Full-Time

WELCOME TO TEAM SELECT
INTERACTIVE BENEFITS GUIDE

January 1, 2027 – December 31, 2027

Each day, every member of Team Select Home Care plays a vital role in bringing our mission and core values to life. It is with sincere pleasure that we acknowledge your invaluable contributions by offering a comprehensive benefits package for you and your loved ones. We invite you to review the benefits information provided in this guide.

MEDICAL | DENTAL | VISION | LIFE | FSAs AND MORE



How to use this interactive guide

Links to websites | Access to documents | Links to videos



Benefits Eligibility

All employees who work at least 30 hours per week are eligible to participate in our benefit plans. Eligible participants include employee, spouse, domestic partner (affidavit required), and dependent children up to age 26.

- The coverage you elect during Open Enrollment begins January 1, 2027.
- As a new hire, coverage begins after you satisfy the new hire waiting period.
- Coverage ends if you no longer meet eligibility requirements, contributions are discontinued, or the group insurance policy is terminated.

Changing Your Benefits Outside Of Open Enrollment

The benefits you elect during the 2027 benefits plan year will remain in effect through December 31, 2027. You cannot make changes to the benefits you elect until the next open enrollment period unless you have a qualifying event. The Health Insurance Portability And Accountability Act of 1996 (HIPAA) provides employees additional opportunities to enroll in a group health plan if they experience a loss of other coverage or certain life events. If you are declining coverage at this time for either yourself or your eligible dependents, you may be able to enroll yourself and/or your eligible dependents in coverage at a later date, if there is a loss of other coverage.

You have the right to elect coverage during the plan year if your or your dependent's Medicaid/Children's Health Insurance Program (CHIP) coverage terminates due to discontinuation of eligibility under the program or if you become eligible for a Medicaid/CHIP premium assistance subsidy (if available in your state) provided that you request enrollment within 60 days of the loss of coverage or eligibility for premium assistance subsidy.

Qualifying Life Events

A qualifying event is a personal event that may require you to either add or remove coverage for yourself and/or your dependents.

Qualifying Life Events include:

- Marriage, divorce, or legal separation
- Birth or adoption of a dependent child
- Death of a dependent spouse or child
- Gain or loss of coverage for you or your eligible dependents
- Reaching age 26 for dependent children

Important Deadline For Qualifying Event Changes

You must make any coverage change within 30 days of the qualifying event. Log in to Workday and complete the Life Event Benefit Change wizard to elect/change all desired qualified benefits, within the 30-day deadline, except for a Medicare or Medicaid entitlement event, in which case you must make changes within 60 days of the event.

You must include documentation to substantiate your qualifying event. If you miss the deadline, or do not provide the supporting documentation, changes will not be approved. Please contact Benefits within 30 days if you have any questions or believe that you may qualify for an election change.

Note: In the event that you miss the 30-day deadline to report a qualifying event, Team Select is unable to retroactively make changes to the enrollment due to IRS tax regulations (including any monthly costs which the employee may have incurred).

Reviewing and Updating Your Beneficiaries

Regularly updating beneficiary designations for financial accounts like life insurance and retirement plans is crucial to ensuring assets go to intended recipients.

There are primary beneficiaries, who receive assets and benefits first, and contingent beneficiaries, who receive them if the primary beneficiaries are unavailable.



To avoid common errors, update beneficiary designations after significant life changes, such as marriage, divorce, death of a spouse or child, birth of a child or similar event that alters your family.

You should also update your beneficiary listing if a beneficiary changes their name (e.g. marriage).

Seek guidance from Benefits if you are unsure of how to make changes to your beneficiaries.

My Benefit Advisor (MBA) – Medicare Assistance

My Benefit Advisor helps team members understand Medicare and navigate coverage options. Educational sessions are ideal for individuals approaching age 65 or planning for retirement. One-on-one consultations are also available by appointment.

To register, please contact benefits@tshc.com for available dates and times.

Understanding Medicare
We provide you with educational materials and a personal Medicare specialist.

Simplifying Enrollment
MBA reduces the stress of the enrollment process by providing step-by-step guidance.

Reviewing Plan Options
MBA has access to an extensive list of insurance companies and their plans.

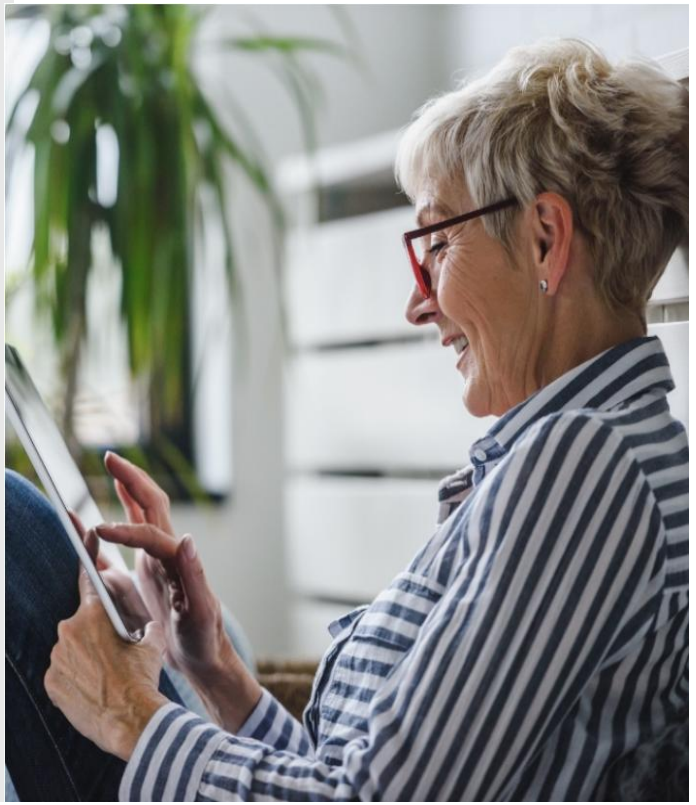
If you have any questions about Medicare or need help reviewing your options, please contact Patty Norton or Karen Coia at My Benefit Advisor:

For Patty Norton: **Book Appointment**; For Karen Coia: **Book Appointment**.

Learn More: Listen to a recorded webinar

New To Medicare?

Watch this brief Medicare 101 overview to understand enrollment timelines, coverage options, and key decisions



Watch Medicare 101 →

MyBenefits2Go Mobile App

The app is a quick and simple way for you and your enrolled dependents to access benefit summaries and other important information about our group plans. Store photos of ID cards in the app and easily locate carrier and HR contact information—all in one place. The MyBenefits2GO app is free for iPhone and Android.



Highlights of the Mobile App

- Access benefit information on the go
- Convenient contact information to carriers and HR Resources
- View plan information in one place
- Stay organized by storing ID cards in the app

It's FREE! Find MyBenefits2Go in the App Store or Google Play

- Search "MyBenefits2Go" in the app store for iPhone and Android
- Download
- Enter code **R33867** when prompted

Terms and Definitions

Before reviewing our benefits, take a look at some terms that may be helpful in understanding and comparing the plans offered to you. By learning a few key insurance terms, you'll be more informed and better able to understand what, exactly, goes into your insurance coverage.

Deductible: The amount of healthcare costs you have to pay for with your own money before your plan will start to pay anything.

Embedded Deductible: An embedded deductible assigns a separate deductible to each covered individual within a family, with benefits applied after the individual deductible is met. This may or may not apply to your plans.

Shared Deductible: A shared deductible combines individual deductibles within a family, requiring the total expenses for covered services to reach a combined threshold (the family deductible) before insurance coverage begins. This may or may not apply to your plans.

Coinsurance: After the deductible (if applicable), you and the plan share the cost. For example, if the plan pays 80%, your coinsurance share of the cost is 20%. You are billed for your coinsurance after your visit.

Copay: A set fee you pay instead of coinsurance for some healthcare services, i.e. a doctor's office visit. You pay the copay at the time you receive care.

Out-of-Pocket Maximum: Protects you from big medical bills. Once costs "out of your own pocket" reach this amount, the plan pays 100% of most eligible expenses for the rest of the plan year.



In and Out-of-Network: In-network services will always be the lowest cost option. Out-of-network services will cost more or may not be covered.

Balance Billing: In-network providers are not allowed to bill more than the plan's allowable charge, but out-of-network providers are. For example, if the provider fee is $100 but the plan allows only $70, an out-of-network provider may bill YOU the extra $30. This is called balance billing.

We're always working to ensure providers are charging a fair price for medical procedures. That's why we utilize Value-Based Pricing (VBP) plans, designed to take care of members while reducing out-of-pocket costs.

What is Value-Based Pricing?

Unlike the PPOs, HMOs, and other plans you may be familiar with, VBP is designed to lower medical costs for you and your dependents. Value-based pricing is a transparent way of determining how much hospitals will be paid for certain services.

With VBP, the health plan sets a maximum price it pays for certain medical procedures (the "reference price"). The reference price is based on the amount Medicare pays for the same procedures plus a percentage. The maximums are set with location in mind, so they differ based on where you live.

Sample Procedure	Traditional Health Plan	Our VBP Plan for 2027
Starting Price	$75,000 (what the hospital wants to bill)	$15,000 (what Medicare would pay)
Plan Price	$45,000 (hospital agrees to 60% of the bill)	$22,500 (hospital agrees to 150% of Medicare)
Coinsurance	You pay 20%	You pay 20%
Your Bill	$9,000**	$4,500**

**You pay the listed deductible and coinsurance, up to the annual out-of-pocket maximum.

Hospital Care & Emergency Care

Value-based pricing is a transparent way of determining how much hospitals will be paid for certain services, such as procedures. It works by reimbursing hospitals based on a reference price: Medicare (plus a percentage). Because it is fully transparent and based on costs, the end result is a price that is fair to both the hospital and the patient. Value-based pricing provides open access to facilities with no network restriction.

PRE-CERTIFICATION IS REQUIRED: To receive maximum benefits, please call 5-10 days prior to ALL inpatient admissions and outpatient hospital services. In the event of a true life-threatening emergency, please visit the nearest hospital for your care. Call within 48 hours after an emergency admission. Prior notification is recommended for pregnancy admissions. The facility is advised during the pre-certification process of the price allowed by the plan. You will be responsible for your deductible/coinsurance. **Pre-certification is not a guarantee of benefits or payment.**

In some cases, you may be advised that a facility other than the one recommended by your physician would provide a better benefit under the plan. If possible, it is better to go with a facility that works well with the plan. If you have any questions regarding which facility to use, please call the number on the back of your card for assistance.

Sample Explanation of Benefits (EOB)

This is **not** a bill.

Amount Billed
The full amount charged by the provider before any discounts.

Plan Discount (Amount Not Payable)
The amount not covered by the plan (network discount or difference between billed amount and allowed amount).

Plan Allowed Amount
The amount the plan considers eligible for payment (based on contracted rates or reference pricing).

Plan Paid
The amount paid by your medical plan to the provider.

Your Responsibility
The amount you may owe (deductible, coinsurance and/or copay). This is not a bill. Compare this amount to any bill you receive from the provider.

UMR

PO BOX 30541 Salt Lake City, UT 84130-0541
T 800.826.9781(TTY) T 801.806.4000

Employee:	Jane Doe
Employee address:	1234 Anywhere Street Anytown, ST 12345
Group number:	76-543210001
Member ID:	999999999
Employer name:	ABC Company, Inc.
Notice date:	03/22/2024

Patient: Elizabeth Blank
Claim number **9999999999**
Provider name **XYZ Provider Inc.**
Patient account **1234567890**

							PLAN PAYS		YOU PAY			
Service date(s)	Revenue code	Service code(s)	Amount billed by provider	Your deductible	Your coinsurance	Amount not payable by you	Plan paid	Allowed amount	Applied to coinsurance	To copayment	Not covered	Total you may owe
01/20/24-01/20/24	451	99213	$150.00	$100.00	$0.00	$40.00	$10.00	$100.00	$0.00	$0.00	$0.00	$40.00
Totals			**$150.00**	**$100.00**	$0.00	**$40.00**	**$10.00**	**$100.00**	$0.00	$0.00	$0.00	**$40.00**

The totals may not reflect any payment/information previously given for this claim. Please see the Claims Detail section at the end of this statement for more claim information.

Remarks code explanations:

Code	Description
MA	Provider adjustment amount. This is not the responsibility of the member.

Plan payments made on this claim: **Payment to:** XYZ Provider Inc. **Payment date:** 03/05/2024 **Payment amount:** $10.00



Understanding Your EOB & Medical Bills

Your Explanation of Benefits (EOB) shows how a medical claim was processed. It is not a bill.

1. **Receive care** You visit a provider or facility. The provider submits a claim to your medical plan.
2. **Review your EOB** Your EOB shows what was billed, what the plan allowed or paid, and what you may owe.
3. **Compare your bill** When you receive a bill from your provider, compare it to your EOB. If the amounts do not match, contact your plan (UMR or HealthSCOPE) for assistance.

Your Medical Benefits

Choosing your medical coverage is a two-step process. First, select one of three plan designs. Then, choose how you want to access care– through UMR or HealthSCOPE Benefits.



1 Choose your plan design

Three medical plan designs are available with either UMR or HealthSCOPE Benefits.

$1,000 Deductible

$5,000 Deductible

HDHP w/HSA

2 Choose how you want to access care

Once you choose your plan design, choose how you want to access care.

UMR UnitedHealthcare Choice Plus

- ✓ UnitedHealthcare Choice Plus network
- ✓ Pre-negotiated network rates
- ✓ Lower costs when using network providers
- ✓ Higher employee premiums

OR

HealthSCOPE BENEFITS

- ✓ Open access –no traditional network restrictions
- ✓ Value Based Pricing (VBP)
- ✓ Care Management + ClaimDOC Advocacy
- ✓ Lower employee premiums

Compare the Medical Plan Designs

Feature	$1,000 Plan	$5,000 Plan	HDHP Plan
Deductible • Individual • Family	$1,000 $2,000*	$5,000 $10,000*	$5,000 $10,000*
Out-of-Pocket Maximum • Individual • Family	$9,450 $18,900	$9,450 $18,900	$8,050 $16,100
Coinsurance	20% AD	20% AD	20% AD
Preventive Care	Covered at 100%		
PCP Office Visit	$20 copay	$20 copay	20% AD
Specialty Office Visit	$40 copay	$40 copay	20% AD
Teladoc Virtual Visit	Amount Paid Varies	Amount Paid Varies	20% AD
Urgent Care	$75 copay	$75 copay	20% AD
Emergency Room	$500 copay	$500 copay	20% AD
Inpatient Hospital	20% AD	20% AD	20% AD
Outpatient Diagnostic X-ray & Lab	20% AD	20% AD	20% AD
Major Lab – MRI, PET/CAT Scans	$500 copay	$500 copay	20% AD
Prescription Drugs	Same prescription drug program for all plans See Prescription Drugs →		

*Embedded; AD = After Deductible

Find a Provider

UMR — UnitedHealthcare Choice Plus

Traditional Network
Higher employee premiums

Find a UMR Provider →

1. Go to umr.com or open the UMR app.
2. Select **Find a Provider**.
3. Search for UnitedHealthcare Choice Plus Network.

HealthSCOPE BENEFITS

Open Access | Value-Based Pricing (VBP)
Lower employee premiums

Find Care →

1. Go to healthscopebenefits.com or open the HealthSCOPE app.
2. Select **Find Care**.
3. Open access –you're not limited to a traditional provider network.

USING HEALTHSCOPE? BEFORE YOU SCHEDULE CARE:
Confirm your provider or facility participates with your VBP plan and whether preauthorization is required. Need help finding care, understanding your benefits or working with a provider?
Call ClaimDoc Advocacy at (888) 330-7295.

Optum Rx®

Is Your Prescription Covered?

Look up your medication to see if it's covered, which cost tier it's on, and if any special rules apply (such as prior authorization, step therapy or other limits).

Save money by choosing Generic drugs whenever possible.

Generics provide the same therapeutic benefits as their brand-name counterparts while helping reduce your out-of-pocket prescription costs.



CHECK DRUG COVERAGE →

View your plan's Optum Rx Prescription Drug List.

Prescription Drugs			
Feature	**$1,000 Plan**	**$5,000 Plan**	**HDHP Plan**
Tier 1 Generic	$15	$15	$15 AD
Tier 2 Preferred Brand	$30	$30	$30 AD
Tier 3 Non-Preferred Brand	$60	$60	$60 AD
Tier 4 Specialty	20% up to $500	20% up to $500	20% up to $500
Rx Mail Order (90-Day Supply)	2.5x Retail Copay	2.5x Retail Copay	2.5x Retail Copay AD

Optum Rx on the go

Place, manage and track your orders anytime from your phone or tablet in the OptumRx mobile app. You can also:

- Check for lower cost options (generic or preferred alternatives)
- Access your digital member ID card
- Avoid waiting in lines at the pharmacy with Optum Home Delivery
- Find a nearby pharmacy

Taking a specialty medication?
Optum Specialty Pharmacy provides medication delivery, refill support, clinical guidance, and assistance with medication affordability. We're here for you 24/7 by calling (855) 427-4682 or visit **Optum Specialty Rx.**

Automatic Refills & Home Delivery

Your prescription may be eligible to enroll in the automatic refill program. Just choose a start date, and Optum Home Delivery will take care of setting up your automatic refills for you. If a prescription is eligible, the prescription details page will display an auto refill section where you can enroll.

Need help?

If you have questions about automatic refills or need help managing your prescriptions, contact **Optum Home Delivery** or call the number on the back of your member ID card.

Medical Resources on the Go

Manage your benefits, find care, check claims and get support anytime.

UMR UnitedHealthcare Choice Plus

UMR app or **UMR.com**

- ✓ Digital ID card
- ✓ Claims & EOBs
- ✓ Benefits & plan details
- ✓ Find a provider
- ✓ Estimate costs

Go to umr.com →

HealthSCOPE BENEFITS

HealthSCOPE app or **HealthSCOPEbenefits.com**

- ✓ Digital ID card
- ✓ Claims & EOBs
- ✓ Benefits & plan details
- ✓ Find care
- ✓ Care & Claims Support

Go to healthscopebenefits.com →

HEALTHSCOPE MEMBER SUPPORT

Extra help navigating your care and your claims.

CARE Management
Personalized support for complex or ongoing health needs and care coordination (888) 304-5103.

ClaimDOC Advocacy
Help finding care, working with providers and resolving billing or claim issues (888) 330-7295.

Teladoc HEALTH

Teladoc | Virtual Care

24/7 virtual access to board-certified physicians by phone, video, or mobile app. Members can receive care for many common, non-emergency conditions and may receive prescriptions when medically appropriate, often avoiding more costly urgent care or emergency room visits.

Care anywhere, anytime for:

- Cold and flu symptoms
- Allergies
- Pink eye
- Respiratory infections
- Sinus issues
- Skin conditions
- Other routine, non-emergency medical concerns



Get care now in less than 15 minutes* by visiting Teladoc Health or call (800) 835-2362. Teladoc is available to both UMR and HealthSCOPE members.

*Average wait time. Teladoc is not available internationally.



Health Savings Account (HSA)

Pinnacle FINANCIAL PARTNERS

If you are enrolled in our **HDHP Plan** and have elected a Health Savings Account (HSA), your contributions are tax-exempt, meaning you save on both FICA and Federal taxes when contributing through payroll. Your HSA funds can be used to pay for unreimbursed medical, dental or vision expenses for you and your dependents, whether or not they are covered by your health plan. You can even use funds to pay for COBRA, long-term care, and Medicare (but not Medigap) premiums. Your HSA works like a personal bank account - no 'use-it or lose-it' rule. Funds remain in your account until needed, even if you change jobs or retire.

The HSA is not an automatic feature of enrolling in a HDHP; it is a separate enrollment that you must make through Workday. Similar to other direct deposits you may already have, you can increase, decrease, start or stop your HSA contributions throughout the year.

How much can I contribute to an HSA?

For 2027, the contribution limits are:

- $4,500 for Individual Coverage - just you on the plan
- $9,000 for Family Coverage - you and any number of dependents
- If you're age 55 or older, you can contribute up to $1,000 more than the limits listed here

Who is eligible to open and fund an HSA?

Anyone who is:

- covered by a qualified HDHP (HSA Open Access Plan); and
- not covered under another medical plan that is not a qualified HDHP - including Medicare, Medicaid, TriCare, VA and/or a Health Care Flexible Spending Account (FSA), including a spouse's FSA.

What if I establish an HSA mid-year?

Your HSA contributions are generally determined on a monthly basis. If you establish an HSA mid-year, you're allowed to make the full year's contribution, provided you are eligible on January 1 of that year and you remain eligible to make HSA contributions throughout the next calendar year.

How do I make contributions to my HSA?

You can contribute to your HSA through payroll deductions.

Where can I find a list of qualified expenses?

Refer to the list found in Publication 502 on the IRS website.

When can I start using the funds in my HSA?

You can use the funds in your HSA once they are available. You can reimburse yourself for qualified HDHP expenses months or even years later if you retained receipts and your HSA was established when the expense occurred.

Can I use my HSA to pay for non-qualified expenses?

Non-qualified expense withdrawals are subject to income tax and a 20% penalty until age 65. After age 65, non-qualified expense withdrawals are penalty-free but remain subject to income tax.

What happens to my HSA if I leave my employer?

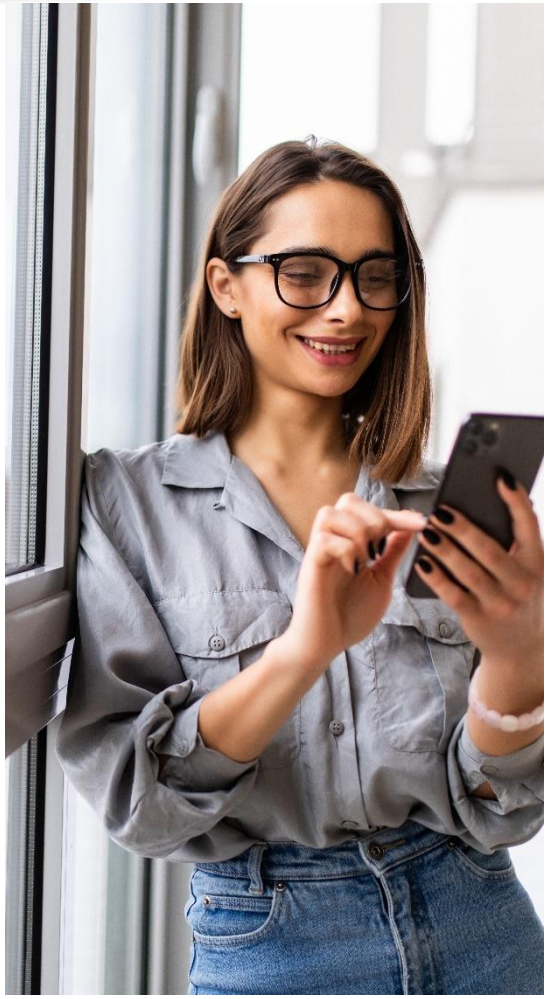
The HSA is yours to keep. If you continue to meet the eligibility criteria for funding the account, you can continue making contributions to your HSA. If you are no longer eligible to fund the account, you're still eligible to spend the money (tax-free) on qualified expenses, and you will be required to pay the monthly maintenance fee assessed by the HSA vendor and deducted from your account.

Can I use the money in my HSA to pay for my dependents' health care expenses?

You can use the money in your HSA to pay for the health care expenses belonging to your eligible spouse and/or dependent children - even if they are not covered as your dependents. Refer to Internal Revenue Code Section 152 to determine if your spouse and/or child is an eligible dependent.

Can couples establish a "joint" HSA and both make contributions, including "catch-up" contributions?

"Joint" HSAs are not permitted. Each spouse should consider establishing an HSA in his or her own name. This allows you to both make catch-up contributions when you are age 55 or older.



Flexible Spending Accounts (FSAs)

You have the opportunity to pay for out-of-pocket medical, dental, vision, and/or dependent care expenses with pre-tax dollars with a Flexible Spending Account (FSA) through Pinnacle.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income or FICA taxes on the portion of your paycheck you contribute to your FSA.

If you still have money in the account at the end of the Calendar Year (January 1, 2027), you will have a 3-month extension period to turn in additional eligible expenses from the prior Plan Year. You will be able to roll over up to $700 into the new calendar year. Any money remaining in the account when the extension period ends is forfeited; this is the "use-it or lose-it" rule.

FSA elections can only be changed during Open Enrollment or due to a Qualifying Event. Per IRS guidelines, FSA contributions must be elected every year.

Plan Year: January 1, 2027 – December 31, 2027

2027 Healthcare Flexible Spending Account Annual Contribution Limit: **$3,500**

2027 Dependent Care Annual Contribution Limit: **$7,500**

IMPORTANT NOTE: *If you will be funding an HSA, you cannot participate in the Health Care FSA.*



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Health Care FSA

A Health Care FSA is used to reimburse out-of-pocket health care expenses incurred by you, your spouse and/or your children; whether you cover them or not. Eligible expenses include deductibles, coinsurance, copays, etc. Your Health Care contributions are pre-loaded to a debit card; you have immediate access to the funds and will pay them back throughout the year via payroll deduction.

Dependent Care FSA

A Dependent Care FSA is used to reimburse work-related expenses while you or your spouse work, look for work or attend school full-time and are physically unable to care for your dependent. Eligible expenses cover care for children under 13 or dependents unable to care for themselves. This includes daycare, preschool, and before/after school programs. Funds are payroll deducted and are not pre-loaded onto a debit card.

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Transportation & Parking Spending Accounts (QTAs)

This is a pre-tax benefit that allows employees to set aside money for work-related commuting expenses. The funds are automatically deducted from your paycheck and can be accessed by using your Pinnacle debit card. An alternative is to submit receipts for reimbursement. You must accumulate the funds before using them to cover expenses.

Transit covers public transportation cost, such as, bus, train, subway, and vanpool fares. Parking covers parking expenses near your workplace or a location where you commute for public transit.

Plan Year: January 1, 2027 – December 31, 2027

2027 Transit Spending Account Monthly Contribution Limit: Up to **$350**

2027 Parking Spending Account Monthly Contribution Limit: Up to **$350**



IMPORTANT NOTE:

This benefit is only available to employees who live in **Illinois** or **Pennsylvania**.

LEARN MORE

What Are Commuter Benefits?

https://flimp.live/HubDeliverablesCommuter



Dental

Our dental plan benefits are provided through MetLife's PDP Network. The table below outlines how some of the most common services are paid at in-network and out-of-network providers and facilities. While you have the ability to see any dentist, you will pay less for care when you see an in-network dentist.

As a voluntary benefit, you are responsible for the cost of this coverage through payroll deduction.

To find a dental provider: visit https://providers.online.metlife.com/findDentist or call (800) 942-0854 to speak with a MetLife representative.

MetLife Dental Plans				
Benefit / Feature	**High Plan**		**Low Plan**	
	PDP Network	**Out-of-Network**	**PDP Network**	**Out-of-Network**
Deductible • Individual • Family	$50 $150		$50 $150	
Plan Year Maximum	$2,000		$1,000	
Preventive Services	Covered at 100%		Covered at 100%	
Basic Services You pay	0% AD	20% AD	20% AD	50% AD
Major Services You pay	40% AD	50% AD	70% AD	85% AD
Orthodontia Services (up to age 19)	Covered at 50%; deductible does not apply		Not covered	
Orthodontia Lifetime Maximum	$1,500		Not covered	

AD = After Deductible
Please refer to your plan documents for full details and exclusions.

VSP Vision Plan

Our vision plan benefits are provided through the VSP Vision Network. The table below outlines how some of the most common services are paid at in-network providers and facilities. You will pay less for care when you see an in-network physician. As a voluntary benefit, you are responsible for the cost of this coverage through payroll deduction.

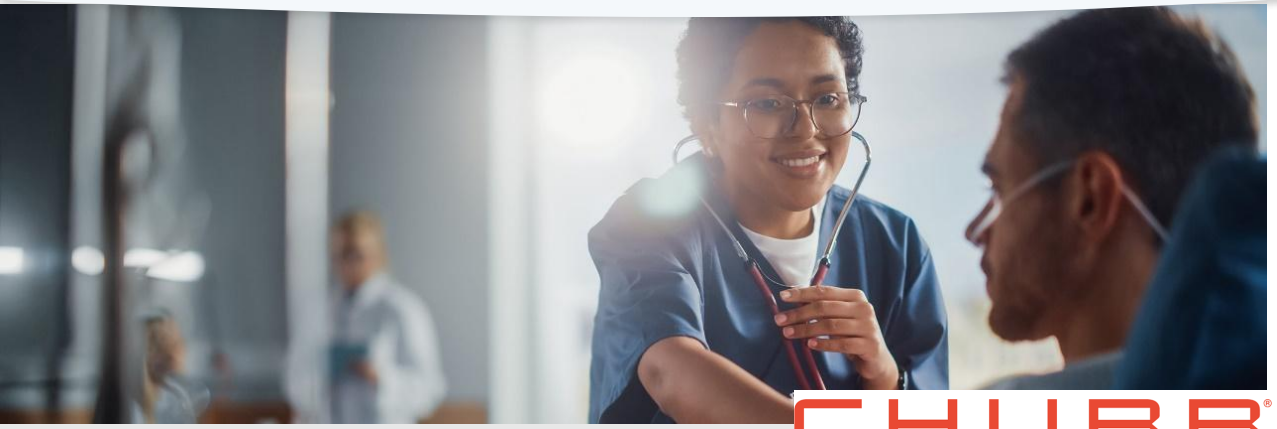


vsp VISION

VSP Vision Plan		
Benefits / Feature	**Base Plan**	**Buy-Up Plan**
Frequency		
Exam / Lenses / Contact Lenses	Once every 12 months	Once every 12 months
Frames	Once every 24 months	Once every 12 months
Eye Exam	$10 copay	$10 copay
Eyeglass Lenses		
•Single •Lined Bifocal •Lined Trifocal •Lined Lenticular	$25 copay for all listed lenses	$25 copay for all listed lenses
Frames	$150 allowance	$180 allowance + 20% discount on remaining balance
Contact Lenses *(In lieu of glasses)*	$130 allowance	$130 allowance
Supplemental Benefits		
VSP LightCare	Non-prescription blue light filtering glasses/sunglasses- Covered in full after copay (up to frame allowance)	Non-prescription blue light filtering glasses/sunglasses- Covered in full after copay (up to frame allowance)
VSP EasyOptions	N/A	$200 frame allowance, anti-reflective coating, photochromic lenses, premium progressive lenses, OR $200 contact lens allowance

Additional Benefits	
Extra Savings Contracted VSP Providers	•$70 Walmart/Costco frame allowance •Laser Vision Correction: Average 15% off retail price or 5% off promotional price. •Retinal Screening: no more than a $39 copay on routine retinal screening as an enhancement to a Well Vision Exam. •Glasses and Sunglasses. •Extra $20 to spend on featured frame brands. Go to vsp.com/offers for details. •20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam. •Hearing Aid Discounts through TruHearing.
Diabetic Eye Care Plus Program	Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.

To find a vision provider: visit www.vsp.com/eye-doctor or call (800) 877-7195 to speak with a VSP representative.



Hospital Indemnity Insurance

Everyone deserves protection against hospital bills

Hospital stays can be pricey, and often unexpected. Even the best medical plans can leave you with extra expenses to pay or services that aren't covered such as plan deductibles, copays, extra costs for out-of-network care, or non-covered services.

Many people aren't prepared to handle these extra costs, so having this extra financial support when the time comes may mean less worry for you and your family.

LEARN MORE

What is Hospital Indemnity Insurance?

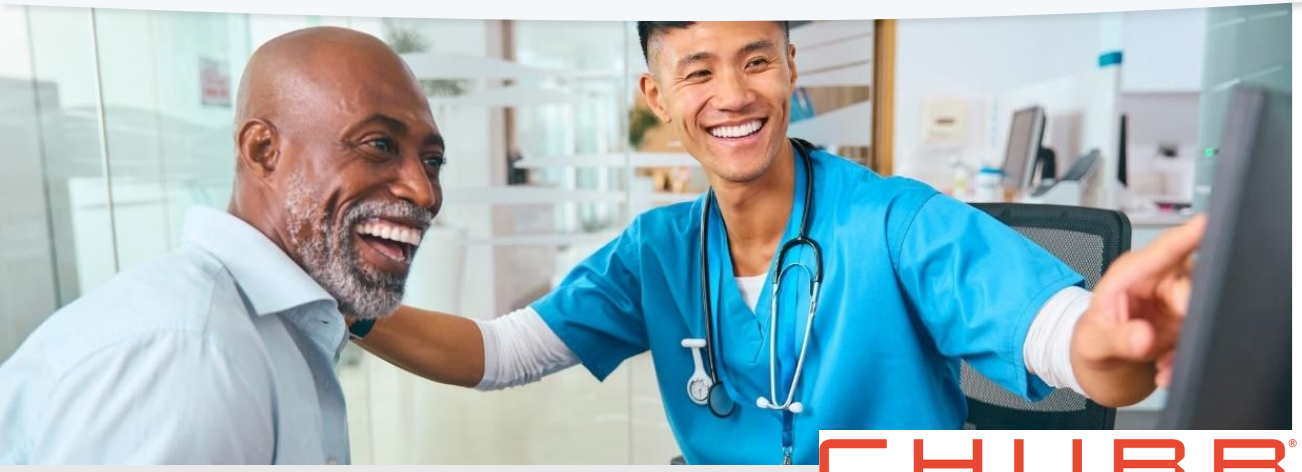
https://flimp.me/HubDeliverablesHospitalIndemnity

Value of Hospital Indemnity Insurance

- Cash benefit for unplanned or uninsured expenses resulting from a hospitalization due to sickness or injury
- Premiums are convenient and paid through payroll deduction
- Coverage is guaranteed with no medical questions asked
- There are no deductibles, no copayments and no network restrictions
- Benefits are portable, take it with you if you leave or change jobs

Benefits can help you pay for:

- Costs that are not covered by health plans
- Deductibles and copays left by major medical insurance
- Replacement of your income while receiving care or your spouse's income while they're by your side
- Out-of-network costs for alternative treatment
- Travel for care and treatment, or even a second opinion
- Contractor or handyman to make changes to your home after an illness, such as a wheelchair ramp



Group Critical Illness Insurance

Protection that may help ease the financial, mental, and emotional burden that comes with cancer

Cancer can affect anyone – and treatment can be costly. While cancer survival rates are on the rise, out-of-pocket costs pose a substantial economic burden to patients and their families. In fact, the average out-of-pocket cost for a person battling cancer is estimated to be $2,598 a month, and cancer patients are twice as likely to declare bankruptcy than healthy people. Even with the best medical plan, you can be left with unexpected costs. Deductibles, out-of-network treatments, home health care needs and travel are just some of the costs you could face if diagnosed with cancer, leaving you with reduced savings.

Age-based rates for this coverage can be found in Workday.

Value of Group Critical Illness with Cancer Coverage

- Cash benefits for a diagnosis of invasive and non-invasive cancers
- Affordable premiums paid through payroll deduction
- Coverage is guaranteed with no medical questions asked
- No restrictions on network or medical provider
- Benefits are portable, take it with you if you leave or change jobs

Benefits can help you pay for:

- Your medical plan's annual deductible
- Non-medical expenses resulting from treatment
- Alternative and experimental treatment
- Daily expenses like food and utilities
- Contractor fees for home modifications, such as a wheelchair ramp

LEARN MORE

What is Critical Illness Insurance?

https://flimp.me/HubDeliverablesCI

Important Coverage Notice: The Critical Illness plan with CHUBB pays based on date of diagnosis. This means if you were/are being tested for a diagnosis but not yet diagnosed until after your policy's effective date, the plan would pay the benefits.

Group Accident Insurance

Help protect your family from the out-of-pocket costs of an accident

CHUBB Employee Benefits' Accident insurance plan complements your group health insurance and covers unexpected expenses that result from all kinds of accidents, even sports-related and household ones.

CHUBB's simple-to-use, expense-based plan has no schedule of benefits, and eligible services related to the original accident are covered, even if they're incurred on different days or with different providers. Think of it as "one bucket" of money you could use to pay for deductibles and copays. It pays 100% of eligible services and supplies related to an accidental injury (unless covered by workers' compensation or similar law) up to the benefit limits.

LEARN MORE

What is Accident Insurance?

https://flimp.me/HubDeliverablesAccident



Value of Accident Insurance

- Pays a lump sum cash benefit for covered expenses due to accidental injuries
- Coverage is available for your spouse and children
- Pays in addition to other insurance
- Affordable premiums, conveniently payroll deducted
- Benefits are portable, take it with you if you leave or change jobs

How Can Accident Insurance Help?

Medical expenses:

- Copays
- Deductibles
- Other care you are financially responsible for under your medical plan

Non-medical expenses while recovering:

- Groceries
- Rent or mortgage
- Car payments
- Childcare

Voluntary Short-Term Disability			
% of Income Replaced	**Maximum Weekly Benefit**	**Benefit Waiting Period**	**Maximum Benefit Period**
60% of weekly earnings while meeting the definition of disability	$2,000 per week	7 days	13 weeks
Pre-existing Condition Limitation	Any condition that you receive medical attention for in the 6 months prior to your effective date of coverage that results in a claim during the first 12 months of coverage, would not be covered.		

Voluntary Long-Term Disability			
% of Income Replaced	**Maximum Monthly Benefit**	**Benefit Waiting Period**	**Maximum Benefit Period**
60% of monthly earnings while meeting the definition of disability	$5,000 per month	90 days	Up to Social Security Normal Retirement Age
Pre-existing Condition Limitation	Any condition that you receive medical attention for in the 3 months prior to your effective date of coverage that results in a claim during the first 12 months of coverage, would not be covered.		

Voluntary Short-Term and Long-Term Disability

We offer Short-Term Disability (STD) insurance and Long-Term Disability (LTD) insurance through New York Life. As voluntary benefits, you are responsible for paying the cost of this coverage through post-tax payroll deduction. Rates for these coverages are salary-based and can be found in Workday.

In the event you become disabled from a non-work-related injury or sickness, disability income benefits are provided as a source of income. You are not eligible to receive short-term disability benefits if you are receiving workers' compensation benefits.

Benefit amounts may be reduced by other income such as sick leave and state disability income.

Certain benefits might include active work requirements under which insurance coverage does not begin unless and until an employee is actively at work. Notwithstanding anything in the Benefit Guide to the contrary, all active work and/or active employment requirements applicable under a plan must be satisfied.

Voluntary Life and Accidental Death & Dismemberment

If you are a full-time eligible employee, Voluntary Life and AD&D is available for purchase through New York Life. When initially eligible at hire, you are guaranteed the insurance amount below without submitting any Evidence of Insurability (EOI) or answering health questions if you enroll within 30 days of initial eligibility date. Coverage above the guaranteed issue amount will be subject to EOI. It is your responsibility to complete and submit the required EOI forms within 30 days of the date you apply for coverage. If you elect Voluntary Life Insurance, your Voluntary AD&D benefit amount will be equal to your Voluntary Life Insurance election.

Coverage is available for you and your dependent(s). You must elect coverage for yourself before electing coverage for dependents. Rates for this coverage can be found in Workday.

Coverage	Benefit Amounts	Guarantee Issue Applies to newly eligible only
Employee	$10,000 up to a maximum of $200,000	$200,000
Spouse	$5,000 increments not to exceed 50% of employee benefit or $100,000	$50,000 Not to exceed 50% of employee benefit
Children up to age 26	$10,000	$10,000



Voluntary Life and AD&D Insurance benefits reduce by 33% at age 70 and 55% at age 75.

Certain benefits might include active work requirements under which insurance coverage does not begin unless and until an employee is actively at work. Notwithstanding anything in the Benefit Guide to the contrary, all active work and/or active employment requirements applicable under a plan must be satisfied.

Furthermore, insurance coverage for eligible dependents may be delayed if they are confined (at home, in a hospital, or in any other institution or facility) or disabled on the date insurance would otherwise begin, in accordance with the terms of the policy. Conversion and portability options are available, please reach out to Benefits for more information within 30 days of your exit.

Please refer to your plan documents for full details and exclusions.

Health and Wellbeing Resources

It's important to know what benefits you have when a question comes up. Whether it's finding free counseling or managing your finances, help is available through your Team Select Home Care health and well-being benefits as well as several national resources.

FindHelp.org

On www.findhelp.org, you can search for and connect to support for reduced cost help related to food, housing, goods, transit, health, money, care, education and legal needs based on your zip code.

988Lifeline.org

Need Immediate Help in a Crisis? Whether you're facing mental health struggles, emotional distress, alcohol or drug use concerns, or just need someone to talk to, our caring counselors are here for you. You are not alone. Dial 988 or visit the 988 Suicide & Crisis Lifeline online at www.988lifeline.org.

NAMI

NAMI is the National Alliance on Mental Illness, the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. If you or someone you know needs help (depression, anxiety, stress, PTSD, grief, domestic abuse, substance abuse, sexual assault, etc.), call the NAMI helpline at (800) 950-6264, email helpline@nami.org, or text 62640.



Confidential Employee Assistance Plan

The Employee Assistance Plan (EAP) can assist you during challenging times when you need a little extra help. Whether the issues are big or small, the EAP support program is available to help you and your family find a solution to restore peace of mind. All employees have free, confidential access to a program that offers support, guidance and resources.

- Child and senior care issues
- Relationships
- Workplace conflicts
- Stress, anxiety and depression
- Life improvement and personal achievement
- Legal and financial consultation
- 100% CONFIDENTIAL

You and your household members have access to three face-to-face sessions with a behavioral counselor. Access New York Life's EAP Program 24 hours a day, 7 days a week by calling (800) 344-9752 or by going online at www.guidanceresources.com, using Web ID: **NYLGBS**.

Available to all employees and members of their household, including children up to age 26.

Will Preparation and Planning

Help protect your and your family's financial future. This simple, online Will preparation tool helps you create a customized Will built around your state-specific laws. You can also create other legal documents, like a living Will and power of attorney document. It's easy, safe and secure. Get prepared at www.guidanceresources.com and use the Web ID: **NYLGBS**.

Identity Theft

Use our online tips and prevention kit to help stop identity theft before it happens. If someone steals your identity, we can help. Just call our personal case managers for step-by-step assistance. Real-time support is available anytime, from anywhere in the world. For help, please call (800) 344-9752 or visit www.guidanceresources.com and use the Web ID: **NYLGBS**.

Pet Insurance

As a Team Select employee, you're eligible for preferred pricing on coverage for your pets through ASPCA pet insurance. For more information, contact ASPCA at (877) 343-5314 or visit www.aspcapetinsurance.com/teamselect; enter discount code: **PET18TSHC**.

Coverage includes accidents, illnesses, cancer, hereditary conditions, behavioral issues and more. You can also add preventive care. This benefit is a discount program; you pay ASPCA directly.



Watch this short video to learn more about Voluntary Insurance Plans.



Work/Life Balance Programs

Whether your needs are big or small, New York Life Group Benefit Solutions is there for you with the Employee Assistance & Wellness Support program.

It can help you and your family find solutions and restore your peace of mind. This is just another example of how we are committed to putting benefits to work for people.

New York Life Group's suite of value-add resources includes:

GuidanceResources

When you need information quickly to help handle life's challenges, you can visit www.guidanceresources.com and use the Web ID: **NYLGBS** for resources and tools on topics such as health and wellness, legal regulations, family and relationships, work and education, money and investments, and home and auto. You will also have access to articles, podcasts, videos, slideshows, on-demand trainings and "Ask the Expert," which provides personal responses to your questions.

Well-being Coaching

Sometimes you may need help with personal challenges and physical issues that can be overwhelming. To help you achieve your goals, you will have access to a certified coach who will work with you, one on one, to address health and well-being issues such as burnout, time management and coping with stress. You have access to five sessions per year. All sessions are conducted telephonically.

FamilySource

Managing the everyday concerns of home, work and family can be difficult. To help resolve those concerns, you have access to family care service specialists that provide customized research, educational materials and prescreened referrals for childcare, adoption, elder care, education, and pet care.

Contacts

Benefit	Carrier	Phone	Website
Medical	UMR Group #: 76418543	(800) 826-9781	www.umr.com
	HealthSCOPE Group #76418544 HealthSCOPE (eligibility, claims/appeals, benefits) CARE (pre-certifications, case management) ClaimDoc (find a provider, member advocacy)	 (844) 600-0920 (888) 304-5103 (888) 330-7295	 www.healthscopebenefits.com https://portal.claim-doc.com/
Prescription	OptumRx Retail Pharmacy OptumRx Specialty Pharmacy	(877) 559-2955 (855) 427-4682	www.optumrx.com www.specialty.optumrx.com
Virtual Care	Teladoc	(800) 835-2362	www.teladochealth.com
Health Savings Account **Flexible Spending Accounts (FSAs)**	Pinnacle Bank	(888) 282-2605	www.pnfp.com
Dental	MetLife Group #: 235398	(800) 942-0854	www.metlife.com
Vision	VSP Group #: 30095638	(800) 877-7195	www.vsp.com
Life and Accidental Death and Dismemberment (AD&D), Disability	New York Life	(800) 362-4462	www.mynylgbs.com
Accident, Critical Illness, and Hospital Indemnity	CHUBB	(833) 542-2013	www.chubb.com/WorkplaceBenefitsClaims
Will Prep/Estate Planning and Identity Theft **Employee Assistance Plan (EAP)**	New York Life	(800) 344-9752	www.guidanceresources.com WEB ID: NYLGBS When registering, you will be asked to provide the first 5-characters of the company name. Please type "TEAM " (with a space included).
Pet Insurance	ASPCA	(877) 343-5314	www.aspcapetinsurance.com/teamselect
Benefit Questions	Benefits Resource Center (BRC) Monday – Friday 8am – 5pm EST & CST	(855) 874-0835	Email: BRCSouth@usi.com

Legal Notices

Employees can access these notices in Workday. You may also request a printed copy of the required notices by contacting Benefits.

IMPORTANT: Our benefit package is designed under "Section 125" of the IRS Code. This allows you to take advantage of federal and state laws by purchasing some of your benefits with pre-tax dollars. Under Section 125, any required contributions for medical, dental, vision, HSA, and FSA will be made with pre-tax dollars.

REMINDER: You may only change your pre-tax benefit elections once per year, during open enrollment, unless you experience a qualified life event.

Click or scan the QR code to access the Annual Legal Notices.



This Benefit Guide is designed to provide basic information regarding employee benefit plans and programs available to eligible employees of Team Select Home Care and its subsidiaries. It does not detail all of the terms, conditions, restrictions, and exclusions contained in the plan documents, carrier contracts or the Summary Plan Descriptions (SPDs) for the various benefit plans and programs. This overview merely summarizes the employee benefit plans and programs and does not create any contractual rights for any current or former employee or any other individual. The benefit provisions of the applicable plan document, contract or SPD will govern the determination of any individual's rights under any employee benefit plan or program. This document does not constitute a plan document or SPD as defined by the Employee Retirement Income Security Act of 1974, as amended (ERISA). Team Select Home Care and its subsidiaries reserve the right to amend or terminate any of its employee benefit plans and programs at any time and without notice or cause.