abnormality and associated functional medical impairment.
- Adding pyromania and kleptomania to the list of services not covered under the plan unless they are tied to a conduct or impulse control disorder diagnosis.
- The requirement to maintain a written, specific and detailed treatment program requiring your full-time residence and participation in the residential treatment definition was replaced with the requirement to offer organized treatment services that feature a planned and structured regimen of care in a 24-hour setting.
- When a covered person is eligible for Medicare on a primary basis but chooses not to enroll in Medicare, the policy will pay as secondary and benefits will be calculated using Medicare's approved amount or Medicare's limiting charge.
- Some travel expenses related to covered health care services received from a network provider may be paid back as determined by us.
- The allowed amount (which includes mileage) for emergency ground ambulance transportation provided by an out-of-network provider is a rate agreed upon by the provider or determined based upon the median amount negotiated with network providers for the same or similar service, unless a different amount is required by applicable law.
- The prior authorization requirement for extended outpatient treatment visits, with or without medication management, is removed.
- For all inpatient benefits, the out-of-network prior authorization requirement has been removed for emergency admissions.
- When covered health care services are received from an out-of-network provider as arranged by us, including when there is no network provider who is reasonably accessible or available to provide covered health care services, allowed amounts are an amount negotiated by us or an amount permitted by law.
- The rehabilitation cost share will apply to all visits, including the first 3 visits, for any combination of manipulative treatment and physical therapy for new low back pain.
- The policy charge is based on the enrollment records as provided by you at the time the invoice for the policy charge is issued. You must notify us of enrollments, terminations or other changes in writing or through our electronic system or by other methods as determined by us.
- Under the definition of "Experimental or Investigational Service(s)", the following sources were removed as criteria to identify appropriate use: the American Hospital Formulary Service; the United States Pharmacopoeia Dispensing Information. And the following sources were added: AHFS Drug Information (AHFS DI) under therapeutic uses section; Elsevier Gold Standard's Clinical Pharmacology under the indications section; DRUGDEX System by Micromedex under the therapeutic uses section and has a strength recommendation rating of class I, class IIa, or class IIb; National Comprehensive Cancer Network (NCCN) drugs and biologics compendium category of evidence 1, 2A, or 2B. Experimental or investigational service(s) are only obtainable, with regard to outcomes for the given indication, within research settings.
- When biosimilars become available, pharmacy tiers may change for reference products or the reference products may be excluded.
- Durable Medical Equipment, including certain insulin pumps and related supplies, is excluded.
- Convenience care medications are excluded.
- The reference to the smart fill program has been removed.

Uniform Modification Notice

- Certain prescription drug products for tobacco cessation are excluded.
- Any cost-sharing changes are described in your renewal package.

Refer to the benefit documents for specific coverage details. Rates and/or benefits may be subject to regulatory approval. If the rates or products offered are changed as a result of the regulatory review process, we will advise you as soon as possible.

If you have any questions or would like to discuss, please contact me.

We're looking forward to another year of serving you and your employees.

GORMAN & COMPANY

Plan Changes Notice

Quartz

Changes to Group Certificates for 2024 Renewal

Improved transparency in Summary of Benefits and Coverage (SBC) by: • Adding "deductible does not apply" in various locations to clearly indicate when the deductible does not apply based on plan selected; and, • Clarifying under limitations for diagnostic tests and imaging that prior authorization may be required.
Added coverage for over-the-counter hearing aids. Dollar and frequency limits may apply.
Revised panniculectomy exclusion. May be covered following weight loss if medically necessary.
Modified language to support covering services provided via care management programs.
Added general exclusions for "wart removal" and "services not rendered."
Updated hair removal exclusion to cover if authorized by Quartz for covered gender-affirming care.
Updated coverage at $0 for the following preventive services: • Removed requirement to cover aspirin to prevent cardiovascular risk; • Added screening for anxiety for individuals aged 8-18; • Allowed repeat screening for type 2 diabetes six months post-partum for individuals with positive screening test in early post-partum period; • Added COVID-19 vaccinations; and, • Changed upper age limit for HIV screening from 18 to 21.
Clarified that: • Sublingual allergy treatment is covered if FDA-approved and on the formulary; • Medical benefit drugs are no longer listed in the formulary; • Glucometers and continuous glucose monitors may be covered under the pharmacy, rather than medical, benefit; and, • Quartz plans cover one initial contact lens per eye for specific reasons when medically necessary.
Removed age limits for initiating treatment of autism spectrum disorder.
Revised to support using Cigna for the PPO network and wrap network for HMO and POS plans. • Allowed Cigna to perform medical necessity determinations & process appeals in certain situations. • Removed requirement that member go in-network for certain services under a PPO or POS plan. • Updated prior authorization lists for PPO and out-of-area services under HMO and POS, and instructions for how a member can locate the correct list. • For HMO and POS plans, allowed that out-of-network referrals and prior authorization requests come to Quartz first but may be redirected to Cigna if provider is outside Quartz service area.
Added a new special enrollment period for individuals voluntarily losing other group coverage during the annual open enrollment period of another employer group health plan.
Clarified that "Extension of Coverage Due to Total Disability" applies only when group policy terminates (not certificate).
Clarified that legal wards of covered spouses are eligible for coverage.
For small group plans, removed language stating Quartz will coordinate benefits with Medicare when a member is eligible for Medicare, even if they did not enroll.
Updated Continuity of Care language to more clearly comply with requirements of the No Surprises Act.
Revised Group Master Policy Agreements to assume responsibility for groups' compliance with Air Ambulance reporting requirements and submitting the annual Gag Clause Prohibition Compliance Attestation for fully insured groups; updated language to clearly state that group is responsible for providing employer vs. member-paid premium information to Quartz for prescription drug reporting.

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting