keep your heart at home

Village

CAREGIVING

2026 Benefit Guide

Medical

Dental

Vision

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A Message from HR at Village Caregiving, LLC

It's that time of year again — Open Enrollment is here! This year's lineup includes Medical, Dental, and Vision Insurance, plus our full suite of voluntary benefits through UNUM. There are two important changes you'll want to know about:

First, is our new premium structure**.** We're moving away from percentage-based premiums and switching to a tiered setup — Employee Only, Employee + Spouse, Employee + Children, and Family. The IRS recently raised the ACA compliance percentage from 9.02% to 9.96% (for the second year in a row), which is one reason we're making this change. The new structure also gives us more flexibility moving forward. Due to the change, everyone **must** log in to the ADP Workforce Now app during Open Enrollment and make a new medical plan selection this year.

Second, we are moving to a new vision provider. We're switching from NVA Vision to Bento Vision, which partners with VSP — the largest vision provider network in the U.S.

Our goal is to offer benefits that are easy to understand, easy to access, and affordable for everyone. We will continue to gather feedback from the field and get better year after year.

You'll find everything you need to review your options and make your selections in this Open Enrollment brochure. Take a few minutes to look it over and choose the plan that fits you best.

Thanks for everything you do!

—Village Caregiving HR Team

Eligibility

Eligible Employees:

You may enroll in the Village Caregiving, LLC Employee Benefits Program if you are a Full-Time employee working at 30 Hours per Week.

Eligible Dependents:

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse and children up to age 26.

When Coverage Begins:

The effective date for your benefits is January 1, 2026. Newly hired employees and dependents will be effective in Village Caregiving, LLC's benefits programs First of Month Following DOH. All elections are in effect for the entire plan year and can only be changed during Open Enrollment unless you experience a family status event.

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage

Note: Some states (currently, California, Massachusetts, New Jersey, Rhode Island, Washington D.C., and Vermont) may impose a tax on residents who do not have health insurance coverage, subject to limited exceptions.

Family Status Change:

A change in family status is a change in your personal life that may impact your eligibility or dependent's eligibility for benefits. Examples of some family status changes include:

- Change of legal marital status (i.e., marriage, divorce, death of spouse, legal separation)
- Change in number of dependents (i.e., birth, adoption, death of dependent, ineligibility due to age)
- Change in employment or job status (spouse loses job, etc.)

If such a change occurs, you must make the changes to your benefits within 30 days of the event date. Documentation may be required to verify your change of status. Failure to request a change of status within 30 days of the event may result in your having to wait until the next open enrollment period to make your change. Please contact HR to make these changes.

At the Doctor's Office

It's recommended that you choose an in-network primary care physician (PCP) for your medical coverage, even though it is not required. A PCP can be your Family Practitioner, Internist, General Medicine, Pediatrician, or an OB/GYN (Obstetrician and Gynecologist). Each member of your family may have a different PCP.

If you are newly enrolling in medical benefits, make an appointment with your PCP- even if you're NOT sick, once the plan year has begun. This relationship will set the foundation for staying healthy—today and well into the future.

Network Provide/Facility Search

Make sure that your provider or facility is in-network. To locate a network provider, follow the steps below or call (877) 804-4629.

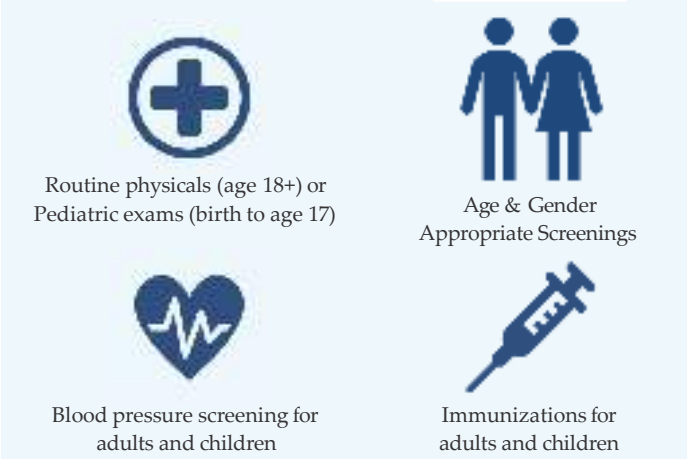
- Visit www.hnas.com and login to your account to find an in-network provider.
- Visit https://www.bcbs.com/login to find an in-network provider.

Preventive Care

You and your family have access to a wide range of preventive services under the Affordable Care Act. These services are 100% covered by your medical plan when using in-network providers. For more details about the covered services please visit

www.healthcare.gov/coverage/preventive-care-benefits.

Common preventive services include:



Member Service Portal

Your medical carrier's member portal is your access to secure, personalized services with interactive health tools built around you, your benefits, and your health. Access the HealthNow Administrative Services at www.hnas.com. Once you are registered your personal health information will be available to you 24/7, including:

- Finding care
- Managing prescriptions
- Managing claims
- Staying healthy
- Getting coverage and cost details

Need your health data on the run? Download your free carrier app from the App Store or Google Play. Use your mobile device to search for doctors, hospitals and more! Just search for HNAS.com.

Medical Insurance

Medical Benefits

Village Caregiving, LLC will continue to offer medical coverage. The charts below are a brief outline of what is offered. Please refer to the summary plan description for complete plan details.

	HealthNow Administrative Services Plan Option / PPO Highmark Network		HealthNow Administrative Services Plan Option / HDHP Highmark Network		HealthNow Administrative Services Plan Option / PP02 Highmark Network	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Annual Deductible						
Individual	$2,000	$4,000	$2,000	$4,000	$9,000	N/A
Family	$4,000	$8,000	$4,000	$8,000	$18,000	N/A
Coinsurance	80%	50%	100%	50%	80%	N/A
Maximum Out-of-Pocket*						
Individual	$6,900	$8,000	$2,000	$8,000	$9,200	N/A
Family	$13,800	$16,000	$4,000	$16,000	$18,400	N/A
Physician Office Visit						
Primary Care	$25 copay per visit	50% after deductible	100% after deducible	50% after deductible	80% after deductible	Not Covered
Specialty Care	$75 copay per visit	50% after deductible	100% after deducible	50% after deductible	80% after deductible	Not Covered
Preventive Care						
Adult Periodic Exams	100%	50% after deductible	100%	50% after deductible	100%	Not Covered
Well-Child Care	100%	50% after deductible	100%	50% after deductible	100%	Not Covered
Diagnostic Services						
X-ray and Lab Tests	80% after deductible	50% after deductible	100% after deducible	50% after deductible	800% after deductible	Not Covered
Complex Radiology	80% after deductible	50% after deductible	100% after deducible	50% after deductible	80% after deducible	Not Covered
Urgent Care Facility	$50 copay per visit	50% after deductible	100% after deducible	50% after deductible	80% after deducible	Not Covered
Emergency Room Facility Charges*	$300 copay per Visit	$300 copay per Visit	100% after deducible	100% after in-network deductible	80% after deducible	80% after in-network deductible
Inpatient Facility Charges	80% after deductible	50% after deductible	100% after deducible	50% after deductible	Not Covered	Not Covered
Outpatient Facility and Surgical Charges	80% after deductible	50% after deductible	100% after deducible	50% after deductible	Not Covered	Not Covered

	HealthNow Administrative Services Plan Option / PPO Highmark Network		HealthNow Administrative Services Plan Option / HDHP Highmark Network		HealthNow Administrative Services Plan Option / PPO 2 Highmark Network	
	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits	In-Network Benefits	Out-of-Network Benefits
Mental Health						
Inpatient	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Not Covered	Not Covered
Outpatient	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Not Covered	Not Covered
Substance Abuse						
Inpatient	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Not Covered	Not Covered
Outpatient	80% after deductible	50% after deductible	100% after deductible	50% after deductible	Not Covered	Not Covered
Other Services						
Chiropractic	80% after deductible	50% after deductible	100% after deductible	50% after deductible	80% after deductible	Not Covered
Retail Pharmacy (30 Day Supply)						
Generic (Tier 1)	20%	Not covered	0% after deductible	Not covered	$10 copay	Not covered
Preferred (Tier 2)	20%	Not covered	0% after deductible	Not covered	$30 copay	Not covered
Non-Preferred (Tier 3)	20%	Not covered	0% after deductible	Not covered	$50 copay	Not covered
Preferred Specialty (Tier 4)	20%	Not covered	0% after deductible	Not covered	20%	Not covered
Mail Order Pharmacy (90 Day Supply)						
Generic (Tier 1)	20%	Not covered	0% after deductible	Not covered	$20 copay	Not covered
Preferred (Tier 2)	20%	Not covered	0% after deductible	Not covered	$50 copay	Not covered
Non-Preferred (Tier 3)	20%	Not covered	0% after deductible	Not covered	$70 copay	Not covered
Preferred Specialty (Tier 4)	20%	Not covered	0% after deductible	Not covered	20%	Not covered

Enrollment in a Health Savings Account is available to employees that enroll in the High Deductible Health Plan (HDHP) Medical Plan

See the following pages for more information on how a HSA can benefit you and your family

Health Savings Accounts

Maximize your savings

A Health Savings Account, or HSA, is a tax-advantaged savings account you can use for healthcare expenses. Along with saving you money on taxes, HSAs can help you grow your nest egg for retirement.

You must enroll in the High Deductible Health Plan (HDHP) to take advantage of a HSA.

How an HSA works:

- Contribute to your HSA by payroll deduction, online transfer or personal check.
- Pay for qualified healthcare expenses for yourself, your spouse and your dependents. Both current and past expenses are covered if they're from after you opened your HSA.
- Use your Benefits Card to pay directly, or pay out of pocket for reimbursement or to grow your HSA funds.
- Roll over any unused funds year to year. It's your money — for life.
- Invest your HSA funds and potentially grow your savings.[1]

Am I eligible for an HSA?

You're most likely eligible to open an HSA if:

- You have a qualified high-deductible health plan (HDHP).
- You're not covered by any other non-HSA-compatible health plan, like Medicare Parts A and B.
- You're not covered by TriCare.
- No one (other than your spouse) claims you as a dependent on their tax return.

How much can I contribute?

The IRS limits how much you can contribute to your HSA every year. This includes contributions from your employer, spouse, parents and anyone else.[2]

2025

	SINGLE PLAN	FAMILY PLAN
Maximum contribution limit	$4,300	$8,550

2026

	SINGLE PLAN	FAMILY PLAN
Maximum contribution limit	$4,400	$8,750

What's covered?

You can use your HSA funds to pay for any IRS-qualified healthcare expenses, like doctor visits, hospital fees, prescriptions, dental exams, vision appointments, over-the-counter medications and more.

Visit **hsabank.com/QME** for a full list.

Catch-up contributions

You may be eligible to make a $1,000 HSA catch-up contribution if you're:

- Over 55.
- An HSA accountholder.
- Not enrolled in Medicare (if you enroll mid-year, annual contributions are prorated).

Triple tax savings

A huge way that HSAs can benefit you is they let you save on taxes in three ways.

1. You don't pay federal taxes on contributions to your HSA.[3]
2. Earnings from interest and investments are tax-free.
3. Distributions are tax-free when used for qualified healthcare expenses.

[1] Investment accounts are not FDIC insured, may lose value and are not a deposit or other obligation of, or guarantee by the bank. Investment losses which are replaced are subject to the annual contribution limits of the HSA.

2 HSA contributions in excess of IRS limits are subject to penalty and tax unless the excess and earnings are withdrawn prior to the tax filing deadline as explained in IRS Publication 969.

3 Federal tax savings are available regardless of your state. State tax laws may vary. Consult a tax professional for more information.

Visit **hsabank.com** or call the number on the back of your debit card for more information.

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You enrolled in your HSA

What happens next?

We'll show you the way to a healthier financial future by helping you plan, save and pay for healthcare.

Get started

- Use your HSA as soon as your qualified health plan is effective. If your effective date is mid-month, your HSA eligibility begins the first day of the following month.
- Pay for any IRS-qualified healthcare expenses that you incur once your HSA is active with funds in your HSA.
- Log in to your online account to add authorized signers and order debit cards.

Verify your identity

In accordance with the USA Patriot Act, you may receive a letter verifying your identity. HSA Bank may close your account if you don't supply the proper forms of identification within 90 days of your account opening.

Watch your mail

Keep an eye out for two important mailings that should arrive 7–10 business days after your HSA application is processed:

1. **Your welcome kit.**
2. **Your Benefits Card** — and additional cards for any authorized signers on your account.

HSA Bank does not provide tax or legal advice. This communication is for informational purposes only and not intended as tax or legal advice. If tax or legal advice is needed, please consult with a qualified professional.

Visit **hsabank.com** or call the number on the back of your debit card for more information.

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HSA Frequently Asked Questions

What is a Health Savings Account (HSA)?

An HSA is a tax favored account used in conjunction with an HSA-compatible health plan. The funds in the account are used to pay for IRS-qualified healthcare expenses such as services applied to the deductible, dental, vision and more.

Who can get an HSA?

Any eligible individual that:

- Is covered by an HSA-compatible health plan.
- Is not covered by other health insurance (except certain types of limited coverage).
- Is not enrolled in Medicare.
- Is not claimed as a dependent on someone else's tax return.
  - Children cannot establish an HSA.
  - Eligible spouses can establish their own HSA.

How much can I contribute annually to an HSA?

Visit hsabank.com/irs-guidelines to view the annual HSA contribution limits.

Catch-Up contributions

Accountholders who meet the qualifications below are eligible to make an HSA catch-up contribution of $1,000.

- Health Savings accountholder.
- Age 55 or older (regardless of when in the year an accountholder turns 55).
- Not enrolled in Medicare (if an accountholder enrolls in Medicare mid-year, catch-up contributions should be prorated).

Spouses who are 55 or older and covered under the accountholder's healthcare insurance can also make a catch-up contribution into a separate HSA in their own name.

Can any high-deductible health insurance policy qualify for an HSA?

It can be a health maintenance organization (HMO), preferred provider option (PPO), or indemnity plan as long as it meets the IRS requirements. Your insurance company will determine if the policy is an HSA-compatible health plan.

Who can make contributions?

Contributions can come from employers, the accountholder, or third parties. The combined contribution amount is subject to the IRS contribution limits.

Are there income restrictions?

There are no income restrictions for opening or contributing to an HSA.

Is an HSA compatible with an HRA/FSA?

Yes, this is permitted if the combination is:

- "Limited purpose" flexible spending accounts (FSAs) and Health Reimbursement Arrangements (HRAs) that restrict reimbursements to certain permitted benefits such as vision, dental or preventive care benefits.
- "Post-deductible" FSA or HRAs that only provide reimbursement after the minimum annual deductible has been satisfied under the HDHP.

What are the advantages of an HSA?

HSA funds roll over year-to-year; there are tax benefits on contributions, earnings and distributions; and long-term investment opportunities are available.

If I set up an HSA through my employer, what happens if I switch jobs?

The funds are portable and go with you.

Can I make distributions for non-healthcare expenses?

Yes, though the distribution may be subject to income tax and penalties. After the age of 65, you can use the funds for non-qualified expenses without penalty, though the funds may be subject to income tax.

Visit **hsabank.com** or call the number on the back of your debit card for more information.

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Dental Insurance

Dental Benefits

Regular dental checkups can help find early warning signs of certain health problems, which means you can get the care you need to get healthy. Village Caregiving, LLC will continue to offer a dental program. Please refer to the summary plan description for complete plan details.

	Bento Dental Plan / Bento (Platinum, Gold) and Cigna DPPO SA Plus Networks	
	In-Network Benefits	Out-of-Network Benefits
Annual Deductible		
Individual	$50	$0
Family	$150	$0
Waived for Preventive Care?	Yes	Yes
Annual Maximum		
Per Person / Family	$1,000	$1,000
Preventive	100%	100%
Basic	80% after deductible	80% after deductible
Major	50% after deductible	50% after deductible
Orthodontia		
Benefit Percentage	50%	50%
Adults (and Covered Full-Time Students, if Eligible)	Not covered	Not covered
Dependent Child(ren)	Covered to age 19	Covered to age 19
Lifetime Maximum	$1,000	$1,000
Benefit Waiting Periods	0 months	0 months

Vision Insurance

Make Eye Health a Priority with VSP!

Your health comes first with VSP and BENTO. Take a look at your VSP vision care coverage.

Routine eye exams have saved lives.

Did you know an eye exam is the only non-invasive way to view blood vessels in your body? Your VSP® network eye doctor can detect signs of over 270 health conditions during and eye exam.*

Savings you'll love.

See and look your best without breaking the bank. VSP members get exclusive savings on popular frame brands and contact lenses, and they get additional discounts on things like LASIK, and more.

The choice is yours!

VSP gives you thousands of in-network choices, including private practice doctors, regional and national optical retail chains, or online at **eyeconic.com**®. You'll get the most out of your benefits at a VSP Premier Edge™ location.

VSP PREMIER edge

Preferred private practice and retail in-network choices

private practice doctors

Visionworks

Provider Network: VSP Choice

Create an account today.
Questions?
http://www.vsp.com or **800.877.7195**

vsp | bento

BENEFIT	DESCRIPTION	COPAY
YOUR COVERAGE WITH A VSP DOCTOR		
WELLVISION EXAM	• Focuses on your eyes and overall wellness • Routine retinal screening • Every 12 months	$10 Up to $39
ESSENTIAL MEDICAL EYE CARE	• Retinal imaging for members with diabetes covered-in-full • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP network doctor for details. • Available as needed	$20 per exam
PRESCRIPTION GLASSES		**$25**
FRAME‡	• $170 Featured Frame Brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $80 Costco frame allowance • Every 24 months	Included in Prescription Glasses
LENSES	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	Included in Prescription Glasses
LENS ENHANCEMENTS	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 12 months	$0 $95 - $105 $150 - $175
CONTACTS (INSTEAD OF GLASSES)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
ADDITIONAL SAVINGS	**Glasses and Sunglasses** • Discover all current eyewear offers and savings at **vsp.com/offers**. • 20% savings on unlimited additional pairs of prescription or non-prescription glasses/sunglasses, including lens enhancements, from a VSP provider within 12 months of your last WellVision Exam.	
	Laser Vision Correction • Average of 15% off the regular price; discounts available at contracted facilities.	
	Exclusive Member Extras for VSP Members • Contact lens rebates, lens satisfaction guarantees, and more offers at **vsp.com/offers**. • Save up to 60% on digital hearing aids with TruHearing®. Visit **vsp.com/offers**/special-offers/hearing-aids for details. • Enjoy everyday savings on health, wellness, and more with VSP Simple Values.	
YOUR COVERAGE GOES FURTHER IN-NETWORK		
With so many in-network choices, VSP makes it easy to get the most out of your benefits. You'll have access to preferred private practice, retail, and online in-network choices. Log in to **vsp.com** to find an in-network doctor.		

*Full Picture of Eye Health, American Optometric Association, 2020.

‡Coverage with a retail chain may be different or not apply.

VSP guarantees member satisfaction from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business. TruHearing is not available directly from VSP in the states of California and Washington. VSP Premier Edge™ is not available for some members in the state of Texas.

To learn about your privacy rights and how your protected health information may be used, see the VSP Notice of Privacy Practices on **vsp.com**. Eyeconic is a VSP-affiliated company.

Classification: Restricted

What Your Benefits Will Cost

Company asks employees to contribute a nominal amount to the insurance premium for their medical, dental, and vision benefits. Semi-monthly payroll deductions are shown here.

Employee Contributions (Monthly)	
HealthNow Administrative Services - PPO Highmark Network	
Employee	$157.50
Employee & Spouse	$275.00
Employee & Child(ren)	$237.50
Family	$337.50
HealthNow Administrative Services - HDHP Highmark Network	
Employee	$192.50
Employee & Spouse	$302.50
Employee & Child(ren)	$265.00
Family	$365.00
HealthNow Administrative Services – PPO 2 Highmark Network	
Employee	$96.25

Employee Contributions (Monthly)	
Bento - Dental Plan / Bento (Platinum, Gold) and Cigna DPPO SA Plus Networks	
Employee	Company Paid
Employee & Spouse	
Employee & Child(ren)	
Employee & Spouse & Child(ren) (Family)	

Employee Contributions (Monthly)	
Bento - Vision VSP Standard Network	
Employee	Company Paid
Employee & Spouse	
Employee & Child(ren)	
Employee & Spouse & Child(ren) (Family)	

First Stop Health explained on the next pages is available to employees who enroll in the PPO2 Medical Plan

Activate your account

firststophealth.com 888-691-7867

keep your heart at home

Village CAREGIVING

Getting started with virtual care.

Get convenient care for your body and mind - all via phone or video.

Urgent Care Issues

Talk to a provider in minutes for sinus issues, UTI, cold, flu, skin rash and more. Available for all ages!

Prevention & Wellness

Check in on your current health and make a personalized plan to stay healthy and strong.

Mental Healthcare

Diagnosis and treatment, including prescriptions* when appropriate, for depression, anxiety and more.

Health Management

Support managing diabetes, high blood pressure, high cholesterol, COPD and more.

Referrals, Tests and More

Providers can order labs, screenings and provide referrals to in-network specialists.*

Village Caregiving provides First Stop Health virtual care to employees enrolled in the Caregiving plan and their immediate family members. A visit costs $0.

First Stop Health Virtual Therapy is a short-term, solution-focused service that may not be appropriate for all concerns. First Stop Health is not meant to replace any current mental health treatment plans. For those under the age of 18, program use will be considered on a case-by-case basis.

First Stop Health

How to use virtual primary care!

Here's how to schedule a primary care visit to check in on your health.

Claim your account.

You're all set up. It takes just a few minutes to claim your account via our mobile app or at firststophealth.com.

Schedule a visit.

Answer a few questions, choose your doctor and get scheduled as soon as tomorrow.

See your new doctor.

Have an annual checkup or get ongoing care for diabetes, high blood pressure, depression, anxiety and more.

Make a plan.

You and your doctor will develop a health plan best suited to you and your lifestyle.

Claim your account and get care!

Village

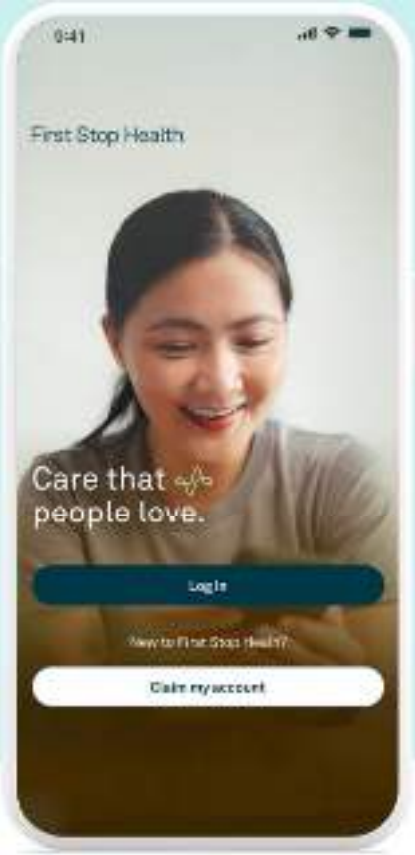
firststophealth.com/virtual-primary-care-patients

*First Stop Health services are not intended to constitute a health plan. Those under 18 are welcome to use 24/7 virtual urgent care only. *Providers at First Stop Health do not prescribe controlled substances. Costs according to your medical plan may apply for prescriptions, lab orders and other non-FSH services.*

First Stop Health

How to claim your account.

You have access to First Stop Health Virtual Care. Claim your account now!



Mobile App

1. Download the First Stop Health mobile app
2. Tap “Claim my account” and set up your account using the last 4 digits of your SSN number

Website

1. Go to firststophealth.com
2. Click 'Log In' in the upper right
3. Select “Claim my account”
4. Claim your account using the last 4 digits of your SSN / using your employee ID number

Village CAREGIVING — keep your heart at home

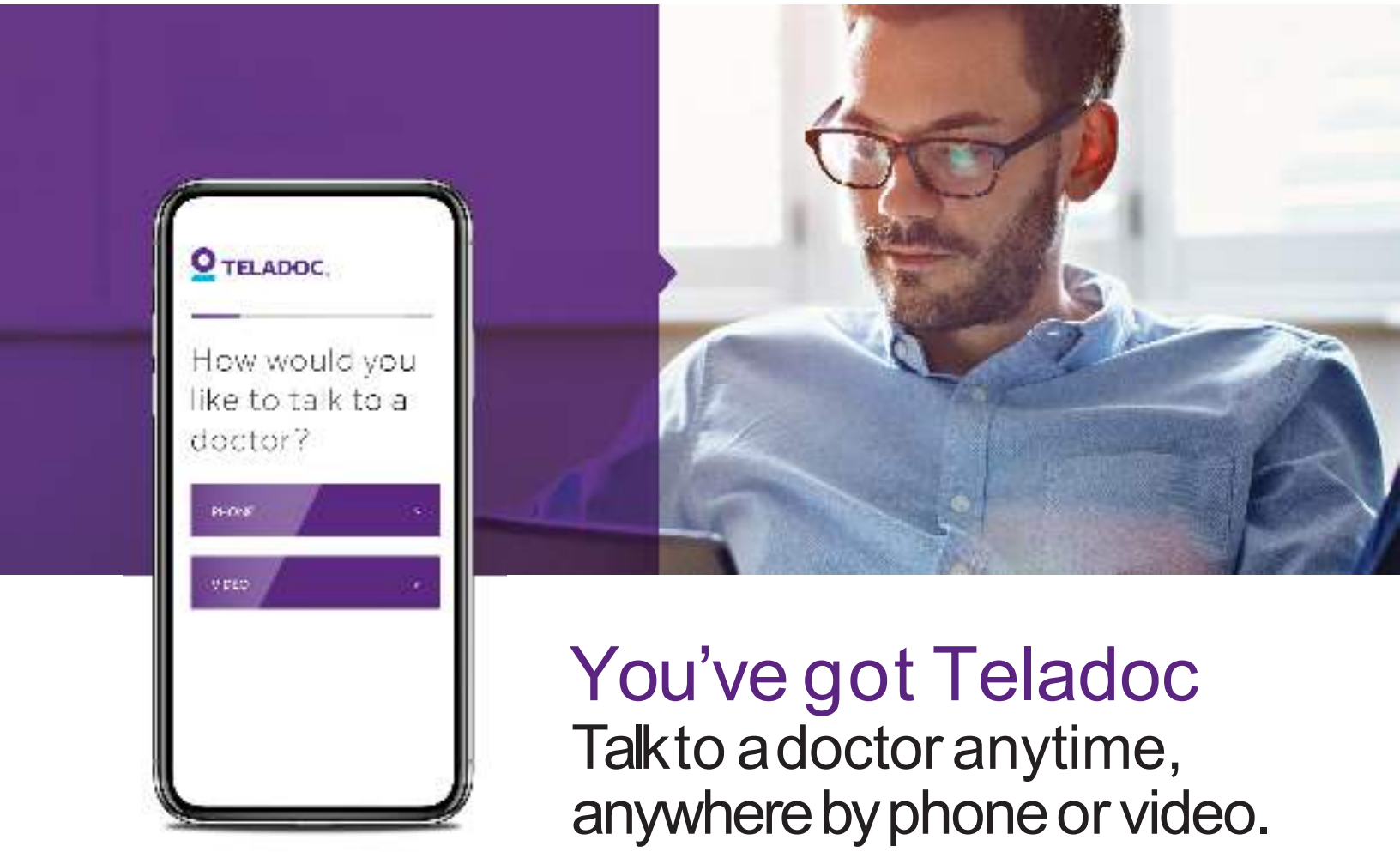
Get care today!

Scan to get the app, go to firststophealth.com or call (888) 691-7867.

Stay Healthy Anytime:
Use Teladoc for 24/7 Virtual Care

You can use Teladoc services if you enroll in the PPO or the HDHP. Teladoc does not align with the PPO2 plan.

TELADOC®



You've got Teladoc

Talk to a doctor anytime, anywhere by phone or video.

Set up your account today to talk to a U.S.-licensed physician for non-emergency medical conditions like the flu, sinus infections, bronchitis, and much more.

Create account

Use your phone, the app, or the website to create an account and complete your medical history

Talk to a doctor

Request a time and a Teladoc doctor will contact you

Feel better

The doctor will diagnose symptoms and send a prescription if necessary

Talk to a doctor

Visit

Call | Download the app □ | □

TELADOC®

Set up your Teladoc account in 4 easy steps

Download the app to talk to a doctor anytime, anywhere* by phone or video.

1 **Download the app**
Search for "Teladoc" in the App Store or on Google Play.

2 **Set up your account**
Once you've downloaded the app, select "Set up your account."

3 **Enter basic contact information**
Provide some information about yourself to confirm your eligibility. We'll confirm we found your benefits and you'll continue creating your account.

4 **Create your account**
Enter your address and phone number, create a username and password, pick security questions, and agree to terms and conditions.

*Teladoc is not available internationally.

Download the app to talk to a doctor

Visit

Call | Download the app □ | □

Can my family use Teladoc?
This varies depending on your specific Teladoc plan. Most plan designs allow you to use the Teladoc service for you, your spouse, and your dependents. Dependents over 18 years old must call our service center to request a visit. For dependents under 18 years old, the primary account holder must request a visit on their behalf through the app, website, or by phone.

How much does it cost?
The cost of a Teladoc visit varies depending on the type of visit you are requesting and your plan design. Please refer to your welcome letter, or call if you wish to confirm pricing prior to requesting a visit. You will also see the visit fee during the visit request process.

Who are the Teladoc doctors?
Teladoc doctors are U.S. board-certified internists, family doctors, and pediatricians. They average 20 years of experience and are licensed to practice in your state.

Can Teladoc physicians prescribe medications?
Yes, when medically appropriate, doctors can prescribe medications. If a prescription is not required, the doctor may provide the member with instructions for managing symptoms or following up with their primary care doctor.

Can my primary care doctor get a record of my Teladoc visit?
With your consent, we'll send an electronic copy of your Teladoc visit to your primary care doctor.

Can I use Teladoc while traveling?
Teladoc is available in all 50 states, so you can use the service while traveling within the United States. Some restrictions may apply.

Who should I contact if I have questions or encounter an issue?
We aim to make your experience with us as seamless as possible. If you have any further questions or encounter an issue, please visit our website at Teladoc.com or call our member services team at .

Does Teladoc offer any other services?
Your plan does offer additional services. Please log in to your account to see what else is available to you.

Download the app to talk to a doctor

Visit

Call | Download the app □ | □

TELADOC

Teladoc member
Frequently Asked Questions

What is Teladoc?
Teladoc is a healthcare service that offers convenient, confidential access to quality doctors 24/7, anytime, anywhere.

By scheduling a visit with one of our U.S. board-certified and licensed medical doctors,
you can be diagnosed, treated, and prescribed medication if necessary.

What can I use Teladoc for?
Teladoc can help you with everyday, non-emergency healthcare issues, including sinus problems, allergies, flu symptoms, and much more. Skip the waiting room and the trip to the ER. We're here to help you feel better, faster, and get you back to living your life.

Does Teladoc replace my doctor?
No. Teladoc doesn't replace your primary care doctor. Teladoc should be used for non-emergency illnesses when it is not convenient to get to the doctor or it is outside of regular office hours.

How do I set up my account?
Download the Teladoc app, visit the website, or call the number below to set up your account.

Do I need to have my insurance information available?
No. Teladoc is a separate benefit,
and your insurance information is not required to have a visit.

How do I pay for the visit?
If there is a fee, you can pay with your HSA (health savings account) card, credit card, prepaid debit card, or by PayPal.

Is there a time limit when talking to the doctor? And am I charged more for taking longer?
There is no time limit for visits, and there is no extra charge for longer doctor visits.

How do I access Teladoc?
The service can be accessed by app, web, or phone, and visits are available by phone or video.

If the Teladoc doctor recommends that I see my primary care doctor or a specialist, do I still have to pay the Teladoc visit fee?
Just like any doctor appointment, there is a fee for the consulting doctors time. However, your plan covers this cost.

Village Caregiving provides a suite of voluntary benefits available illustrated on the following pages

Unum Dental™

Dental Insurance can help you pay for dental exams, cleanings and other services.

How does it work?

Good dental care is critical to your overall well-being. With Unum Dental insurance, you can get the attention your teeth need — at a cost you can afford.

Unum Dental allows you to see any dentist you choose. To get the most from your benefits and reduce out-of-pocket costs, choose an in-network provider by utilizing our large national network. These providers have agreed to file your claims and uphold the highest quality standards. You can find in-network providers at unumdentalcare.com.

Why is this coverage so valuable?

- Routine dental care keeps your mouth and whole body healthy.
- Your plan is backed by Unum's commitment to excellence in customer service.
- Personalized website to manage your benefits including claims information, ID cards and more.
- There's no waiting period for preventive and basic services.

What else is included?

Pregnancy benefit

An extra cleaning for expecting mothers in their 2nd or 3rd trimester.

Wellness benefits

Oral cancer screenings for patients 40 and older with high risk factors.

Unumdentalcare.com

Use unumdentalcare.com to search for providers, manage your benefits and learn about good dental health. Features include easy access to ID Cards, claims history and coverage information.

Virtual Dental Visits

24/7 dental care for dental emergencies when an in-person visit isn't an option. Available for active dental members*. Visit unumdentalcare.com and click Virtual Dental Visits to get started.

Carryover benefits

Members who take care of their teeth, but use only part of their annual maximum benefit during a benefit period are rewarded with extra benefits in future years! Carryover benefits will be accrued and stored in the insured's carryover account to be used in the next benefit year.

The limits for this policy/certificate are:	Passive PPO	Passive PPO
Carryover benefit	$350	$250
Threshold limit	$700	$500
Carryover account limit	$1,250	$1,000

*Virtual dental visits are a preventive service and subject to policy year benefit maximum.

Coverage details and costs

Overview	Passive PPO		Passive PPO	
Benefit Year Maximum*	$1,500		$1,000	
Deductible**	$50 in-network and out-of-network Maximum 3 per family		$50 in-network and out-of-network Maximum 3 per family	
Plan Coinsurance	**In-network**	**Out-of-Network**	**In-network**	**Out-of-Network**
Class A Preventive	100%	100%	100%	100%
Class B Basic	80%	80%	80%	80%
Class C Major	50%	50%	N/A	N/A

*Applies to Class A, B and C Services, if applicable
**Waived for Class A (applies to Class B and C Services)

Dental Coverage	Passive PPO	Passive PPO
	Monthly cost†	Monthly cost†
You	$28.31	$18.88
You and your spouse	$55.98	$37.02
You and your children	$63.50	$54.18
Family	$91.16	$78.84

†Rates guaranteed for 24 months from the effective date.

Dental carryover benefit and how it works

Each benefit year a member must have:

- One cleaning,
- One regular exam, and
- Total dental claims for preventive, basic and major covered procedures paid during the year below the threshold limit.
- If all three criteria above are met, a portion of the annual maximum will carry over to the next year.

Other Specifications:

- Each covered family member receives their own carryover benefit.
- Group carryover benefit rider must be in effect for one benefit year before any members can utilize carryover benefits.
- A member must be on the plan for a minimum of three months before accruing carryover benefits.
- Carryover benefit may be used toward preventive, basic and major covered services only
- A member's carryover account will be eliminated, and the accrued carryover benefits lost if the insured has a break in coverage for any length of time or any reason.

Dependent children

Dependent age guidelines vary by state. Please refer to your policy certificate or call our Contact Center at (888) 400-9304.

Services not listed

If you expect to require a dental service not included on this brochure, it may still be covered. Please call our Contact Center at (888) 400-9304 to confirm your exact benefits.

Alternate treatment

Unum covers the least expensive most commonly used and accepted American Dental Association treatments. Plan members may elect a more expensive treatment, but will be responsible for the cost difference resulting from the more expensive procedure.

Covered Procedures & Waiting Periods	Passive PPO	Passive PPO
CLASS A PREVENTIVE SERVICES	Waiting Period: None • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) – (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36 months) • Space Maintainers for children up to age 16 (1 per 24 months) • Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for ages 40+)	Waiting Period: None • Routine exams (2 per 12 months) • Prophylaxis (2 per 12 months) – (1 additional cleaning or periodontal maintenance per 12 months, if member is in 2nd or 3rd trimester of pregnancy) • Bitewing x-rays (maximum of 4 films; 1 per 12 months) • Fluoride treatment for children up to age 16 (1 per 12 months) • Sealants for children up to age 16 (permanent molars, 1 per 36 months) • Space Maintainers for children up to age 16 (1 per 24 months) • Adjunctive pre-diagnostic oral cancer screening (1 per 12 months for ages 40+)
CLASS B BASIC SERVICES	Waiting Period: None • Emergency Treatment (1 per 12 months) • Full mouth/panoramic x-rays (1 per 24 months) • Simple restorative services (fillings) – Posterior composite restorations • Simple extractions • Periodontal maintenance (2 per 12 month in combination with prophylaxis)	Waiting Period: None • Emergency Treatment (1 per 12 months) • Full mouth/panoramic x-rays (1 per 24 months) • Simple restorative services (fillings) – Posterior composite restorations • Simple extractions • Periodontal maintenance (2 per 12 month in combination with prophylaxis)
CLASS C MAJOR SERVICES	Waiting Period: None • Oral Surgery (extractions and impacted teeth) • Anesthesia (subject to review, covered with complex oral surgery) • Repair of crown, denture or bridge • Inlays and onlays • Non-Surgical periodontics • Surgical periodontics (gum treatments) • Endodontics (root canals) • Crowns, bridges, dentures and endosteal implants (in lieu of a 2 or 3—unit bridge)	

Refer to your certificate of coverage for the services covered under your plan.

Exclusions and Limitations

Unum members whose dental plan includes coverage of crowns and bridges will have the option of choosing an endosteal implant to replace a missing tooth instead of a conventional fixed 3-unit bridge, when a 3-unit bridge is approved for coverage. Crowns placed on implants will also be covered. Other implants or implant related services are not covered.The following dental services are not covered unless stated otherwise in the Certificate of Coverage:

- any treatment which is elective or primarily cosmetic in nature and not generally recognized as a generally accepted dental practice by the American Dental Association, as well as any replacement of prior elective or cosmetic restorations;
- the correction of congenital malformations;
- replacement of a removable device or appliance that is lost, missing or stolen, and for the replacement of removable appliances that have been damaged due to abuse, misuse, or neglect. This may include but not be limited to removable partial dentures or dentures;
- replacement of any permanent or removeable device or appliance unless the device or appliance is no longer functional and is older than the limitation in the Schedule of Covered Procedures. This may include but not be limited to bridges, dentures and crowns;
- any appliance, service, or procedure performed for the purpose of splinting, to alter vertical dimension or to restore occlusion;
- any appliance, service or procedure performed for the purpose of correcting attrition, abrasion, erosion, abfraction, bite registration, or bite analysis;
- charges for implants (except noted above), removal of implants, precision or semi-precision attachments, denture duplication, or dentures and any associated surgery, or other customized services or attachments;
- services provided for any type of temporomandibular joint (TMJ) dysfunction, muscular, skeletal deficiencies involving TMJ or related structures, myofascial pain.

Limitations:

- Multiple restorations on one surface are payable as one surface. Multiple surfaces on a single tooth will not be paid as separate restorations. On any given day, more than 8 periapical x-rays or a panoramic film in conjunction with bitewings will be paid as a full mouth radiograph. Pre-estimates are recommended for any treatment expected to exceed $300.

Takeover benefits:

Takeover benefits apply if we are taking over a comparable benefits plan from another carrier and only if there is no break in coverage between the original plan and the takeover date. Takeover is available to those individuals insured under the employer's dental plan in effect at the time of the employer's application. If takeover benefits are included in your benefits, then waiting periods for service will be waived for the individuals currently insured under the employer's previous plan during the month prior to coverage moving to us. Application of takeover benefits is subject to Underwriting review and approval. New hires with prior-like dental coverage (lapse in coverage must be less than 63 days) will receive takeover credit for the length of time they had with the prior carrier and must provide proof of coverage (including coverage dates) to receive takeover credit (i.e. one page benefit summary, Certificate of Creditable Coverage, etc.).

Late entrants:

Employees that waive coverage at initial enrollment (within 31 days of effective date) or in the new employee eligibility period and/or terminate coverage with Unum will have a twelve (12) month waiting period applied to basic and major services and orthodontia upon re-applying. The prior carrier is responsible for reimbursement of costs for procedures begun prior to the effective date.

A Network Access plan is available.

THIS POLICY PROVIDES LIMITED BENEFITS

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form Series Dental DN-2002, DN-2007 and DN-2015 or contact your Unum Dental representative.

Underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

EN-2026 FOREMPLOYEES (2-23)

Better benefits at work.℠

unum.com

Unum Vision®
Powered by EyeMed

Plan features:

Members have the freedom to choose any provider from EyeMed's Insight Network. Our network offers the right mix of independent, national retail and regional retail providers like Lens Crafters, Pearle Vision, Target Optical and many more. Members can also purchase glasses and contact lenses online at Glasses.com and ContactsDirect.com.

Covered benefits:

Exam: Each member is entitled to a comprehensive vision exam. An exam co-pay applies and is outlined in the grid at right.

Materials: Each member has coverage for covered services and materials. Purchases are subject to benefit frequencies and co-pays. Plan features include:

- **Frame benefit:** You may choose any frame within a provider's collection, subject to the retail frame allowance listed at right. If the cost is greater than the plan's benefits, you are responsible for the difference.
- **Eyeglass lens benefit:** Standard plastic (CR-39 Plastic Material) single vision, bifocal, trifocal, and specialty lenses are generally covered after any applicable materials copay. If covered by plan allowance, you are responsible for any cost greater than the plan's benefit.
- **Contact lens benefit:** Members electing contact lenses instead of eye glass lenses may apply the contact lens allowance to any lenses in the provider's collection. If the cost is greater than the plan's benefits, you are responsible for the difference.

Laser vision correction: Discounts are available with participating surgery providers across the country (not an insured benefit)

How much does it cost?

Monthly premium	
You	$6.33
You and your spouse	$12.65
You and your children	$12.83
Family	$18.56

EyeMed benefits:

Vision Care Services	In-network Member Cost	Out-of-network Reimbursements
Exam (1 per 12 months)	$10 co-pay	Up to $40
Retinal Imaging Benefit	Up to $39	Not covered
Standard Plastic Lenses (1 per 12 months)		
Single Vision	$25 co-pay	Up to $30
Bifocal	$25 co-pay	Up to $50
Trifocal	$25 co-pay	Up to $70
Lenticular	$25 co-pay	Up to $70
Standard Progressive	$90 co-pay	Up to $50
Premium Progressive Lens		
Premium Progressive Tier 1	$110 co-pay	Up to $50
Premium Progressive Tier 2	$120 co-pay	Up to $50
Premium Progressive Tier 3	$135 co-pay	Up to $50
Premium Progressive Tier 4	$90 co-pay (80% of charge less than $120 allowance)	Up to $50
Lens Options Polycarbonate Lenses (under age 19)	Covered	Up to $32
Frames (1 per 24 months) Members may select any frame available	$130 allowance	Up to $91
Contact Lenses (1 per 12 months) In lieu of eyeglass lenses		
Elective	$130 allowance	Up to $130
Non-Elective	Covered	Up to $210
Standard Contact Lens Fitting Exam Fee*	Up to $40	Not covered

*The standard contact lens fitting exam fee applies to a new or existing contact lens user who wears spherical disposable, daily wear, or extended wear lenses only.

Unum Vision Powered by EyeMed members will receive the following discounts on materials at in-network providers only:

- 40% off for a complete second pair of glasses.
- 20% off non-prescription sunglasses.
- 20% off remaining balance beyond plan coverage.

Laser Vision Correction Network

Membership provides access to preferred pricing. Transactions are handled directly between members and providers. Refractive surgery is an elective procedure and may involve potential risks to patients. This is not an insured benefit. Unum cannot and does not guarantee the outcome of any refractive surgical procedure or a total elimination of the need for glasses or contacts. Providers may not be available in all metropolitan areas. Login to www.eyemedvisioncare.com/unum for a list of participating laser vision correction providers.

Hearing Savings Plan included at no additional cost to the member!

Unum offers a Hearing Savings Plan at no additional cost, to all of its Unum Vision Powered by EyeMed members. Partnering with Amplifon, the Hearing Savings Plan provides:

- 40% off hearing exams at thousands of convenient locations nationwide
- Discounted set pricing on thousands of hearing aids, including those with the newest, most advanced technology
- Low price guarantee – if you find the same product at a lower price elsewhere, Amplifon will beat it by 5%
- 60-day hearing aid trial period with no restocking fees
- Free batteries for 2 years with initial purchase
- 3-year warranty plus loss and damage coverage

Other Unum Vision Specifications

Dependent children: Dependent age guidelines vary by state. Please refer to your policy certificate or contact customer service at (855) 652-8686.

Services not listed: If you expect to require a vision service not included on this brochure, it may still be covered. Refer to the member portal at www.eyemedvisioncare.com/unum, to confirm your exact benefits. This is a primary vision care benefit and is intended to cover only eye examinations and/or corrective eyewear. Medical or surgical treatment of eye disease or injury is not provided under this plan. Coverage may not exceed the lesser of actual cost of covered services and materials or the limits of the policy.

No benefits will be paid for services, materials connected with, or charges arising from:

Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; Medical and/or surgical treatment of the eye, eyes or supporting structures; services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof; any Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear; Plano (non-prescription) lenses; Non-prescription sunglasses; Two pair of glasses in lieu of bifocals; Services or materials provided by any other group benefit plan providing vision care; Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order; Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

Member receives a 20% discount on items not covered by the plan at EyeMed In-Network locations. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Plan discounts cannot be combined with any other discounts or promotional offers. In certain states, members may be required to pay the full retail rate and not the negotiated discount rate with certain participating providers. Please see EyeMed's online provider locator to determine which participating providers have agreed to the discounted rate. Discounts on vision materials may not be applicable to certain manufacturers' products EyeMed Vision Care reserves the right to make changes to the products on each tier and the member out-of-pocket costs.

Fixed pricing is reflective of brands at the listed product level. All providers are not required to carry all brands at all levels. Service and amounts listed above are subject to change at any time. Fees charged by a Provider for services other than a covered benefit must be paid in full by the Insured Person to the Provider. Such fees or materials are not covered under the Policy. Benefit allowances provide no remaining balance for future use within the same Benefit Frequency.

A Network Access plan is available.

THIS POLICY PROVIDES LIMITED BENEFITS

This brochure is not intended to be a complete description of the insurance coverage available. The policies or their provisions may vary or be unavailable in some states. The policies have exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form Series VI-2002, VI-2007 and VI-2019 or contact your Unum Vision representative.

Vision plans are marketed by Unum and EyeMed, administered by First American Administrators and underwritten by Starmount Life Insurance Company, Baton Rouge, LA.

Village Caregiving

Term Life and Accidental Death & Dismemberment (AD&D) Insurance

How does it work?

You choose the amount of coverage that's right for you, and you keep coverage for a set period of time, or "term." If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more.

AD&D Insurance is also available, which pays a benefit if you survive an accident but have certain serious injuries. It pays an additional amount if you die from a covered accident.

Why is this coverage so valuable?

If you buy a minimum of $10,000 of coverage now, you can increase your coverage in the future up to $150,000 to meet your growing needs. There would be no medical underwriting to qualify for coverage.

What else is included?

A 'Living' Benefit — If you are diagnosed with a terminal illness with less than 12 months to live, you can request 75% of your life insurance benefit (up to $500,000) while you are still living. This amount will be taken out of the death benefit, and may be taxable. **These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable.** Recipients should consult their tax attorney or advisor before utilizing living benefit payments.

Waiver of premium — Your cost may be waived if you are totally disabled for a period of time.

Portability — You may be able to keep coverage if you leave the company, retire or change the number of hours you work.

Employees or dependents who have a sickness or injury having a material effect on life expectancy at the time their group coverage ends are not eligible for portability.

Who can get Term Life coverage?

If you are actively at work at least 16.50 hours per week, you may apply for coverage for:

You:	Choose from $10,000 to $500,000 in $10,000 increments, up to 5 times your earnings. You can get up to $150,000. This is the amount of coverage you can qualify for with no medical underwriting.
Your spouse:	Get up to $100,000 of coverage in $5,000 increments. Spouse coverage cannot exceed 100% of the coverage amount you purchase for yourself. Your spouse can get up to $50,000 with no medical underwriting, if eligible (see delayed effective date).
Your children:	Get up to $10,000 of coverage in $1,000 increments if eligible (see delayed effective date). One policy covers all of your children until their 19th birthday − or until their 26th birthday if they are full-time students. The maximum benefit for children live birth to 6 months is $1,000.

Who can get Accidental Death & Dismemberment (AD&D) coverage?

You:	Get up to $500,000 of AD&D coverage for yourself in $10,000 increments to a maximum of 5 times your earnings.
Your spouse:	Get up to $100,000 of AD&D coverage for your spouse in $5,000 increments, if eligible (see delayed effective date).
Your children:	Get up to $10,000 of coverage for your children in $1,000 increments if eligible (see delayed effective date).

No medical underwriting is required for AD&D coverage.

How much coverage can I get?

Calculate your costs

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the rate table (at right) to find the rate based on age.
   (Choose the age you will be when your coverage becomes effective on 06/01/2024. To determine your spouse rate, choose the age the employee will be when coverage becomes effective on 06/01/2024.)
4. Enter your cost.

	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $_____	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $_____	= $_____
Child	$_____,000	÷ $1,000 = $_____	X $_____	= $_____
			Total cost	

Employee monthly rate		Spouse monthly rate	Child monthly rate
Age	Per $10,000 of coverage	Per $5,000 of coverage	$0.426 per $1,000 of coverage
	Cost	Cost	
15-24	$0.640	$0.265	
25-29	$0.760	$0.370	
30-34	$1.020	$0.570	
35-39	$1.140	$0.920	
40-44	$1.270	$1.320	
45-49	$1.910	$2.090	
50-54	$2.920	$3.185	
55-59	$5.460	$4.550	
60-64	$8.390	$6.090	
65-69	$16.140	$8.105	
70-74	$26.180	$14.840	
75+	$26.180	$49.865	

1. Enter the AD&D coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the AD&D rate table (at right) to find the rate.
4. Enter your cost.

AD&D				
	1	2	3	4
Employee	$_____,000	÷ $10,000 = $_____	X $0.300	= $_____
Spouse	$_____,000	÷ $5,000 = $_____	X $0.150	= $_____
Child	$_____,000	÷ $1,000 = $_____	X $0.030	= $_____
			Total cost	

AD&D monthly rates		
	Coverage amount	Rate
Employee	per $10,000 of coverage	$0.300
Spouse	per $5,000 of coverage	$0.150
Child	per $1,000 of coverage	$0.030

Billed amount may vary slightly.
If you apply for coverage above the guaranteed issue amount, you may be subject to medical underwriting which may affect your ability to get the larger coverage amount. In order to purchase coverage for your dependents, you must buy coverage for yourself. Coverage amounts cannot exceed 100% of your coverage amounts.

Exclusions and limitations

Actively at work

Eligible employees must be actively at work to apply for coverage. Being actively at work means on the day the employee applies for coverage, the individual must be working at one of his/her company's business locations; or the individual must be working at a location where he/she is required to represent the company. If applying for coverage on a day that is not a scheduled workday, the employee will be considered actively at work as of his/her last scheduled workday. Employees are not considered actively at work if they are on a leave of absence or lay off.
An unmarried handicapped dependent child who becomes handicapped prior to the child's attainment age of 26 may be eligible for benefits. Please see your plan administrator for details on eligibility.
Employees must be U.S. citizens or legally authorized to work in the U.S. to receive coverage. Employees must be actively employed in the United States with the Employer to receive coverage. Employees must be insured under the plan for spouses and dependents to be eligible for coverage.

Exclusions and limitations

Life insurance benefits will not be paid for deaths caused by suicide occurring within 24 months after the effective date of coverage. The same applies for increased or additional benefits.

AD&D specific exclusions and limitations:

Accidental death and dismemberment benefits will not be paid for losses caused by, contributed to by, or resulting from:

- Disease of the body; diagnostic, medical or surgical treatment or mental disorder as set forth in the latest edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Suicide, self-destruction while sane, intentionally self-inflicted injury while sane or self-inflicted injury while insane
- War, declared or undeclared, or any act of war
- Active participation in a riot
- Committing or attempting to commit a crime under state or federal law
- The voluntary use of any prescription or non-prescription drug, poison, fume or other chemical substance unless used according to the prescription or direction of your or your dependent's doctor. This exclusion does not apply to you or your dependent if the chemical substance is ethanol.
- Intoxication – 'Being intoxicated' means your or your dependent's blood alcohol level equals or exceeds the legal limit for operating a motor vehicle in the state or jurisdiction where the accident occurred.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.
Delayed Effective Date: if your spouse or child has a serious injury, sickness, or disorder, or is confined, their coverage may not take effect. Payment of premium does not guarantee coverage. Please refer to your policy contract or see your plan administrator for an explanation of the delayed effective date provision that applies to your plan.

Age Reduction

Coverage amounts for Life and AD&D Insurance for you and your dependents will reduce to 65% of the original amount when you reach age 65, and will reduce to 50% of the original amount when you reach age 70. Coverage may not be increased after a reduction.

Termination of coverage

Your coverage and your dependents' coverage under the policy ends on the earliest of:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are actively employed (unless coverage is continued due to a covered layoff, leave of absence, injury or sickness), as described in the certificate of coverage

In addition, coverage for any one dependent will end on the earliest of:

- The date your coverage under a plan ends
- The date your dependent ceases to be an eligible dependent
- For a spouse, the date of a divorce or annulment
- For dependents, the date of your death

Unum will provide coverage for a payable claim that occurs while you and your dependents are covered under the policy or plan.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al or contact your Unum representative.
Life Planning Financial & Legal Resources services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.
Unum complies with state civil union and domestic partner laws when applicable.
Underwritten by:
Unum Life Insurance Company of America, Portland, Maine

Short Term Disability Insurance

How does it work?

If a covered illness or injury keeps you from working, Short Term Disability Insurance replaces part of your income while you recover. As long as you remain disabled, you can receive payments for up to 12 weeks.

You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

You can use the money however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

Short Term Disability Insurance pays you a weekly benefit if you have a covered disability that keeps you from working.

What else is included?

Cesarean section benefit

If you have a Cesarean section, you will be considered disabled for a minimum period of six weeks unless you return to work before the end of the time.

Consider your expenses

Utilities	$
Housing	$
Groceries	$
Transportation	$
Child care/Elder care	$
Medical/Personal care	$
Education	$
Insurance	$

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 16 hours per week. Cover 60% of your weekly income, up to a maximum benefit of $2,500 per week. The weekly benefit may be reduced or offset by other sources of income. *See the Legal Disclosures for more information.

If you don't sign up now but decide to apply later, you may have to answer health questions.

Elimination period (EP)

This is the number of days that must pass between your first day of a covered disability and the day you can begin to receive your disability benefits.

Your benefits would begin after 0 days if you become disabled due to an injury and 7 days if you become disabled due to an illness.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 12 week benefit duration.

Calculate your cost

- For step 2:

Enter your rate from the Rate Chart, based on your age. (Choose the age you will be when your coverage becomes effective on 06/01/2024.)

Disability worksheet

1 Calculate your weekly disability benefit.

$_____ ÷ 52 = $_____ x 60% = $_____

Your annual earnings | Your weekly earnings | (Max % of income covered) | Max weekly benefit available (if the amount exceeds the plan max of $2,500, enter $2,500.

2 Calculate your cost per paycheck.

$_____ ÷ 10 = $_____ x $_____ = $_____ x 12 = $_____ ÷ _____ = $_____

Your weekly benefit amount | Your rate | Your monthly cost | Your annual cost | Number of paychecks per year | Your cost per paycheck

Age	Rates
15-24	$1.366
25-29	$1.873
30-34	$1.844
35-39	$1.419
40-44	$1.188
45-49	$1.314
50-54	$1.449
55-59	$1.691
60-64	$1.930
65+	$2.315

Billed amount may vary slightly. Your rate is based on your age and will increase as you move to the next age band. * The maximum covered annual income is $216,666.

Exclusions and Limitations

Active employee

You are considered in active employment, if on the day you apply for coverage, you are being paid regularly by your employer for the required minimum hours each week and you are performing the material and substantial duties of your regular occupation.

Delayed effective date of coverage

Insurance coverage will be delayed if you are not an active employee because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective.

Definition of disability

You are considered disabled when Unum determines that, due to sickness or injury:

- You are unable to perform the material and substantial duties of your regular occupation; and
- You are not working in any occupation.

We will continue to pay you a disability benefit after you have received benefits under this plan for at least 4 consecutive weeks if:

- You begin performing at least one of the material and substantial duties of your regular occupation or another occupation; and
- You have a 20% or more loss in weekly earnings due to the same sickness or injury.

You must be under the regular care of a physician in order to be considered disabled.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

'Substantial and material acts' means the important tasks, functions and operations generally required by employers from those engaged in your usual occupation that cannot be reasonably omitted or modified. Unless the policy specifies otherwise, as part of the disability claims evaluation process, Unum will evaluate your occupation based on how it is normally performed in the national economy, not how work is performed for a specific employer, at a specific location or in a specific region.

Deductible sources of income

Your disability benefit may be reduced by deductible sources of income and any earnings you have while you are disabled, including such items as group disability benefits or other amounts you receive or are entitled to receive:

- Workers' compensation or similar occupational benefit laws
- State compulsory benefit laws
- Automobile liability insurance policy
- Motor vehicle insurance policy or plan
- No fault motor vehicle plan
- Legal judgments and settlements
- Salary continuation or sick leave plans, if applicable
- Other group or association disability programs or insurance
- Social Security or similar governmental programs

Exclusions and limitations

Benefits will not be paid for disabilities caused by, contributed to by, or resulting from:

- War, declared or undeclared or any act of war
- Active participation in a riot
- Intentionally self-inflicted injuries;
- Loss of professional license, occupational license or certification;
- Commission of a crime for which you have been convicted;
- Any period of disability during which you are incarcerated;
- Any occupational injury or sickness (this will not apply to a partner or sole proprietor who cannot be covered by law under workers' compensation or any similar law);

The loss of a professional or occupational license does not, in itself, constitute disability.

Termination of coverage

Your coverage under the policy ends on the earliest of the following:

- The date the policy or plan is cancelled
- The date you no longer are in an eligible group
- The date your eligible group is no longer covered
- The last day of the period for which you made any required contributions
- The last day you are in active employment except as provided under the covered layoff or leave of absence provision.

Unum will provide coverage for a payable claim that occurs while you are covered under the policy or plan. This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form C.FP-1 et al., or contact your Unum representative.

Underwritten by: Unum Life Insurance Company of America, Portland, Maine

Group Hospital Insurance

How does it work?

Group Hospital Insurance helps covered employees and their families cope with the financial impacts of a hospitalization. You can receive benefits when you're admitted to the hospital for a covered accident, illness or childbirth.

Why is this coverage so valuable?

- The money is payable directly to you — not to a hospital or care provider. The money can also help you pay the out-of-pocket expenses your medical plan may not cover, such as co-insurance, co-pays and deductibles.
- You get accessible rates when you buy this coverage at work.
- The cost is conveniently deducted from your paycheck.
- The benefits in this plan are compatible with a Health Savings Account (HSA).
- You may take the coverage with you if you leave the company or retire. You'll be billed directly.

Be Well Benefit

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

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

Group Hospital Insurance can pay benefits that help you with the costs of a covered hospital visit.

Who can get coverage?

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

Employee must purchase coverage for themselves in order to purchase spouse or child coverage. Employees must be legally authorized to work in the United States and actively working at a U.S. location to receive coverage.

How much does it cost?

Your monthly premium	
You	$19.45
You and your spouse	$39.83
You and your children	$31.55
Family	$51.93

Coverage may vary by state. See exclusions and limitations.
This plan has a childbirth limitation. See disclosures for more information.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	$1,000
Hospital Daily Stay	Payable per day up to 30 days	$150
ICU Daily Stay	Payable per day up to 15 days	$150

Additional Inpatient Care		
Rehab/Subacute Rehab Unit	Payable for maximum of 30 days per insured per calendar year	$100

Exclusions and Limitations

Hospital insurance filed policy name is Group Hospital Indemnity Insurance Policy. The definition of hospital does not include certain facilities. See your contract for details.

Active employment

You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 16 hours per week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Childbirth Limitation

We will pay benefits due to Childbirth for any Insured after the Insured's Coverage Effective Date.
Childbirth or Complications of Pregnancy will be covered to the same extent as any other Covered Sickness.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- being intoxicated;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
- treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
- any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
- Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
- stroke, Alzheimer's disease, trauma, viral infection; or
- other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage

If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.
Otherwise, your coverage under this certificate ends on the earliest of:
- the date the Policy is cancelled by us or your Employer;
- the date you are no longer in an Eligible Group;
- the date your Eligible Group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made; or
- the last day you are in Active Employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.
We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

THIS INSURANCE PROVIDES LIMITED BENEFITS
This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for hospital insurance.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Policy Form GHIP16-1 and Certificate Form GHIC16-1 or contact your Unum representative.
Unum complies with applicable civil union and domestic partner laws.

Underwritten by: Unum Insurance Company, Portland, Maine

Group Critical Illness Insurance

How does it work?

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

Why should I buy coverage now?

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

Be Well Benefit

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

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

Who can get coverage?

You:	Choose $10,000, $20,000 or $30,000 of coverage with no medical underwriting to qualify if you apply during this enrollment.
Your spouse:	Spouses can get 100% of the employee coverage amount as long as you have purchased coverage for yourself.
Your children:	Children from live birth to age 26 are automatically covered at no extra cost. Their coverage amount is 50% of yours. They are covered for all the same illnesses plus these specific childhood conditions: cerebral palsy, cleft lip or palate, cystic fibrosis, Down syndrome, spina bifida, type 1 diabetes, sickle cell anemia and congenital heart disease. The diagnosis must occur after the child's coverage effective date.

Why is this coverage so valuable?

- The money can help you pay out-of-pocket medical expenses, like deductibles.
- You can use this coverage more than once. Even after you receive a payout for one illness, you're still covered for the remaining conditions and for the reoccurrence of any critical illness with the exception of skin cancer. The reoccurrence benefit can pay 100% of your coverage amount. Diagnoses must be at least 180 days apart or the conditions can't be related to each other.

What's covered?

Critical Illnesses

- Heart attack
- Stroke
- Major organ failure
- End-stage kidney failure
- Sudden cardiac arrest
- Coronary artery disease
  Major (50%):
  Coronary artery bypass graft or valve replacement
  Minor (10%):
  Balloon angioplasty or stent placement

Cancer conditions

- Invasive cancer — all breast cancer is considered invasive
- Non-invasive cancer (25%)
- Skin cancer — $500

Progressive diseases

- Amyotrophic Lateral Sclerosis (ALS)
- Dementia, including Alzheimer's disease
- Multiple Sclerosis (MS)
- Parkinson's disease
- Functional loss
- Huntington's Disease
- Lupus
- Muscular Dystrophy
- Myasthenia Gravis
- Systemic Sclerosis (Scleroderma)
- Addison's Disease

Supplemental conditions

- Loss of sight, hearing or speech
- Benign brain tumor
- Coma
- Permanent Paralysis
- Occupational HIV, Hepatitis B, C or D
- Occupational PTSD

Paid at 25%

- Infectious Diseases
- Pulmonary Embolism
- Transient Ischemic Attack (TIA)
- Bone Marrow/Stem Cell

Please refer to the certificate for complete definitions of these covered conditions. Coverage may vary by state. See exclusions and limitations.

Monthly costs		
Age	**Employee coverage: $10,000 Spouse coverage: $10,000 Be Well benefit: $50**	
	Employee	Spouse
under 25	$2.50	$2.50
25 - 29	$2.50	$2.50
30 - 34	$4.30	$4.30
35 - 39	$4.30	$4.30
40 - 44	$9.50	$9.50
45 - 49	$9.50	$9.50
50 - 54	$18.20	$18.20
55 - 59	$18.20	$18.20
60 - 64	$33.60	$33.60
65 - 69	$33.60	$33.60
70 - 74	$33.60	$33.60
75 - 79	$33.60	$33.60
80 - 84	$33.60	$33.60
85+	$33.60	$33.60

Monthly costs		
Age	**Employee coverage: $20,000 Spouse coverage: $20,000 Be Well benefit: $50**	
	Employee	Spouse
under 25	$5.00	$5.00
25 - 29	$5.00	$5.00
30 - 34	$8.60	$8.60
35 - 39	$8.60	$8.60
40 - 44	$19.00	$19.00
45 - 49	$19.00	$19.00
50 - 54	$36.40	$36.40
55 - 59	$36.40	$36.40
60 - 64	$67.20	$67.20
65 - 69	$67.20	$67.20
70 - 74	$67.20	$67.20
75 - 79	$67.20	$67.20
80 - 84	$67.20	$67.20
85+	$67.20	$67.20

Monthly costs		
Age	**Employee coverage: $30,000 Spouse coverage: $30,000 Be Well benefit: $50**	
	Employee	Spouse
under 25	$7.50	$7.50
25 - 29	$7.50	$7.50
30 - 34	$12.90	$12.90
35 - 39	$12.90	$12.90
40 - 44	$28.50	$28.50
45 - 49	$28.50	$28.50
50 - 54	$54.60	$54.60
55 - 59	$54.60	$54.60
60 - 64	$100.80	$100.80
65 - 69	$100.80	$100.80
70 - 74	$100.80	$100.80
75 - 79	$100.80	$100.80
80 - 84	$100.80	$100.80
85+	$100.80	$100.80

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 16 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Your paycheck deduction will include the cost of coverage and the Be Well Benefit. Actual billed amounts may vary.

Exclusions and limitations

We will not pay benefits for a claim that is caused by, contributed to by, or occurs as a result of any of the following:

- committing or attempting to commit a felony; being engaged in an illegal occupation or activity; injuring oneself intentionally or attempting or committing suicide, whether sane or not; active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, injury as an innocent bystander, or injury for self-defense; participating in war or any act of war, whether declared or undeclared; combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations; voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; being intoxicated; and a Date of Diagnosis that occurs while an Insured is legally incarcerated in a penal or correctional institution.

Additionally, no benefits will be paid for a Date of Diagnosis that occurs prior to the Coverage Effective Date. Date of diagnosis must be after the coverage effective date.

End of employee coverage

If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the: date this policy is canceled by Unum or your employer; date you are no longer in an eligible group; date your eligible group is no longer covered; date of your death; last day of the period any required premium contributions are made; or last day you are in active employment.

However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage during Absences provision or if you elect to continue coverage for you, your Spouse, and Children under Portability of Critical Illness Insurance.

Unum will provide coverage for a payable claim that occurs while you are covered under this certificate.

Unum complies with applicable civil union and domestic partner laws.

THIS INSURANCE PROVIDES LIMITED BENEFITS

This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this coverage.

This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to Certificate Form UIC-GCIC16-2 and Policy Form UIC-GCIP16-2 or contact your Unum representative.

Underwritten by: Unum Insurance Company, Portland, Maine

Group Accident Insurance

How does it work?

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

Why is this coverage so valuable?

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

Who can get coverage?

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

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

What's included?

Be Well Benefit

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

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

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 25% increase in payable benefits within the Injury and Treatment schedule of benefit categories. See disclosures and schedule of benefits for more information.

How much does it cost?

Your monthly premium	Option 1
You	$17.01
You and your spouse	$30.25
You and your children	$40.87
Family	$54.11

SCHEDULE OF BENEFITS

Accidental Death and Dismemberment

AD&D	
Employee	$50,000
Spouse	$25,000
Children	$12,500
Common Carrier Benefit can pay if the insured individual is injured as a fare-paying passenger on a common carrier (examples include mass transit trains, buses and planes)	
Employee	$50,000
Spouse	$25,000
Children	$12,500
Dismemberment	
Both Feet	$50,000
Both Hands	$50,000
One Foot	$25,000
One Hand	$25,000
Thumb and Index Finger of the same Hand	$12,500
Coma	
Coma	$10,000
Home & Vehicle Modifications	
Home & Vehicle Modifications	$1,500
Loss of Use	
Hearing (one ear)	$12,500
Hearing	$25,000
Sight of one Eye	$25,000
Sight of both Eyes	$50,000
Speech	$25,000
Paralysis	
Uniplegia	$12,500
Hemi/Paraplegia	$25,000
Triplegia	$37,500
Quadriplegia	$50,000

Hospitalization

Admission	$1,200
Admission – Hospital ICU (added to Admission)	$1,000
Daily Stay (365 days)	$300
Daily Stay – Hospital ICU (added to Daily Stay)	$400

Injury

Injury due to felony & sexual assault	$250
Organized Sports	25%
Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	$1,000
2nd Degree Burns - 20% or greater of skin surface	$2,000
3rd Degree Burns - Less than 5% of skin surface	$4,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	$10,000
3rd Degree Burns - 20% or greater of skin surface	$20,000
Concussion	
Concussion	$500
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	$150
Dislocations	
Knee joint (other than patella)	$3,000
Ankle bone or bones of the foot (other than toes)	$6,000
Hip joint	$6,000
Collarbone (sternoclavicular)	$1,500
Elbow joint	$900
Hand (other than Fingers)	$900
Lower Jaw	$900
Shoulder	$2,000
Wrist joint	$2,000
Collarbone (acromioclavicular and separation)	$600
Finger or Toe (Digit)	$300
Kneecap (patella)	$900
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	$200
Fractures	
Skull (except bones of Face or Nose), Depressed	$8,000
Hip or Thigh (femur)	$6,000
Skull (except bones of Face or Nose), Non-depressed	$4,000
Vertebrae, body of (other than Vertebral Processes)	$2,400
Leg (mid to upper tibia or fibula)	$4,500
Pelvis	$2,400

Injury

Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$1,200
Upper Arm between Elbow and Shoulder (humerus)	$1,200
Upper Jaw, Maxilla (other than alveolar process)	$1,200
Ankle (lower tibia or fibula)	$1,500
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$1,500
Foot or Heel (other than Toes)	$800
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$1,500
Kneecap (patella)	$800
Lower Jaw, Mandible (other than alveolar process)	$800
Vertebral Processes	$800
Rib	$800
Tailbone (coccyx), Sacrum	$800
Finger or Toe (Digit)	$400
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	$200
Lacerations	
No Repair	$85
Repair Less than 2 inches	$250
Repair At least 2 inches but less than 6 inches	$500
Repair 6 inches or greater	$1,000
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$1,250
One Digit (a Thumb or Big Toe)	$1,875
Two or more Digits	$2,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	$250
Ruptured or Herniated Disc	
One Disc	$210
Two or more Discs	$350

Recovery

At-Home Care	$100
Physician Follow-Up Visits	$75
Physician Follow-Up Maximum Visits	6

SCHEDULE OF BENEFITS

Recovery

Prescription Drug	$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	$100
Behavior Health Therapy	$20
Behavior Health Therapy visits	15
Therapy Services (chiro, speech, PT, occ, acupuncture/alternative)	$50
Therapy Services Maximum Days	15

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$60
General Anesthesia	$150
Connective Tissue	
Exploratory without Repair	$75
Repair for One Connective Tissue	$600
Repair for Two or more Connective Tissues	$900
Eye Surgery	
Eye Surgery, Requiring Anesthesia	$200
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,000
Exploratory	$100
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	$100
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	$100
Knee Cartilage (Meniscus) with Repair	$500
Outpatient Surgical Facility	

Surgery

Outpatient Surgical Facility	$200
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$100
One Disc	$525
Two or more Discs	$800

Treatment

Organized Sports	25%
Ambulance	
Air	$1,000
Ground	$500
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$50
Tier 2 (bedside commode, cold therapy system, crutches)	$100
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$200
Emergency Dental Repair	
Dental Crown	$350
Dental Extraction	$115
Filling or Chip Repair	$90
Imaging	
Tier 1: X-rays or Ultrasound	$100
Tier 2: Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$200
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$150
Prosthetic Device	
One Device or Limb	$750
Two or more Devices or Limbs	$1,500
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$250
Not Burns - 20% or greater of skin surface	$500
Treatment	
Emergency Room Treatment	$200
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$100

Treatment

Transfusions	$400
Transportation (per trip)	$100
Treatment in a Physician's Office or Urgent Care Facility (initial)	$200

Organized Sports Benefit
This increased benefit payment will be applied if the covered Accident occurs while playing an organized sport that required formal registration to participate and is officiated by someone certified to act in that capacity.

Active employment
You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required minimum 16 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees have a 0 day waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.
If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-medigap-guide-health-insurance.pdf

Effective date of coverage
Coverage becomes effective on the first day of the month in which payroll deductions begin.

Exclusions and limitations
We will not pay benefits for a claim that is caused by, contributed to by, or occurs as the result any of the following:
- committing or attempting to commit a felony;
- being engaged in an illegal occupation or activity;
- injuring oneself intentionally or attempting or committing suicide, whether sane or not;
- active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
- participating in war or any act of war, whether declared or undeclared;
- combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
- a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
- elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of trauma, infection, or other diseases;
- any Sickness, bodily infirmity, or other abnormal physical condition or Mental or Nervous Disorders, including diagnosis, treatment, or surgery for it;
- Infection. This exclusion does not apply when the infection is due directly to a cut or wound sustained in a Covered Accident;
- experimental or investigational procedures;
- operating any motorized vehicle while intoxicated;
- operating, learning to operate, serving as a crew member of any aircraft or hot air balloon, including those which are not motor-driven, unless flying as a fare paying passenger;
- jumping, parachuting, or falling from any aircraft or hot air balloon, including those which are not motor-driven;
- travel or flight in any aircraft or hot air balloon, including those which are not motor-driven, if it is being used for testing or experimental purposes, used by or for any military authority, or used for travel beyond the earth's atmosphere;#practicing for or participating in any semi-professional or professional competitive athletic contests for which any type of compensation or remuneration is received;
- riding or driving an air, land or water vehicle in a race, speed or endurance contest; and
- engaging in hang-gliding, bungee jumping, sail gliding, parasailing, parakiting, or BASE jumping.

The Accidental Death and Dismemberment Benefits are also subject to the following Exclusions. We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
- being intoxicated; and
- voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, intoxicant, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician

Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of Coverage
If you choose to cancel your coverage your coverage ends on the first of the month following the date you provide notification to your employer. Otherwise, your coverage ends on the earliest of the:
- the date this policy is canceled by Unum or your employer;
- the date you are no longer in an eligible group;
- the date your eligible group is no longer covered;
- the date of your death;
- the last day of the period any required premium contributions are made;
- the last day you are in active employment.
  However, as long as premium is paid as required, coverage will continue
- in accordance with the Continuation of your Coverage during Absences provision; or
- if you elect to continue coverage for you, your Spouse, and Children under Portability of Accident Insurance.
  We will provide coverage for a Payable Claim that occurs while you are covered under this certificate

THIS IS A LIMITED BENEFITS POLICY
This coverage is a supplement to health insurance. It is not a substitute for essential health benefits or minimum essential coverage as defined in federal law. Insureds in some states must be covered by comprehensive health insurance before applying for this coverage.
This information is not intended to be a complete description of the insurance coverage available. The policy or its provisions may vary or be unavailable in some states. The policy has exclusions and limitations which may affect any benefits payable. For complete details of coverage and availability, please refer to certificate form GAC16-1 et al. and GAC16-2 and Policy Form GAP16-1 et al. in all states or contact your Unum representative.
Unum complies with state civil union and domestic partner laws when applicable.

Underwritten by: Unum Insurance Company, Portland, Maine

Changes in Benefit Elections

Open Enrollment:

With few exceptions, Open Enrollment is the only time of year when you can make changes to your benefits plan. All elections and changes take effect on the first day of the plan year. During Open Enrollment, you can:

- Add, change, or delete coverage
- Add, or drop dependents from coverage
- Enroll, or re-enroll in dependent or health care flexible spending accounts. To continue your FSA benefits, you must re-enroll each plan year.

If you do not make your 2026 benefit elections, you will automatically be defaulted to your prior year elections, except for the FSA, which will default to zero ($0) elections.

Benefit Resources

USI Benefit Resource Center

Have Questions? Need Help?

Village Caregiving, LLC is excited to offer access to the USI Benefit Resource Center (BRC), which is designed to provide you with a responsive, consistent, hands-on approach to benefit inquiries. Benefit Specialists are available to research and solve elevated claims, unresolved eligibility problems, and any other benefit issues with which you might need assistance. The Benefit Specialists are experienced professionals, and their primary responsibility is to assist you.

BRCEast@usi.com
Monday - Friday
Monday through Friday
8:00am to 5:00pm
Eastern & Central
Standard Time
855-874-6699
24 hours a day, 7 days a week

Carrier Contacts

Please contact Human Resources to complete any changes to your benefits that are not related to your initial or annual enrollment.

	CARRIER	PHONE NUMBER	WEBSITE
Medical PPO	HealthNow Administrative Services	(877) 804-4629	www.hnas.com
Dental PPO	Bento	(800) 734-8484	www.bento.net
Vision	Bento	(800) 877-7195	www.vsp.com

This brochure summarizes the benefit plans that are available to Village Caregiving, LLC eligible employees and their dependents. Official plan documents, policies and certificates of insurance contain the details, conditions, maximum benefit levels and restrictions on benefits. These documents govern your benefits program. If there is any conflict, the official documents prevail. These documents are available upon request through the Human Resources Department. Information provided in this brochure is not a guarantee of benefits.