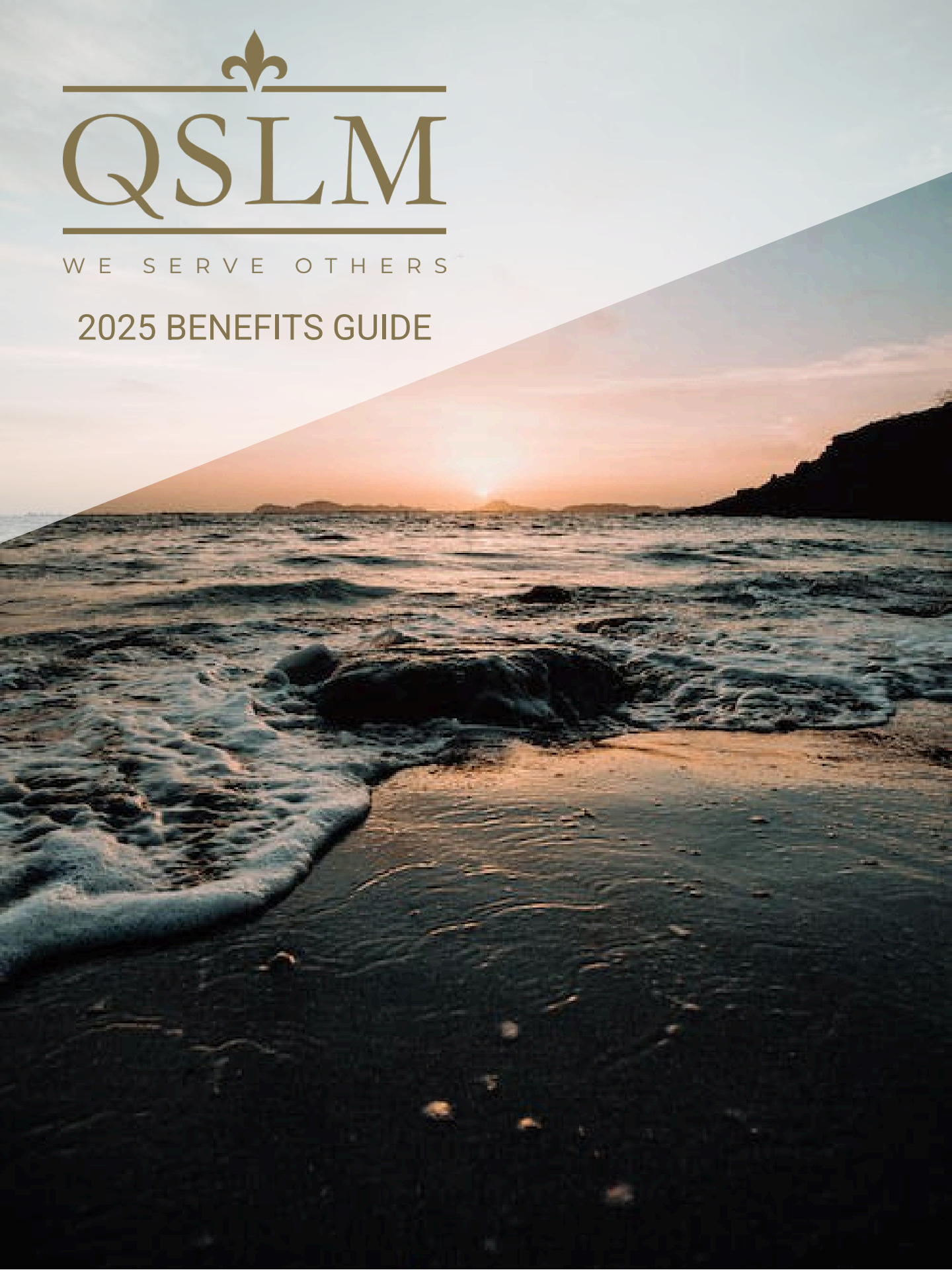
QSLM

WE SERVE OTHERS

2025 BENEFITS GUIDE



WELCOME

At QSL Management, we believe that you, our employees, are our most important asset. Helping you and your families achieve and maintain good health – physical, emotional and financial – is the reason we offer you this benefits program. We are providing you with this overview to help you understand the benefits that are available to you and how best to use them. Please review it carefully.

While we've made every effort to make sure that this guide is comprehensive, it cannot 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 the benefits are paid.

The benefits in this summary are effective January 1, 2025 – December 31, 2025.

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CONTENTS

Eligibility & Enrollment

Plan Year:
January 1, 2025 – December 31, 2025

Benefit Eligibility

Full-time employees scheduled to work 30 hours or more per week are eligible for benefits the first of the month following 60 days after your date of hire.

Many of the plan options offer coverage for eligible dependents, including:

- Your legal spouse.
- Your children to age 26, regardless of student, marital, or tax-dependent status (including a step-child placed with you for adoption, or a child who you are the legal guardian).
- Your dependent children of any age who are physically or mentally unable to care for themselves.

Enrollment Information

You can sign up for benefits or change your benefit elections at the following times:

- 30 days from your eligibility date to enroll in benefits as a new hire.
- During the annual open enrollment benefits period.
- Within 30 days of experiencing a **Qualifying Life Event.**

Please Note: the choices you make at this time will remain the same through **December 31, 2025**

What is a Qualifying Life Event?

A **Qualifying Life Event** (QLE) is an event that occurs outside of your open enrollment period, allowing you to make changes to your plan choices. These include:

- Marriage, divorce, or legal separation.
- Birth or adoption of an eligible child.
- Death of your spouse or covered child.
- Change in your spouse's work status that affects benefit eligibility.
- Qualified Medical Child Support Order.

MEDICAL PLANS

	$4000 HDHP		$2500 PPO	
BENEFITS	**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
Out of Pocket Maximum	Embedded		Embedded	
Individual	$5,750	Unlimited	$6,000	$12,000
Family	$12,500	Unlimited	$12,000	$24,000
	If any family member reaches $5,750 of the out-of-pocket maximum, then the OOP is satisfied for that individual family member.		If any family member reaches the individual out-of-pocket maximum, then the OOP is sqatisfied for that individual family member	
Coinsurance	70%	50%	80%	60%
Preventive Services				
Wellness & Preventive Services	Covered 100%	Not covered	Covered 100%	Not covered
Physician Services				
Office Visit (PCP/SP)	30% AD	50% AD	$40 copay	40% AD
Lab & X-ray	30% AD	50% AD	20%	40% AD
Hospital Services				
Inpatient	30% AD	50% AD	20% AD	40% AD
Outpatient	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 *(True ER Visit)*		$500 copay per visit then 20% AD *(True ER Visit)*	
Prescription Coverage				
Deductible	Combined with medical	Not covered	$100	Not covered
Out of Pocket Maximum	Combined with medical		Combined with medical	
Preferred Generic	$15 copay AD		$15 copay AD	
Preferred Brand	$40 copay AD		$40 copay AD	
Non-Preferred Brand/Generic	$75 copay AD		$75 copay AD	
Specialty	30% AD		20% up to $250 ($125 minimum) AD	
Mail Order *(90-day supply)*	$37.50/$100/ $187.50 copay AD		$37.50/$100/ $187.50 copay AD	

The information above is a summary of medical coverage only. Please access your detailed plan information and limitations at **www.umr.com**.

Note: *Deductibles, copays, and coinsurance accumulate toward the out-of-pocket maximums. Usual, Customary, and Reasonable charges apply for all out-of-network benefits.*

Pharmacy Coverage

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

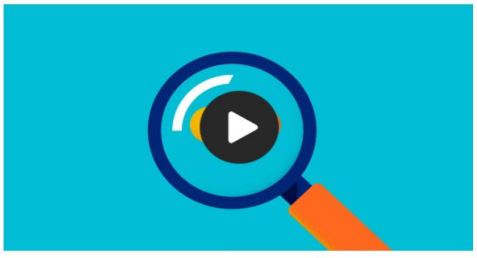
To get the most out of your prescription drug coverage, note where your prescriptions fall within your plan's drug formulary tiers and ask your doctor for advice. Generic drugs are usually the lowest cost option. Generics are required by the Food and Drug Administration (FDA) to perform the same as brand-name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

To find out if a drug is on your plan's formulary, visit optumrx.com. Be sure to show your ID card to your pharmacist.

Using this link, members can:

- Use the "Find a network pharmacy" tool to locate their preferred pharmacy location and ensure its network capability.
- Use the "Drug pricing tool" for average cost calculation on your medications
- Use the "Prescription drug list" to identify medication exclusions, alternatives, and tiers within the Formulary list.

Click to play video



Your Pharmacy benefits and Prescription Drug coverage is administered through OptumRx. Learn more here!

Click to play video

THE FORMULARY DRUG TIERS DETERMINE YOUR COST

$	Generic Drug
$$	Brand Name Drug
$$$	Specialty Drug

Valuable UMR Resources and Services

Here are a few other benefits you will receive when you enroll in one of our UMR (a united healthcare company) medical plans.

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 Lincoln Financial. Employees can purchase additional coverage and/or enroll their dependents. Please refer to page 13 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**.

Teladoc

Teladoc gives you round-the-clock access to U.S. board-certified doctors, from home or on the go. Call or connect online or using the Teladoc mobile app for affordable medical care, when you need it. Visit **Teladoc.com** or call **1-800-Teladoc**.

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**.

Find an In-Network Provider:
www.umr.com
***Network:* UnitedHealthcare Choice Plus**

UMR
A UnitedHealthcare Company

Rediscover your passion for health with One Pass Select

One Pass Select™ can help you reach your fitness goals while finding new passions along the way. Find a routine that's 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.

Find your fit with One Pass Select:

At the gym

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

At home

Work out 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 easy to plan 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	✗	✓	✓	✓	✓

*A one-time enrollment fee will apply.

Learn more and enroll today at OnePassSelect.com

One Pass Select is a voluntary program featuring a subscription-based nationwide gym network, digital fitness and grocery delivery service. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them. Purchasing discounted gym and fitness studio memberships, digital fitness or grocery delivery services may have tax implications. Employers and individuals should consult an appropriate tax professional to determine if they have any tax obligations with respect to the purchase of these discounted memberships or services under this program, as applicable.

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Mental Health

Employee Assistance Program (EAP)

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

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

You can receive counseling through the EAP up to 4 sessions per person, per issue, per year. These can be virtual or face to face.

Contact:

Phone: (888) 628-4824 *(24/7 access)*
Website: www.GuidanceResources.com
Username: LFGsupport
Password: LFGsupport1

ComPsych®
— The GuidanceResources Company® —

You matter

- Call **911** or go to the nearest emergency room if you or someone you know is in a crisis
- Call or text **988** anytime to be connected to trained counselors with the **National Suicide Prevention Lifeline**

Smoking Cessation Resources

American Lung Association.

Want help to quit smoking or Vaping? ALA can help with tips and support for you or your loved one.

Lung HelpLine 1-800-586-4872

Smokefree.gov

Text Quit to 47848

Created by The National Cancer Institute, Smokefree.gov offers tools & tips to stop smoking and vaping.

Quit.com

1-800-419-4766

Get Ready to quit Smoking. Sign up for MyQuit. Customized email support program to help you through your quit smoking journey.

HSA

Health Savings Account

Only employees enrolled in the $4,000 HDHP through UMR will have access to a Health Savings Account (HSA). An HSA is an easy way to save pre-tax earnings to help pay for healthcare expenses.

Eligibility Requirements:

- You are enrolled in the UMR HDHP
- You are not covered by a non-HSA plan, health care FSA, health reimbursement agreement, or your spouse's plan
- You are not a claimed tax dependent
- You are not enrolled in Medicare or Tricare
- You have not received any Veterans Benefits in the last three months

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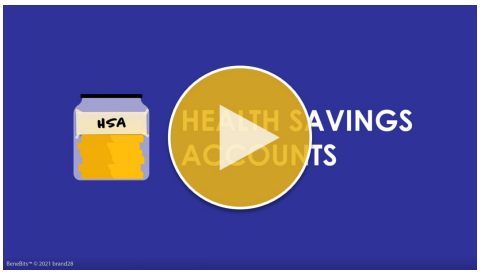


2025 Contribution Limit:

Individual: $4,300
Family: $8,550

Note: If you, the employee, will be age 55 or older at any time during the calendar year, you are eligible to contribute an additional 'catch-up' contribution of up to $1,000. You can contribute the full amount regardless of whether you enroll mid-year or what month you turn age 55.

navia benefit solutions

FSA

Flexible Spending Account & Limited Purpose

For employees enrolled in the UMR Base PPO plan, you will 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 expenses.

2025 Contribution Limit:

Individual: $3,300

You can't change your contribution amount mid-year without a qualified reason, so be sure to estimate carefully. Any unused funds after the 60-day run out will be forfeited.

USE IT OR LOSE IT!

Enrolled in the HDHP and HSA plans, but want to contribute to an FSA?

If you are enrolled in the HDHP and contribute to a Health Savings Account (HSA), you are ineligible to participate in a traditional FSA plan. However, if you want to put away more funds, you can participate in a **Limited Purpose FSA** which allows you to put away dollars on a pre-tax basis, but you can only be reimbursed for out-of-pocket dental and/or vision expenses incurred by you and your eligible dependents.

Up to $5,000 for 2025 tax-free!

A Dependent Care Flexible Spending Account (FSA) can help families save potentially hundreds of dollars per year on day care.

Here's how the Dependent Care FSA works

You set aside money from your paycheck, before taxes, to pay for work-related day care expenses. Eligible expenses include not only childcare, but also before and after school care programs, preschool, and summer day camp for children under age 13. The account can also be used for day care for a spouse or other adult dependent who lives with you and is physically or mentally incapable of self-care.

You can set aside up to $5,000 per household for the 2025 plan year. You can pay your dependent care provider directly from your DCFSA account, or you can submit claims to get reimbursed for eligible dependent care expenses you pay out of pocket.

DPFSA

Dependent Care Flexible Spending Account

navia benefit solutions

Voluntary Dental

Ameritas

Dental benefits are available to you and your dependents. The Dental plan features a network of providers who offer their services at a discounted rate. When you go to an in-network dentist, you'll save money. The information below is a summary of coverage only.

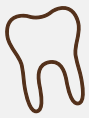
Why sign up for Dental coverage?

It's important to go to the dentist regularly. Brushing and flossing are great, but regular exams catch dental issues early before they become more expensive and difficult to treat.

That's where dental insurance comes in. Dental insurance makes it easier and less expensive to get the care you need to maintain good oral health.

How to Find In-Network Providers:

Visit www.ameritas.com



Questions?

Call **800-487-5553**
Group ID: 010-062842

BENEFITS	Basic Plan In-Network	Enhanced Plan In-Network
Lifetime Deductible (Preventive & Ortho Waived)		
Individual	$50	$50
An individual only needs to satisify their deducitble once for the entirity of the plan with Ameritas.		
Annual Maximum		
Per Member	$1,000	$1,500
Coinsurance		
Diagnostic & Preventive ***(oral exams, cleanings, x-rays, etc.)***	Plan Pays 100%	Plan Pays 100%
Basic Services ***(fillings, extractions, periodontics, etc.)***	Plan Pays 80%	Plan Pays 80%
Major Services ***(dentures, crowns, etc.)***	Plan Pays 50%	Plan Pays 50%
Orthodontia		
Children (18 & Under)	Plan Pays 50%	Plan Pays 50%
Lifetime Maximum	$1,000	$1,500

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.

Voluntary Vision

Ameritas

Why sign up for Vision coverage?

Vision coverage helps with the cost of eyeglasses or contacts. But even if you don't need vision correction, an annual eye exam checks the health of your eyes and can even detect more serious health issues such as diabetes, high blood pressure, high cholesterol, and thyroid disease.

BENEFITS	Basic Plan EyeMed	Enhanced Plan VSP
Frequency		
Exam	Once every 12 months	
Prescription Lenses	Once every 12 months	
Frames	Once every 24 months	
Contact Lenses *(in lieu of glasses)*	Once every 12 months	
In-Network		
Exam	$10 copay	$10 copay
Materials	$25 copay	$10 copay
Lenses - Single | Bifocal | Trifocal	Covered 100% after copay	Covered 100% after copay
Frame Allowance	$130 allowance	$180 allowance
Contact Lenses (elective)	$130 allowance *(in lieu of lenses & frames)*	$180 allowance *(in lieu of lenses & frames)*
Out of Network (reimbursements)		
Exam	Up to $35	Up to $45
Lenses - Single | Bifocal | Trifocal	Up to $25 | Up to $40 | Up to $55	Up to $30 | Up to $50 | Up to $65
Frame Allowance	Up to $65	Up to $70
Contact Lenses (elective)	Up to $104 *(in lieu of lenses & frames)*	Up to $145 *(in lieu of lenses & frames)*

Reminder: To find a quality eye doctor in your area, please review a few easy steps below:

Basic Plan with EyeMed

1. Visit **ameritas.com** to find a provider
2. Visit **eyemedvisioncare.com** for benefit information
3. EyeMed Customer Care Center: 1-866-289-0614
   (8 a.m. to 11 p.m. ET Monday through Saturday, 11 a.m. to 8 p.m. ET Sunday)

Enhanced Plan with VSP

1. Visit **ameritas.com** to find a provider
2. Visit **vsp.com** for benefit information
3. VSP Call Center: 1-800-877-7195
   (5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday)

If you choose an out-of-network provider, you pay the provider in full and submit a claim for reimbursement of covered services and products.

Voluntary Life and Disability

Voluntary Life/AD&D

Eligible employees can purchase voluntary life and matching accidental death and dismemberment coverage to ensure their loved ones are protected should something happen. Employees are responsible for the full cost and rates are based on age and coverage level.

Coverage:

- Employees can elect up to 5x their annual salary to a maximum of $500,000. Guaranteed issue amount of $150,000.
- Spouses can elect up to lesser of 50% of employee amount or $250,000. Guaranteed issue amount of $30,000.
- Children 14 days to 6 months can elect $250. Children 6 months up to age 19 (25 years if full-time student), can elect up to $10,000.

Note: *Evidence of Insurability is required if you previously declined coverage or wish to elect more than two increment levels.*

Voluntary Short-term Disability

Eligible employees can purchase voluntary STD coverage to ensure they continue to receive an income if they were to be out of work for a short period of time due to illness or injury. Employees are responsible for the full cost and rates are based on age and coverage level.

Benefit: Replaces 60% of covered weekly earnings (maximum of $1,250 per week) up to the 24th week of disability after a 14-day elimination period. 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.

Voluntary Long-term Disability

Eligible employees can purchase voluntary LTD coverage to ensure they continue to receive an income if they were to be out of work for a long period of time due to illness or injury. Employees are responsible for the full cost and rates are based on age and coverage level.

Benefit: Replaces 60% of covered monthly earnings (maximum of $5,000 per month) up to Social Security Normal Retirement Age after a 180-day elimination period. 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.

Lincoln Financial Group®

Note: *Please be sure you keep your beneficiary information up to date.*

Voluntary Benefits

You can enroll in accident, critical illness, and hospital indemnity benefits offered through Lincoln Financial Group. These voluntary benefits provide financial protection that can enhance your current benefits package and help cover financial gaps through lump sum payments when you or a covered dependent experiences a covered accident, is diagnosed with a covered critical illness, or is admitted to the hospital.

Accident

Accident insurance helps offset unexpected costs that can add up due to common injuries such as fractures, dislocations, burns, emergency room or urgent care visits, and 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.

Critical Illness

Critical illness insurance 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 paid directly to you. Use it to help cover medical costs, transportation, childcare, lost income, or any other need following a critical illness.

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.

IMPORTANT: This is a fixed indemnity policy, NOT Health Insurance
This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You are still responsible for paying the cost of your care.

- The Payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- Visit HealthCare.gov online or call 1-800*-318-2596 (TTY:1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Lincoln Financial Group®

Voluntary Plans Continued

Experian: Your Financial Expert

Experian is a financial wellness platform to assist you in achieving personal financial wellness while providing identity theft protection.

Identity Theft Protection

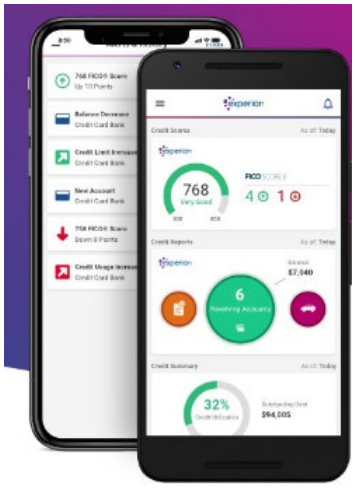
Identity theft is serious. Victims can spend hundreds, even thousands of dollars, and weeks of their own time to repair the damage done to their good names and credit records. The longer identity fraud goes undetected, the more expensive and difficult it becomes to resolve. For an affordable monthly 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. Choose between the following 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.



GET MORE INFORMATION

Benefit	Carrier/Vendor	Website/Email	Phone Number
Medical	UMR	www.umr.com	800-826-9781
Pharmacy (Rx)	Optum Rx	www.optumrx.com	800-356-3477
Health Savings Account	Navia	https://www.naviabenefits.com hsa@naviabenefits.com	866-987-0031
Flexible Spending Account	Navia	https://www.naviabenefits.com customerservice@naviabenefits.com	800-669-3539
Dependent Care FSA	Navia	https://www.naviabenefits.com customerservice@naviabenefits.com	800-669-3539
Dental	Ameritas	https://dentalnetwork.ameritas.com	800-487-5553
Vision (EyeMed)	Ameritas	https://www.ameritas.com/	866-289-0614
Vision (VSP)	Ameritas	https://www.ameritas.com/	800-877-7195
Voluntary Life and AD&D	Lincoln Financial	www.mylincolnportal.com	800-423-2765
Voluntary Short-Term Disability	Lincoln Financial	www.mylincolnportal.com	800-320-7585
Voluntary Long-Term Disability	Lincoln Financial	www.mylincolnportal.com	800-320-7585
Employee Assistance Program (EAP)	Guidance Resources	www.GuidanceResources.com	888-628-4824
Voluntary Benefits (Accident, Critical Illness & Hospital Indemnity)	Lincoln Financial	www.mylincolnportal.com	800-423-2765
ID Protection + My Financial Expert	Experian	https://www.experian.com/help/login.html	866-617-1894
Human Resources	IDHR	qslmhr@idhr.co	

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

Click to play video

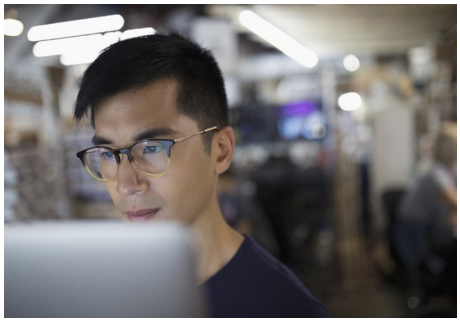
Explanation of Benefits

COST COMPARISON

	Total Monthly Cost	QSL Contribution	Employee Contribution	Per Pay Period
$4000 HDHP				
Employee Only	$720.93	$655.93	$65.00	$32.50
Employee & Spouse	$1,378.00	$853.00	$525.00	$262.50
Employee & Child(ren)	$1,228.10	$928.10	$300.00	$150.00
Employee & Family	$2,043.29	$1,468.29	$575.00	$287.50
$2500 PPO				
Employee Only	$919.83	$664.83	$255.00	$127.50
Employee & Spouse	$1,740.23	$840.23	$900.00	$450.00
Employee & Child(ren)	$1,562.79	$912.79	$650.00	$325.00
Employee & Family	$2,583.96	$1,433.96	$1,150.00	$575.00

	Total Monthly Cost	Per Pay Period	Total Monthly Cost	Per Pay Period
Voluntary Dental	**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
Voluntary Vision	**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

	Total Monthly Cost	Per Pay Period
Voluntary Accident		
Employee Only	$6.59	$3.30
Employee & Spouse	$11.11	$5.56
Employee & Child(ren)	$12.44	$6.22
Employee & Family	$16.82	$8.41
Voluntary Hospital Indemnity		
Employee Only	$9.81	$4.91
Employee & Spouse	$20.99	$10.50
Employee & Child(ren)	$15.33	$7.67



COST COMPARISON CONTINUED

	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 monthly coverage**
18-24	$0.093	$0.086	$0.679	$0.191
25-29	$0.093	$0.089	$0.634	$0.191
30-34	$0.109	$0.109	$0.600	$0.191
35-39	$0.124	$0.124	$0.623	$0.546
40-44	$0.191	$0.191	$0.758	$0.927
45-49	$0.286	$0.286	$0.905	$1.205
50-54	$0.428	$0.428	$1.019	$1.707
55-59	$0.618	$0.618	$1.460	$2.200
60-64	$0.723	$0.723	$1.867	$1.707
65-69	$1.299	$1.299	$2.184	$1.144
70-74	$2.490		$2.220	$1.144
75+	$2.490		$2.220	$1.144

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

Voluntary Critical Illness	
All Employees	**Per $1,000 of coverage**
Employee	$1.311
Spouse	$1.311
Child	$0.443

Experian Financial	Total Monthly Cost	Per Pay Period
Premium Plan - Basic		
Employee Only	$6.40	$3.20
Employee & Spouse	$13.00	$6.50
Employee & Child(ren)	$13.00	$6.50
Employee & Family	$13.00	$6.50
Elite Plan - Enhanced		
Employee Only	$9.80	$4.90
Employee & Spouse	$18.00	$9.00
Employee & Child(ren)	$18.00	$9.00
Employee & Family	$18.00	$9.00

Medicare Part D Notice

Important Notice from QSL Management 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 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 has determined that the prescription drug coverage offered by OptumRx 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 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 UMR is creditable (e.g., as good as Medicare coverage), you can retain your existing prescription drug 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 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 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 QSL Management 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).

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: [09/2023]

Name of Entity/Sender: QSL Management, LLC
Contact: Acuity Group HR
***Address*:** 219 E. Garden Street, Suite 400; Pensacola FL 32502
Email: QSLMHR@acuity-grp.com
Phone: 855-563-9396

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: $5,000/$10,000, 70%; PPO: $2,500/$5,000, 80%. If you would like more information on WHCRA benefits, contact your Human Resources team.

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, contact your Human Resources team.

HIPAA Notice of Special Enrollment Rights

If you decline enrollment in QSL Management's 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's 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's 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 describing how health information about you may be used and disclosed. You may obtain a copy of the Notice of Privacy Practices by contacting your Human Resources team.

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.

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

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: 1-844-854-4825

OKLAHOMA – Medicaid and CHIP

Website: http://www.insureoklahoma.org | Phone: 1-888-365-3742

OREGON – Medicaid and CHIP

Website: http://healthcare.oregon.gov/Pages/index.aspx | Phone: 1-800-699-9075

PENNSYLVANIA – Medicaid and CHIP

Website: https://www.pa.gov/en/services/dhs/apply-for-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, 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

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 8.39% in 2024 (9.02% in 2025) of your modified adjusted household income.

QSLM

WE SERVE OTHERS