Know Your Benefits

Human Technologies Corporation

Human Technologies Corporation strives to provide you and your family with a comprehensive and valuable benefits package. This is an overview of your 2024 benefits package as well as what you will need to do for Open Enrollment.

If you have questions or need more information, contact:

Christine Saporito
Benefits Specialist
(315) 570-6915
csaporito@htcorp.net

CARRIER CONTACT INFORMATION

Benefit	Carrier/Vendor	Website	Phone Number
Health/Medical	UMR	https://www.umr.com	1-800-826-9781
Child Health Plus	NYS of Health	https://nystateofhealth.ny.gov	1-800-698-4KIDS TTY 1-877-898-5849
Flexible Spending Account	UMR	https://www.umr.com	1-800-826-9781
Health Reimbursement Arrangement	UMR	https://www.umr.com	1-800-826-9781
Dental	Guardian	https://www.guardianlife.com/	1-888-600-1600
Vision	Guardian	https://www.guardianlife.com/	1-888-600-1600
Short-Term Disability	Guardian	https://www.guardianlife.com/	1-888-600-1600
Long-Term Disability	Guardian	https://www.guardianlife.com/	1-888-600-1600
Specified Disease	Guardian	https://www.guardianlife.com/	1-888-600-1600
NYS Statutory DBL	Guardian	https://www.guardianlife.com/	1-888-600-1600
Basic Life	The Business Council	https://members.bcnys.org/	518-465-1571
Voluntary Group Life	The Business Council	https://members.bcnys.org/	518-465-1571

COST BREAKDOWN

Medical – Hybrid

If you meet the requirements of our wellness program, your annual premium will be reduced by $1,000 if you enroll as a single and $2,000 if you enroll as 2 person or family and your spouse also meets the requirements:

Non-Wellness

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$907.05	$459.15	$447.90	$211.92	$206.72
2 Person	$1,887.94	$1,206.48	$681.46	$556.84	$314.52
Family	$2,604.38	$1,876.20	$728.18	$865.94	$336.08

Wellness

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$907.05	$375.82	$531.23	$173.46	$245.18
2 Person	$1,887.94	$1,039.81	$848.13	$479.91	$391.44
Family	$2,604.38	$1,709.53	$894.85	$789.01	$413.01

Medical – HDHP $2,600

If you meet the requirements of our wellness program, your annual premium will be reduced by $1,345 if you enroll as a single and $2,690 if you enroll as 2 person or family and your spouse also meets the requirements:

Non-Wellness

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$719.08	$217.00	$502.08	$100.15	$231.73
2 Person	$1,496.67	$898.22	$598.45	$414.56	$276.21
Family	$2,064.69	$1,429.19	$635.50	$659.63	$293.31

Wellness

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$719.08	$104.92	$614.16	$48.42	$283.46
2 Person	$1,496.67	$674.06	$822.61	$311.10	$379.67
Family	$2,064.69	$1,205.04	$859.65	$556.17	$396.76

Medical – HDHP $5,500

If you meet the requirements of our wellness program, your annual premium will be reduced by $1,345 if you enroll as a single and $2,690 if you enroll as 2 person or family and your spouse also meets the requirements:

Non-Wellness

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$585.78	$188.20	$397.58	$86.86	$15.29
2 Person	$1,219.25	$638.89	$580.36	$294.87	$22.32
Family	$1,681.93	$1,071.40	$610.53	$494.49	$23.48

Wellness

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$585.78	$76.12	$509.66	$35.13	$6.74
2 Person	$1,219.25	$414.73	$804.52	$191.41	$10.64
Family	$1,681.93	$847.24	$834.69	$391.03	$11.04

Dental

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$31.21	$15.60	$15.61	$7.20	$7.20
Family	$89.32	$73.71	$15.61	$34.02	$7.20

Vision

Election	Monthly Plan Cost	Monthly Employee Cost	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Employee Only	$7.15	$7.15	$0.00	$3.30	$0.00
Family	$15.38	$15.38	$0.00	$7.10	$0.00

BENEFIT OVERVIEW

Medical

Below is a list of associated costs for some of the most common **IN-NETWORK** expenses with these plan offerings. *For a comprehensive overview, see Plan Summary.*

Option	Hybrid **Closed to New Entrants**	$2,600 HDHP	$5,500 HDHP
Deductible (Individual/Family)	$1,000 / $3,000	$2,600 / $5,200	$5,500 / $11,000
Coinsurance (after deductible is met)	20%	0%	0%
Out of Pocket Maximum (Individual/Family)	$4,200 / $12,600	$5,500 / $11,000 Per Person Cap: $6,650	$5,500 / $11,000 Per Person Cap: $6,650
PCP Office Visit	$25 Copay	Subject to Deductible; Then Covered in Full	Subject to Deductible; Then Covered in Full
Specialist Office Visit	$40 Copay	Subject to Deductible; Then Covered in Full	Subject to Deductible; Then Covered in Full
Inpatient Care	Subject to Deductible; Then 20% Coinsurance	Subject to Deductible; Then Covered in Full	Subject to Deductible; Then Covered in Full
Outpatient Surgery	Subject to Deductible; Then 20% Coinsurance	Subject to Deductible; Then Covered in Full	Subject to Deductible; Then Covered in Full
Teladoc	$10 Copay; Then Covered in Full	*Subject to Deductible; Then Covered in Full	*Subject to Deductible; Then Covered in Full
Urgent Care	$40 Copay	Subject to Deductible; Then Covered in Full	Subject to Deductible; Then Covered in Full
Emergency Room	$150 Copay	Subject to Deductible; Then Covered in Full	Subject to Deductible; Then Covered in Full
Rx Coverage	$5/$35/$70	$5/$35/$70	Subject to Deductible; Then Covered in Full
Preventive Rx Rider	Not Included	Included	Included

**Teladoc under the HDHP $2,600 and HDHP $5,500 will be billed at $49.00 per visit for general medicine and $85.00 per visit for dermatology.*

Health Care Flexible Spending Account (FSA)

A Health Care FSA is an account in an employee's name that reimburses the employee for qualified health care expenses. It allows an employee to fund qualified expenses with pre-tax dollars deducted from the employee's paychecks. The employee can receive cash reimbursement up to the total value of the account for covered expenses incurred during the benefit plan year and any applicable grace period.

If you elect an FSA, you must specify how much you would like to contribute to the FSA for the year. ***Keep in mind, an FSA has a "use-it-or-lose-it" provision!*** That means any unused funds at the end of the plan year will be forfeited. So, be sure to choose an amount that will cover medical expenses but is not so high that you end up with unused funds at the end of the year.

Keep in mind, if you elect a plan that is paired with an HRA and you elect an FSA, your HRA funds will be used first when you use your card. If you have both an HRA & an FSA account and only want to use your FSA funds, you will need to manually submit for reimbursement. See Human Resources for a reimbursement form.

- For 2024, the maximum amount that can be contributed to your Health FSA has not yet been announced by the IRS but is expected to increase to $3,200.
- CARRYOVER: For 2024, the maximum amount that the IRS allows participants to carry over has not yet been announced but is expected to increase to $640 in unused funds into the next year. We have opted to offer this carryover.

Health Reimbursement Account (HRA)

A health reimbursement arrangement (HRA) is an employer-funded account that is designed to reimburse employees for qualified medical expenses that are paid for out-of-pocket. An HRA is entirely employer-funded, essentially boosting your salary with tax-free money for health care expenses. Employees are NOT able to contribute to an HRA.

Employer Annual Contribution:

	$2,600 HDHP	$5,500 HDHP
Single	$1,300	$2,500
Employee + Spouse	$2,600	$5,000
Employee + Child	$2,600	$5,000
Family	$2,600	$5,000

**Employer contributions are made on a quarterly basis*

The funds in your HRA can be used toward the following expenses only:

- Medical Deductible
- Pharmacy Expenses

Dental

Dental Plan Options

For a comprehensive overview, see Plan Summary.

	Option 1
Plan Name	DentalGuard Preferred PPO
Annual Deductible (Individual/Family)	$50 / $150
Annual Maximum	$1,500
Reimbursement Schedule	In-Network: Fee-Schedule Out-of-Network: 90% UCR
Coinsurance Preventive / Basic / Major / Orthodontia	100% / 80% / 50% / 50%
Orthodontia Lifetime Maximum (Up to Age 19)	$2,000
Dependent/Student Age Limit	20 / 26

Vision

Vision Plan Options

For a comprehensive overview, see Plan Summary.

	Option 1
Plan Name	Full Feature Designer
Network	Davis Vision
Exam	$10 Copay
Materials	$20 Copay
Spectacle Lenses	$0 After Copay
Frames	$0 After Copay
Contact Lenses (Elective)	85% of Amount over $130
Dependent/Student Age Limit	20/26
Service Frequencies Exams/Lenses/Frames	12/12/24 Months

Life Insurance – Employer Paid

Group Term Life

For a comprehensive overview, see Plan Summary.

Coverage Details	Benefit Amount
Basic Life	1.5x Basic Annual Earnings
Accidental Death & Dismemberment	100% of Life Insurance Benefit
Plan Maximum	$250,000
Guarantee Issue	$250,000
Age Reduction	Age 65 but younger than 70: 65% Age 70 or older: 40%
Accelerated Death Benefit	75% to $500,000

Voluntary Life Insurance – Employee Paid

Supplemental Life

For a comprehensive overview, see Plan Summary.

Coverage Details	Benefit Amount
Supplemental Life	$1,000 to $200,000 in $10,000 Increments, Not to Exceed 5x Employee's Basic Annual Earnings
Spouse Life	$10,000 to $50,000 in $10,000 Increments, not to exceed 50% of Employee's Supplemental Life Amount
Child Life	Up to $4,000
Plan Maximum	$200,000
Age Reduction	Age 65 but younger than 70: 65% Age 70 and older: 40%
Guarantee Issue	Employee: $100,000 Spouse: $30,000
Accelerated Death Benefit	75% to $500,000

Disability

	NYS Statutory DBL	Short-Term Disability	Long-Term Disability
Provided By My Employer?	Yes (Includes Out of State Coverage)	Yes – Employee Paid	Yes – Leadership ONLY
Benefits Begin	Date of Hire	8th Day	181st Day
Waiting Period	7 Days	7 Days	181 Days
Percentage of Income Replaced	50% up to $300/week	40% of Salary up to $1,000/week	60% of Salary up to $5,000/month
Maximum Benefit	26 Weeks	26 Weeks	To Age 65, Standard ADEA

Human Technologies covers the cost of NYS Statutory Disability, with the exception of a $0.60 weekly payroll deduction.

Please note, you are NOT eligible for disability benefits if you are receiving Workers' Compensation.

Specified Disease

Specified Disease insurance is a ***supplemental policy for people who already have health insurance***. It provides you with additional payment to help cover expenses such as deductibles, treatments and livings costs.

Health coverage is becoming more expensive with higher co-pays, premiums, and deductibles. Specified disease insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Plus, it is portable and payments are made directly to you.

Employees may choose a lump sum benefit of $5,000 to $20,000 in $5,000 increments.

Benefit Amount	1st Occurrence	2nd Occurrence
Invasive Cancer	100%	50%
Skin Cancer	$250 per Lifetime	Not Covered
Heart Attack	100%	50%
Stroke	100%	50%
Kidney Failure	100%	50%

This is NOT a complete overview of the conditions covered. See your benefit summary for more information.

CHILD HEALTH PLUS

Free or low-cost health insurance for your child(ren)!

Child Health Plus (CHP) is a New York State sponsored health insurance program. Your child will receive health care at a low premium cost, or no cost at all, depending on your income level, for these and other services:

- Regular well visits and immunizations
- Inpatient hospital care
- Prescription drugs and over-the-counter-drugs
- Dental care (does not include braces)

There are some eligibility requirements in order to enroll in the coverage.

Your child is eligible for Child Health Plus if:

- Your child is a New York State resident
- Your child is less than 19 years of age
- Your child is not eligible for Medicaid
- Your child has little or no other health insurance

For more information about eligibility and pricing, visit:

https://www.health.ny.gov/health_care/child_health_plus/eligibility_and_cost.htm

Note: before enrolling, check with your primary care provider to see if they accept Child Health Plus.

Additional Resources

Human Technologies Health Plan

Hybrid Summary of Benefits

A UnitedHealthcare Company

All claims must be filed within 12 months from the date the claim is incurred or the claim will be denied.

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible Per Person Family *Deductibles are combined for in and out-of-network Providers, except where noted.	$1,000.00 $3,000.00	
Out-of-Pocket Maximum Per Calendar Year Per Person Family *Maximums are combined for in and out-of-network Providers, except where noted.	$4,200.00 $12,600.00	
Primary Care Physician Office Visits	$25.00 copay; $0.00 copay for Children under age 19.	60% after deductible
Specialist Office Visits	$40.00 copay	60% after deductible
Urgent Care Visit	$40.00 copay	60% after deductible
Emergency Room *Copay waived in-network if admitted within 24 hours	$150.00 copay, no deductible	$150.00 copay, no deductible
Ambulance *Ground, water or air ambulances that are Medically Necessary and appropriate are covered.	$150.00 copay	
Durable Medical Equipment	80% after deductible	60% after deductible
Outpatient Diagnostic X-Ray and Lab	$40.00 copay	60% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible
Inpatient Hospital Services *Prior Authorization requested	80% after deductible	60% after out-of-network deductible
Physical Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	$40.00 copay per visit	60% after out-of-network deductible
Speech, Occupational Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	$40.00 copay per visit	60% after deductible
Preventive/Routine Exams	100%; deductible waived	60% after deductible
Immunizations	100%; deductible waived	60% after deductible
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	60% after deductible
Mammograms	100%; deductible waived	60% after deductible
Preventive/Routine Pap Test	100%; deductible waived	60% after deductible
Preventive/Routine PSA and Prostate Screening	100%; deductible waived	60% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	60% after deductible
Preventive/Routine Hearing Exams *Limited to one exam per calendar year (Adult & Child)	$40 copay	60% after deductible
Women's Preventive Health Care	100%; deductible waived	60% after deductible

Prescription Drug Benefits

Retail Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (up to a 30-day supply)

For Generic Drugs	$5.00 *Copay waived for children under age 19/Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$35.00
For Non-Preferred Brand Drug	$70.00

Retail 90 RX Pharmacy Option – Participating Pharmacy

Co-Pay Per Prescription (up to a 90-day supply)

For Generic Drugs	$10.00 *Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$70.00
For Non-Preferred Brand Drugs	$140.00

Mail Order Option – Optum RX

Co-Pay Per Prescription (up to a 90-day supply)

For Generic Drugs	$10.00
For Preferred Brand Drugs	$70.00
For Non-Preferred Drugs	$140.00

Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification card.

Optum RX Member Services: 1-877-559-2955

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

UMR℠

A UnitedHealthcare Company

Human Technologies Health Plan

2600 HDHP Plan Option Coverage Summary

All claims must be filed within 12 months from the date the claim is incurred or the claim will be denied.

A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible Per Person Family *Deductibles are combined for in and out-of-network Providers, except where noted. On a family contract the entire family deductible must be satisfied before copay and co-insurance benefits apply.	$2,600.00 $5,200.00	$5,200.00 $10,400.00
Out-of-Pocket Maximum Per Calendar Year Per Person Family *Maximums are combined for in and out-of-network Providers, except where noted.	$5,500.00 $11,000.00 *An individual enrolled in a family contract will not be required to meet more than a $6,650.00 embedded Out-of-Pocket maximum.	$11,000.00 $22,000.00
Primary Care Physician Office Visits	100% after deductible	90% after deductible
Specialist Office Visits	100% after deductible	90% after deductible
Urgent Care Visit	100% after deductible	90% after deductible
Emergency Room *Out-of-Network is subject to in-network deductible.	100%; subject to $2,600 deductible	
Ambulance *Ground, water or air ambulances that are Medically Necessary and appropriate are covered.	100% after deductible	Ground Ambulance 100%, subject to $2,600 deductible. Air Ambulance 90% subject to out-of-network deductible.
Durable Medical Equipment *Prior Authorization requested over $2,500.00	100% after deductible	90% after deductible
Outpatient Diagnostic X-Ray and Lab	100% after deductible	90% after deductible
Outpatient Hospital Services	100% after deductible	90% after deductible
Inpatient Hospital Services *Prior Authorization requested	100% after deductible	90% after deductible
Physical Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy	100% after deductible	90% after deductible
Speech, Occupational Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy	100% after deductible	90% after deductible
Preventive/Routine Exams	100%; deductible waived	90% after deductible *well child care 100% no deductible
Immunizations	100%; deductible waived	90% after deductible *well child care 100% no deductible
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	90% after deductible
Mammograms	100%; deductible waived	90% after deductible
Preventive/Routine Pap Test	100%; deductible waived	90% after deductible
Preventive/Routine PSA and Prostate Screening	100%; deductible waived	90% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	90% after deductible
Preventive/Routine Hearing Exams *Limited to one exam per calendar year (Adult & Child)	100%; deductible waived	90% after deductible
Women's Preventive Health Care	100%; deductible waived	90% after deductible

UMR Customer Service: 1-800-826-9781 www.umr.com **Submit Claims to:** UMR P.O. Box 30541 Salt Lake City, UT 8413

Prescription Drug Benefits

Deductible must be satisfied before copays are applicable. Note: The deductible is waived for certain preventive drugs.

Retail Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (up to a 30-day supply)	
For Generic Drugs	$5.00 *Copay waived for children under age 19/Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$35.00
For Non-Preferred Brand Drug	$70.00
Retail 90 RX Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (up to a 90-day supply)	
For Generic Drugs	$10.00 *Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$70.00
For Non-Preferred Brand Drugs	$140.00
Mail Order Option – Optum RX	
Co-Pay Per Prescription (up to a 90-day supply)	
For Generic Drugs	$10.00
For Preferred Brand Drugs	$70.00
For Non-Preferred Drugs	$140.00

Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. The Plan Out-of-Pocket maximum does apply to prescription drug benefits. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.

Optum RX Member Services: 1-877-559-2955

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Human Technologies Health Plan

5500 HDHP Plan Option Coverage Summary

All claims must be filed within 12 months from the date the claim is incurred or the claim will be denied.

UMR
A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible/Out-Of-Pocket maximum Per Person Family *Maximums are combined for in and out-of-network Providers, except where noted. On a family contract the entire family deductible must be satisfied before copay and co-insurance benefits apply.	$5,500.00 $11,000.00 *An individual enrolled in a family contract will not be required to meet more than a $6,650.00 embedded Out-of-Pocket maximum.	$11,000.00 $22,000.00
Primary Care Physician Office Visits	100% after deductible	100% after deductible
Specialist Office Visits	100% after deductible	100% after deductible
Urgent Care Visit	100% after deductible	100% after deductible
Emergency Room	100%; after $5,500.00 deductible applies	
Ambulance *Ground, water or air ambulances that are Medically Necessary and appropriate are covered.	100%; after $5,500.00 deductible applies	
Durable Medical Equipment *Prior Authorization requested over $2,500.00.	100% after deductible	100% after deductible
Outpatient Diagnostic X-Ray and Lab	100% after deductible	100% after deductible
Outpatient Hospital Services	100% after deductible	100% after deductible
Inpatient Hospital Services *Prior Authorization requested.	100% after deductible	100% after deductible
Physical Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	100% after deductible	100% after deductible
Speech, Occupational Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	100% after deductible	100% after deductible
Preventive/Routine Exams	100%; deductible waived	100%; deductible waived
Immunizations	100%; deductible waived	100%; deductible waived
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	100%; deductible waived
Mammograms	100%; deductible waived	100%; deductible waived
Preventive/Routine Pap Test	100%; deductible waived	100%; deductible waived
Preventive/Routine PSA and Prostate Screening	100%; deductible waived	100%; deductible waived
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	100%; deductible waived
Preventive/Routine Hearing Exams *Limited to one exam per calendar year (Adult & Child)	100%; deductible waived	100%; deductible waived
Women's Preventive Health Care	100%; deductible waived	100%; deductible waived

Prescription Drug Benefits

Deductible must be satisfied before co-insurance is applicable. Note: The deductible is waived for certain preventive drugs.

Retail Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (30-day supply)	
For Generic Drugs	0% Copay *Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	0% Copay
For Non-Preferred Brand Drug	0% Copay
Retail 90 RX Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (90-day supply)	
For Generic Drugs	0% Copay
For Preferred Brand Drugs	0% Copay
For Non-Preferred Brand Drugs	0% Copay
Mail Order Option – Optum RX	
Co-Pay Per Prescription (90-day supply)	
For Generic Drugs	0% Copay
For Preferred Brand Drugs	0% Copay
For Non-Preferred Drugs	0% Copay

Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. The Plan Out-of-Pocket maximum does apply to prescription drug benefits. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.

Optum RX Member Services: 1-877-559-2955

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ONLINE ENROLLMENT

Easier Than Ever. Welcome to Online Enrollment.

We're thrilled to introduce a game-changing update from **CANARX**: Online Enrollment, making the process simpler, safer, and smarter than ever before.

Navigating healthcare options can be complex, but **CANARX** is dedicated to providing you with a hassle-free experience. Our HIPAA-compliant online forms ensure your privacy while streamlining the enrollment journey. Just head to canarx.com, log in with your WebID **(contact your plan administrator if unknown)** and you're all set!

With a few clicks, you'll be on your way to accessing the care you deserve. No more cumbersome paperwork or lengthy processes – **CANARX** has your back.

Ready to embrace the future of enrollment? Visit canarx.com today and experience the convenience firsthand. We're excited to bring you this innovative enhancement and look forward to serving you better than ever.

CANARX

READY TO START SAVING?
ENROLL TODAY!
1-866-893-MEDS (6337)

$0 COPAY Prescription Option

CANARX administers the voluntary $0 copay international mail-order prescription option. For program information (including searchable medication listing) and to enroll online or to download an enrollment form, visit **canarx.com** and use **WebID: HTCORP**.

Program Features

- $0 copay *(no cost to members)*
- voluntary mail-order program
- enroll anytime
- hundreds of brand-name maintenance medications offered *(no generics)*
- medications must be tried locally before ordering through this program *(no 'new to you' medications)*
- prescriptions are dispensed and shipped from licensed and regulated pharmacies located in Canada, the United Kingdom and Australia
- delivered direct to member's home at no charge
- 4 weeks delivery time
- convenient refill service

Enrollment Process

Step One | CHECK FOR MEDICATION

Check to see if your medication is offered. Full listing can be found on the website or call CANARX at **1-866-893-6337**.

Step Two | ENROLL

Enroll online or complete an enrollment form (separate form required for each member ordering). Submit the printed enrollment form and copy of photo ID via secure upload at **canarxdocs.com**, or send by mail or fax.

Step Three | SUBMIT PRESCRIPTION

Request a prescription for a 3-month supply, with 3 refills. Mail **original** prescription to CANARX or have your physician's office fax it **directly** to CANARX at **1-866-715-6337** (prescriptions are ONLY accepted by fax when sent from the physician's office).

For assistance or more information
call CANARX (toll free) **at 1-866-893-6337**

Mailing Address:

CANARX
PO Box 3009
Windsor, ON N8N 2M3
Canada

canarx.com
WebID: HTCORP

Welcome to UMR

Take a few minutes to learn more about your plan

At UMR, our job is to support you and your employer as you engage in the health plan available to you and your dependents. We're here to guide you in your health care experience and help you live a healthier life.

Try to carry it with you wherever you go and present it at your next health care visit or trip to the pharmacy.

Your card tells you your member ID number, along with your toll-free customer service number and important information your health care providers need to file claims for services you receive.

It will ensure you get discounted rates when you receive services from in-network doctors, clinics and hospitals.

If you have any questions along the way, simply call the member services number on the back of your card. You'll be connected to a team of individuals assigned to answer your questions about eligible services or how your claim was paid.

Use your card to create an account on umr.com. Log in anytime. We're open 24/7 to:

- Look up in-network providers
- View your benefits and claims information
- Access commonly used forms
- Review your financial activity
- Find other tools for improving your health

After you set up your account online, you can also visit **umr.com** on the go with your smart phone or mobile device. To access our mobile Web site, simply visit **umr.com** on your mobile device and you'll be automatically directed to our mobile site. Get quick and easy access to your claim and benefit information anytime, anywhere.

Start using your benefits today!

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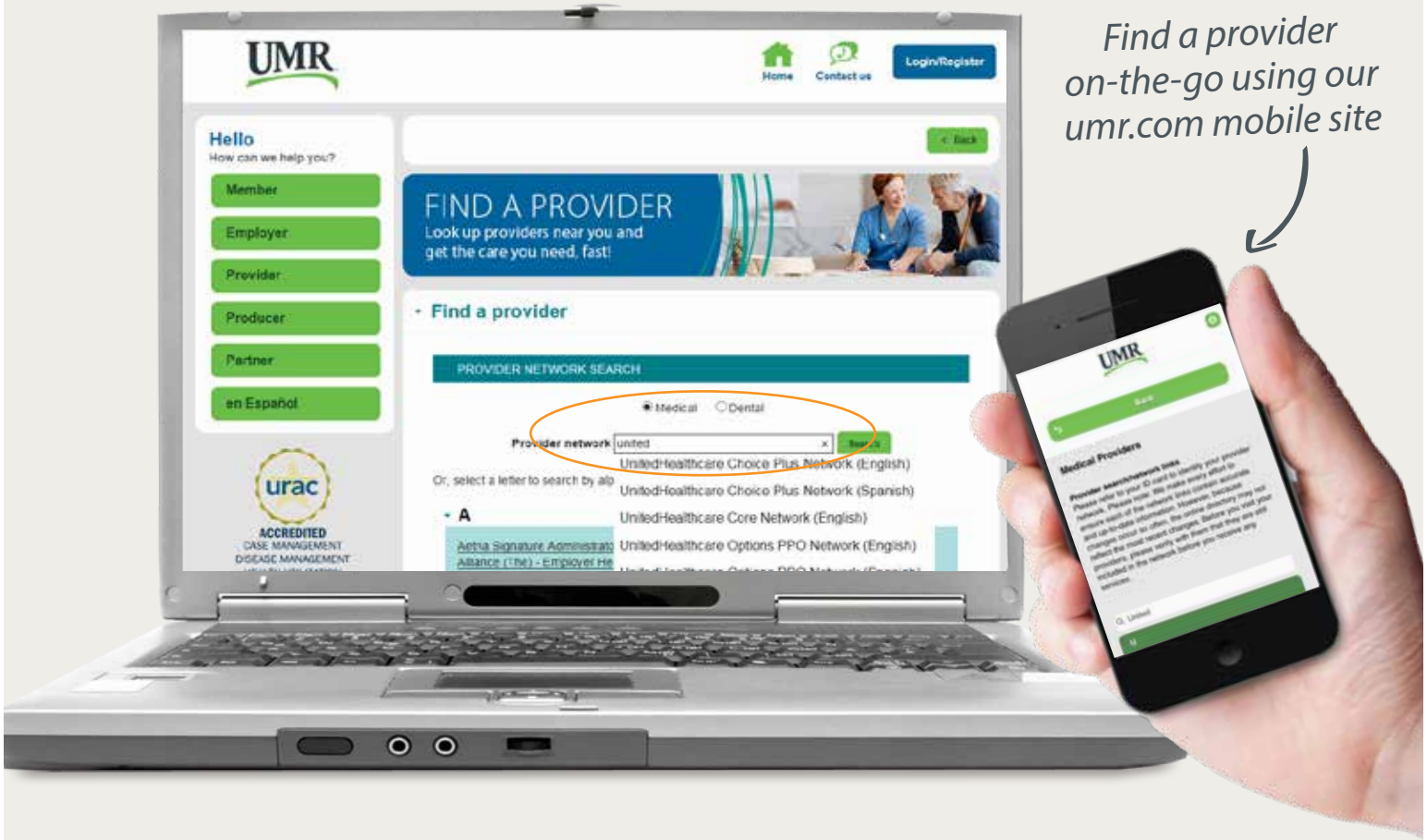
Find a provider

Your preferred provider networks will be the UnitedHealthcare Choice Plus Network and the POMCO Select Medical Network.

1 Go to **umr.com** and select **"Find a provider"**

2 Search by using our alphabet navigation or type **UnitedHealthcare Choice Plus Network** or **POMCO Select Medical Network** into the search box and follow the prompts



Find a provider on-the-go using our umr.com mobile site

Questions?

Call UMR Customer Service at **1-800-826-9781**.

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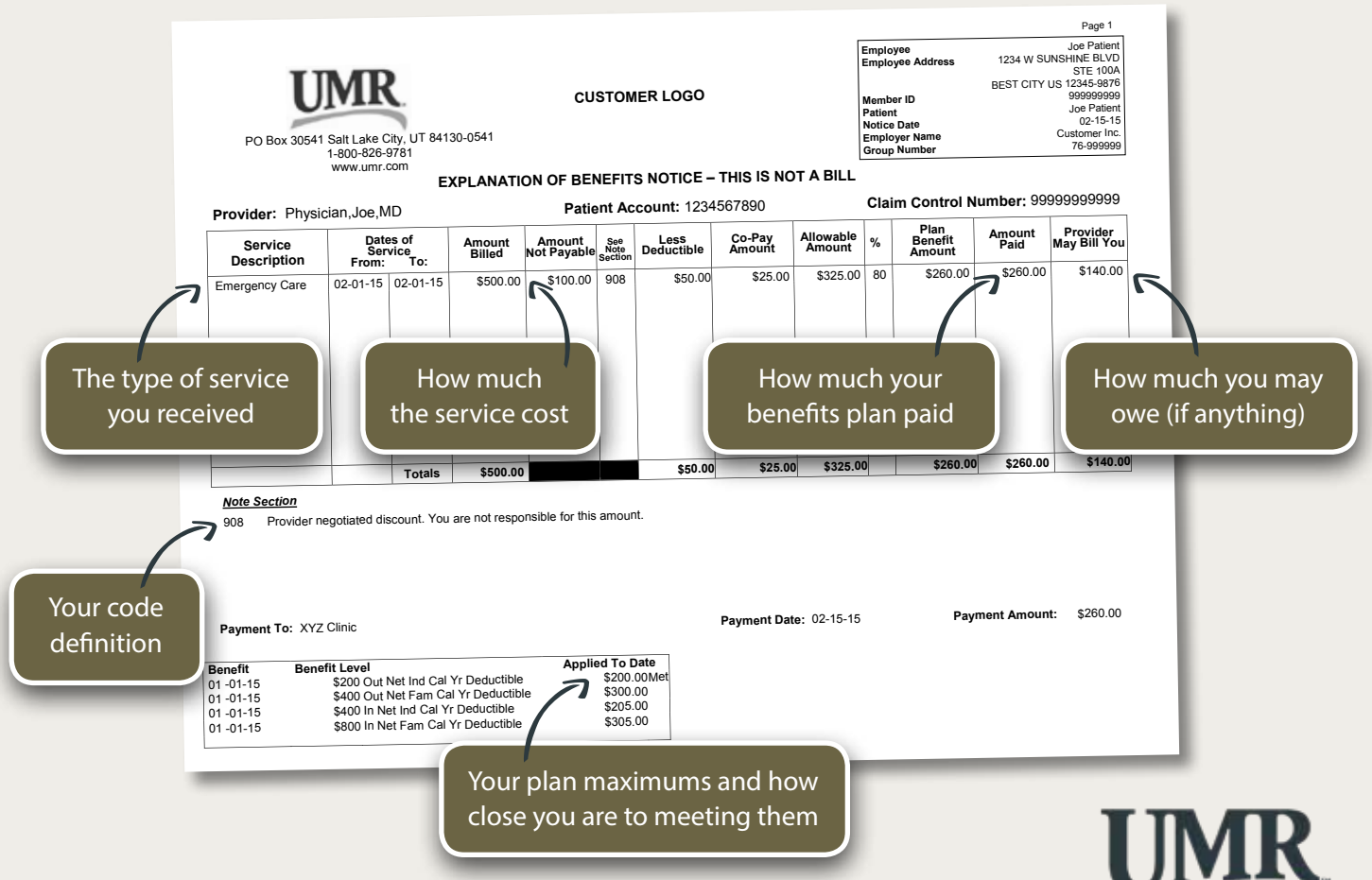
You deserve an explanation

An explanation of benefits (EOB) is not a bill. It simply tells you everything you might want to know about your claims.

Among the more important things included on your EOB are:

- The service you received
- How much the service cost
- How much you may owe, if anything
- A notes section that explains the meaning of any special codes
- A section that shows how close you are to meeting any plan maximums

There is a second page that includes contact numbers if you have questions. It also tells you how to file an appeal if you want a claim decision reviewed.



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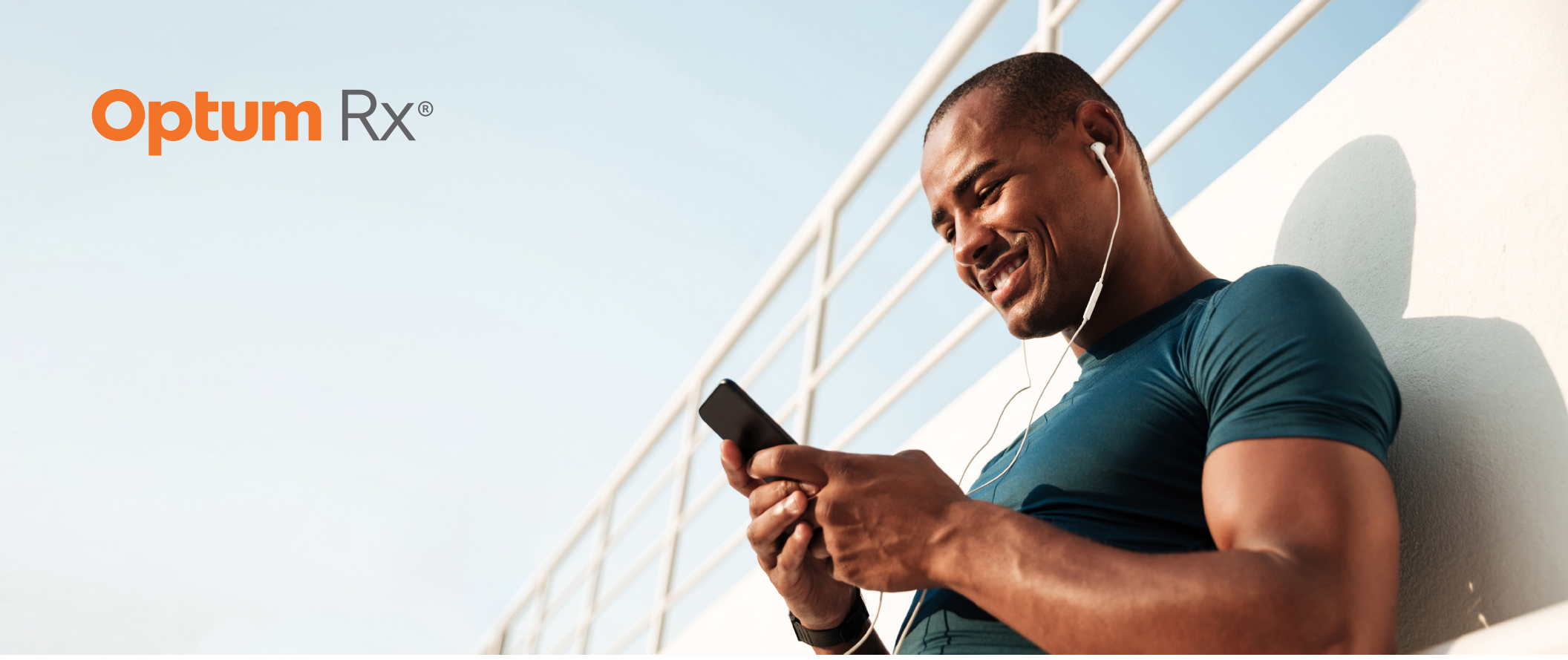


Optum Rx Price Edge delivers discounted pricing on medications

This discount price solution helps you save on generic medications whether they are covered by your pharmacy benefit plan or not.

How Optum Rx Price Edge works:

You're already set up. Keep using your current network pharmacy.

Fill your prescriptions as usual and automatically get lower copays on some covered medications.

For medications not covered, even over-the-counter products, receive a discounted price with a prescription from your doctor.

Scan here to download the Optum Rx app or log in at **OptumRx.com** to check medication prices.

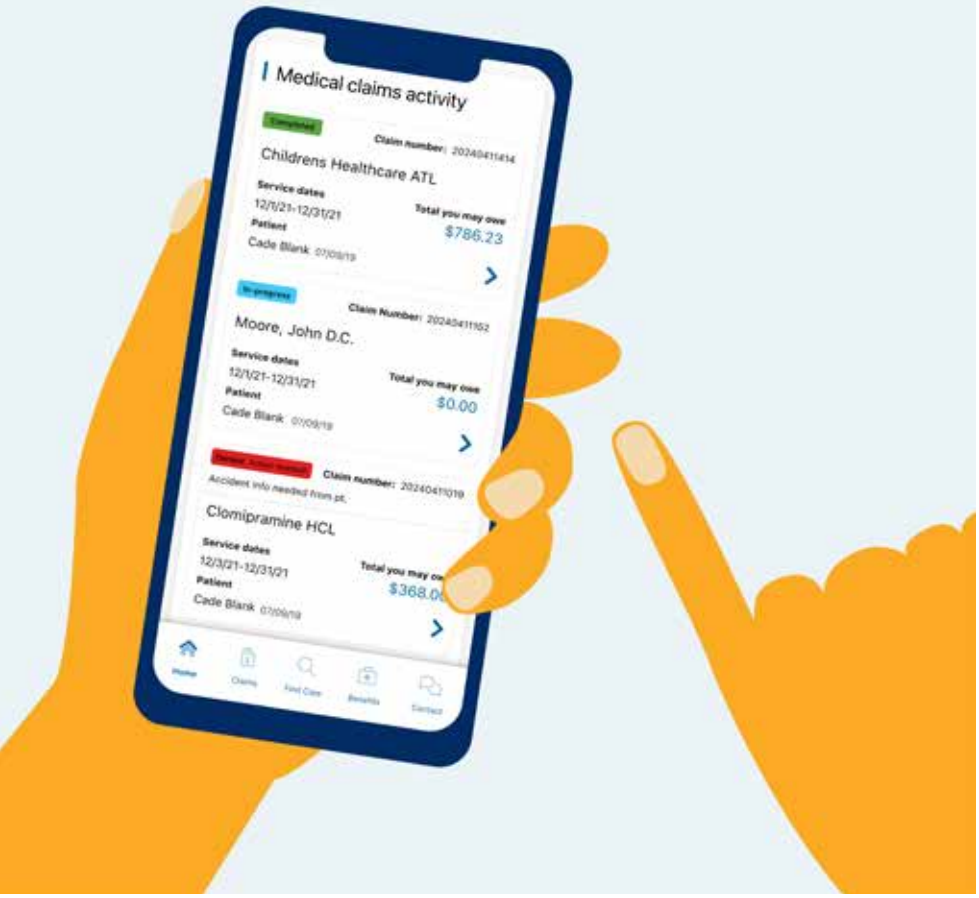
Welcome to a

smarter, simpler, faster

way to manage your health care benefits,

right from the palm of your hand.

UMR on the go!



The UMR app has a smart fresh look, simple navigation, and faster access to your health care benefits information. View your plan details on demand - anytime, anywhere.

With a single tap, you can:

- Access your digital ID card
- Look up in-network health care providers
- Find out if there's a co-pay for your upcoming appointment
- View your recent medical and dental claims
- Chat, call or message UMR's member support team

Download the UMR app today!

Simply scan the QR code or visit your app store to get started.

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"Things to do" on umr.com

Your health care manager at your fingertips

Log on to **umr.com** to see a personalized to-do list that highlights the steps YOU need to take to stay on top of your health and keep your benefits up to date. Personalization is based on your company's health benefits plan and the programs you are eligible for.

Visit **umr.com** today to take advantage of this time-saving feature!

Needs attention

Marked complete. No more action needed

"Things to do" may prompt you to:

- Review and complete health actions
- Provide/verify your email address
- Provide other insurance information
- Update security questions
- Review new claims
- Be promptly alerted to any denied claims
- Provide accident details
- Go paperless
- Get to know UMR
- Take your clinical health risk assessment (CHRA)

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Shop and save for a healthy you

Explore **store.optum.com/hsa-fsa-shop**

The Optum Store makes it easy to take care of your health – at a great price. You'll find a wide range of health and care products that you can buy with your UMR health savings account (HSA) and flexible spending account (FSA) funds – all from your member portal.

Shop with confidence

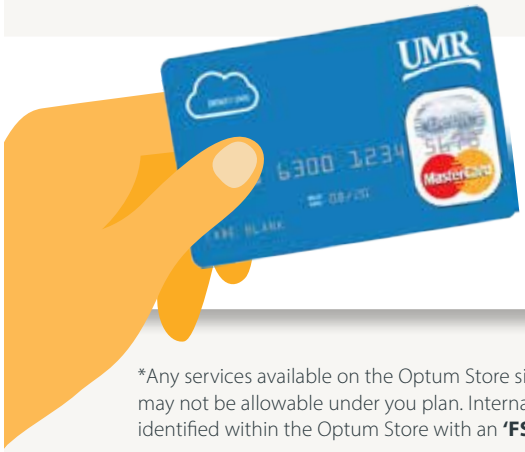
We do the research, so you don't have to. It's easy to find HSA/FSA-eligible items, all at your fingertips. Over 70% of the products found on this site are eligible.*

Hold on to your receipt

When you use your UMR debit card at the Optum Store, your purchases are automatically processed. But keep in mind, for FSAs, receipts may be required for each purchase. And for HSAs, keep your receipts for tax purposes.

You can shop over 1,500 health and wellness products, including:

- Over-the-counter products for common ailments such as cold, allergy, sinus, feminine care, etc.
- Vitamins and supplements
- Skincare and sun care products
- Diagnostics and test kits
- Consumer Health Technology (activity monitors, baby monitors)



Enjoy a 15% discount**

When you purchase from **store.optum.com/hsa-fsa-shop**, receive a 15% discount when you enter the promo code **UMR15**. If you access the store directly from your UMR member portal, the discount is automatically applied at checkout.

*Any services available on the Optum Store site that are not for over-the-counter purchases may not be allowable under you plan. Internal Revenue Service (213(d)) eligible services are identified within the Optum Store with an **'FSA eligible or HSA eligible'** indicator.

**The Optum Store promo may only be used for over-the-counter (OTC) items on the Optum Store. It may not be used for transferred or new prescriptions, care services, the On/Go COVID-19 Antigen Self-Test Kit or for any breast pumps. The promo code cannot be combined with any other offers or codes.

The Optum Store is an affiliate of the RVOHealth families of companies.

Optum Store

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Frequently asked questions:

Flexible Spending Account (FSA)

General FSA

Q: Where can I find my account balance or the status of my claim?

A: You can access your account information via **umr.com** or by contacting a Customer Care representative at 1-800-826-9781.

When contacting customer service, you will be prompted to enter your member ID. If you don't have your member ID, you will be redirected to an operator. As an alternative, you may submit a question to our Customer Care representatives by email from the **umr.com** member website.

Q: What information do I need to register for access to the member website?

A: You will need to provide your name, group ID number, member ID number and date of birth. You may also be asked to provide an email address so you can obtain important notices about your benefit plan.

After entering this information, you will be prompted to record a personalized username and password. This username and password is required each time you log in to the member website.

Q: How do I get my group number?

A: Your group number can be found in the welcome letter you received when your flex account was originally set up. If you do not have this number, a Customer Care representative can help you obtain it.

Q: How long does it take for a claim to be processed?

A: The standard turnaround time for most dependent care account (DCA) claims is within 3-5 working days. For health care account (HCA) claims, the general turnaround time is 5-7 working days. A small percentage of claims will occasionally require further substantiation or clarification.

Please note: Once the claim is processed, it will appear on the member website.

Q: Is my claim eligible for reimbursement?

A: Please refer to your summary plan document (SPD) for specific regulations. A general list of eligible and ineligible expenses is also provided on the member website. This list is not all-inclusive and is subject to change at any time.

Flexible Spending Account (FSA)

Q: What is the best way to file my claim?

A: The fastest way your claim will be processed would be if you file the claim online. Just log onto **umr.com** and follow the prompts to your flex account. Complete the "File a claim" process and upload your supporting document.

You can track the status of the online claim and will have a message on your site when a payment will be issued.

Online claims are generally processed within 2-5 business days of receipt.

Q: If I want to submit a paper claim for reimbursement from my FSA, how do I complete the claim form(s)?

A: To access the forms, register or log in to the UMR member website, and then follow the prompts to view your FSA information.

There are two separate claim forms: one for dependent care claims and one for health care claims. Be sure you are using the correct one.

You will need to complete all sections on the claim form, as well as sign and date it.

Q: What documentation is required to verify the eligibility of my FSA expense?

A: You will need to include a copy of third-party documentation containing 1) date of service, 2) type of service, 3) charged amount, 4) name of the provider, and 5) any insurance paid on the expense, if applicable, for each claim.

- For dependent care requests, the third-party documentation can either be in the form of a receipt from the provider, or the provider can sign the claim form verifying the information listed is correct.
- For health care requests, an EOB from your benefits administrator is the best form of documentation; however, we can take an itemized receipt or statement if the previously mentioned information is included.

To allow for proper reimbursement, you must include the total reimbursement amount being requested on the claim form. The claim form needs to be signed and dated by the employee. UMR cannot process your request without a signature. Make a copy of your documents for your records before mailing or faxing this information to the address/fax number provided on the claim form. You may also upload your documentation and submit a claim in the FSA section of the member website.

Q: What information should I include when I fax an FSA claim to UMR?

A: Include your completed claim form and third-party documentation along with a cover sheet with the employer name, employee name, daytime phone number, and number of pages being sent. The toll-free fax number for submitting your claims is provided on the claim form.

Q: Why wasn't I reimbursed the full amount that I requested?

A: Dependent care claims can only be reimbursed up to the amount that is currently contributed to the account at the time that the claim is processed. The balance of the claim will hold in the account and pay out as more contributions are made to the account.

Health care FSA

If a health care claim is not paid in full, review the denial letter or EOB to determine why the services were denied under your FSA.

Some reasons include:

- **Duplicate expense** - We previously paid this same expense.
- **Over annual election** - You have already been paid your full annual election and have no funds remaining in the account.
- **Claim filing deadline expired** - There is a certain time frame you have to submit claims at the end of the plan year. If a claim is filed after that date, it would be denied.
- **Additional documentation is needed** - There are several reasons why the original documentation was not sufficient. Your denial or EOB will explain what is needed to allow your claim.

Q: Is there a limit to the amount of money that can be contributed to a health care FSA?

A: Health care FSAs can have minimum and maximum contribution amounts. Please refer to your plan document for the specific limit allowed by your plan.

Q: What is a letter of medical necessity and what expenses require this?

A: Expenses that could be considered dual purpose (having both medical and personal benefits) may need a medical practitioner's note explaining the diagnosis and treatment action that is needed for this specific medical condition. Some examples of expenses that require a letter of medical necessity are: massage therapy, capital expenses, weight loss programs and dietary supplements.

Q: Can the member submit a copy of the medical practitioner's recommendation with each claim or are they required to get an original note with each claim submission?

A: The medical practitioner's recommendation is valid for one calendar year, unless a lesser length of time is specified in the letter. We keep a copy of these letters on file.

Q: Who needs to write the letter of medical necessity?

A: The letter of medical necessity needs to come from a medical practitioner who has the "professional competence" to diagnose and treat the illness.

Q: May I be reimbursed for my spouse's medical expenses, or is the account meant only for my expenses?

A: The health care FSA can be used to cover the eligible medical, dental, vision or over-the-counter items of the member or their eligible dependents. If you are unsure who an eligible dependent is, please refer to your plan document or your tax advisor.

Q: Are prescription co-pays reimbursable?

A: Yes. Prescription drugs are an eligible expense.

Q: Are insurance premiums of any kind allowable for reimbursement under the health care FSA?

A: No.

Q: How are orthodontia claims reimbursed?

A: Please refer to your employer's plan document for orthodontia administration.

Q: Is there a limit to the amount of over-the-counter items that can be purchased?

A: The Internal Revenue Service (IRS) regulations state that in order for an expense to be eligible for reimbursement under the health care FSA, the expense must have been incurred within the plan year. So only eligible over-the-counter items that are purchased AND used within that plan year will qualify for reimbursement. Stockpiling over-the-counter items at the end of the plan year to use up any remaining balances will not be acceptable.

If you have a question regarding the number of items you can purchase, please contact a Customer Care representative for assistance.

Q: Are dietary supplements a reimbursable expense?

A: Dietary supplements can be reimbursable if they treat a specific medical condition. However, they also fall into the "dual-purpose" category and would need a letter of medical necessity as stated earlier.

Q: Are shipping and sales tax costs included?

A: Yes. Shipping costs and sales tax are a part of the expense to obtain the item and are reimbursable.

Q: Can I be reimbursed for an electronic toothbrush prescribed by my dentist?

A: No, because everyone uses a toothbrush to maintain general health.

Dependent care (FSA)

Q: Does it matter if the provider does not claim the income on their tax return?

A: The provider will only need to claim the income if it is over a certain amount, which depends on their age and marital status. Check with a tax consultant, or visit the IRS website for more information.

Q: Would kindergarten expenses be eligible for reimbursement?

A: No. Kindergarten is considered educational in nature, whether it is half-day, full-day, voluntary, or state mandated. Therefore, it is not a qualifying expense.

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Adding your UMR debit card into your mobile wallet

Easy and contactless payments through your mobile phone

Your mobile wallet is an application in your smartphone that can store your debit and credit cards, allowing you to use your phone to make payments.

Over half of the largest retailers incorporate mobile payment for their products and services, and now you can add your UMR debit card to your mobile wallet to pay for your qualified expenses from your phone. Mobile wallets can store your card data safely and transmit it to the retailer with the use of near-field communication (NFC).* Cards added in a mobile wallet securely transfer transactions through a tokenization process.

You will be able to add your UMR debit card to your Google Pay, Apple Wallet or Samsung Wallet.

Adding your debit card to your wallet is

- **Fast and easy:** The set up to add your debit card is simple to complete, and once added to your wallet, with just a tap, you can make a payment, saving you time and the hassle of searching for the appropriate debit card at the checkout.
- **Safe and convenient:** Rather than having to carry a physical card, it is stored in your mobile wallet and minimizes the loss or theft of your card.
- **Efficient:** Adding your debit card to your smartphone means having to carry less in your actual wallet.

Eligible plans

With any active UMR plan that has issued you a debit card, you are able to add to your smartphone for mobile payments. These plans include:

- Flexible spending account (FSA)
- Dependent Care
- Transit
- Parking
- Health saving account (UMR HSA)
- Health reimbursement account (HRA) except HRAs with claim payment system

Qualified payments

UMR will ensure your debit card is configured to allow your expenses as outlined in your specific plan.

Adding your UMR debit card to your mobile wallet

Important note: *If you have already set up your account on our website, you may have been asked to provide UMR with an email address and mobile phone number. If you have done so, please note that you must do so again when following the instructions for setting up the mobile wallet. You must activate your debit card before adding it to your mobile wallet.*

Whether you have an Apple, Samsung or Google device, use the following steps to set up the mobile wallet for your UMR debit card.

Step 1: Log in to the UMR portal and select **Account balances**.

Step 2: Select the **type of plan** you have, either FSA, HSA or HRA.

Step 3: On the next screen, click the green **View account** button.

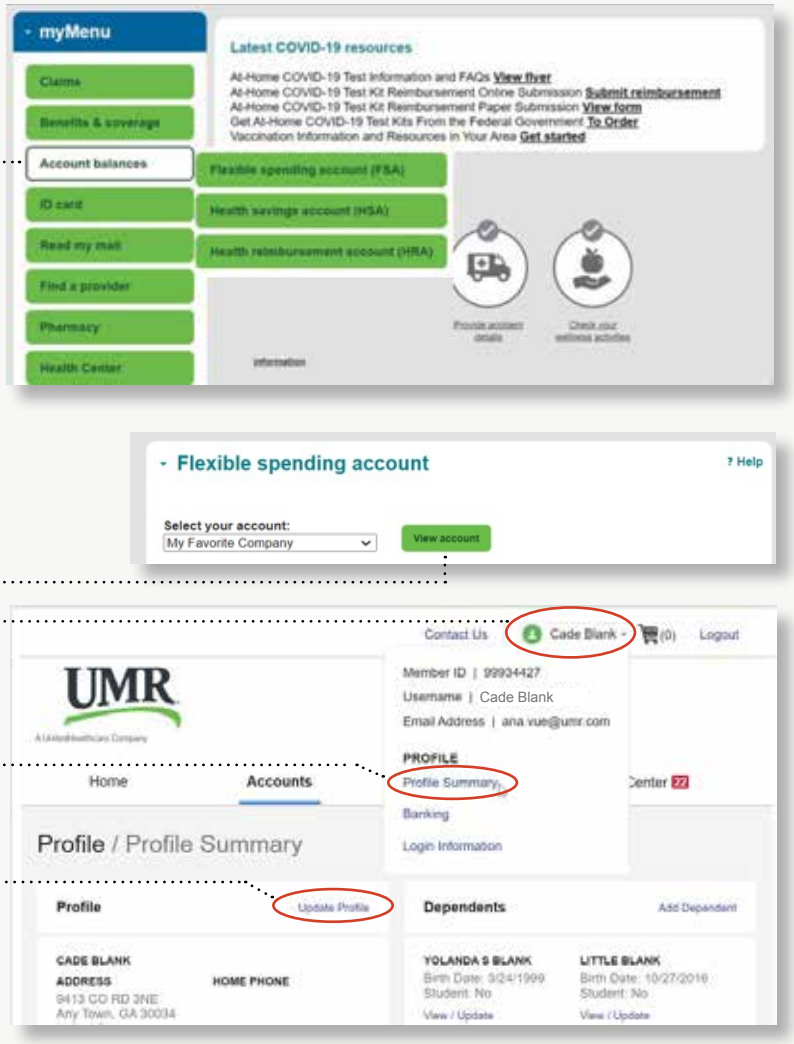
Step 4: Select your **user profile name** at the top of the screen for a drop-down menu.

Step 5: On the drop-down menu, click **Profile Summary**.

Step 6: On the Profile Summary page, click **Update Profile** to add or verify your email address and mobile phone number.

Step 7: After ensuring you have a wi-fi connection, open the mobile wallet application on your smart phone.

Step 8: Follow the prompts on your phone to set up the wallet.



*NFC-near-field communication are standards that permit your mobile phone and other devices to exchange messages. It is a wireless connection between your smartphone and another device in close proximity.

**213(d) medical expenses refer to Section 213 of the Internal Revenue Code. The IRS defines qualified medical care expenses within the IRS Section 213(d).

More information about your mobile pay options with UMR

Accessibility	When you receive a UMR debit card, you must activate it before adding it to your mobile wallet.
	You will be able to use your card for 213(d) eligible expenses through your smartphone's payment application.
	Whether you have Google Pay, Samsung Wallet or Apple Wallet applications, you can add your debit cards to your mobile device and make payments. Please review your application's procedures and terms of service for more details.
	If you are enrolled in a transit plan, you can use your debit card for transit expenses. Qualified transportation expenses which cover your commute to and from your place of work will allow you to use your mobile wallet to pay for the MTA New York transit system and most of the country's transit systems except for the Washington D.C. Metro transit system.
Substantiation	Per IRS regulations, we may request documentation from you to validate the expenses from your debit card transactions and ensure they are eligible for reimbursement. You can submit documentation as an itemized receipt, statement, bill or explanation of benefits (EOB) showing: • The provider that administered the service • Date the service was incurred • What service was provided • Total amount of the service and amount insurance paid (if applicable)
	If the transaction cannot be substantiated via any of the automated processes, you may receive a request from UMR to submit appropriate documentation. This would be the same documentation that you would include with a manually filed claim.
	Substantiation is not required for your UMR HSA distributions.
Security	UMR adheres to strict guidelines to safeguard our members, therefore: • Mobile phone number and email must be updated or validated at the onset when adding your UMR debit card to your phone • Dependents or individuals other than you cannot call in to add your debit card to your mobile phone • If you decide to call UMR Customer Service to complete the process, you will be required to pass multi-level authentication questions • A verification code is sent for you to input to your phone before your card is added to your smartphone • An immediate notification is sent to your mobile phone or email as soon as your card was successfully added
	In the event of unexpected security breach or theft of your UMR debit card, through your smartphone payment application, you can update the debit card status in your member portal so that it is locked and inaccessible until you update the status.

(Continued)

Customization	It is expected that your physical UMR debit card may look different from the image of the same debit card in your phone; however, there is no change in the core debit card functionality.
	Unlike your other debit/credit cards in your smartphone, you have the option to distinguish your UMR debit card from your other mobile cards by labeling or naming the card.
Termination	If you are terminated by your employer and depending on your plan, you may have the option to continue to use your debit card through your mobile pay application.
	If you are terminated from an FSA, HRA or Transit plan, your card will be disabled and will no longer function in your mobile wallet.

Removal of UMR debit card from your mobile wallet

If you no longer want your debit card in your smartphone's wallet, you can follow the procedure outlined by your smartphone for removal.

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24/7 doctor visits via phone or mobile app

TELADOC

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

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone, video or mobile app

Prompt treatment, median call back, in 10 minutes

A network of doctors that can treat every member of the family

Prescriptions sent to pharmacy of choice if medically necessary

Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!

visit **Teladoc.com**
or call
1-800-Teladoc

Google play

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus problems
- Skin problems
- And more

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

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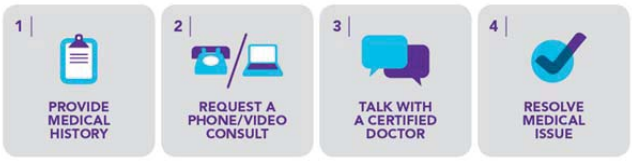
How To Register For Teladoc

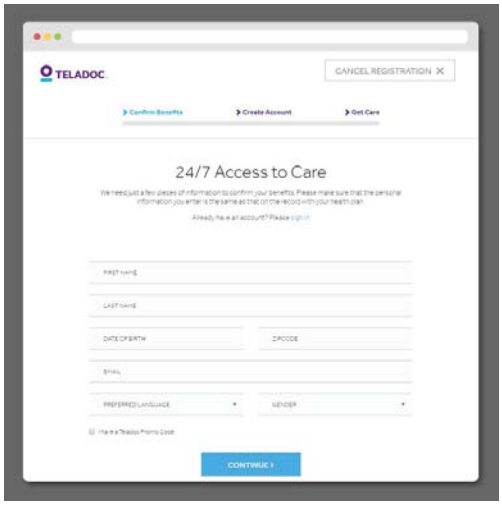
Registering for Teladoc is a quick and easy process. Once registered, you are four steps away from being well!

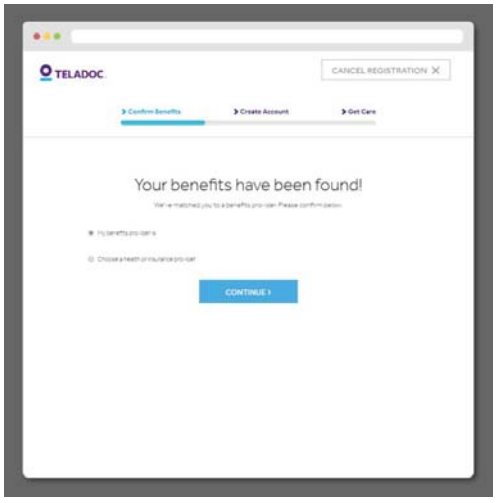


We suggest registering once you have access to the Teladoc service. Registration takes less than 10 minutes and saves vital time when you're not feeling well.

To register, follow these easy steps:

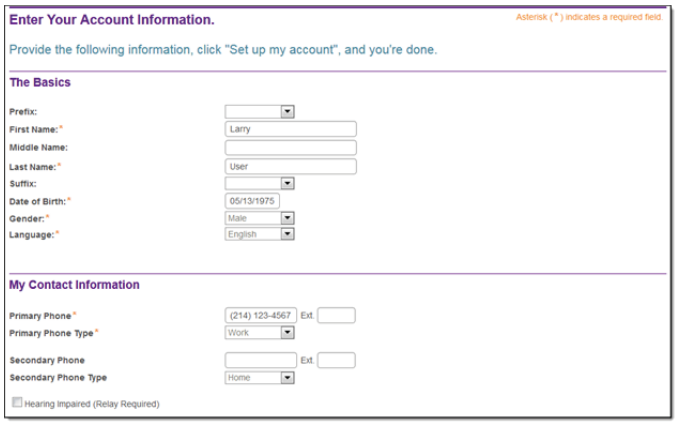
1. Go to Teladoc.com
2. Select *Set Up Account* and enter all required fields (Ex: First/Last Name, DOB, Zip, etc). When you're found, simply select your benefit provider (UMR). If you're not found, click on *Look me up using my health or insurance provider.* Search and highlight UMR. Once UMR is selected from the drop down, a field will appear to enter your *Insurance Card ID* information.





If you ever need help or have questions, you can call our call center 24/7/365 at 800-Teladoc (835-2362)

3. From there, the registration page will appear. You will be prompted to enter your basic information (Ex: Contact, Address, Login). Lastly, it will ask for you to electronically accept the terms, conditions, and privacy policy



4. After accepting the terms, you will then be presented with the option to complete your medical history, go to the home page to register eligible dependents, or perform any other account functions.

***Helpful Hint:** If scheduling a consult, have your credit card handy (if copay applies) and make sure your medical history is completed.

Welcome to Health Navigator, powered by PinnacleCare!

We specialize in providing access to top specialists, especially when you...

- Receive a new diagnosis
- Have a surgery recommendation
- Feel unsure of your doctor's medical advice
- Require a top healthcare specialist
- Want help to find a new primary care provider

When facing an unexpected healthcare challenge, our advisors will help you...

- Review your case
- Understand your condition
- Gather your medical records
- Understand your treatment options
- Expediently schedule appointments
- Obtain opinions from experts
- Make informed decisions
- Achieve better medical outcomes

As a member, you have access to personal support for any healthcare challenge you are facing. Our team provides you access to top experts, and helps you navigate the complicated world of healthcare so you can have peace of mind, and focus on what really matters—your health.

Access Health Navigator for the confidence that you are making the right healthcare decisions for you and your family.

Contact Health Navigator when you need access to a specialist or new primary care doctor:
Phone: **888-352-4969**;
Online: **sunlife.com/healthnav**

Representatives are available Monday through Friday 8:00 a.m.–6:00 p.m. (ET)

Not approved for use in New Mexico.

PinnacleCare is a member of the Sun Life family of companies.

PinnacleCare and its employees do not diagnose medical conditions, recommend treatment options or provide medical care, and any information or services provided should not be considered medical advice. Any medical decisions should be made only after consultation with and at the direction of your medical provider. Any person or entity who provides health care services following a referral or other service provided does so independently and not as an agent or representative of PinnacleCare.

Group stop-loss insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 07-SL REV 7-12. In New York, group stop-loss insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 07-NYSL REV 7-12. Product offerings may not be available in all states and may vary depending on state laws and regulations. Product offerings may not be available in all states and may vary depending on state laws and regulations.

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SLPC 31063 03/22 (exp. 03/24)

Frequently Asked Questions

What does Health Navigator, powered by PinnacleCare do?

Our care advisors guide you to appropriate care and connect you with specialists to provide expert opinions for serious or complex medical conditions. We are an unbiased resource to which you can turn to when facing or trying to prevent a major health problem. Our services facilitate your access to top specialists trained and experienced in your condition to provide an expert review of your diagnosis and treatment options.

How does this differ from what I get through my doctor and health plan?

We work solely on your behalf to help navigate your specific care or treatment. Our team guides you through what can be an incredibly stressful, confusing and time-consuming process. We work with medical professionals to confirm your diagnosis at the onset, and then connect you with experienced specialists to inform you about the most current and effective treatment options. We collaborate with your doctor as needed.

Health Navigator works in conjunction with your health plan and other service providers to help you maximize your benefits.

For example, if your doctor recommends back or spine surgery, we can help you consider the available treatment options to assess if surgery is the best option for you. Our care advisors will work with your medical carrier to help you find the most qualified surgeon from the available premier providers based on the type of surgery you need.

How does this service help me?

We help you to prevent inappropriate procedures and treatments that could result in further harm or unnecessary expense. Health Navigator saves you the time and frustration of gathering your medical records and investigating multiple specialists and facilities for their expertise, performance, insurance coverage and scheduling availability.

How do I access Health Navigator?

You can speak with a care advisor Monday through Friday from 8:00 a.m. to 6:00 p.m. (ET). You can reach us at 888-352-4969 or visit us at www.sunlife.com/healthnav.

When should I contact Health Navigator?

You can contact us any time with any concerns you may have around navigating your healthcare. You should contact us when you receive a serious diagnosis or are struggling with a complex condition, a recommendation for surgery, or a significant change in a current treatment plan.

What defines a serious or complex condition?

A complex condition is a serious diagnosis that will involve rigorous treatment, a choice of treatment options, or a prolonged recovery and can result in significant healthcare costs and/or time away from work. Examples include conditions involving: cardiac, spine and joint replacement surgeries; cancer; transplants; and other serious or complex diagnostic challenges.

Can you provide an example of a change in treatment?

A change of treatment might entail a new drug or a recommendation for a surgical procedure or therapy. For example, if you have been receiving injections for back-related issues and a physician is now recommending surgery.

What should I expect when I contact Health Navigator?

When you reach out for a consultation, our intake team will ask for your name, address, and date of birth for security and to confirm eligibility. A care advisor will then contact you to gather your medical history and the details of your current diagnosis. Your care advisor will review your case and consult with our medical team to determine the appropriate course of action.

What services are covered under this benefit?

Depending on your situation, we may provide you with a confirmation of your diagnosis from a medical professional, recommendations on top specialists, scheduling of your appointments, and/or research on your diagnosis. Our team will coordinate the gathering and forwarding of key medical records to a recommended specialist. Your care advisor will also advocate on your behalf for access to information, top specialists, and Centers of Excellence (COE).

How will this work with my health insurance?

There is no cost to you for using the service and obtaining an expert review of your medical records, diagnosis, and treatment options. Should you wish to schedule a visit with an expert provider, we will attempt to identify specialists who participate in your health insurance network. We can also provide you with out-of-network specialists for cases where the specialist's expertise may be crucial to your health outcome. In those instances, coverage for eligible services will be based on your medical plan's out-of-network coverage reimbursement level (if applicable) and will be subject to reasonable and customary amounts. Please contact your claims administrator for details about out-of-network coverage based on the healthcare plan you are enrolled in.

Are our conversations kept confidential?

Yes, all of your interactions with Health Navigator, powered by PinnacleCare are confidential. We are a HIPAA-compliant company and maintain the privacy of your protected health information.

Can you also find a doctor for routine/ primary care?

Yes. Primary care physicians are your partners in health. We interview each identified physician as part of their vetting process to ensure we select physicians that match your preferences and needs. It is important that a physician's education, pursuits of specialized training and areas of interest and clinical focus be considered. Health Navigator also uses patient experiences to collaborate research findings when possible; for primary care physicians, patient feedback can often serve as an important data point for validating thoroughness and dedication to patient care.

Contact us: Representatives are available Monday through Friday 8:00 a.m.–6:00 p.m. ET.

Phone: 888-352-4969
Online: www.sunlife.com/healthnav

Not approved for use in New Mexico.

PinnacleCare is a member of the Sun Life family of companies.

PinnacleCare and its employees do not diagnose medical conditions, recommend treatment options or provide medical care, and any information or services provided should not be considered medical advice. Any medical decisions should be made only after consultation with and at the direction of your medical provider. Any person or entity who provides health care services following a referral or other service provided does so independently and not as an agent or representative of PinnacleCare.

Group stop-loss insurance policies are underwritten by Sun Life Assurance Company of Canada (Wellesley Hills, MA) in all states, except New York, under Policy Form Series 07-SL REV 7-12. In New York, group stop-loss insurance policies are underwritten by Sun Life and Health Insurance Company (U.S.) (Lansing, MI) under Policy Form Series 07-NYSL REV 7-12. Product offerings may not be available in all states and may vary depending on state laws and regulations. Product offerings may not be available in all states and may vary depending on state laws and regulations.

GSLFL-10554-EE-j SLPC 31064 03/22 (exp. 03/24)

Sun Life®

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Take advantage of your benefits!

Let us handle the healthcare stuff.

As your personal Health Pro, I'll simplify your healthcare experience, so you can spend time on better things. I can help you:

Understand your benefits
Clear up any confusion about your health plan.

Find great doctors
Locate highly rated doctors, dental providers and eye care professionals.

Pay less for prescriptions
Get recommendations for lowering the cost of your medications.

Save money on healthcare
Compare prices and choose more cost-effective options.

Resolve billing errors
Don't overpay! Your Health Pro can help you avoid paying more than you owe.

Schedule appointments
Have your appointments scheduled at times most convenient for you.

Contact your Health Pro to get started!
Phone: 800-513-1667 ext. 1602
Email: Petra.Imouokhome@alight.com
Web Portal: member.alight.com

Guardian

HUMAN TECHNOLOGIES CORP.
ALL OTHER ELIGIBLE EMPLOYEES
Group Number: 00507708

Customer Service (888) 600-1600
Monday to Friday | 8am to 8:30pm ET

Welcome to
Workplace benefits

Everyone deserves a Guardian

Every day, Guardian gives 26 million Americans the security they deserve through our insurance and wealth management products and services.

We've partnered with your organization to offer you a range of employee benefits. Inside this pack, you'll find the plans your employer thinks you might benefit from.

Know your benefits

Your benefits support your physical and financial wellbeing, to help keep you and your loved ones protected.

With Guardian, you're in good hands. We've been delivering on our promises for over 150 years, and we're looking forward to doing the same for you too.

1. Read through this information.
2. Find out more about your benefits.
3. Talk to your employer if you need help or have any questions.

Your coverage options

Dental insurance	Taking care of teeth and overall health
Vision insurance	Looking after your eyesight and related health issues
Short term disability insurance	Coverage if you're temporarily unable to work
Specified disease insurance	Taking care of the expenses if you're critically ill

This document is a summary of the major features of the insurance coverage that's been agreed to with your employer – it isn't your contract.

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Watch our video
Learn how dental insurance can protect your long-term health.

Dental insurance

Taking care of your teeth is about more than just covering cavities and cleanings. It also means accounting for more expensive dental work, and your overall health.

With dental insurance, routine preventive care can lead to better overall health. And you'll be able to save money if any extensive dental work is required.

Who is it for?

Everyone should have access to great dental coverage, which is why we offer comprehensive plans that are available through employers as part of your benefit offerings.

What does it cover?

Dental insurance helps to protect your overall oral care. That includes services like preventive cleanings, x-rays, restorative services like fillings, and other more serious forms of oral surgery if you ever need them.

Why should I consider it?

Poor oral health isn't just aesthetic, it's also been linked to conditions including diabetes, heart disease, and strokes. So, while brushing and flossing every day can help keep your teeth clean, nothing should replace regular visits to the dentist.

You will receive these benefits if you meet the conditions listed in the policy.

Staying healthy

Joe visits his dentist for a routine dental cleaning, to take care of his teeth as well as his overall health.

Oral health is about more than just teeth and gums. It's also essential for a range of other health and wellbeing reasons:

Cardiovascular disease: Some research suggests that heart disease, clogged arteries, and infections may be linked to inflammation and infections from oral bacteria.

Osteoporosis: Weak and brittle bones may be linked to tooth loss.

Diabetes: Research shows that people with gum disease find it more difficult to control their blood sugar levels.

Alzheimer's disease: Tooth loss before the age of 35 may be a risk factor for Alzheimer's disease.

All information contained here is from the Mayo Clinic, Oral Health: A Window to Your Overall Health, www.mayoclinic.com. 2018.

HUMAN TECHNOLOGIES CORP.
ALL OTHER ELIGIBLE EMPLOYEES
2020-104309 (07/22)

Kit created 08/10/2022
Group number: 00507708

Guardian®

Your dental coverage

PPO plan, you can visit any dentist; but you pay less out-of-pocket when you choose a PPO dentist. Out-of-network benefits are based on a percentile of the prevailing fee data for the dentist's zip code.

Your Dental Plan	**PPO**	
Your Network is	DentalGuard Preferred	
Calendar year deductible	*In-Network*	*Out-of-Network*
Individual	$50	$50
Family limit	3 per family	
Waived for	Preventive	Preventive
Charges covered for you (co-insurance)	*In-Network*	*Out-of-Network*
Preventive Care	100%	100%
Basic Care	80%	80%
Major Care	50%	50%
Orthodontia	50%	50%
Annual Maximum Benefit	$1500	
Maximum Rollover	Yes	
Rollover Threshold	$700	
Rollover Amount	$350	
Rollover In-network Amount	$500	
Rollover Account Limit	$1250	
Lifetime Orthodontia Maximum	$2000	
Dependent Age Limits(Non-Student/Student)	20/26	

Guardian®

Your dental coverage

A Sample of Services Covered by Your Plan:

		PPO *Plan pays (on average)*	
		In-network	*Out-of-network*
Preventive Care	Cleaning (prophylaxis)	100%	100%
	Frequency:	Once Every 6 Months	
	Fluoride Treatments	100%	100%
	Limits:	Under Age 19	
	Oral Exams	100%	100%
	Sealants (per tooth)	100%	100%
	X-rays	100%	100%
Basic Care	Anesthesia*	80%	80%
	Fillings‡	80%	80%
	Perio Surgery	80%	80%
	Periodontal Maintenance	80%	80%
	Frequency:	Once Every 6 Months	
	Repair & Maintenance of Crowns, Bridges & Dentures	80%	80%
	Root Canal	80%	80%
	Scaling & Root Planing (per quadrant)	80%	80%
	Simple Extractions	80%	80%
	Surgical Extractions	80%	80%
Major Care	Bridges and Dentures	50%	50%
	Dental Implants	50%	50%
	Inlays, Onlays, Veneers**	50%	50%
	Single Crowns	50%	50%
Orthodontia	Orthodontia	50%	50%
	Limits:	Child(ren)	

This is only a partial list of dental services. Your certificate of benefits will show exactly what is covered and excluded. **For PPO and or Indemnity members, Crowns, Inlays, Onlays and Labial Veneers are covered only when needed because of decay or injury or other pathology when the tooth cannot be restored with amalgam or composite filing material. When Orthodontia coverage is for "Child(ren)" only, the orthodontic appliance must be placed prior to the age limit set by your plan; If full-time status is required by your plan in order to remain insured after a certain age; then orthodontic maintenance may continue as long as full-time student status is maintained. If Orthodontia coverage is for "Adults and Child(ren)" this limitation does not apply. *General Anesthesia – restrictions apply. ‡For PPO and or Indemnity members, Fillings – restrictions may apply to composite fillings.

Guardian®

Your dental coverage

Manage Your Benefits:

Go to www.Guardianlife.com to access secure information about your Guardian benefits including access to an image of your ID Card. Your on-line account will be set up within 30 days after your plan effective date.

Find A Dentist:

Visit www.Guardianlife.com
Click on "Find A Provider"; You will need to know your plan, which can be found on the first page of your dental benefit summary.

EXCLUSIONS AND LIMITATIONS

Important Information about Guardian's DentalGuard Indemnity and DentalGuard Preferred Network PPO plans: This policy provides dental insurance only. Coverage is limited to those charges that are necessary to prevent, diagnose or treat dental disease, defect, or injury. Deductibles apply. The plan does not pay for: oral hygiene services (except as covered under preventive services), orthodontia (unless expressly provided for), cosmetic or experimental treatments (unless they are expressly provided for), any treatments to the extent benefits are payable by any other payor or for which no charge is made, prosthetic devices unless certain conditions are met, and services ancillary to surgical treatment. The plan limits benefits for diagnostic consultations and for preventive, restorative, endodontic, periodontic, and prosthodontic services. The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract # GP-1-DG2000 et al.
PPO and or Indemnity Special Limitation: Teeth lost or missing before a covered person becomes insured by this plan. A covered person may have one or more congenitally missing teeth or have lost one or more teeth before he became insured by this plan. We won't pay for a prosthetic device which replaces such teeth unless the device also replaces one or more natural teeth lost or extracted after the covered person became insured by this plan. R3-DG2000

Guardian®

Oral Health Rewards Program

Regular visits to the dentist can help prevent and detect the early signs of serious diseases.

That's why Guardian's Maximum Rollover Oral Health Rewards Program encourages and rewards members who visit the dentist, by rolling over part of your unused annual maximum into a Maximum Rollover Account (MRA). This can be used in future years if your plan's annual maximum is reached.

Automatic rollover

Submit a claim (without exceeding the paid claims threshold of a benefit year), and Guardian will roll over a portion of your unused annual dental maximum.

How maximum rollover works*

Depending on a plan's annual maximum, if claims made for a certain year don't reach a specified threshold, then the set maximum rollover amount can be rolled over.

Plan annual maximum**	Threshold	Maximum rollover amount	In-network only rollover amount	Maximum rollover account limit
$1,500 Maximum claims reimbursement	**$700** Claims amount that determines rollover eligibility	**$350** Additional dollars added to a plan's annual maximum for future years	**$500** Additional dollars added if only in-network providers were used during the benefit year	**$1,250** The limit that cannot be exceeded within the maximum rollover account

* This example has been created for illustrative purposes only.

** If a plan has a different annual maximum for PPO benefits vs. non-PPO benefits, ($1500 PPO/$1000 non-PPO for example) the non-PPO maximum determines the Maximum Rollover plan. May not be available in all states.

Guardian's Dental Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. Plan documents are the final arbiter of coverage. Information provided in this communication is for informational purposes only. Dental Policy Form No. GP-1-DEN-16. GUARDIAN® is a registered service mark of The Guardian Life Insurance Company of America ® ©Copyright 2019 The Guardian Life Insurance Company of America.

2020-105050 (07/22)

Guardian®

Watch our video
How vision insurance can help you see clearly as you get older.

Vision insurance

Vision insurance helps protect the health of your eyes by providing coverage for benefits that often aren't covered by regular medical insurance.

Protecting your eyesight means allowing for routine visits to the optometrist for eye exams, as well as coverage for glasses and contacts. Make sure your eyes remain in great shape at any age – no matter how much time you spend staring at digital screens.

Who is it for?

Even if you have perfect eyesight, it's important to have regular eye exams to make sure you're still seeing clearly. Most of us may eventually need vision correction, which is why we offer vision insurance to cover some of the costs.

What does it cover?

Vision insurance covers benefits not typically included in medical insurance plans. It covers things like routine eye exams, allowances towards the purchase of eyeglasses and contact lenses, as well as discounts on corrective Lasik surgery.

Why should I consider it?

Regular eye exams can detect more than failing eyesight, they can also pick up diseases like glaucoma and diabetes. Vision problems are one of the most prevalent disabilities in the United States, making vision insurance especially useful for anyone who regularly needs to purchase eyeglasses or contacts, or anyone who simply wants to help protect their eyesight and general health.

You will receive these benefits if you meet the conditions listed in the policy.

20/20 coverage

David notices that his vision is deteriorating. He goes in for an eye exam, and is diagnosed with myopia, which means he needs glasses.

Average cost of vision exam: **$171**

Average cost of frames and lenses: **$350**

Total cost: **$521**

With a Vision policy from Guardian, David pays just **$10** for his eye exam. After **$25** in copay, his lenses are fully covered, and he pays **$96** for his frames.

David's total out-of-pocket expense is **$131**, saving him **$390**.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

HUMAN TECHNOLOGIES CORP.
ALL OTHER ELIGIBLE EMPLOYEES
2020-104313 (07/22)

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Guardian®

Your vision coverage

Option 1: Significant out-of-pocket savings available with your **Full Feature** plan by visiting one of Davis Vision's network locations including retail centers such as Costco®, Wal-Mart®, JCPenney®, Target®, Sam's Club®, Pearle®, Visionworks®. You can also use your network benefits online at Visionworks®.com, glasses®.com, WarbyParker®.com, or 1800contacts®.com.

Your Vision Plan	**Full Feature - Designer**	
Your Network is	Davis Vision	
Copay		
Exams Copay	$ 10	
Materials Copay *(waived for elective contact lenses)*	$ 20	
Sample of Covered Services	*You pay (after copay if applicable):*	
	In-network	*Out-of-network*
Eye Exams	$0	Amount over $50
Single Vision Lenses	$0	Amount over $48
Lined Bifocal Lenses	$0	Amount over $67
Lined Trifocal Lenses	$0	Amount over $86
Lenticular Lenses	$0	Amount over $126
Frames	80% of amount over $130*[2]	Amount over $48
Contact Lenses *(Elective and conventional)*	85% of amount over $130*	Amount over $105
Contact Lenses *(Planned replacement and disposable)*	85% of amount over $130*	Amount over $105
Contact Lenses *(Medically Necessary)*	$0	Amount over $210
Cosmetic Extras	Avg. 40-60% off retail price	No discounts
Glasses *(Additional pair of frames and lenses)*	50% at Visionworks and 30% at other in network providers	No discounts
Laser Correction Surgery Discount	Savings of 40-50% off national average price thru Davis laser vision network	No discounts
Service Frequencies		
Exams	Every calendar year	
Lenses *(for glasses or contact lenses)*‡‡	Every calendar year	
Frames	Every two calendar years	
Network discounts *(glasses and contact lens professional service)*	Applies to first purchase & courtesy discount from most providers on subsequent purchases.	
Dependent Age Limits (Non-Student/ Student)	20/26	
	Visit www.Guardianlife.com and click on "Find a Provider"	

This is only a partial list of vision services. Your certificate of benefits will show exactly what is covered and excluded.

Your vision coverage

Davis

- ‡‡Benefit includes coverage for glasses or contact lenses, not both.
- Contact lenses from Davis Vision's Collection are available at most private practice locations with Full Feature and Materials Only plans. Contacts from the collection are covered in full including fitting and evaluation, in excess of the plan's materials copay. Elective contacts that are not part of the Collection are covered up to the plan's elective contact lens allowance and the materials copay is waived.
- *Additional discounts are not available at all private practice locations. Costco, Walmart, Sam's Club, glasses.com, and 1800contacts.com do not allow additional discounts.
- For Davis Vision, complete eyeglasses must be purchased at one time from one provider. For example, if a member purchases only lenses, he or she cannot purchase frames later in the same benefit period. The member is not eligible for new vision materials until the next benefit period. Only charges for an initial purchase can be used toward the material allowance. Any unused balance remaining after the initial purchase cannot be banked for future use.
- [2]Extra $50 at Visionworks stores and at Visionworks.com.
- In Network Routine Retinal Screening Covered after no more than a $39 copay.
- Members can use their in network benefits at visionworks.com, warbyparker.com, glasses.com, and 1800contacts.com. Additional discounts are not available at glasses.com or 1800contacts.com. Discounts may vary at Warby Parker.

EXCLUSIONS AND LIMITATIONS

Important Information: This policy provides vision care limited benefits health insurance only. It does not provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. Coverage is limited to those charges that are necessary for a routine vision examination. Co-pays apply. The plan does not pay for: orthoptics or vision training and any associated supplemental testing; medical or surgical treatment of the eye; and eye examination or corrective eyewear required by an employer as a condition of employment; replacement of lenses and frames that are furnished under this plan, which are lost or broken (except at normal intervals when services are otherwise available or a warranty exists). The plan limits benefits for blended lenses, oversized lenses, photochromic lenses, tinted lenses, progressive multifocal lenses, coated or laminated lenses, a frame that exceeds plan allowance, cosmetic lenses; U-V protected lenses and optional cosmetic processes.

The services, exclusions and limitations listed above do not constitute a contract and are a summary only. The Guardian plan documents are the final arbiter of coverage. Contract #GP-1-DAVIS-05-VIS et al.

Laser Correction Surgery:

In Network savings of 40-50% off national average price of traditional Lasik are available at over 1000 locations across the Davis nationwide network of laser vision correction providers

Laser surgery is not an insured benefit. The surgery is available at a discounted fee. The covered person must pay the entire discounted fee. In addition, the laser surgery discount may not be available in all states.

Guardian®

Watch our video
How short term disability insurance can supplement your income.

Short term disability insurance

Disability insurance covers a part of your income, so you can pay your bills if you're injured or sick and can't work.

Disability may be more common than you might realize, and people can be unable to work for all sorts of different reasons. There are times when many disabilities can be caused by Illness, including common conditions like heart disease and arthritis. However, many disabilities aren't covered by workers' compensation.

Who is it for?

If you rely on your income to pay for everyday expenses, then you should probably consider disability insurance. It helps ensure that you'll receive a partial income if you're injured or too sick to work.

What does it cover?

Many disability insurance plans pay out a portion or percentage of your income if you're diagnosed with a serious illness or experience an injury that prevents you from doing your job.

Why should I consider it?

Accidents happen, and you can't always anticipate if or when you'll become sick or injured. That's why it's important to have a disability policy that helps you pay your bills in the event of being unable to collect your normal paycheck.

You will receive these benefits if you meet the conditions listed in the policy.

Partial income replacement

Mike injures his back in a bicycle accident and can't work for 13 weeks.

Unpaid time off work: **13 weeks**

Elimination period: **1 week**

After a 1-week elimination period following his accident, Mike's Guardian Short Term Disability policy kicks in and replaces **$400** of his weekly income for the remaining **12 weeks** of his rehabilitation.

This gives him a total of **$4,800** to cover his expenses while he's unable to work.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

HUMAN TECHNOLOGIES CORP.
ALL OTHER ELIGIBLE EMPLOYEES
2021-117408 (03/23)

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Group number: 00507708

Guardian®

Your short term disability coverage

	Short-Term Disability
Coverage amount	40% of salary to maximum $1000/week
Maximum payment period: Maximum length of time you can receive disability benefits.	26 weeks
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	Not Applicable
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

Earnings definition: Your covered salary excludes bonuses and commissions.

Short-Term Disability Plan Cost Illustration:

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses.

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
Your premium rate	$0.540	$0.620	$0.940	$0.860	$0.700	$0.700	$0.940	$1.190	$1.460
					Election Cost Per Age Bracket				
	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
$20,000 Annual Salary $154 Weekly Benefit	$3.84	$4.41	$6.68	$6.11	$4.98	$4.98	$6.68	$8.46	$10.38
$40,000 Annual Salary $308 Weekly Benefit	$7.68	$8.81	$13.36	$12.23	$9.95	$9.95	$13.36	$16.92	$20.75
$60,000 Annual Salary $462 Weekly Benefit	$11.51	$13.22	$20.04	$18.34	$14.93	$14.93	$20.04	$25.37	$31.13
$80,000 Annual Salary $615 Weekly Benefit	$15.33	$17.60	$26.68	$24.41	$19.87	$19.87	$26.68	$33.78	$41.44
$100,000 Annual Salary $769 Weekly Benefit	$19.17	$22.01	$33.36	$30.52	$24.85	$24.85	$33.36	$42.24	$51.82
$120,000 Annual Salary $923 Weekly Benefit	$23.00	$26.41	$40.04	$36.64	$29.82	$29.82	$40.04	$50.69	$62.20
$140,000 Annual Salary $1,000 Weekly Benefit	$24.92	$28.62	$43.39	$39.69	$32.31	$32.31	$43.39	$54.92	$67.39
$45,000 Annual Salary $346 Weekly Benefit	$8.62	$9.90	$15.01	$13.73	$11.18	$11.18	$15.01	$19.00	$23.32
$50,000 Annual Salary $385 Weekly Benefit	$9.60	$11.02	$16.70	$15.28	$12.44	$12.44	$16.70	$21.15	$25.94
$55,000 Annual Salary $423 Weekly Benefit	$10.54	$12.10	$18.35	$16.79	$13.67	$13.67	$18.35	$23.23	$28.50
$60,000 Annual Salary $462 Weekly Benefit	$11.51	$13.22	$20.04	$18.34	$14.93	$14.93	$20.04	$25.37	$31.13
$65,000 Annual Salary $500 Weekly Benefit	$12.46	$14.31	$21.69	$19.85	$16.15	$16.15	$21.69	$27.46	$33.69
$70,000 Annual Salary $538 Weekly Benefit	$13.41	$15.40	$23.34	$21.35	$17.38	$17.38	$23.34	$29.55	$36.25
$75,000 Annual Salary $577 Weekly Benefit	$14.38	$16.51	$25.03	$22.90	$18.64	$18.64	$25.03	$31.69	$38.88
$80,000 Annual Salary $615 Weekly Benefit	$15.33	$17.60	$26.68	$24.41	$19.87	$19.87	$26.68	$33.78	$41.44
$85,000 Annual Salary $654 Weekly Benefit	$16.30	$18.71	$28.37	$25.96	$21.13	$21.13	$28.37	$35.92	$44.07
$90,000 Annual Salary $692 Weekly Benefit	$17.25	$19.80	$30.02	$27.47	$22.36	$22.36	$30.02	$38.01	$46.63

	< 25	25–29	30–34	35–39	40–44	45–49	50--54	55–59	60+
$95,000 Annual Salary									
$731 Weekly Benefit	$18.22	$20.92	$31.71	$29.02	$23.62	$23.62	$31.71	$40.15	$49.26
$100,000 Annual Salary									
$769 Weekly Benefit	$19.17	$22.01	$33.36	$30.52	$24.85	$24.85	$33.36	$42.24	$51.82
$105,000 Annual Salary									
$808 Weekly Benefit	$20.14	$23.12	$35.06	$32.07	$26.11	$26.11	$35.06	$44.38	$54.45
$110,000 Annual Salary									
$846 Weekly Benefit	$21.09	$24.21	$36.70	$33.58	$27.33	$27.33	$36.70	$46.47	$57.01
$115,000 Annual Salary									
$885 Weekly Benefit	$22.06	$25.33	$38.40	$35.13	$28.59	$28.59	$38.40	$48.61	$59.64

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

Evidence of Insurability may be required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.

You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.

We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.

This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.

If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.

When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

Contract # GP-1-STD-15-1.0 et al.

Guardian's Group Short Term Disability Insurance is underwritten and issued by The Guardian Life Insurance Company of America, New York, NY. Products are not available in all states. Policy limitations and exclusions apply. Optional riders and/or features may incur additional costs. This policy provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services. Plan documents are the final arbiter of coverage.
Policy Form #GP-1-STD07-1.0, et al, GP-1-STD-15

Guardian®

Watch our video
How specified disease insurance helps cover the costs of treatment.

Specified disease insurance

Specified disease insurance may help you cover expenses not covered by your health insurance.

It's a cash payment you receive if you ever experience a serious illness like cancer, a heart attack, or a stroke, giving you the financial support to focus on recovery.

Who is it for?

Specified disease insurance is a supplemental policy for people who already have health insurance. It provides you with an additional payment to cover expenses like deductibles, treatments, and living costs.

What does it cover?

Specified diseases include strokes, heart attacks, Parkinson's disease and cancer. Our policies can cover over 30 major illnesses, helping you stay financially stable by paying you a lump sum if you're diagnosed with one of them.

Why should I consider it?

Health coverage is becoming more expensive, with higher co-pays, premiums, and deductibles. Specified disease insurance is an affordable way to supplement and pay for additional expenses that your health insurance doesn't cover. Our policies typically provide payments for the first and second time you're diagnosed with a covered illness.

Plus, specified disease insurance is portable and payments are made directly to you.

You will receive these benefits if you meet the conditions listed in the policy.

Critical costs

John is hospitalized after a heart attack, and has to cover the cost of five days as an inpatient.

Average heart attack hospitalization expense: **$53,000**

Average Major Medical deductible: **$1,500**

Major Medical covers 80% of the cost after the deductible is met, but John's still responsible for 20%: **$10,300**.

Total out-of-pocket amount for John (deductible + coinsurance): **$11,800**.

John has a **$10,000** Guardian Specified Disease policy, which covers the majority of these out-of-pocket expenses.

This example is for illustrative purposes only. Your plan's coverage may vary. See your plan's information on the following pages for specific amounts and details.

Guardian

Your specified disease coverage

	SPECIFIED DISEASE	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $20,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
Spouse Benefit	May choose a lump sum benefit of $2,500 to $10,000 in $2,500 increments up to 50% of the employee's lump sum benefit.	
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit	
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue.**	
Portability: Allows you to take your Specified Disease coverage with you if you terminate employment.	Included	
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	6 months prior, 6 months after	

WELLNESS BENEFIT	
Employee Per Year Limit	$50
Spouse Per Year Limit	$50
Child Per Year Limit	$50

Your specified disease coverage

Condition Definitions

- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis referred to as [Coronary Heart Disease].
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Specified Disease Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Specified Disease.

Spouse coverage premium is based on Employee age

Child cost is included with employee election.

	Bi-weekly Premiums Displayed *Election Cost Per Age Bracket*					
	< 30	*30-39*	*40-49*	*50-59*	*60-69*	*70+*
Employee						
$5,000	$0.69	$1.06	$2.29	$4.75	$8.61	$15.46
$10,000	$1.39	$2.12	$4.57	$9.51	$17.22	$30.92
$15,000	$2.08	$3.19	$6.85	$14.26	$25.82	$46.39
$20,000	$2.77	$4.25	$9.14	$19.02	$34.43	$61.85
Benefit Amount Up To 50% of Employee Amount to a Maximum of $10,000						
Spouse						
$2,500	$0.35	$0.53	$1.15	$2.38	$4.30	$7.73
$5,000	$0.69	$1.06	$2.29	$4.75	$8.61	$15.46
$7,500	$1.04	$1.59	$3.43	$7.13	$12.91	$23.19
$10,000	$1.39	$2.12	$4.57	$9.51	$17.22	$30.92

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR SPECIFIED DISEASE:

We will not pay benefits for the First Occurrence of a Specified Disease if it occurs less than 3 months after the First Occurrence of a related Specified Disease for which this Plan paid benefits. By related we mean either: (a) both Specified Diseases are contained within the Cancer Related Conditions category; or (b) both Specified Diseases are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Specified Disease unless the Covered Person has not exhibited symptoms or received care or treatment for that Specified Disease for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Specified Disease plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Specified Disease plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on late enrollees. This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Specified Disease insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

Guardian®

Electronic Evidence of Insurability (EOI)

Our online EOI forms are an easier, quicker alternative to traditional paper forms, helping you get covered when you need to provide additional information.

There are a few situations where you need to answer health questions, enroll for higher amounts of coverage, or request coverage after the initial eligibility period. In all of these situations, our online EOI form keeps things simple.

Electronic EOI keeps things simple

With Guardian's electronic EOI forms, your data is kept secure at every stage of the process. And with fewer errors than hand-written forms, and faster submission digitally, it's easier than ever to complete it and get covered.

Electronic EOI can be used for*:

- Basic life
- Voluntary life
- Short term disability
- Long term disability

How it works

You will receive a letter or email from your employer or Guardian with instructions and a unique link to submit your EOI form online.

First register and create an account on Guardian Anytime. Then simply fill out the form, electronically sign it, and click 'Submit'.

Once we receive the form, we'll contact you with any questions, before notifying you (and your employer if the coverage amount changes).

*Applicable to coverage requiring full Evidence of Insurability (not applicable to conditional issue amounts). Electronic EOI is available using most internet browsers.

2020-109652 (10/22)

Guardian

Employee Assistance Program

We all need a little support every now and then.

Guardian's Employee Assistance Program gives you and your family members access to confidential personal support, across everything from stress management and nutrition to handling legal or financial issues.

The services available include consultations with experienced professionals, as well as access to resources and discounts designed to help you in a variety of different ways.

How it can help

Consultative services are available to provide direct support and assistance

Work/life assistance that can help you save money and balance commitments

Access legal and financial assistance and resources – including WillPrep Services

How to access

To access the WorkLifeMatters Employee Assistance Program, you'll need a few personal details.

Visit
worklife.uprisehealth.com

Access Code
worklife

For more information or support, you can reach out by phoning **1 800 386 7055**. The team is available 24 hours a day, 7 days a week[1].

This service is only available if you purchase qualifying lines of coverage. See your plan administrator for more details.

WorkLifeMatters Program services are provided by Uprise Health, and its contractors. Guardian does not provide any part of WorkLifeMatters program services. Guardian is not responsible or liable for care or advice given by any provider or resource under the program. This information is for illustrative purposes only. It is not a contract. Only the Administration Agreement can provide the actual terms, services, limitations and exclusions. Guardian and Uprise Health reserve the right to discontinue the WorkLifeMatters program at any time without notice. Legal services provided through WorkLifeMatters will not be provided in connection with or preparation for any action against Guardian, Uprise Health, or your employer. WorkLifeMatters Program is not an insurance benefit and may not be available in all states.

[1]Office hours: Monday-Friday 6 a.m.–5 p.m. PST.

2021-117403 (3/23)