Weber Gallagher

benefits

FOR BENEFITS EFFECTIVE JULY 1, 2025 – JUNE 30, 2026

welcome!

We are pleased to present our benefit offerings for the 2025-2026 plan year. Weber Gallagher strives to offer you and your dependents a competitive and comprehensive benefits package. We offer medical, prescription drug, vision and dental benefits and encourage you to take the time to educate yourself about these and other benefit options available to you.

QUESTIONS?

If you have questions about your benefits, please contact the Conner Strong & Buckelew Benefits Member Advocacy Center at **800.563.9929** (Monday through Friday, 8:30 am to 5:00 pm ET) or go to **www.connerstrong.com/memberadvocacy**

INSIDE THIS GUIDE

ELIGIBILITY & MAKING PLAN CHANGES

WHO IS ELIGIBLE FOR BENEFITS?

Employees who work a regular schedule of 30 hours or more per week are eligible to enroll in the benefits described in this Guide.

Employees who do not work a regular schedule of 30 or more hours per week may also elect to participate in benefits. However, these employees would be required to pay the full premium associated with those elections.

A new hire is eligible to participate in Medical and Dental benefits on the first of the month following date of hire. For all other benefits, a new hire is eligible to participate on the first of the month following the first 30 days of employment.

Eligible Dependents:

- Legal Spouse
- Children, legally adopted children, step-children, and children for whom you/your spouse are a court-appointed legal guardian
  - Children are covered up to age 26 for medical, dental and vision up to the last day of month of their 26th birthday.

DON'T FORGET!

Once you have made your elections, you will not be able to change them until the next Open Enrollment period, unless you experience a qualified change in status.

WHAT IS A "QUALIFIED CHANGE IN STATUS"?

Qualified status changes include: marriage, divorce, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you, your spouse, commencement or termination of adoption proceedings, or change in your spouse's benefits or employment status.

If an eligible dependent had other coverage and such coverage is lost, the eligible dependent may be eligible for enrollment during a "special enrollment period," which is usually the 30-day period following the date that other coverage was lost, due to a qualified change in status.

You must notify HR and supply proof of the event within 30 days of experiencing a qualified status change.

ENROLLMENT INSTRUCTIONS

The benefits you select will be in effect through the next benefit plan year, July 1, 2025 – June 30, 2026.

HOW TO ENROLL

All employees must log in to ADP to enroll in, make changes to, or waive the medical/ prescription drug, dental, vision, Flexible Spending Account (FSA) or voluntary benefits available to you.

Important note related to enrollment in the Sun Life Voluntary coverage: In addition to making your elections via ADP, you will also be required to complete an Evidence of Insurability (EOI) form which can be found on the intranet, HR HUB, or via Human Resources. Based on the information you provide on the EOI you can either be approved or denied for additional coverage. If you do not complete the form, you will not be enrolled in the additional coverage.

REMINDER regarding FSA participation: The IRS requires that you re-elect to participate in the FSA every plan year.

Note: If you are currently participating in the medical FSA, remember that you can carry over limited current medical FSA funds to the new plan year. You **MUST** elect to participate in the new plan year in order to have access to these funds.

If you elect to participate in the HSA Qualified HDHP medical plan, you will be able to participate in the Health Savings Account (HSA). You will not be able to participate in the Traditional Medical FSA for the new plan year. If you have funds in the medical FSA currently, up to $660 of the unused FSA funds left in your account at the end of the current plan year may be carried over to a Limited Purpose FSA. That money will be available to you only for any dental and vision expenses you may incur in the new plan year.

Please review additional information regarding the HSA within this guide.

ADMINISTERED BY CIGNA

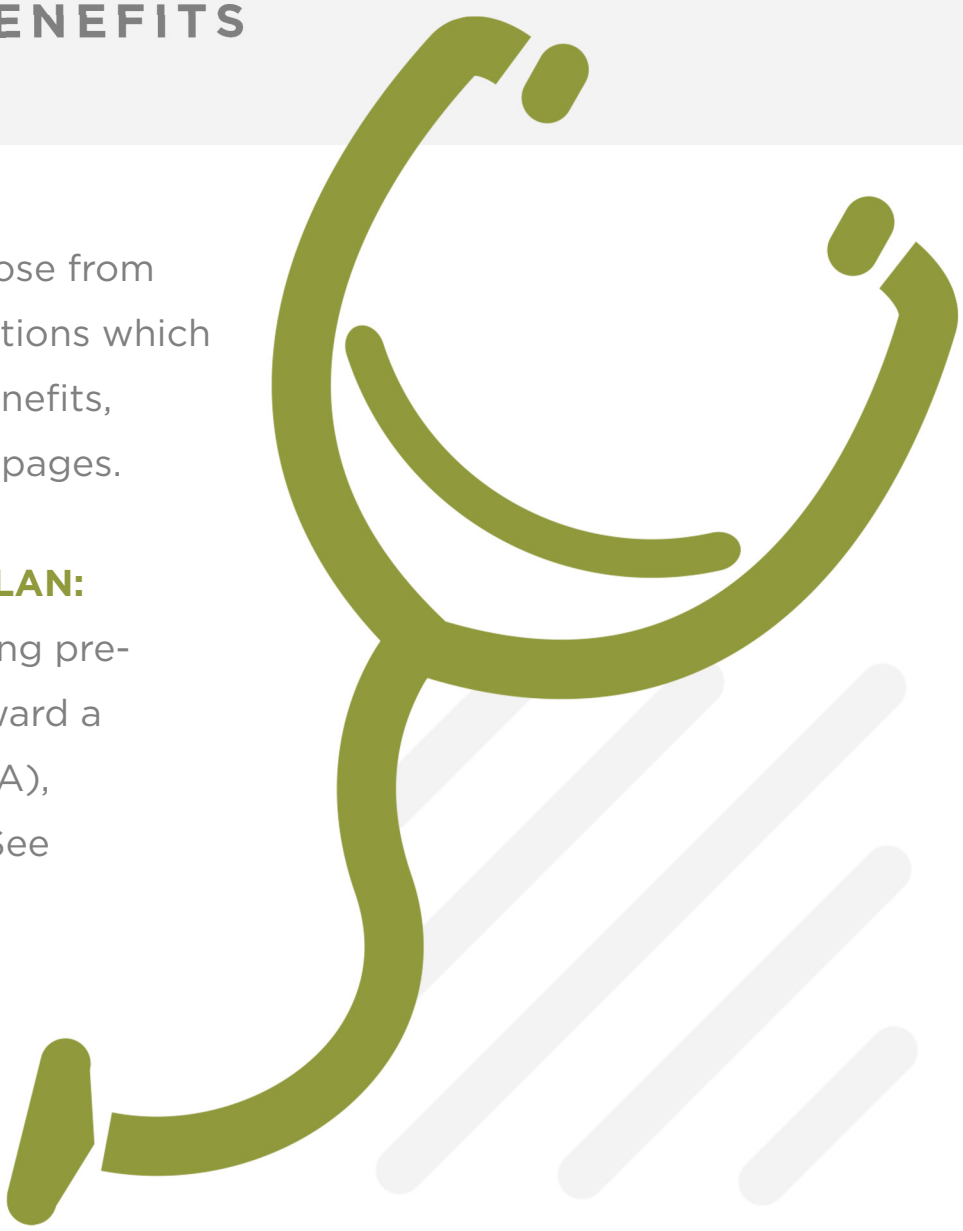
MEDICAL & PRESCRIPTION PLANS

YOUR 2025-26 BENEFITS

Eligible employees may choose from **three** Cigna medical plan options which include prescription drug benefits, as outlined on the following pages.

IF YOU ELECT THE HDHP PLAN:

You have the option of making pre-tax payroll contributions toward a Health Savings Account (HSA), administered by FlexFacts. See **page 19** for more details.



MEDICAL BENEFITS: CIGNA

Below is a summary of the medical plans available to you, effective July 1, 2025.

	HSA-QUALIFIED HDHP	MID PLAN	HIGH PLAN
IN-NETWORK BENEFITS			
Deductible (July 1, 2025 - June 30, 2026) Individual/Family	1,650/$3,300**	$750/$1,500	$500/$1,000
Firm HSA Funding Individual/Family	$825/$1,650	N/A	N/A
Out-of-Pocket Maximum (July 1, 2025 - June 30, 2026) Individual/Family	$6,900/$13,800***	$5,000/$10,000	$4,000/$8,000
Preventive Care Services	Covered 100%	Covered 100%	Covered 100%
PCP Office Visit	Plan pays 80%*	Plan pays 80%*	$30 copay
Specialist Office Visit	Plan pays 80%*	Plan pays 80%*	$60 copay
Diagnostic Laboratory	Plan pays 80%*	Plan pays 80%*	Plan pays 90%
Diagnostic X-Ray/Imaging (MRI, CT-Scan)	Plan pays 80%*	Plan pays 80%*	$100 copay
Emergency Room	Plan pays 80%*	Plan pays 80%*	$150 copay
Urgent Care Center	Plan pays 80%*	Plan pays 80%*	$50 copay per visit
Telehealth	Plan pays 80%*	Plan pays 80%*	$30 copay per visit
Inpatient Hospital	Plan pays 80%*	Plan pays 80%*	Plan pays 90%*
Outpatient Surgery	Plan pays 80%*	Plan pays 80%*	Plan pays 90% *
OUT-OF-NETWORK BENEFITS (SUBJECT TO BALANCE BILLING)			
Deductible (July 1, 2025 - June 30, 2026) Individual/Family	$5,000/$10,000	$5,000/$10,000	$5,000/$10,000
Out-of-Pocket Maximum (July 1, 2025 - June 30, 2026) Individual/Family	$10,000/$20,000	$10,000/$20,000	$10,000/$20,000
Coinsurance	Plan pays 50%*	Plan pays 60%*	Plan pays 70%*

* After deductible

** (Per IRS guidelines) Full Family Deductible: The family deductible must be met if employee covers self and one or more dependent.

*** Once any one individual meets the individual out-of-pocket maximum, their expenses are covered at 100% for the balance of the plan year, all other family members must collectively meet the family out-of-pocket maximum before the plan pays 100%.

PRESCRIPTION BENEFITS: CIGNA

Below is a summary of the medical plans available to you, effective July 1, 2025.

	HSA-QUALIFIED HDHP	MID AND HIGH PLANS
RETAIL PHARMACY (UP TO A 30-DAY SUPPLY)		
Generic	Plan pays 80%*	$20 copay
Preferred Brand	Plan pays 80%*	$40 copay
Non-Preferred Brand	Plan pays 80%*	$60 copay
MAIL ORDER PHARMACY (UP TO A 90-DAY SUPPLY)		
Generic	Plan pays 80%*	$40 copay
Preferred Brand	Plan pays 80%*	$80 copay
Non-Preferred Brand	Plan pays 80%*	$120 copay

* After medical deductible

Please note: Prescription drug costs will accumulate towards the medical plan out-of-pocket maximum.

CIGNA 90-DAY PRESCRIPTION FOR MAINTENANCE MEDICATIONS

Maintenance medications must be filled in a 90-day supply at a retail pharmacy or Home Delivery pharmacy to be covered under your plan. Maintenance medications are those medications that are taken regularly, over time, to treat an ongoing health condition, such as diabetes, high blood pressure, cholesterol or asthma.

You will be able to receive three 30-day fills before your maintenance medication is not covered. **If you haven't switched to a 90-day supply after three fills, your plan won't cover the cost of the medication.** Having a 90-day supply of your medication on-hand typically means you're less likely to miss a dose.

Your plan offers a retail pharmacy network that gives you more choice in where you can fill your 90-day prescriptions. There are thousands of retail pharmacies in the network.

For more information about the Cigna pharmacy network, you can go to **www.Cigna.com/Rx90network**.

MAXIMIZE YOUR PHARMACY BENEFITS

SAVE ON YOUR PRESCRIPTIONS WITH MAIL ORDER

When you use the Cigna Home Delivery Pharmacy to fill your maintenance drug prescriptions, you will receive a 90-day (3-month) supply for the cost of two retail copays. In addition to the savings, your prescriptions will be delivered right to your home.

To learn more about using mail order, simply visit **www.cigna.com**.

HOW MUCH CAN YOU SAVE WHEN YOU USE MAIL ORDER?

RETAIL PHARMACY	MAIL ORDER	ANNUAL SAVINGS
Preferred Brand-Name **$40 copay**	Preferred Brand-Name **$80 copay**	**$160**
Annual cost *($40 x 12 fills per year)* **$480**	Annual cost *($80 x 4 fills per year)* **$320**	

SAVE WITH GENERIC DRUGS

A generic drug is a version of a brand drug. Generic drugs are reviewed and approved by the U.S. Food and Drug Administration (FDA), just as brand drugs are. According to the FDA, compared to its brand counterpart, a generic drug:

- is chemically the same
- is as safe and effective
- meets the same standards set by the FDA

The major difference is that the generic drug often costs much less.

GOODRX

Compare Prescription Prices and Save!

GoodRx is a valuable resource that allows you to compare prescription drug prices at local and mail-order pharmacies and discover free coupons and savings tips. This is a great resource for members enrolled in the HDHP plan!

Learn more about Good Rx and start saving today by visiting **connerstrong.goodrx.com**.

DID YOU KNOW?

You don't need to use your prescription benefits through Cigna to take advantage of the savings available through GoodRx. Some of the discounts found on GoodRx can be less expensive than your costs using the Cigna plan.

TELEMEDICINE: CIGNA TELEHEALTH CONNECTION

The care you need— when, where, and how you need it. Introducing Cigna Telehealth Connection.

Cigna provides access to two telehealth services as part of your medical plan election – through **MDLIVE**. Cigna Telehealth Connection lets you get the care you need – including most prescriptions – for a wide range of minor conditions. Now you can connect with a board-certified doctor via video chat or phone, without leaving your home or office. Participants may access this benefit when, where and how it works best for them!

Choose when: Day or night, weekdays, weekends and holidays.

Choose where: Home, work or on the go.

Choose how: Phone or video chat.

If you pre-register with **MDLIVE**, you can speak with a doctor for help with:

- Sore throat
- Headache
- Stomachache
- Fever
- Cold and flu
- Allergies
- Rash
- Acne
- UTIs and more

NEW! MDLIVE PREVENTIVE CARE IMAGING SCREENINGS

MDLIVE now offers a preventive imaging service aimed at making early detection easier and more convenient. You can receive assistance from a dedicated care coordinator to provide personalized support to schedule imaging appointments at an in-network imaging facility. Ongoing support is available on the MDLIVE Patient Portal.

THE COST SAVINGS ARE CLEAR

Televisits with Amwell and MDLIVE can be a cost-effective alternative to a convenience care clinic or urgent care center, and cost less than going to the emergency room. Remember, your telehealth services are only available for minor, non-life threatening conditions. **In an emergency, dial 911 or go to the nearest hospital.**

CHOOSE WITH CONFIDENCE

The **MDLIVE** network is comprised of quality national telehealth providers, so you can choose your care confidently. When you can't get to your doctor, Cigna Telehealth Connection is here for you. **Register today so you'll be ready when and where you need it.**

- Set up and create an account with MDLIVE
- Complete a medical history using their virtual clipboard
- Download vendor apps to your smartphone/ mobile device

TO GET STARTED

MDLIVE: Call **888.726.3171**

or visit **MDLiveforCigna.com**

ADDITIONAL CIGNA PROGRAMS

CIGNA ONE GUIDE

The Cigna One Guide service can help you make smarter, informed choices and get the most from your plan. It's the highest level of support that combines the ease of a powerful app with the personal touch of live service. One Guide personal support, tools and reminders can help you stay healthy and save money.

Your One Guide team is a click away to help you:

- Understand your plan
- Know your coverage and how it works
- Get answers to all your health care or plan questions
- Get care
- Find an in-network doctor, lab or urgent care center
- Connect to health coaches, pharmacists and more
- Stay on track with appointments and preventive care
- Take advantage of dedicated one-on-one support for complex health situations
- Maximize your benefits and earn incentives (if provided by your employer)
- Get cost estimates and service comparisons to avoid surprises

Start using Cigna One Guide today – by app, chat or phone. Download the myCignaSM app or call **1.800.Cigna24**.

LIFESTYLE MANAGEMENT PROGRAMS

Whether your goal is to lose weight, quit tobacco or lower your stress levels, you have the power to make it happen. Cigna Lifestyle Management Programs can help – and all at **no additional cost to you**.

Weight Management: Reach your goal of maintaining a healthy weight – all without the fad diets. Create a personal healthy-living plan that will help you build your confidence, be more active and eat healthier.

Tobacco Cessation

Get the help you need to finally quit tobacco. Create a personal quit plan with a realistic quit date. And, get the support you need to kick the habit for good. You'll even get free over-the-counter nicotine replacement therapy.

Stress Management

Learn what causes you stress in your life and develop a personal stress management plan. And, get the support you need to help you cope with stressful situations – both on and off the job.

Over the phone:

- One-on-one wellness coaching
- Convenient evening and weekend hours
- Program workbook and toolkit

Online:

- Convenient support
- Self-paced program

To enroll in any of the programs, you can call the member services number found on the back of your medical ID card or visit **myCigna.com**.

ADMINISTERED BY VSP

VISION PLAN

YOUR 2025-26 BENEFITS

Weber Gallagher offers a voluntary vision plan through VSP. This benefit offers coverage for vision exams and hardware, as outlined on the following page.

VISION BENEFITS: VSP

Eligible employees and their eligible family members may enroll in the VSP Choice plan. Please refer to the VSP plan materials for additional coverage details.

	VSP CHOICE PLAN	
	IN-NETWORK	OUT-OF-NETWORK
Routine Exam	$10 copay	Up to $45 reimbursement
Prescription Glasses	$10 copay	See Frames and Lenses for reimbursement
Frames	$200 allowance, 20% off amount over your allowance	Up to $70 reimbursement
Lenses Single Vision Bifocal Trifocal	Included in Prescription Glasses	 Up to $30 reimbursement Up to $50 reimbursement Up to $65 reimbursement
Lens Enhancements Standard Progressive Premium Progressive Custom Progressive	 $0 $95–$105 $150–$175	 Up to $50
Contact Lenses (in lieu of glasses) Exam Elective Necessary	 Up to $60 copay $130 allowance $210 allowance after copay	 N/A Up to $105 reimbursement Up to $210
Frequency Vision Exam Frames Lenses	 Once every 12 months Once every 24 months Once every 12 months	

To find doctors in your neighborhood, visit **www.vsp.com** or call **800.877.7195**.

DENTAL PLANS

YOUR 2025-26 BENEFITS

Good dental health is important to your overall well-being. At the same time, we all need different types of dental treatment. The Cigna Dental plans, offered by Weber Gallagher, provide varying levels of coverage for Diagnostic/ Preventive Services, Basic Services, Major Services, and Orthodontia.

You may select either the Core PPO or Buy-Up PPO dental plans offered through Cigna. **When enrolled in a Cigna PPO dental plan, you will not have to select a Primary Care Dentist!**

DENTAL BENEFITS: CIGNA

Eligible employees and their eligible family members may enroll in either of the Cigna dental plans, which include 100% coverage for preventive services.

	CORE PPO		BUY-UP PPO	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Calendar Year Deductible Individual/Family	$50/$150	$75/$225	$50/$150	$75/$225
Calendar Year Maximum (per patient)	$1,250	$1,250	$2,250	$2,250
Preventive & Diagnostic Services Exams, Cleanings, Bitewing X-rays (each twice in a calendar year) Fluoride Treatment (once in a calendar year, children to age 19)	Covered 100%	Covered 100%	Covered 100%	Covered 100%
Basic Services Fillings, Extractions Endodontics (root canal) Periodontics, Oral Surgery Sealants	Plan pays 100% after deductible	Plan pays 80% after deductible	Plan pays 100% after deductible	Plan pays 80% after deductible
Major Services Crowns, Gold Restorations Bridgework Full and Partial Dentures	Plan pays 60% after deductible	Plan pays 50% after deductible	Plan pays 60% after deductible	Plan pays 50% after deductible
Orthodontia Benefits (children age 19 and below)	Plan pays 50%	Plan pays 50%	Plan pays 50%	Plan pays 50%
Orthodontia Lifetime Maximum (per patient)	$2,000	$2,000	$2,000	$2,000

* Out-of-Network coverage is based on usual, customary and reasonable "UCR" charges. Members who use dentists outside of the network may be balance billed the difference between UCR and that dentist's actual charges.

ADMINISTERED BY SUNLIFE

LIFE, AD&D & DISABILITY PLANS

YOUR 2025-26 BENEFITS

Life and Accidental Death & Dismemberment (AD&D) insurance provides protection to those who depend on you financially, in the event of your death or an accident that results in death or serious injury.

Short-Term and Long-Term Disability also help to protect your income in the event that you become disabled and are unable to work.

LIFE & DISABILITY INSURANCE: SUN LIFE

Life, AD&D and Long-Term Disability Insurance is **100% paid by Weber Gallagher.**

Short-Term Disability and Voluntary Employee Life are **100% employee paid.**

LIFE & AD&D INSURANCE

Life insurance is provided by Weber Gallagher to all full-time employees **at no cost to you**. In the event of a claim, your beneficiary will be entitled to receive a lump sum dollar amount from this policy. Your beneficiary is the person (or entity) you choose who will receive the death benefit from your policy in the event of a claim. If you do not have a beneficiary, your state's laws determine who receives the benefit. This benefit will reduce beginning at age 65 and will terminate at retirement.

For additional information related to the Life and AD&D policy, please refer to the Life & Disability benefit highlights included in this packet.

LONG-TERM DISABILITY INSURANCE

Long-Term Disability insurance is provided by Weber Gallagher to all full-time employees **at no cost to you**. If you are disabled due to a non-work related illness or injury for more than 90 days, you may be eligible to receive a monthly benefit amount from this policy. The benefit can continue up to social security normal retirement age, subject to approval.

For additional information related to the Long-Term Disability policy, please refer to the Life & Disability benefit highlights included in this packet.

SHORT-TERM DISABILITY

(Applies to Full-Time Staff & Associates ONLY)

- **Weekly Benefit Percent:** 60%
- **Maximum Weekly Benefit:** $1,000
- **Elimination Period** (day on which benefits will be payable for your disability): 1st day for Accidents & 8th day for Illness
- **Maximum Duration of Benefit** (subject to approval): 13 weeks (includes elimination period)

VOLUNTARY EMPLOYEE LIFE INSURANCE

(Applies to All Full-Time Employees)

- **Employee:** 3x Salary or $1,000,000 ($10,000 increments)
- **Spouse:** 50% of Employee Amount up to $100,000 ($5,000 increments)
- **Dependent Child(ren):** 15 Days to 19 (25 if full-time student) $10,000
  - **Birth to 14 Days**: $500
- **Guaranteed Issue Amounts:**
  - Employee: $100,000 or 3x Salary
  - Spouse: $30,000
  - Child(ren): $10,000
- **Benefit Reduction Schedule:** 65% at age 65; 40% at age 70.

For additional details and Evidence of Insurability (EOI) requirements, please refer to the Life & Disability benefit highlights.

ADDITIONAL VOLUNTARY BENEFITS: SUN LIFE

All Full-Time and Part-Time benefit eligible employees may choose to participate in any of the following benefits.

CRITICAL ILLNESS

When you, your spouse or child is diagnosed with a covered condition, you can receive a cash benefit to help pay unexpected costs not covered by your health plan. While health plans may cover direct costs associated with a critical illness, including cancer, you can use your benefit to help with related expenses like lost income, child care, travel to and from treatment, deductibles and copays.

- **Employee:** You can choose between $10,000 and $40,000 of coverage, in increments of $10,000. No medical questions asked.
- **Spouse:** If you elect coverage for yourself, you can choose between $10,000 and $40,000 of coverage, in increments of $10,000. No medical questions asked. Cannot exceed 100% of Employee coverage amount.
- **Child(ren):** If you elect coverage for yourself, you can choose between $5,000 and $20,000 of coverage, in increments of $5,000. No medical questions asked. Not to exceed 50% of your coverage amount. An eligible child is defined as your child from birth to age 26.

ACCIDENT INSURANCE

When you, your spouse or child has a covered accident, like a fall from a bicycle that requires medical attention, you can receive cash benefits to help cover the unexpected costs. Accident insurance can be used however you want, and it pays in addition to any other coverage you may already have. Benefits are payable directly to you. There are no health questions or pre-existing condition limitations.

Once your coverage goes into effect, you can file a claim for covered accidents that occur after your insurance plan's effective date. Unless otherwise specified, benefits are payable only once for each covered accident, as applicable.

To learn more about maximizing the voluntary benefits available to you, visit SunLife's Voluntary Benefit Explorer page at: **https://SunLife.co/WeberGallagher**

PRE-TAX SAVINGS ACCOUNTS

YOUR 2025-26 BENEFITS

If you participate in the HDHP, eligible employees can elect to participate in the **Health Savings Account (HSA)**. The HSA is a tax-exempt savings account that can be used for eligible healthcare expenses.

If you are not eligible for the HSA, a Healthcare **Flexible Spending Account (FSA)** is another type of tax-exempt account that allows you to set aside funds that can be used for eligible healthcare expenses.

HEALTH SAVINGS ACCOUNT (HSA)

ARE YOU ELECTING THE HDHP PLAN?

If you participate in the HSA-Qualified HDHP, you may be eligible to participate in a Health Savings Account (HSA). An HSA is a tax-exempt savings account that can be used for contributions, earnings and withdrawals for eligible expenses. **You can also elect to participate in a Limited Purpose FSA (LPFSA)**, which can be used for eligible dental and vision expenses. More details can be found on page 20.

HSA ADVANTAGES

- An HSA is portable, meaning that if you leave your employer, you can take your HSA funds with you.
- There is no "use it or lose it" provision with an HSA. If you don't use the money in your account by the end of the year, it just stays there and collects interest on a tax-deferred basis.
- An HSA includes a banking partner that offers you several investment options that suit your needs.
- An HSA does not require third party substantiation for transactions; however, you should keep records of these transactions in the event of an IRS audit.

HSA ELIGIBILITY

You may contribute to an HSA if you:

- Are covered under an HSA Qualified high deductible health plan (HDHP)
- Do not have disqualifying coverage such as other "first dollar" medical coverage etc.
- Are not entitled to (eligible and enrolled) Medicare
- Cannot be claimed as a dependent on someone else's tax return

HSA CONTRIBUTIONS

For 2025, the contribution limits are: **$4,300 for individual coverage and $8,550 for family coverage.** This annual maximum includes funds contributed by the Firm as well as funds contributed by the employee. The annual catch-up contribution for age 55 and older is $1,000 per month.

If you elect the HSA Qualified HDHP for the new plan year, the Firm will contribute $825 into your HSA if enrolled as Single or $1,650 if enrolled as a Family. The Firm funded amount will be available with the first pay of the new plan year.

Employees electing the HSA July 1, 2025 will have 90 days to submit Medical claims with dates of service up to June 30, 2025 **if** they participated in an FSA for the prior plan year. Any funds up to $660 after the 90 day run out will need to rollover into a Limited Purpose FSA "LPFSA" for future use.

GETTING STARTED IS EASY!

If you elect the HSA-Qualified HDHP for 2025 and wish to participate in the HSA, you need to make your election via the ADP enrollment site. If you are turning 65 or older, please see **medicare.gov** for restrictions on HSA accounts.

FLEXIBLE SPENDING ACCOUNTS: FLEXFACTS

A Flexible Spending Account (FSA) allows you to have money deducted from your pay on a pre-tax basis and put into an account that you can use to pay for eligible expenses. There are three types of accounts, Medical, Dependent Day Care and Commuter (Parking & Transit).

TRADITIONAL MEDICAL FSA

To participate in the FSA, you must make an election before the beginning of the plan year via the ADP enrollment site. Your annual election is divided by 24 pays during the year and the funds are taken out of your pay on a pre-tax, semi-monthly basis over the course of the plan year.

The Plan is subject to the Use It or Lose It rules set forth by the IRS. However, the Firm allows you to carry over up to $640 of unused Medical FSA funds from the current plan year to the new plan year, starting July 1, 2025. The "run out period" allows a participant to continue to submit receipts to FlexFacts to be reimbursed for expenses incurred during the July 1, 2024 - June 30, 2025 plan year. The run out period ends September 30, 2025. Additionally, the "*run out period*" allows a participant to continue to submit receipts to FlexFacts to be reimbursed for expenses incurred during the July 1, 2025 - June 30th, 2026 plan year. This run out period ends September 30, 2026.

Common expenses that are eligible include; co-pays, deductibles, prescriptions, vision and dental expenses. The maximum you can elect for the 2025 plan year is $3,300.

Employees enrolled in an HSA cannot enroll in the Traditional Medical FSA.

A complete list of expenses eligible under the medical FSA is available at **www.flexfacts.com**. Click on the FSA Eligible Expense Table link at the bottom of the page and enter in Access Code **"flex2011"**.

LIMITED PURPOSE FSA (LPFSA)

Available to HSA participants only. The IRS allows members who participate in a Health Savings Account to also elect a LPFSA. LPFSA participants may contribute up to $3,300 to be used for eligible dental and vision expenses only.

If you participated in the Traditional Medical FSA during the July 1, 2024 – June 30, 2025 plan year and you elect to participate in the HSA to coincide with enrollment in the HSA-Qualified HDHP medical plan for the new plan year, beginning July 1, 2025, unused funds up to $640 in that Traditional Medical FSA will be transferred to a LPFSA.

FLEXIBLE SPENDING ACCOUNTS: FLEXFACTS

DEPENDENT DAY CARE FSA

Common expenses that are eligible include; daycare facilities, after school programs, summer day camp, and in home babysitters. The maximum that you can elect is $5,000 per calendar year per family unit. If you are married filing separately the maximum is $2,500. Dependent children are covered under this account to the age of 13.

If you have unused funds in this account at the end of the plan year, you may still access those funds to pay expenses until September 30, 2025. Unused funds will not carry over into the new plan year. Participants are still able to submit receipts for reimbursement to FlexFacts for expenses incurred in the July 1, 2024 – June 30, 2025 plan year up until September 30, 2025.

PARKING AND TRANSIT ACCOUNTS

You can put money aside pre-tax to pay for transit and/or parking at or near your place of employment. The maximum amount you may contribute for parking and transit is $325 per month. Unused funds left in this account at the end of the plan year, will carry over into the new plan year.

FILING A CLAIM

The full annual election under your medical flexible spending account is available on the first day of the plan year. Dependent care funds are available as they are deducted from your pay.

The easiest way to use your funds is by using your Flex Facts debit card at the point of service. The card can be used at any medical or dependent care facility that accepts MasterCard. You can also use your card at most pharmacies. When you use your card, funds are automatically deducted from your account to pay for eligible expenses.

Please note that you should retain all of your receipts. The IRS requires that we request copies of receipts for certain claims. If you are required to send in receipts an e-mail or letter will be sent to you the business day after you use your card.

CONTACT FLEX FACTS

- FlexFacts Login: **https://flexfacts.wealthcareportal.com**
- Call: **877.94.FACTS** (32287)
  Monday – Thursday, 8:30 am to 8:30 pm EST & Friday, 8:30 am to 5:30 pm EST
- Email: **support@flexfacts.com**
- Fax: **877-747-8564**
- Mail: 1200 River Avenue, Suite 5C, Lakewood, NJ 08701

COLLEGE SCHOLARSHIPS

COLLEGE SCHOLARSHIPS

Don't miss the opportunity to enroll in the College Tuition Benefit, which provides a free college scholarship for each child you register.

- Each Weber, Gallagher, Simpson, Fires & Newby employee will receive 500 reward points upon enrolling. Married employees are eligible for 1,000 reward points.
- Your initial reward grows each year by 5% of your 401k account balance.
- Children must not have completed the 10th grade in order to be eligible as a beneficiary.
- Beneficiaries can be your children, grandchildren, nieces, nephews or godchildren.
- The most one child can utilize in tuition reward points is one year's tuition spread over the four years.
- Please visit: **www.CollegeTuitionBenefit.com** to see our network of participating schools.

HOW TO REGISTER

To register for the College Tuition Benefit, complete the following steps:

1. Visit www.CollegeTuitionBenefit.com
2. Click on "Register" at left side of screen
3. Use the following information and complete the registration:
   - Employee Information:
     - Employer Name: Weber
     - Password: Scholarship
   - Spouse Information:
     - Employer Name: Weber Spouse
     - Password: Scholarship

When a spouse registers, they must use an email address different from the one used by the employee!

BENEFITS MEMBER ADVOCACY CENTER

BENEFITS MEMBER ADVOCACY CENTER

Conner Strong & Buckelew

The Benefits Member Advocacy Center (Benefits MAC), provided by Conner Strong & Buckelew, can help you an your covered family members navigate your benefits. Contact the Benefits MAC to:

- Find answers to your benefits questions
- Search for participating network providers
- Clarify information received from a provider or your insurance company, such as a bill, claim, or explanation of benefits (EOB)
- Guide you through the enrollment process or how you can add or delete coverage for a dependent
- Rescue you from a benefits problem you've been working on
- Discover all that your benefit plan have to offer!

TO CONTACT MEMBER ADVOCACY

- Call **800.563.9929**, Monday through Friday, 8:30 am to 5 pm (EST)
- Email: **cssteam@connerstrong.com**
- Submit a request online at **www.connerstrong.com/memberadvocacy**

Member Advocates are available Monday through Friday, 8:30 am to 5:00 pm ET. After hours, you will be able to leave a message with a live representative and receive a response by phone or remail during business hours within 24 to 48 hours of your inquiry.

LEGAL NOTICES

Notice Regarding Special Enrollment

Loss of other coverage (excluding Medicaid or a State Children's Health Insurance Program). If you decline enrollment for yourself or for an eligible dependent (including your spouse) while other health insurance or group health plan coverage (including COBRA coverage) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the Company stops contributing toward your or your dependents' other coverage). However, you must request enrollment within [30 days or any longer period that applies under the plan] after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment. When the loss of other coverage is COBRA coverage, then the entire COBRA period must be exhausted in order for the individual to have another special enrollment right under the Plan. Generally, exhaustion means that COBRA coverage ends for a reason other than the failure to pay COBRA premiums or for cause (that is, submission of a fraudulent claim). This means that the entire 18-, 29-, or 36-month COBRA period usually must be completed in order to trigger a special enrollment for loss of other coverage.

Loss of eligibility for Medicaid or a State Children's Health Insurance Program. If you decline enrollment for yourself or for an eligible dependent (including your spouse) while Medicaid coverage or coverage under a state children's health insurance program (CHIP) is in effect, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage. However, you must request enrollment within 60 days after your or your dependents' coverage ends under Medicaid or CHIP. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.
New dependent by marriage, birth, adoption, or placement for adoption. If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your new dependents. However, you must request enrollment within [30 days or any longer period that applies under the plan] after the marriage, birth, adoption, or placement for adoption. If you request a change within the applicable timeframe, coverage will be effective the date of birth, adoption or placement for adoption. For a new dependent as a result of marriage, coverage will be effective the first of the month following your request for enrollment.

Eligibility for Medicaid or a State Children's Health Insurance Program. If you or your dependents (including your spouse) become eligible for a state premium assistance subsidy from Medicaid or through a state children's health insurance program (CHIP) with respect to coverage under this plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' determination of eligibility for such assistance. If you request a change within the applicable timeframe, coverage will be effective the first of the month following your request for enrollment.

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 issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

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 benefits. If you have any questions, please speak with Human Resources.

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Weber Gallagher offers a series of health coverage options. You should receive a Summary of Benefits and Coverage (SBC) during Open Enrollment. These documents summarize important information about all health coverage options in a standard format. Please contact Human Resources if you have any questions or did not receive your SBC.

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 March 17, 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

LEGAL NOTICES

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: 1-800-403-0864
Member Services Phone: 1-800-457-4584

IOWA – Medicaid and CHIP (Hawki)
Medicaid Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid
Medicaid Phone: 1-800-338-8366
Hawki Website:
https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki
Hawki Phone: 1-800-257-8563
HIPP Website: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/fee-service/hipp
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: 1-800-977-6740
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: 1-800-356-1561
CHIP Premium Assistance Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710 (TTY: 711)

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: https://www.dhs.pa.gov/CHIP/Pages/CHIP.aspx
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: https://www.hhs.texas.gov/services/financial/health-insurance-premium-payment-hipp-program
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: https://dvha.vermont.gov/members/medicaid/hipp-program
Phone: 1-800-250-8427

VIRGINIA – Medicaid and CHIP
Website: https://coverva.dmas.virginia.gov/learn/premium-assistance/famis-select and https://coverva.dmas.virginia.gov/learn/premium-assistance/health-insurance-premium-payment-hipp-programs
Medicaid/CHIP Phone: 1-800-432-5924

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 March 17, 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

This benefit summary provides selected highlights of the employee benefits program at Weber Gallagher. It is not a legal document and shall not be construed as a guarantee of benefits nor of continued employment at Weber Gallagher. All benefit plans are governed by master policies, contracts and plan documents. Any discrepancies between any information provided through this summary and the actual terms of such policies, contracts and plan documents shall be governed by the terms of such policies, contracts and plan documents. Weber Gallagher reserves the right to amend, suspend or terminate any benefit plan, in whole or in part, at any time. The authority to make such changes rests with the Board of Directors.