GORMAN & COMPANY

Integrity. Innovation. Community.

BENEFITS GUIDE 2025 - QUARTZ

Photo by JW Aerial Image

If you have any questions, please contact:

HR@gormanusa.com

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If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page number(s) 30-31 where Notice of Creditable Coverage begin for more details.

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). You have the option of purchasing other voluntary benefits for you, your spouse, and/or your child(ren) (voluntary life, accidental death & dismemberment, 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

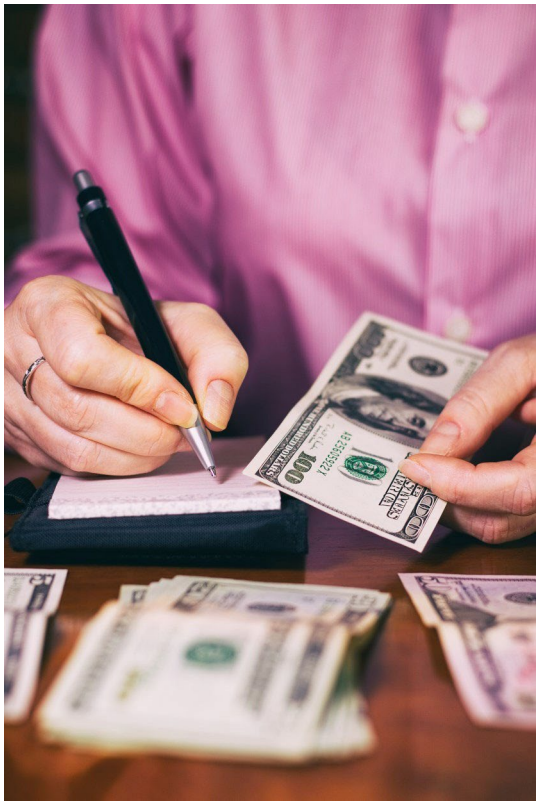
2025 Employee Contributions (Bi-Weekly)

MEDICAL — QUARTZ						
	HMO 1000	POS 1000	HMO 3000	POS 3000	HMO—HDHP	POS—HDHP
Employee	$69.78	$73.61	$59.11	$64.56	$49.05	$51.52
Employee + Spouse/DP	$238.81	$251.92	$202.27	$220.93	$167.87	$176.32
Employee + Child(ren)	$195.39	$206.11	$165.49	$180.76	$137.34	$144.26
Family	$348.77	$367.92	$295.41	$322.66	$245.16	$257.50

*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

2025 Employee Contributions (Monthly)

Voluntary Life and AD&D Insurance			
Age	Employee Per $10,000 of coverage	Spouse/DP Per $5,000 of coverage	Child Per $2,000 of coverage
15-29	$0.60	$0.30	Get up to $10,000 of coverage in $2,000 increments. One policy covers all of your eligible dependent children until their 19th birthday – or until their 26th birthday if they are full-time students. The maximum benefit for children live birth to 6 months is $1,000 Rate: $.442 per $2,000 of coverage
30-34	$0.70	$0.35	
35-39	$0.99	$0.495	
40-44	$1.70	$0.85	
45-49	$2.60	$1.30	
50-54	$3.99	$1.995	
55-59	$6.99	$3.495	
60-64	$9.92	$4.96	
65-69	$18.40	$9.20	
70+	$28.50	$14.25	
AD&D	$0.26	$0.13	$.052

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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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	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.

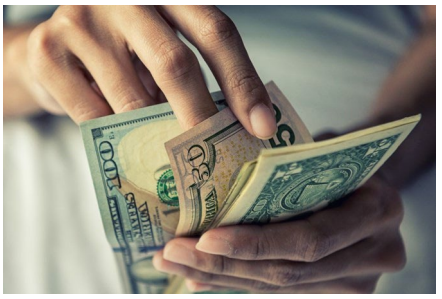
Your plan covers cost of covered services.

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 an 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.

- **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.

Annual Company Contribution

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

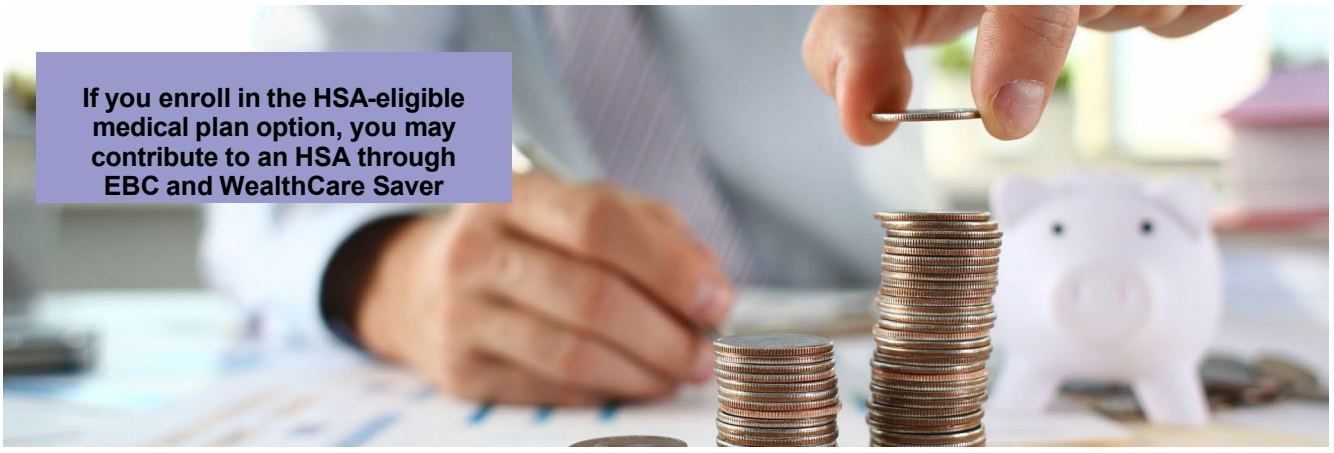
In order for a dependent under age 26 to use HSA money, they must qualify as your IRS Dependent. Additional rules apply if your spouse or tax-eligible dependent also has an HSA.

Are you eligible for an HSA?

- If you enroll in a HDHP, you are eligible to open an 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).

2025 IRS Annual Contribution Limits

Employee Only	$4,300
EE +1 and Family	$8,550
Catch up	$1,000



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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 $660 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.

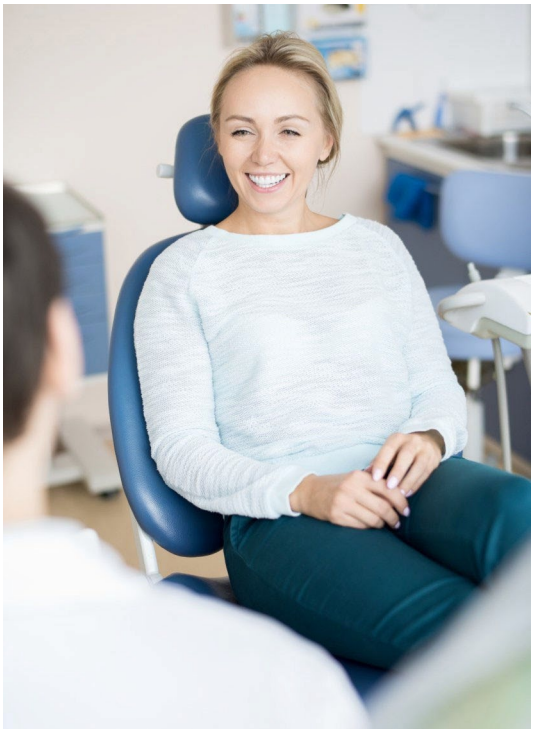
Feature	Healthcare FSA	Dependent Care FSA
Maximum contribution per year	$3,300	$5,000
Can be used for eligible…	Medical, dental and vision expenses for you and your dependents	Daycare expenses for eligible dependents
Carryout or runout period	Up to $660 of unused funds can be carried over to the next 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

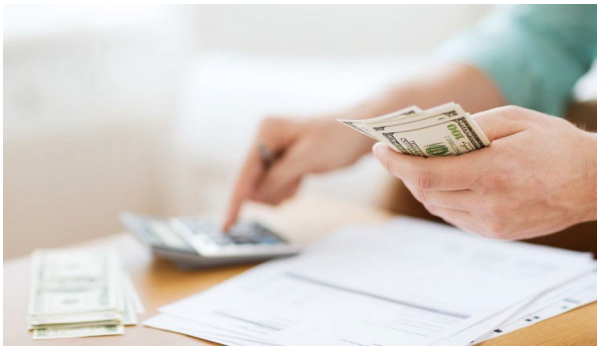
*additional tints and coatings may incur additional out of pocket costs

**contact lens benefit in lieu of eyeglass benefits

EyeMed

Life and Disability Coverage

Administered by UNUM – www.unum.com



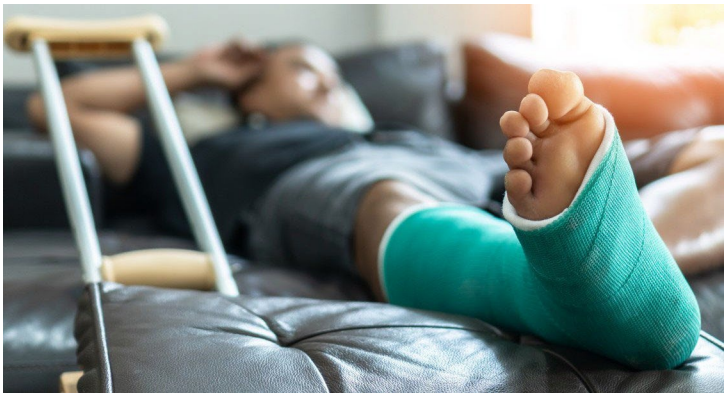
Gorman & Company provides basic life and accidental death and dismemberment (AD&D) insurance through UNUM at no cost to eligible employees. You will automatically be enrolled for this coverage.

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.

	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 100% of your optional life coverage amount) $25,000 Guarantee Issue **Your child(ren):** $1,000 to $10,000, not to exceed 100% 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 100% of your optional life coverage amount) **Your child(ren):** $1,000 to $10,000, not to exceed 100% of your optional life amount.

Gorman & Company also provides disability insurance through UNUM. 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

Employee Assistance Program

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Administered by UNUM - www.unum.com

Help, when you need it most

With your Employee Assistance Program and Work/Life Balance services, confidential assistance is as close as your phone or computer.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor who can help you.

Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief and loss
- Job stress, work conflicts
- Family and parenting problems
- And more

WORK/LIFE BALANCE

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our Work/Life Specialists can answer your questions and help you find resources in your community.

Ask our Work/Life Specialists about:

- Childcare
- Elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions
- Even reducing your medical/dental bills!
- And more

Who is covered?

Unum's EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill SaverTM — helps you save on medical bills

Help is easy to access:

Phone support: 1-800-854-1446

Online support: unum.com/lifebalance

In-person: You can get up to three visits, available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

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Accident Insurance

Administered by Unum - www.unum.com

With Accident insurance, you'll receive a cash benefit for each covered injury and related services. You can use the payment in any way you choose - from expenses Not covered by your major medical plan to day-to-day costs of living such as the mortgage or your utility bills.

How does it work?

Accident Insurance provides a set benefit amount based on the type of injury you have and the type of treatment you need. It covers accidents that occur off the job. And it Includes a range of incidents, from common injuries to more serious events.

Why is this coverage so valuable?

It can help you with out-of-pocket costs that your medical plan doesn't cover, like co-pays and deductibles. You'll have base coverage without medical underwriting. The cost is conveniently deducted from your paycheck. You can keep your coverage if you change jobs or retire. You'll be billed directly

Who can get coverage?	
You	If you're actively at work*
Your spouse	Can get coverage as long as you have purchased coverage for yourself.
Your children	Dependent children from birth until their 26th birthday, regardless of marital or student status

*Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage. See Schedule of benefits for a complete listing of what is covered.

Your monthly premium	Rate
You	$8.38
You and your spouse	$14.57
You and your children	$18.82
Family	$25.01

What's included?

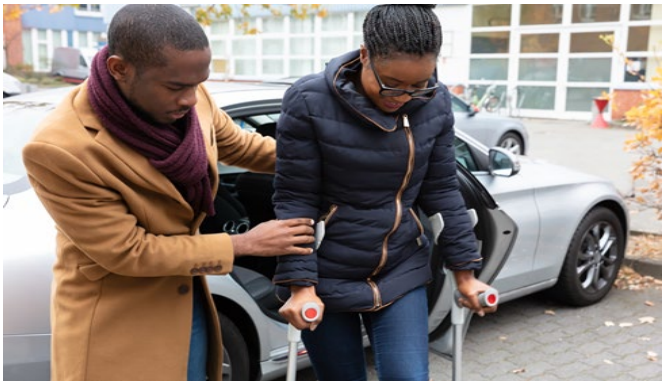
Be Well Benefit

Every year, each family member who has Accident coverage can also receive $50 for getting a covered Be Well screening test, such as:

- Annual exams by a physician include sports physicals, well-child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 10% increase in payable benefits within the Injury and Treatment schedule of benefit categories. See disclosures and schedule of benefits for more information.



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Critical Illness

Administered by UNUM - www.unum.com

How does it work?

If you're diagnosed with an illness that is covered by this insurance, you can receive a lump sum benefit payment. You can use the money however you want.

Why is this coverage so valuable?

The money can help you pay out-of-pocket medical expenses, like deductibles. You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 10% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

Why should I buy coverage now?

It's more accessible when you buy it through your employer and the premiums are conveniently deducted from your paycheck. Coverage is portable. You may take the coverage with you if you leave the company or retire. You'll be billed at home.

What's covered?

Critical Illnesses	
End Stage Renal (Kidney) Failure	100%
Heart Attack (Myocardial Infarction)	100%
Major Organ Failure Requiring Transplant	100%
Stroke	100%
Sudden Cardiac Arrest	100%
Coronary Artery Disease (Major)	50%
Coronary Artery Disease (Minor)	10%

Additional Critical Illnesses for your Children 100% (50% of elected amount)	
Cerebral Palsy	Down Syndrome
Cleft Lip or Palate	Sickle Cell Anemia
Congenital Heart Disease	Spina Bifida
Cystic Fibrosis	Type 1 Diabetes

Progressive Diseases: 100%	
Addison's Disease	Lupus
Amyotrophic Lateral Sclerosis (ALS)	Multiple Sclerosis
Dementia (including Alzheimer's Disease	Multiple Dystrophy
Functional Loss	Myasthenia Gravis
Huntington's Disease	Parkinson's Disease
Systemic Sclerosis (Scleroderma)	

Supplemental: 100%	Supplemental Reduced
Benign brain tumor	Bone Marrow/Stem Cell Transplant (25%)
Coma	Infectious Diseases (25%)
Loss of sight, hearing or speech	Infectious Disease Hospital Consecutive Days (7 Days)
Occupational HIV, Hepatitis B, C or D or PTSD	Pulmonary Embolism (25%)
Permanent Paralysis	Transient Ischemic Attack / TIA (25%)

Cancer	
Invasive Cancer (including all Breast Cancer)	100%
Non-Invasive Cancer	25%
Skin Cancer $	$500

Be Well Benefit

Every year, each family member who has Critical Illness coverage can also receive a payment for getting a covered Be Well Benefit screening test*, such as:

- Annual exams by a physician include sports physicals, well child visits, dental and vision exams
- Screenings for cancer, including pap smear, colonoscopy
- Cardiovascular function screenings
- Screenings for cholesterol and diabetes
- Imaging studies, including chest X-ray, mammography
- Immunizations including HPV, MMR, tetanus, influenza

* Be Well Benefit Amounts based on Coverage Amounts. See the Monthly Rate Tables on the following page.

Who can get coverage?	
You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can only get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	If elected, children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome and spina bifida. The diagnosis must occur after the child's coverage effective date.

Benefits may be subject to a pre-existing condition provision

GORMAN & COMPANY

Critical Illness

Administered by UNUM

Age	Monthly Costs Employee Coverage: $10,000 Spouse Coverage: $10,000 Be Well Benefit: $50	
	Employee	Spouse
under 25	$2.60	$2.60
25 - 29	$2.60	$2.60
30 - 34	$5.20	$5.20
35 - 39	$5.20	$5.20
40 - 44	$8.50	$8.50
45 - 49	$11.20	$11.20
50 - 54	$15.50	$15.50
55 - 59	$20.80	$20.80
60 - 64	$34.70	$34.70
65 - 69	$46.70	$46.70
70 - 74	$63.50	$63.50
75 - 79	$87.40	$87.40
80 - 84	$118.60	$118.60
85+	$130.00	$130.00

Age	Monthly Costs Employee Coverage: $20,000 Spouse Coverage: $20,000 Be Well Benefit: $50	
	Employee	Spouse
under 25	$5.20	$5.20
25 - 29	$5.20	$5.20
30 - 34	$10.40	$10.40
35 - 39	$10.40	$10.40
40 - 44	$17.00	$17.00
45 - 49	$22.40	$22.40
50 - 54	$31.00	$31.00
55 - 59	$41.60	$41.60
60 - 64	$69.40	$69.40
65 - 69	$93.40	$93.40
70 - 74	$127.00	$127.00
75 - 79	$174.80	$174.80
80 - 84	$237.20	$237.20
85+	$260.00	$260.00

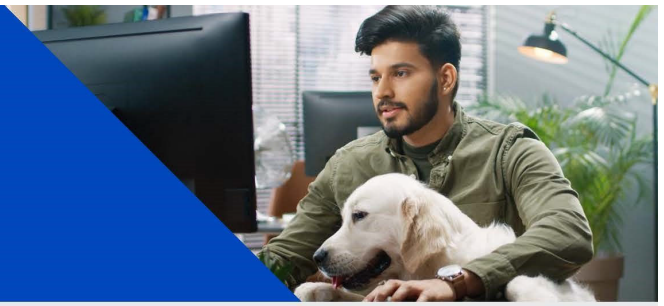
Age	Monthly Costs Employee Coverage: $30,000 Spouse Coverage: $30,000 Be Well Benefit: $50	
	Employee	Spouse
under 25	$7.80	$7.80
25 - 29	$7.80	$7.80
30 - 34	$15.60	$15.60
35 - 39	$15.60	$15.60
40 - 44	$25.50	$25.50
45 - 49	$33.60	$33.60
50 - 54	$46.50	$46.50
55 - 59	$62.40	$62.40
60 - 64	$104.10	$104.10
65 - 69	$140.10	$140.10
70 - 74	$190.50	$190.50
75 - 79	$262.20	$262.20
80 - 84	$355.80	$355.80
85+	$390.00	$390.00

GORMAN & COMPANY

Pet Insurance

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)
- Floating Holiday

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.

GORMAN & COMPANY

Additional Benefits Overview

Education Reimbursement:
To encourage the professional and personal development of Gorman & Company team members, the Company may provide reimbursement to eligible team members for job-related courses taken at accredited colleges or universities. All full-time and full-time 75 team members who have been employed with the Company for at least six (6) months are eligible for the Education Reimbursement Program. Team members must receive approval from their supervisor and Human Resources prior to signing up for a course. Only courses that are directly related to the team member's position or a potential career path at the Company will be considered.

Paid Parental Leave:
Full-time regular and full-time 75 regular team members are eligible for up to 4 weeks of paid parental leave that can be used within 3 months following the birth or adoption of the team member's child(ren). Parental leave runs concurrently with short-term disability, FMLA, and other State leave programs, if applicable. Unused parental leave will not be paid out upon separation from employment.

Bereavement Leave:
All team members will be granted up to 10 work days of paid bereavement leave in the event of the death of a child or step-child, up to 5 work days of paid bereavement leave in the event of the death of an immediate family member who resides in the team member's household, or up to 3 work days of paid bereavement leave in the event of the death of another immediate family member or for pregnancy loss or miscarriage. Part-time team members will receive bereavement leave pay in accordance with the number of hours they are regularly scheduled to work on that particular day.

Paid Leave for Bone Marrow and Organ Donation:
All team members are eligible for up to 5 days of paid leave to serve as a bone marrow donor, and for up to 3 weeks of paid leave to serve as an organ donor (actual amount of paid leave will be prorated based on employment status).

Jury Duty:
Full-time team members who are called for jury duty will be paid their regular wage for up to one week. This benefit also extends to eligible part-time team members, should they need to serve on jury duty on days they are regularly scheduled to work. In such case, the part-time team member will receive pro-rated jury duty pay in accordance with the number of hours they are regularly scheduled to work on each scheduled day.

For a complete list of benefits and further information please reference the Team Member Handbook.

Contact Information

Benefit	Vendor	Phone	Website or Email
Human Resources	Gorman & Company	608-835-5534	HR@gormanusa.com
Medical	Quartz	Call the number on your ID Card	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	UNUM	866-679-3054	www.unum.com
Disability	UNUM	866-679-3054	www.unum.com
Employee Assistance Program	UNUM	800-854-1446	www.unum..com/lifebalance
Accident	UNUM	866-679-3054	www.unum.com
Critical Illness	UNUM	866-679-3054	www.unum.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://start.myalex.com/gorman		
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, 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 Quartz at 800-362-3310 or www.quartzbenefits.com.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from 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 Quartz at 800-362-3310 or 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:

Plan 1: POS-Quartz Network 1000 (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)
Plan 2: HMO-Quartz Network 1000 (Individual: 20% coinsurance and $1,000 deductible; Family: 20% coinsurance and $2,000 deductible)
Plan 3: POS-Quartz Network 3000 (Individual: 20% coinsurance and $3,000 deductible; Family: 20% coinsurance and $6,000 deductible)
Plan 4: HMO-Quartz Network 3000 (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, 2024. 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	Health Insurance Premium Payment Program All other Medicaid Website: https://www.in.gov/medicaid/ http://www.in.gov/fssa/dfr/ Family and Social Services Administration Phone: 1-800-403-0864 Member Services Phone: 1-800-457-4584

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Legal Notices

IOWA – Medicaid and CHIP (Hawki)	KANSAS – Medicaid
Medicaid Website: Iowa Medicaid | Health & Human Services Medicaid Phone: 1-800-338-8366 Hawki Website: Hawki - Healthy and Well Kids in Iowa | Health & Human Services Hawki Phone: 1-800-257-8563 HIPP Website: Health Insurance Premium Payment (HIPP) | Health & Human Services (iowa.gov) HIPP Phone: 1-888-346-9562	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884 HIPP Phone: 1-800-967-4660
KENTUCKY – Medicaid	**LOUISIANA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kynect.ky.gov Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov/agencies/dms	Website: www.medicaid.la.gov or www.ldh.la.gov/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/health-care-coverage/ Phone: 1-800-657-3672	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005
MONTANA – Medicaid	**NEBRASKA – Medicaid**
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: 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. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP	**NEW YORK – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: 1-800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)	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 and CHIP
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.pa.gov/en/services/dhs/apply-for-medicaid-health-insurance-premium-payment-program-hipp.html Phone: 1-800-692-7462 CHIP Website: Children's Health Insurance Program (CHIP) (pa.gov) CHIP Phone: 1-800-986-KIDS (5437)	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	Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov Phone: 1-888-222-2542 Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT– Medicaid	**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, 2024, 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 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 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, 2025**
Name of Entity/Sender:	**Gorman & Company**
Contact—Position/Office:	**Laurie Halzel – Vice President of Human Resources**
Office Address:	**200 N Main St** **Oregon, Wisconsin 53575-1447** **United States**
Phone Number:	**608-835-7004**

Marketplace Notice

Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

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

What is the Health Insurance Marketplace?

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

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

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

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

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

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

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

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

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

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

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

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

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

What about Alternatives to Marketplace Health Insurance Coverage?

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

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

How Can I Get More Information?

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

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.

GORMAN & COMPANY

Plan Changes Notice

Quartz

Summary of Changes to Group Certificates for 2025 Renewal

This is a non-exhaustive list. Please see your Certificate of Coverage to review all changes.

Removed certain restrictions on bone anchored hearing aid coverage. Coverage is provided for all medically necessary bone anchored hearing aids.
Removed the requirement that in-network prescription drug claims be submitted electronically for benefits to be payable.
Added language to the Summary of Benefits and Coverage (SBC) and Schedule of Benefits (SOB) to accommodate plans with a six-tier drug formulary.
Added a definition for gender dysphoria and modified language surrounding gender dysphoria and gender-affirming service to clarify covered services.
Added an exclusion for the clinically-administered drug delandistrogene moxeparvovec-rokl (Elevidys).
Added an exclusion for hair transplantation.
Updated contact numbers for: • Obtaining prior authorization on prescription drugs - (800) 496-7509; and, • Filing an appeal - (608)644-3416 or Toll Free (866)569-3426.
Added a $20,000 annual limit on claims for emergency services obtained or provided outside of the 50 United States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. Non-emergency services obtained or provided outside of the country remain non-covered services.
Clarified that standard allergy testing (excluding sublingual allergy testing) is a covered benefit under diagnostic testing.
Reinforced that an individual did not need to be covered under the current policy at time of injury to a sound natural tooth for benefits to be payable for extraction and replacement.
Added language to reiterate that treatment, services, and supplies that exceed any maximum benefit limit specified in the policy (e.g., a visit limit) are not covered.
Modified continuity of care (COC) language in Certificates to clarify that COC rights provided under the No Surprises Act are in addition to state-specific COC requirements which could end sooner.
Clarified: • Breast reconstruction is covered when functional impairment results from a congenital defect; • For HMO and PPO plans, where an employee must reside to be eligible, by directing members to the applicable online map; • That the Out-of-Area Dependent Rider for the HMO plan does not cover specialist care; and, • For plans with an embedded deductible, benefits will start to pay for a member once they have met the individual deductible, even if the family deductible has not been met.

Notes

This benefit summary prepared by

Gallagher

Insurance | Risk Management | Consulting