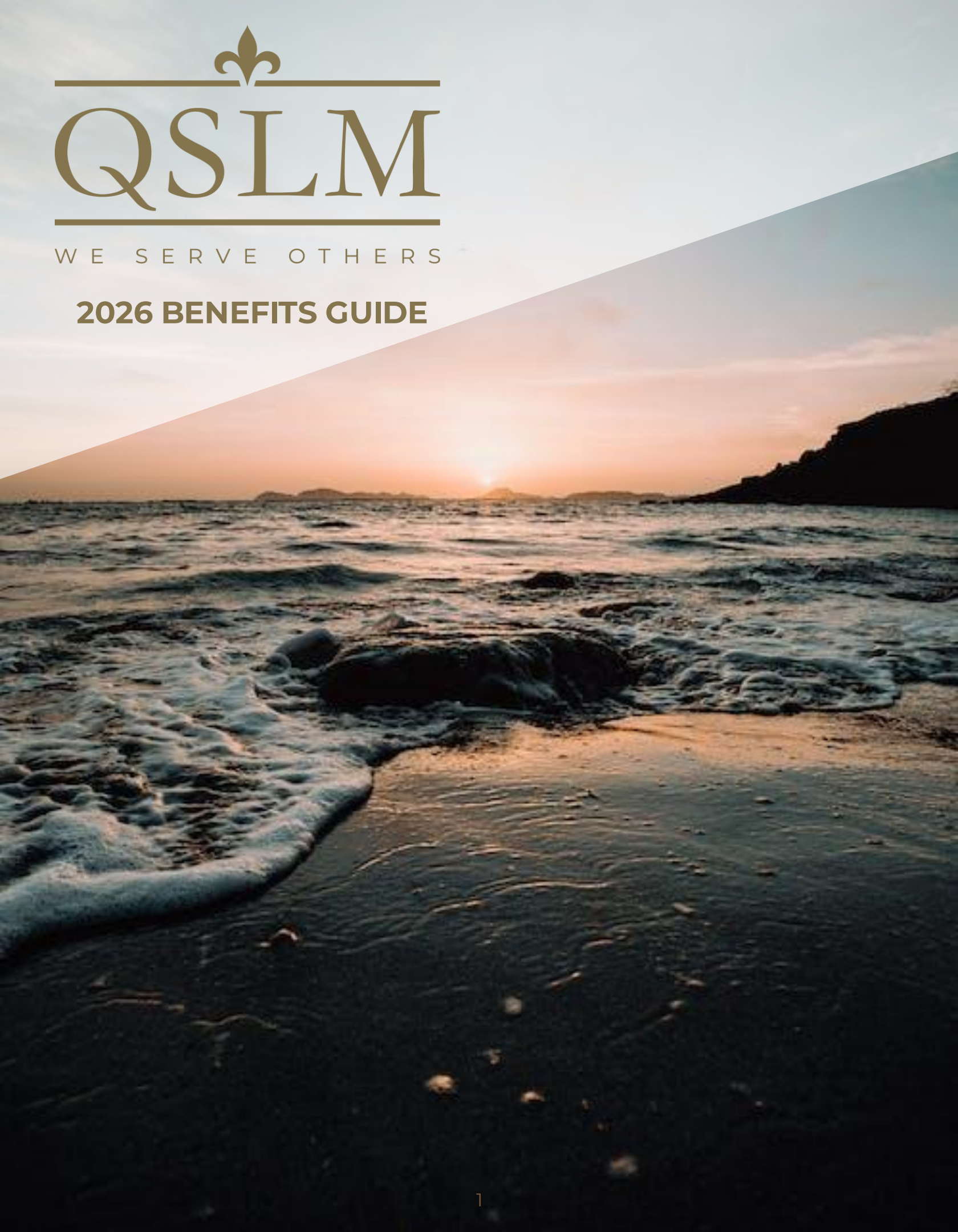
QSLM

WE SERVE OTHERS

2026 BENEFITS GUIDE



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Getting Started

Medical, Dental & Vision

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Wellbeing & Balance

Important Plan Information

This guide is an overview and does not provide a complete description of all benefit provisions. For more detailed information, please refer to your plan benefit booklets or summary plan descriptions (SPDs). The plan benefit booklets determine how all benefits are paid.

Getting Started

2026 Benefits

Effective January 1, 2026 through December 31, 2026

Medicare Part D Notice

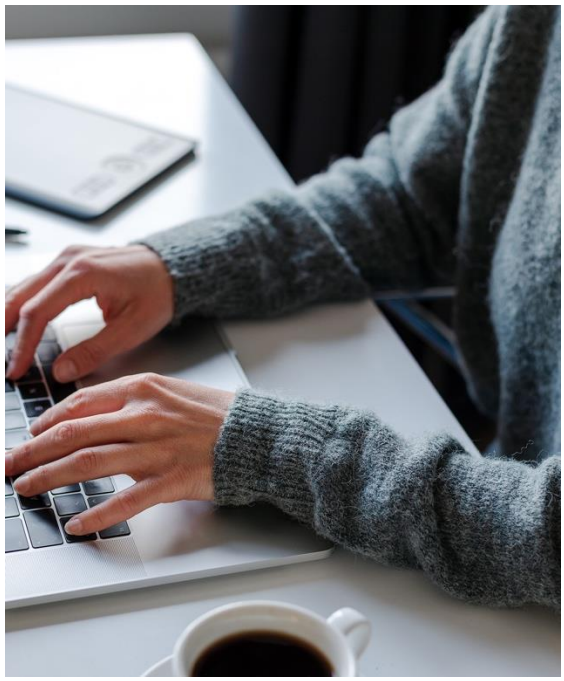
If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see the Important Notices section for more details.

No matter where you are in your career, QSL Management supports you with benefit programs and resources to help you thrive today and prepare for tomorrow.

This guide provides an overview of your healthcare coverage, as well as life, disability, retirement, and more benefits.

You'll find tips to help you understand your medical coverage, save time and money on healthcare, reduce taxes, and balance your work and home life. Take a look at what's available to make the most of your benefits package.

Who's eligible for benefits?



EMPLOYEES

You are eligible if you are a full-time employee working 30 or more hours per week.

ELIGIBLE DEPENDENTS

- Legally married spouse or domestic partner
- Biological, adopted or stepchildren up to age 26
- Children over age 26 who are disabled and depend on you for support
- Children named in a qualified medical child support order (QMCSO)

For additional coverage information, please refer to the benefit booklets for each benefit.

DOMESTIC PARTNER NOTICE

Please note that domestic partner coverage can differ from spouse coverage when Medicare eligibility is a factor.

Medicare is the primary payer for domestic partners with large employer group health plan coverage if a domestic partner can get Medicare due to their age and has group health plan coverage through their partner's current employer.

WHEN YOU CAN ENROLL

If you're a new employee, you can enroll on the first day of the month 60 days following your date of hire, and you must enroll within 30 days of becoming eligible. Existing employees can enroll during the annual open enrollment period.

If you miss the enrollment deadline, you'll need to wait until the next open enrollment.

Have questions about your benefits?

Click to play video

Contact your Alliant Benefit Advocate

Email:
benefitsupport@alliant.com

Phone: (800) 489-1390

Hours: 5 a.m.–5 p.m. (Pacific Time)
Monday–Friday

Get help from a Benefit Advocate

Are you getting married and you're not sure how or when to add your new spouse to your plan? Is your stepchild eligible for your healthcare plan? Do you need help understanding the difference between an HSA and an FSA? A Benefit Advocate can help answer these questions and more.

Benefit Advocates are trained benefit experts who can help you understand and use your healthcare benefits and other coverage. Contact your Benefit Advocate for issues such as:

- General benefit questions
- Eligibility and coverage
- Finding a network provider
- Problems with health care claims or billing, when warranted
- Coverage changes due to life events (such as marriage, a new child, or divorce)

Claims assistance

If you need claims assistance, you may need to complete a HIPAA authorization form to grant your Benefit Advocate permission to work with your insurer and/or healthcare provider(s) to resolve your claims issues. Permission is granted on a limited-duration basis, and only to the individuals listed on the form. You can end the permissions granted by the form at any time. Your Benefit Advocate will provide the form to you when needed.

CHANGING YOUR BENEFITS

Click to play video

Life happens

A change in your life may allow you to update your benefit choices. Watch the video for a quick take on your options.

Outside of open enrollment, you may be able to enroll or make changes to your benefit elections if you have a big change in your life, including:

- Change in legal marital status
- Change in number of dependents or dependent eligibility status
- Change in employment status that affects eligibility for you, your spouse, or dependent child(ren)
- Change in residence that affects access to network providers
- Change in your health coverage or your spouse's coverage due to your spouse's employment
- Change in your or a dependent's eligibility for Medicare or Medicaid
- Court order requiring coverage for your child
- "Special enrollment event" under the Health Insurance Portability and Accountability Act (HIPAA), including a new dependent by marriage, birth or adoption, or loss of coverage under another health insurance plan
- Event allowed under the Children's Health Insurance Program (CHIP) Reauthorization Act (you have 60 days to request enrollment due to events allowed under CHIP).

You must submit any changes within 30 days after the event.

ENROLLING FOR BENEFITS

QSLM BENEFIT WEBSITE

At QSLM, we want to make enrolling in benefits easy. Visit the QSLM Employee Benefits Resource Center using the QR code below, or go to https://qslm.benefitsinfo.com to learn more

At the website, you can:

- **Schedule** your personalized appointment with a benefits counselor to learn more about your options.
- **Review** the Benefits Guide and other tools to learn more about benefit offerings.
- **Enroll** in benefits!

Before you enroll

Know the date of birth, social security number, and address for each dependent you will cover.

Review your enrollment materials to understand your benefit options and costs for the coming year.

HEALTHCARE

Our Commitment

We believe our employees should have access to healthcare coverage that promotes preventive care and helps cover the cost of illness.

Eligible employees and their eligible dependents can enroll in medical, dental, and vision coverage through QSL's Management benefits program.

MEDICAL

Through our carrier, **UMR**, we offer two health plans, both on the **UnitedHealthcare Choice Plus network**, so you can choose the best fit for your health concerns and budget.

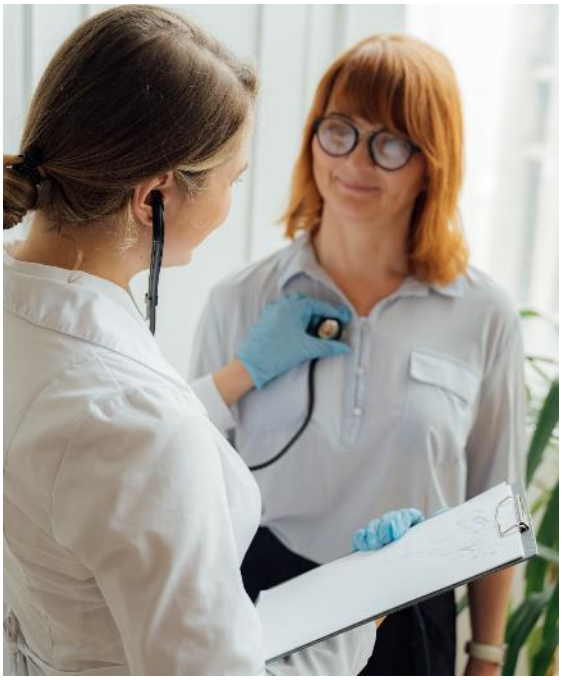
DENTAL

Regular checkups and cleanings are fully covered on the **Ameritas** Dental Plans. If you do need more care, insurance helps cover the cost for fillings, gum disease, orthodontia, and more.

VISION

Our vision plans, also through **Ameritas**, helps cover the cost of eye exams, eyeglasses, and contact lenses to ensure you're seeing and feeling your best.

Which Medical plan is right for you?



Plan type definitions

- **PPO:** preferred provider organization
- **HDHP:** high-deductible health plan

CONSIDER A PPO IF:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).

Plan to consider

UMR $2,500 PPO Plan

CONSIDER AN HDHP IF:

- You want to be able to see any provider, even a specialist, without a referral.
- You want coverage for out-of-network providers (at a higher cost).
- You want tax-free savings on your healthcare costs.
- You want to build a savings account for future healthcare. costs for you and your eligible family members.
- You want an extra way to add to your retirement savings.

Plan to consider

UMR $4,000 HDHP Plan

Watch the video to learn more about the differences between the HDHP and the PPO plans.

MEDICAL PLAN COMPARISON

You may visit any medical provider you choose, but in-network providers offer the highest level of benefits and lower out-of-pocket costs. Our carrier is **UMR** and our network is **United Healthcare Choice Plus.**

	$4000 HDHP		$2500 PPO	
NETWORK: United Healthcare Choice Plus	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Deductible	NON-EMBEDDED		EMBEDDED	
INDIVIDUAL	$4,000	$10,000	$2,500	$5,000
FAMILY	$9,000	$20,000	$5,000	$10,000
Calendar Year Out-of-Pocket Maximum (Embedded)				
	If any family member reached $5,570 of the out-of-pocket maximum, then the OOP is satisfied for that individual family member.		If any family member reached the individual out-of-pocket maximum, then the OOP is satisfied for that individual family member.	
INDIVIDUAL	$5,750	Unlimited	$6,000	$12,000
FAMILY	$12,500	Unlimited	$12,000	$24,000
Physician Services				
PREVENTIVE CARE	Covered 100%	Not covered	Covered 100%	Not covered
PRIMARY CARE/SPECIALIST	30% AD	50% AD	$40 copay	40% AD
TELADOC	30% AD	Not Covered	$40 copay	40% AD
LAB & X-RAY	30% AD	50% AD	20% AD	40% AD
Emergency Services				
URGENT CARE	30% AD	50% AD	$40 copay	40% AD
EMERGENCY ROOM	$500 copay per visit then 30% AD		$500 copay per visit then 20% AD	
Hospital Services				
INPATIENT	30% AD	50% AD	20% AD	40% AD
OUTPATIENT	30% AD	50% AD	20% AD	40% AD
Prescription Drug Services				
DEDUCTIBLE	Combined with Medical	Not Covered	$100	Not Covered
OUT-OF-POCKET MAXIMUM	Combined with Medical		Combined with Medical	
PREFERRED GENERIC (30-day/ retail)	$15 copay AD		$15 copay AD	
PREFERRED BRAND (30-day/retail)	$40 copay AD		$40 copay AD	
NON-PREFERRED BRAND/GENERIC (30-day/retail)	$75 copay AD		$75 copay AD	
SPECIALTY	30% AD		20% up to $250 ($125 min.) AD	
MAIL ORDER (90-DAY SUPPLY)	Pref. Generic: $37.50 Pref. Brand: $100 AD Non-Pref: $187.50 AD		Pref. Generic: $37.50 Pref. Brand: $100 AD Non-Pref: $187.50 AD	

*AD = After Deductible

ADDITIONAL UMR RESOURCES

Critical Illness Employee Coverage – HDHP Enrollment Only

Employees who are enrolled on the UMR Base HDHP will receive $10,000 of Critical Illness coverage with Guardian. Employees can purchase additional coverage and/or enroll their dependents. Please refer to page 24 for more coverage details.

Treatment Cost Calculator

Use the Treatment Cost Calculator to get cost estimates for hundreds of health care services in your area. Knowing what you would expect to pay for medical procedures before receiving care can help you plan ahead and avoid potential surprises. Once enrolled, log in to your member account on umr.com and look for the shopping cart icon on your person home page.

Maternity CARE Program

Whether you are considering having a baby or are already expecting, UMR Maternity CARE can explain how to reduce your risk of complications and prepare you to have a successful, full-term pregnancy and a healthy baby. Call 1-888-438-8105.

UMR CARE App

Personalized care and support on demand, anytime, anywhere. With the CARE App, powered by Vivify Health, you'll experience an integrated health care solution that blends technology with personal connections. Access the enrollment page at go.umr.com/get-care-app.

Download the UMR member app:

With a single tap, you can:

- ✓ Access your digital ID card
- ✓ View claims information
- ✓ Find out if there is a co–pay for your upcoming appointment
- ✓ See how much you've paid toward your deductible, and more

Access the enrollment page at
https://www.umr.com/app-page

VIRTUAL CARE

Get the care you need

Teladoc Health doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Sinus problems
- Urinary tract infection
- Respiratory infection
- Skin problems
- And more!

Talk to a doctor anytime

When you enroll on one of the UMR plans, you have access to Teladoc.

Teladoc Health gives you 24/7/365 access to U.S. board-certified doctors through the convenience of phone, video or mobile app visits. It's an affordable alternative to costly urgent care and ER visits when you need care now.

Meet our doctors

Teladoc Health is simply a new way to access qualified doctors. All Teladoc Health doctors:

- Are practicing PCPs, pediatricians, and family medicine physicians
- Average 20 years' experience
- Are U.S. board-certified and licensed in your state
- Are credentialed every three years, meeting NCQA standards

When should you use Teladoc Health?

Teladoc Health does not replace your primary physician. It is a convenient and affordable option for quality care.

- When you need care now
- If you're considering the ER or urgent care for a non-emergency
- When on vacation, a business trip or away from home
- For short-term prescription refills

Call 800-Teladoc (835-2362)
or visit www.Teladoc.com
for 24/7/365 care.

Teladoc™ HEALTH

Prescriptions breaking your budget?

Click to play video

The formulary drug tiers determine your cost

$	Generic drugs
$$	Brand-name drugs
$$$	Specialty drugs

Understanding the formulary can save you money.

If your doctor prescribes medicine, especially for an ongoing condition, don't forget to check your health plan's drug formulary. It's a powerful tool that can help you make informed decisions about your medication options and identify the lowest cost selection.

What is a formulary?

A drug formulary is a list of prescription drugs covered by your medical plan. Most prescription drug formularies separate the medications they cover into four or five drug categories, or "tiers." These groupings range from least expensive to most expensive cost to you. "Preferred" drugs generally cost you less than "non-preferred" drugs.

Get the most from your coverage

To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to be as effective as brand-name drug equivalents.

To find out if a drug is on the formulary, visit www.optumrx.com or call customer service at 800-356-3477.

Optum Rx®

DENTAL PLAN COMPARISON

When you visit a dentist in the network, you will maximize your savings. These dentists have agreed to reduced fees, which means you won't get charged more than you expected.

To find an in-network provider & access your member portal, visit: www.Ameritas.com

Click to play video

	Basic Plan PPO	Enhanced Plan
	IN-NETWORK	IN-NETWORK
Calendar Year Plan Maximum		
PER MEMBER	$1,000 per individual	$1,500 per individual
Lifetime Deductible		
INDIVIDUAL	$50	$50
Coinsurance		
DIAGNOSTIC & PREVENTIVE SERVICES Exams, cleanings, x-rays, etc.	100% covered	100% covered
BASIC SERVICES Fillings, Sealants, Extractions, Emergency Exams	20% AD	20% AD
MAJOR SERVICES Crowns, Inlays/Onlays, Dentures and Bridgework, Repairs	50% AD	50% AD
Orthodontia		
Children (up to 19th birthday)	50% up to a lifetime maximum benefit of $1,000 per individual; deductible waived	50% up to a lifetime maximum benefit of $1,500 per individual; deductible waived

AD = After Deductible

Reminder: If you choose to receive treatment from an out-of-network provider, you will be balance billed for any amounts over the reasonable and customary (R&C) charges.

VISION PLAN COMPARISON

Even if you have 20/20 vision, an annual eye exam checks the health of your eyes and can detect other health issues. If you do need glasses or contacts, vision coverage helps with the cost.

Below is an overview of the optional coverage available to you. Please refer to the official plan documents for additional information on coverage and exclusions.

	Basic: Ameritas – EyeMed Insight		Enhanced: Ameritas – VSP Choice	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
	Benefit	**Reimbursement**	**Benefit**	**Reimbursement**
EXAM	$10 copay	Up to $35	$10 copay	Up to $45
SINGLE LENSES	$25 copay, then covered 100%	Up to $25	$10 copay, then covered 100%	Up to $30
BIFOCALS		Up to $40		Up to $50
TRIFOCALS		Up to $55		Up to $65
FRAMES	$130 allowance, then 20% of remaining balance	Up to $65 allowance	$180 allowance, then 20% of remaining balance	Up to $70 allowance
Contact Lenses				
Medically Necessary	$25 copay, then covered 100%	Up to $200	$10 copay, then covered 100%	Up to $210
Elective in lieu of glasses	Up to $130 allowance	Up to $104	Up to $180 allowance	Up to $145
Benefit Frequency (based on date of service)				
Exams	Every 12 months		Every 12 months	
Lenses				
Contacts				
Frames	Every 24 months		Every 24 months	

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Ameritas

Health Savings Account (HSA)

Click to play videos

Are you eligible?

The HSA is not for everyone. You're eligible only if you are:

- Enrolled in the UMR $4000 HDHP medical plan.
- Not enrolled in other non-HDHP medical coverage, including Medicare, Medicaid, or Tricare.
- Not a tax dependent.
- Not enrolled in a healthcare flexible spending account (FSA), unless it's a "limited purpose" FSA for dental and vision expenses.

A personal savings account for healthcare.

A Health Savings Account (HSA) is an easy way to pay for healthcare expenses that you have today, and save for expenses you may have in the future.

How the Navia HSA works:

- Your HSA account is set up automatically after you enroll.
- You can contribute up to the limit set by the IRS:

  Individual: $4,400 per year
  Family: $8,750 per year
  Age 55+: $1,000 extra per year

- You can use your HSA debit card to pay for eligible expenses like office visits, lab tests, prescriptions, dental and vision care, and even some drugstore items.

Four reasons to love an HSA

1. **Tax-free.** No federal tax on contributions, or state tax in most states. Withdrawals are also tax-free as long as they're for eligible healthcare expenses.
2. **No "use it or lose it."** Your balance rolls over from year to year. You own the account and can continue to use it even if you change medical plans or leave the company.
3. **Use it now or later.** Use your HSA for healthcare expenses you have today or save the money to use in the future.
4. **Boosts retirement savings.** After you retire, you can use your HSA for healthcare expenses tax-free. You can also use it for regular living expenses, which will be taxable but without penalties.

Find out more

Eligible Expenses

Ineligible Expenses

navia benefit solutions

Flexible Spending Accounts (FSA)

Click to play video

An FSA allows you to set aside tax-free money to pay for healthcare or daycare expenses you expect to have over the coming year.

1. Estimate what your out-of-pocket costs will be for the coming year.
2. FSA/LPFSA: contribute up to $3,400, deducted from your pay pre-tax, meaning no federal or state tax on that amount.
3. During the year, you can use your FSA debit card to pay for services and products. Withdrawals are tax-free when used to pay for qualified healthcare expenses.

FSA contributions are pre-tax, therefore lowering your taxable income.

navia benefit solutions

THREE OPTIONS: WHICH IS RIGHT FOR YOU?

Flexible Spending Account (FSA): For employees enrolled in the **UMR $2500 PPO plan**, you have access to a Flexible Spending Account (FSA). An FSA allows you to deduct money from your paycheck pre-tax to pay for certain qualified medical, dental, and vision expenses.

Limited Purpose FSA (LPFSA): If you are enrolled in the **UMR $4000 HDHP**, you can participate in a Limited Purpose FSA. You can put away dollars on a pre-tax basis but can only use funds for out-of-pocket dental and/or vision expenses.

Dependent Care FSA (DCFSA): If you pay for childcare, you may be eligible to enroll in the Dependent Care FSA. Contribute up to $7,500 per year ($3,750 if married and filing separate tax returns), pretax, to pay for day care expenses for elder or child dependents that are necessary for you or your spouse to work or attend school full-time. You cannot use your Health Care FSA to pay for Dependent Care expenses.

USE IT OR LOSE IT!

Estimate carefully. You can't change your contribution amount mid-year without a qualifying reason. Any unused funds at the end of the year will be forfeited after the 60-day run out period.

COST COMPARISONS

Medical

	Total Monthly Cost	QSL Contribution	Your Cost Per Month	Your Cost Per Pay Period
$4000 HDHP				
EMPLOYEE ONLY	$756.82	$671.82	$85.00	$42.50
EMPLOYEE & SPOUSE	$1,446.61	$871.61	$575.00	$287.50
EMPLOYEE & CHILD(REN)	$1,289.24	$974.24	$315.00	$157.50
EMPLOYEE & FAMILY	$2,145.02	$1,495.02	$650.00	$325.00
$2500 Traditional PPO				
EMPLOYEE ONLY	$965.62	$680.62	$285.00	$142.50
EMPLOYEE & SPOUSE	$1,826.87	$876.87	$950.00	$475.00
EMPLOYEE & CHILD(REN)	$1,640.60	$940.60	$700.00	$350.00
EMPLOYEE & FAMILY	$2,712.61	$1,462.61	$1,250.00	$625.00

Dental

	Total Monthly Cost	Your Cost Per Pay Period	Total Monthly Cost	Your Cost Per Pay Period
	BASIC		**ENHANCED**	
EMPLOYEE ONLY	$28.84	$14.42	$33.44	$16.72
EMPLOYEE & SPOUSE	$56.56	$28.28	$62.12	$31.06
EMPLOYEE & CHILD(REN)	$64.92	$32.46	$75.32	$37.66
EMPLOYEE & FAMILY	$101.52	$50.76	$117.68	$58.84

Vision

	Total Monthly Cost	Your Cost Per Pay Period	Total Monthly Cost	Your Cost Per Pay Period
	BASIC WITH EYEMED		**ENHANCED WITH VSP**	
EMPLOYEE ONLY	$5.76	$2.88	$7.80	$3.90
EMPLOYEE & SPOUSE	$10.92	$5.46	$14.56	$7.28
EMPLOYEE & CHILD(REN)	$12.80	$6.40	$16.60	$8.30
EMPLOYEE & FAMILY	$18.00	$9.00	$23.48	$11.74

Nearing 65? Get to know Medicare

alliantmedicaresolutions.com

Alliant Medicare Solutions is provided by Insuractive LLC, a Nebraska resident insurance agency. Insuractive LLC is wholly owned by Alliant Insurance Services, Inc.

Important deadlines ahead

Most people become eligible for Medicare at age 65. At that time, you'll need to make some important decisions about your health insurance.

But the choice isn't always easy. Maybe you'll keep working after 65. Maybe you have dependents covered by your QSLM-sponsored insurance. Maybe you're just not sure which options could work best for your situation.

Alliant Medicare Solutions

Through QSL Management, you have access to Alliant Medicare Solutions, a free service you, your family, and your friends can use to figure out the best Medicare options for you.

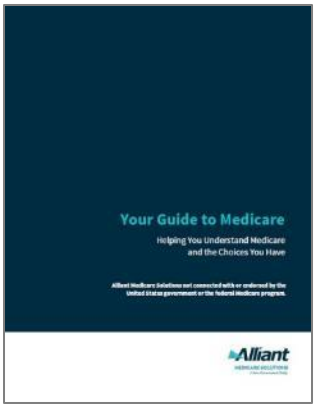
How it works

Gather your current health insurance information.

Call Alliant Medicare Solutions at **(877) 888-0165** to talk to a licensed insurance agent about your current coverage, your Medicare options, and what might work best for your situation.

Alliant Medicare Solutions can help you enroll in Medicare or email policy information for you to review.

Learn more



Your Guide to Medicare

Medicare 101

Social Security Planning

Voluntary Plans

Our Voluntary Plans

Life and AD&D insurance

Health-related plans

Financial security plans

You're unique—and so are your benefit needs

Voluntary benefits are optional coverages that help you customize your benefits package to your individual needs.

You pay the entire cost for these plans, but rates may be more affordable than individual coverage. And you get the added convenience of paying through payroll deduction.

Voluntary benefits are just that: voluntary. You have the freedom and flexibility to choose the benefits that make sense for you and your family. You can also choose not to sign up for voluntary benefits at all—it's up to you.

Voluntary life and AD&D insurance

Guaranteed issue

If you purchase life insurance coverage above a certain limit (the "guaranteed issue" amount) or after your initial eligibility period, you will need to submit evidence of insurability with additional information about your health for the insurance company to approve the amount of coverage.

Protecting those you leave behind

Voluntary life and accidental death and dismemberment (AD&D) insurance allows you to purchase additional life insurance to protect your family's financial security. Coverage is available for your spouse and/or children if you purchase coverage for yourself.

Guardian Plan:

Employee	Increments of $10,000 up to $500,000. Guarantee issue of $150,000.
Spouse	Increments of $5,000 up to 50% of employee amount up to $250,000. Guarantee issue of $30,000
Children	Birth to age 26; Florida residents age 26 if full time student; $10,000

Guardian®

Short-term disability (STD) insurance

Expect the unexpected

Most people underestimate the likelihood of being disabled at some point in their life. Disability insurance replaces part of your pay while you are unable to work so you have a continuing income for living expenses.

STD Benefits

Short-term disability (STD) insurance replaces part of your income for limited duration issues such as:

- Pregnancy issues and childbirth recovery
- Prolonged illness or injury
- Surgery and recovery time

STD payments may be reduced if you receive other benefits such as sick pay, workers' compensation, Social Security, or state disability.

Eligibility

This is a voluntary benefit available to all full-time employees earning at least $15,000 annually. You pay the cost for coverage.

Voluntary STD Benefits

Amount	60% of weekly earnings, up to $1,250 per week.
Pre-Existing Conditions	3/12. Pre-existing conditions apply for 3-months prior, and that condition is ineligible until you have been covered by the plan for at least 12 months.
Begins	After 14 days of disability due to accident or illness.
Duration	24 weeks

Guardian®

Long-term disability (LTD) insurance

Things to know about LTD insurance:

- It can protect you from having to tap into your retirement savings.
- You can use LTD benefits however you need, for housing, food, medical bills, etc.
- Benefits can last a long time—from weeks to even years—if you remain eligible.

LTD benefits cushion the financial impact of a disability

Long-term disability (LTD) insurance replaces part of your income for longer term issues such as:

- Debilitating illness (cancer, heart disease, etc.)
- Serious injuries (accident, etc.)
- Heart attack, stroke
- Mental disorders

If you qualify, LTD benefits begin after short-term disability benefits end. Payments may be reduced by state, federal, or private disability benefits you receive while disabled.

Eligibility

This is a voluntary benefit available to all full-time employees earning at least $15,000 annually. You pay the cost for coverage.

Voluntary LTD Benefits

Amount	60% of monthly earnings, up to $5,000 per month.
Pre-Existing Conditions	3/12. Pre-existing conditions apply for 3-months prior, and that condition is ineligible until you have been covered by the plan for at least 12 months.
Begins	After 180 days of disability due to accident or illness.
Duration	SSNRA (Social Security Normal Retirement Age)

Guardian®

Accident Insurance

Accident insurance from Guardian helps you pay for unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, as well as physical therapy. If you or a covered family member has an accident, this plan pays a lump-sum, tax-free benefit. The amount of money depends on the type and severity of your injury and can be used any way you choose.

COVERAGE	BENEFIT
Ambulance: Air | Ground	$1,250 | $250
Emergency Room Treatment	$150
Child Organized Sport Benefit	Included
Concussion	$150
Dislocation	Up to $6,000
Eye Injury	$300
Family Lodging	$150 per day; up to 30 days
Physician Follow-up Treatment	$75; Up to 6 visits
Fracture	Up to $8,000
Hospital Admission	$1,000
Hospital Confinement	$200 per day; up to 365 days
Hospital ICU Admission	$2,000
Hospital ICU Confinement	$400 per day; up to 15 days
Initial Physician Visit	$75
Prosthesis	$500 per limb
Transportation	.50 per mile; $300 per trip. 3 times per accident
ADDITIONAL BENEFITS / NOTES	
Coverage Type	24 Hour
Wellness Benefit	$50
Portability	Yes

Note: not a complete summary. See plan documents for full benefit details.

Critical Illness Insurance

Critical illness insurance from Guardian can help fill a financial gap if you experience a serious illness such as cancer, heart attack, or stroke. Upon diagnosis of a covered illness, a lump-sum, tax-free benefit is immediately paid to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness. You choose a benefit amount that fits your paycheck and can cover yourself and your family members if needed.

SPECIFICATIONS	AMOUNT
Employee Increments	$10,000
Employee Maximum	$20,000
Employee Guarantee Issue	$20,000
Spouse Increments | Percentage	50% of employee benefit
Spouse Maximum	$10,000
Spouse Guarantee Issue	$10,000
Child Increments | Percentage	50% of employee benefit
Child Guarantee Issue	$10,000
COVERED CONDITION	**PAYABLE AMOUNT**
Benign Brain Tumor	75%
Burn	100%
Invasive Cancer	100%
Heart Attack	100%
Loss of Sight, Hearing, Speech	100%
Major Organ Failure	100%
Skin Cancer	$500 per lifetime
Stroke	100%
ADDITIONAL BENEFITS / NOTES	
Wellness Benefit	$50
Portability	Included

Note: not a complete summary. See plan documents for full benefit details.

Guardian

Hospital Indemnity

Hospital indemnity insurance can enhance your current medical coverage. The plan pays a lump sum, tax-free benefit when you or an enrolled dependent is admitted or confined to the hospital for covered accidents and illnesses. You can use the money you receive under the plan however you see fit, for paying medical bills, childcare, or for regular living expenses like groceries—you decide.

HOSPITAL BENEFITS	AMOUNT
Hospital Admission	$500; 2 admissions per year
Hospital Confinement (up to30 days)	$100
Hospital ICU Admission	$1,000; 2 admissions per year
Hospital ICU Confinement (up to 30 days)	$200
PLAN PROVISIONS	
Wellness Benefit	$50
Portability	Included
Pre-Existing Condition Limitation	None

Note: not a complete summary. See plan documents for full benefit details.

Plans to keep you and your family secure

Identity Theft Protection

Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly premium, identity theft protection from Experian helps protect your personal information through proactive monitoring, identity restoration, and resolution. You can enroll in this program during open enrollment.

Two Plan Options:

- **Premium Plan:**
  Provides essential coverage with credit monitoring, reporting, and tools to help build positive financial habits, as well as complete identity protection and restoration.
- **Elite Plan:**
  Expanded on Premium Plan's offerings to provide comprehensive financial wellness tools and even greater security with device and data protection.

COST COMPARISONS

Guardian Voluntary Life AD&D, STD, LTD

	Voluntary Life And AD&D Employee	Voluntary Life And AD&D Spouse	Voluntary Short-term Disability	Voluntary Long-term Disability
Age	Per $1,000 of coverage	Per $1,000 of coverage	Per $10 of weekly coverage	Per $100 of covered salary
18-24	$0.093	$0.093	$0.645	$0.181
25-29	$0.093	$0.093	$0.602	$0.181
30-34	$0.109	$0.109	$0.570	$0.181
35-39	$0.124	$0.124	$0.592	$0.519
40-44	$0.191	$0.191	$0.720	$0.881
45-49	$0.286	$0.286	$0.860	$1.145
50-54	$0.428	$0.428	$0.968	$1.622
55-59	$0.618	$0.618	$1.387	$2.090
60-64	$0.723	$0.723	$1.774	$1.622
65-69	$1.299	$1.299	$2.075	$1.087
70-74	$2.490	$2.490	$2.109	$1.087
75+	$2.490	$2.490	$2.109	$1.087

Voluntary Child Life
Per $1,000 of Coverage
$0.190

Guardian Voluntary Critical Illness

Voluntary Critical Illness – Child cost included with employee election				
Age Band	Employee rate $10,000 benefit	Employee rate $20,000 benefit	Spouse rate $5,000 benefit	Spouse rate $10,000 benefit
<25	$2.10	$4.20	$1.05	$2.10
25 - 29	$2.20	$4.40	$1.10	$2.20
30 - 34	$3.40	$6.80	$1.70	$3.40
35 - 39	$4.30	$8.60	$2.15	$4.30
40 - 44	$6.20	$12.40	$3.10	$6.20
45 - 49	$8.90	$17.80	$4.45	$8.90
50 - 54	$12.10	$24.20	$6.05	$12.10
55 - 59	$16.40	$32.80	$8.20	$16.40
60 - 64	$21.60	$43.20	$10.80	$21.60
65 – 69	$28.60	$57.20	$14.30	$28.60
70+	$36.50	$73.00	$18.25	$36.50

COST COMPARISONS

Guardian Accident Plan

	Total Monthly Cost	Your Cost Per Pay Period
EMPLOYEE ONY	$6.46	$3.23
EMPLOYEE & SPOUSE	$10.89	$5.45
EMPLOYEE & CHILD(REN)	$12.19	$6.10
EMPLOYEE & FAMILY	$16.62	$8.31

Guardian Hospital Indemnity Plan

	Total Monthly Cost	Your Cost Per Pay Period
EMPLOYEE ONY	$9.81	$4.91
EMPLOYEE & SPOUSE	$20.99	$10.50
EMPLOYEE & CHILD(REN)	$15.33	$7.67
EMPLOYEE & FAMILY	$27.68	$13.84

Experian Identity Theft

	Total Monthly Cost	Your Cost Per Pay Period	Total Monthly Cost	Your Cost Per Pay Period
	PREMIUM PLAN		ELITE PLAN	
EMPLOYEE ONY	$6.40	$3.20	$9.80	$4.90
EMPLOYEE & SPOUSE	$13.00	$6.50	$18.00	$9.00
EMPLOYEE & CHILD(REN)	$13.00	$6.50	$18.00	$9.00
EMPLOYEE & FAMILY	$13.00	$6.50	$18.00	$9.00

Wellbeing & Balance

"The key to keeping your balance is knowing when you've lost it."

A Happier, Healthier You

Creating a healthy balance between work and play is a major factor in leading a happy and productive lifestyle, but it's not always easy.

We offer programs to help you:

- Manage stress, substance use disorder, mental health and family issues.
- Maximize your physical well-being.

Taking care of yourself helps you be more effective in all areas of your life. Be sure to take advantage of these programs to stay at your best.

Employee assistance program (EAP)

Help for you and your household

There are times when everyone needs a little help or advice, or assistance with a serious concern. The ComPsych EAP can help you handle a wide variety of personal issues, such as emotional health, substance use disorder, parenting and childcare needs, financial coaching, legal consultation, and elder care resources.

Best of all, contacting the EAP is completely confidential and free for any member of your immediate household.

No-cost EAP resources

You can receive counseling through ComPsych. Up to 3 sessions per incident.

The EAP is available around the clock to ensure you get access to the resources you need:

- Unlimited phone access 24/7
- Unlimited web access to helpful articles, resources, and self-assessment tools.

ComPsych®
GuidanceResources® Worldwide

EAP Contact

24/7 Live Assistance

Phone: (855) 239-0743

Online: guidanceresources.com

App: GuidanceNow

Web ID: Guardian

Emotional Support

- Anxiety, depression, stress
- Grief, Loss and life adjustments
- Relationship/marital conflicts

Work/Lifestyle

- Child, elder and pet care
- Moving and relocation
- Shelter/government assistance

Legal Guidance

- Divorce, adoption
- Wills, trusts, estates

Online Will Preparation

- EstateGuidance

Financial Resources

- Retirement planning
- Mortgages, Relocation
- Debt, Bankruptcy

Digital Support

- Self-help tools to enhance resilience and well-being
- Information and links to various services and topics
- On-Demand trainings

Smoking Cessation Resources

Quitting tobacco is the best thing you can do for your health. When you're ready, studies show that you are much more likely to quit and stay tobacco-free using a support program.

If you or your covered dependents need help kicking the habit, here are some resources that can help.

SMOKEFREE.GOV

Get help kicking the habit on Smokefree.gov, where you can:

- Explore ways to quit
- Create a specific, personalized plan with realistic, achievable steps
- Get 24/7 support through your smartphone
- Text messaging for encouragement, advice and tips
- Speak to a National Cancer Institute Live Help specialist

AMERICAN LUNG ASSOCIATION

Want to stop smoking or vaping or help a loved one quit? ALA is here for you every step of the way with tools, tips and support. The important thing is to keep trying to quit, until you quit for good.

- Call the Lung HelpLine at 1-800-586-4872
- Expert-led sessions and support from trained facilitators
- Evidence-based group and online programs tailored to different quit journeys

MYQUIT BY NICORETTE

MyQuit.com offers free, evidence-based resources to help individuals quit smoking or using tobacco, providing personalized support every step of the way.

- Free quit plans tailored to your goals and lifestyle
- Access to expert coaching and a 24/7 online support community
- Tips for managing cravings, withdrawal, and staying tobacco-free long-term

Rediscover your passion for fitness

Get started today

Learn more and enroll today at www.onepassselect.com

One Pass Select from UMR

One Pass Select can help you reach your fitness goals while finding new passions along the way. Find a routine that is right for you, whether you work out at home or at the gym. Choose a membership tier that fits your lifestyle and provides everything you need for whole body health in one easy, affordable plan. You and your eligible family members or friends can get started with One Pass Select today.

At the gym
Choose from our large nationwide network of gym brands and local fitness studios Use any gym in the network a create a routine just for you.

At home
Workout at home with live or on-demand online fitness classes. Try the workout builder to get routines created just for you, no matter what your fitness level and interests are.

In the kitchen
Get groceries and household essentials delivered to your home. One Pass Select makes it east to play for everything you need to enjoy delicious, nutritious meals.

Category	Digital	Classic	Standard	Premium	Elite
Monthly fee*	$10	$29	$64	$99	$144
Gym network size	N/A (online fitness classes)	11,000+ gym locations	12,000+ gym and premium locations	14,000+ gym and premium locations	16,000+ gym and premium locations
Grocery delivery	No	Yes	Yes	Yes	Yes

*A one-time enrollment fee will apply

Important Plan Information

In this section, you'll find important plan information, including:

- Contact information for our benefit carriers and vendors
- A summary of the health plan notices you are entitled to receive annually, and where to find them
- A Benefits Glossary to help you understand important insurance terms.
- Required Annual Notices

Plan contacts and resources

Coverage	Contact	Phone	Website or Email
Medical	UMR	800-826-9781	www.umr.com
Pharmacy (Rx)	Optum Rx	800-356-3477	www.optumrx.com
Health Savings Account	Navia	866-987-0031	https://www.naviabenefits.com hsa@naviabenefits.com
Flexible Spending Account	Navia	800-669-3539	https://www.naviabenefits.com customerservice@naviabenefits.com
Dependent Care FSA	Navia	800-669-3539	https://www.naviabenefits.com customerservice@naviabenefits.com
Dental	Ameritas	800-487-5553	https://dentalnetwork.ameritas.com
Vision (Basic - EyeMed)	Ameritas	866-289-0614	https://www.ameritas.com/
Vision (Enhanced - VSP)	Ameritas	800-877-7195	https://www.ameritas.com/
Voluntary Life and AD&D	Guardian	800-627-4200	https://www.cru@glic.com
Voluntary Short-Term Disability	Guardian	800-627-4200	https://www.cru@glic.com
Voluntary Long-Term Disability	Guardian	800-627-4200	https://www.cru@glic.com
Employee Assistance Program (EAP)	ComPsych	855-239-0743	www.GuidanceResources.com
Voluntary Benefits (Accident, Critical Illness & Hospital Indemnity)	Guardian	800-627-4200	https://www.cru@glic.com
ID Protection + My Financial Expert	Experian	866-617-1894	https://www.experian.com/help/login.html
Human Resources	IDHR	800-826-9781	qslmhr@idhr.com

More Questions?

Contact our Benefit Advocate team below:

Phone: (800) 489-1390
Email: benefitsupport@alliant.com
Hours: Monday – Friday, 8 a.m. to 8 p.m. ET

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 36 for more details.

Glossary

Accumulation Period
The period of time during which you can incur eligible expenses toward your deductible, out-of-pocket maximum, and visit limitations. The accumulation period for your deductible and OOP maximum may differ from the period for visit limitations.

Aggregate Deductible
A type of family deductible in which a family must meet the entire family deductible before the plan covers eligible expenses for any individual.

Aggregate Out-of-Pocket Max
A type of family out-of-pocket maximum in which a family must meet the entire family out-of-pocket maximum before the plan pays 100% of eligible expenses for any individual.

Allowed Amount
The maximum amount your insurance plan will pay for an eligible expense. In-network providers cannot bill you for more than the allowed amount.

Ambulatory Surgery Center
A healthcare facility that specializes in same-day surgical procedures.

Annual Limit
The maximum dollar amount or number of visits your plan will cover for a specific service during a plan year. If you reach an annual limit, you must pay all associated costs for that service for the rest of the plan year.

Balance Billing
Balance billing is when an out-of-network provider bills you for more than your plan's allowed amount. For example, if the provider charges $100 but the plan's allowed amount is only $70, an out-of-network provider can bill you for the $30 difference. Balance billing may not be allowed for all services; consult your insurance plan documents for details.

Beneficiary
The people or entities you select to receive a benefit if you die. You must name beneficiaries for life, AD&D, and retirement plans to ensure the money is distributed according to your wishes.

Brand-Name Drug
A drug sold under its trademarked name. For example, Lipitor is the brand name of a common cholesterol medicine. Your coinsurance for brand-name drugs may be higher if there is a generic equivalent available.

Claim
A request for payment that you or your provider submits to your insurance plan after you receive services.

COBRA
The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a federal law allows you to temporarily keep your health insurance after your employment ends, based on certain qualifying events. If you elect COBRA coverage, you pay 100% of the premiums, including any share your employer used to pay, plus a small administrative fee.

Coinsurance
The percentage of the allowed amount you must pay for an eligible expense. Coinsurance will always add up to 100%. For example, if the plan pays 70% of the allowed amount, your coinsurance is 30%. If your plan has a deductible, you pay 100% of most costs until you have paid the deductible amount.

Copayment (Copay)
A flat fee you pay for some services, such as a doctor's office visit. You pay the copayment at the time you receive care. In most cases, copays do not count toward your deductible.

Deductible
The dollar amount you must pay for eligible expenses before your insurance starts covering a portion. The deductible does not apply to preventive care or certain other services.

Dental Basic Services
Services such as fillings, routine extractions, and some oral surgery procedures.

Dental Diagnostic & Preventive
Generally includes routine cleanings, oral exams, X-rays, and fluoride treatments. Most plans limit preventive exams and cleanings to twice a year.

Dental Major Services
Complex or restorative dental work such as crowns, bridges, dentures, inlays, and onlays.

Eligible Expense
Also referred to as a covered service, this is a service or product for which your insurance plan will pay a portion of the allowed amount. Your plan will not cover any portion of the cost if the expense is not eligible, and the amount you pay will not count toward your deductible.

Embedded Deductible
A type of family deductible in which the plan covers eligible expenses for each person as soon as they reach their individual deductible.

Embedded Out-of-Pocket Max
A type of family out-of-pocket maximum in which the plan pays 100% of eligible expenses for a person as soon as they reach their individual out-of-pocket maximum.

Excluded Service
A service for which your insurance will not pay any portion of the cost. These services may also be referred to as "ineligible," "not covered," or "not allowed."

Glossary

Formulary
A list of prescription drugs covered by your medical plan or prescription drug plan. Also called a preferred drug list.

Generic Drug
A drug that has the same active ingredients as a brand-name drug but is sold under a different name. For example, atorvastatin is the generic name for medicines with the same formula as the brand-name drug Lipitor.

Grandfathered
A medical plan that is exempt from certain provisions of the Affordable Care Act (ACA).

In Network
Also known as participating providers, in-network providers have a contract with your insurance plan. They are usually the lowest-cost option because they have agreed not to charge you more than the allowed amount, and your insurance will cover a bigger portion of eligible expenses than with out-of-network providers.

Mail Order
A medical or prescription drug plan feature allowing a 90-day supply of medicines you take routinely to be delivered by mail.

Out of Network
Also known as nonparticipating providers, out-of-network providers do not have a contract with your insurance plan. They are typically a higher-cost option because they can charge you more than your plan's allowed amount, and your insurance will cover a smaller portion of eligible expenses than with in-network providers. Some plans do not cover out-of-network services at all.

Out-of-Pocket Costs
Healthcare expenses you are responsible for paying, whether from your bank account, credit card, or from a health savings account such as an HSA, FSA or HRA. These costs include any deductibles, copays, and coinsurance you pay for eligible expenses, along with the cost of any services your insurance does not cover.

Out-of-Pocket Maximum
The maximum amount of money you will have to spend on eligible expenses during a plan year. Once you spend this amount, your plan covers 100% of eligible expenses for the rest of the plan year.

Outpatient Care
Care from a hospital or clinic that doesn't require you to stay overnight.

Participating Pharmacy
Also known as an in-network pharmacy, a participating pharmacy has a contract with your medical or prescription drug plan. You will typically pay lower prescription costs at a participating pharmacy.

Plan Year
A 12-month period of benefits coverage. The 12-month period may or may not be the same as the calendar year.

Preferred Drug
A list of prescription drugs your insurance will cover at the highest benefit level. The list, also known as a "formulary," is based on an evaluation of effectiveness and cost. Your coinsurance may be higher for drugs that are not on this list, or your insurance may not cover them at all.

Preventive Care
Routine healthcare services that may include screenings, tests, check-ups, immunizations, and patient counseling to prevent illnesses, disease, or other health problems.

Primary Care Provider (PCP)
Your main doctor. Some insurance plans require you to name a PCP, who will direct or approve all of your healthcare and referrals.

Provider
A doctor, dentist, physician's assistant, nurse, hospital, lab, or other healthcare professional or facility that provides healthcare services.

Telehealth/Telemedicine
A virtual visit with a provider using video chat on a computer, tablet or smartphone.

Usual, Customary, and Reasonable (UCR)
The cost of a medical service in a geographic area based on what providers in the area usually charge for the same or a similar medical service. Your plan may use the UCR amount as the allowed amount.

Urgent Care
Care for an illness, injury, or condition that needs attention right away but is not severe enough to require the emergency room. Treatment at an urgent care center generally costs less than an emergency room visit.

Vaccinations
Also known as "immunizations," vaccinations are biological preparations that help prevent or reduce the severity of specific diseases.

Voluntary Benefit
An optional benefit offered by your employer for which you pay the entire premium, usually through payroll deduction.

Medicare Part D Notice

Important Notice from QSL Management, LLC 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 QSL Management, LLC 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. QSL Management, LLC has determined that the prescription drug coverage offered by UMR 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 QSL Management, LLC coverage will not be affected. See below for more information about what happens to your current coverage if you join a Medicare drug plan.

Since the existing prescription drug coverage under QSL Management, LLC is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug

Medicare Part D Notice Continued

coverage and choose not to enroll in a Part D plan; or you can enroll in a Part D plan as a supplement to, or in lieu of, your existing prescription drug coverage.

If you do decide to join a Medicare drug plan and drop your QSL Management, LLC prescription drug coverage, be aware that you and your dependents can only get this coverage back at open enrollment or if you experience an event that gives rise to a HIPAA Special Enrollment Right.

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 QSL Management, LLC 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 or call Acuity Group HR at 855-563-9396. 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 QSL Management, LLC changes. You also may request a copy of this notice at any time.

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

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

For more information about Medicare prescription drug coverage:

- Visit 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 800-MEDICARE (800-633-4227). TTY users should call 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 socialsecurity.gov, or call them at 800-772-1213 (TTY 800-325-0778).

Medicare Part D Notice Continued

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: 11/1/2025
Name of Entity/Sender: QSL Management, LLC
Contact-Position/Office: Acuity Group HR
Address: 219 E Garden Street, Pensacola FL 32502
Phone Number: 855-563-9396

- "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.

Women's Health and 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 this plan. Therefore, the following deductibles and coinsurance apply: HDHP $4,000-70%; PPO $2,500-80%. If you would like more information on WHCRA benefits, call your plan administrator 855-563-9396.

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 the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). If you would like more information on maternity benefits, call your plan administrator at 855-563-9396.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in QSL Management, LLC health plan for you or your dependents (including your spouse) because of other health insurance or group health plan coverage, you or your dependents may be able to enroll in QSL Management, LLC health plan without waiting for the next open enrollment period if you:

- Lose other health insurance or group health plan coverage. You must request enrollment within 30 days after the loss of other coverage.
- Gain a new dependent as a result of marriage, birth, adoption, or placement for adoption. You must request health plan enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.
- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible. You must request medical plan enrollment within 60 days after the loss of such coverage.

If you request a change due to a special enrollment event within the 30 day timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For all other events, coverage will be effective the first of the month following your request for enrollment. In addition, you may enroll in QSL Management, LLC health plan if you become eligible for a state premium assistance program under Medicaid or CHIP. You must request enrollment within 60 days after you gain eligibility for medical plan coverage. If you request this change, coverage will be effective the first of the month following your request for enrollment. Specific restrictions may apply, depending on federal and state law.

Note: If your dependent becomes eligible for a special enrollment right, you may add the dependent to your current coverage or change to another health plan.

Availability of Privacy Practices Notice

We maintain the HIPAA Notice of Privacy Practices for QSL Management, LLC describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting Acuity Group HR 855-563-9396.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

Children's Health Insurance Program (CHIP)

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

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

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

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

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

ALABAMA – Medicaid
Website: http://myalhipp.com/ | Phone: 1-855-692-5447
ALASKA – Medicaid
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
Website: http://myarhipp.com/ | Phone: 1-855-MyARHIPP (855-692-7447)
CALIFORNIA – Medicaid
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+)
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

FLORIDA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
GEORGIA – 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
INDIANA – Medicaid
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: (800) 403-0864 | Member Services Phone: (800) 457-4584
IOWA – Medicaid and CHIP (Hawki)
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
KANSAS – Medicaid
Website: https://www.kancare.ks.gov/ | Phone: 1-800-792-4884 | HIPP Phone: 1-800-967-4660
KENTUCKY – 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
LOUISIANA – Medicaid
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
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: 800-977-6740 | TTY: Maine relay 711
MASSACHUSETTS – Medicaid and CHIP
Website: https://www.mass.gov/masshealth/pa | Phone: 1-800-862-4840 | TTY: 711 Email: masspremassistance@accenture.com
MINNESOTA – Medicaid
Website: https://mn.gov/dhs/health-care-coverage/ | Phone: 1-800-657-3672
MISSOURI – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm | Phone: 573-751-2005
MONTANA – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 | email: HHSHIPPProgram@mt.gov
NEBRASKA – Medicaid

Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 | Lincoln: 402-473-7000 | Omaha: 402-595-1178
NEVADA – Medicaid
Medicaid Website: http://dhcfp.nv.gov | Medicaid Phone: 1-800-992-0900
NEW HAMPSHIRE – Medicaid
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 603-271-5218 | Toll-free number for the HIPP program: 1-800-852-3345, ext. 15218 Email: DHHS.ThirdPartyLiabi@dhhs.nh.gov
NEW JERSEY – Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ | Phone: 800-356-1561 CHIP Premium Assistance Phone: 609-631-2392 | CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 (TTY: 711)
NEW YORK – Medicaid
Website: https://www.health.ny.gov/health_care/medicaid/ | Phone: 1-800-541-2831
NORTH CAROLINA – Medicaid
Website: https://medicaid.ncdhhs.gov/ | Phone: 919-855-4100
NORTH DAKOTA – Medicaid
Website: https://www.hhs.nd.gov/healthcare | Phone: 1-866-614-6005
OKLAHOMA – Medicaid and CHIP
Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742
OREGON – Medicaid and CHIP
Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075
PENNSYLVANIA – Medicaid and CHIP
Website: https://www.pa.gov/en/services/dhs/apply-for-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)
RHODE ISLAND – Medicaid and CHIP
Website: http://www.eohhs.ri.gov/ | Phone: 1-855-697-4347 or 401-462-0311 (Direct RIte Share Line)
SOUTH CAROLINA – Medicaid
Website: https://www.scdhhs.gov | Phone: 1-888-549-0820
SOUTH DAKOTA – Medicaid
Website: http://dss.sd.gov | Phone: 1-888-828-0059
TEXAS – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Texas Health and Human Services Phone: 1-800-440-0493
UTAH – Medicaid and CHIP
Utah's Premium Partnership for Health Insurance (UPP) Website: https://medicaid.utah.gov/upp/ Email: upp@utah.gov | Phone: 1-888-222-2542 | Adult Expansion Website: https://medicaid.utah.gov/expansion/ Utah Medicaid Buyout Program Website: https://medicaid.utah.gov/buyout-program/ CHIP Website: https://chip.utah.gov/
VERMONT – Medicaid
Website: Health Insurance Premium Payment (HIPP) Program | Department of Vermont Health Access Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select or https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs Medicaid/CHIP Phone: 1-800-432-5924
WASHINGTON – Medicaid
Website: https://www.hca.wa.gov/ | Phone: 1-800-562-3022
WEST VIRGINIA – Medicaid and CHIP
Website: https://dhhr.wv.gov/bms/ or http://mywvhipp.com/ Medicaid Phone: 304-558-1700 | CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
WISCONSIN – Medicaid and CHIP
Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm | Phone: 1-800-362-3002
WYOMING – Medicaid
Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ | Phone: 1-800-251-1269

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

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

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

ACA Disclaimer

This offer of coverage may disqualify you from receiving government subsidies for an Exchange plan even if you choose not to enroll. To be subsidy eligible you would have to establish that this offer is unaffordable for you, meaning that the required contribution for employee only coverage under our base plan exceeds 9.02% in 2025 (9.96% in 2026) of your modified adjusted household income.

The “No Surprises” Rules

What you need to know about the “No Surprises” rules

The “No Surprises” rules protect you from surprise medical bills in situations where you can’t easily choose a provider who’s in your health plan network. This is especially common in an emergency situation, when you may get care from out-of-network providers. Out-of-network providers or emergency facilities may ask you to sign a notice and consent form before providing certain services after you’re no longer in need of emergency care. These are called “post-stabilization services.” You shouldn’t get this notice and consent form if you’re getting emergency services other than post-stabilization services. You may also be asked to sign a notice and consent form if you schedule certain non-emergency services with an out-of-network provider at an in-network hospital or ambulatory surgical center.

The notice and consent form informs you about your protections from unexpected medical bills, gives you the option to give up those protections and pay more for out-of-network care, and provides an estimate of what your out-of-network care might cost. You aren’t required to sign the form and shouldn’t sign the form if you didn’t have a choice of health care provider or facility before scheduling care. If you don’t sign, you may have to reschedule your care with a provider or facility in your health plan’s network.

View a sample notice and consent form (PDF).

This applies to you if you’re a participant, beneficiary, enrollee, or covered individual in a group health plan or group or individual health insurance coverage, including a Federal Employees Health Benefits (FEHB) plan.

Deadline for filing lawsuit under ERISA after exhaustion of all claims procedures

Any lawsuit must be filed within 36 months of the final decision on the claim. Exhaustion of all claims and appeals procedure is required prior to filing suit. Please refer to the WRAP Summary Plan Description for the plan specific statute of limitations.

Plan documents

Important documents for our health plan and retirement plan are available in the Education Center section of our benefits website at https://qslm.benefitsinfo.com/Education-Center. Paper copies of these documents and notices are available if requested. If you would like a paper copy, please contact the Plan Administrator.

Summary plan descriptions (SPD)

The legal document for describing benefits provided under the plan as well as plan rights and obligations to participants and beneficiaries.

Summary of benefits and coverage (SBC)

A document required by the Affordable Care Act (ACA) that presents benefit plan features in a standardized format. SBC documents are available in the Education Center section of our benefits website at https://qslm.benefitsinfo.com/Education-Center.

Statement of Material Modifications

This enrollment guide constitutes a Summary of Material Modifications (SMM) to the QSL Management Health & Welfare Plan. It is meant to supplement and/or replace certain information in the SPD, so retain it for future reference along with your SPD. Please share these materials with your covered family members.

QSLM

WE SERVE OTHERS