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2026 - 2027

EMPLOYEE BENEFITS GUIDE

ProTech Assigned Employees

PROTECH SERVICES GROUP

Your Guide to New Hire or Open Enrollment:

June 1, 2026 - May 31, 2027

Welcome!

ProTech Servicea Group offers a comprehensive benefits program designed to support you and your family. Our goal is to provide high-quality, affordable coverage that meets your needs.

This guide provides an overview of your benefit options and helpful information to assist you in choosing the coverage that's right for you. Please review it carefully and reach out with any questions during your enrollment period.

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This guide is only a summary of your benefits. For complete details, please refer to the official plan documents.

ELIGIBILITY & ENROLLMENT



Eligibility:

ProTech's benefits program is available to **full-time employees** working **30 or more hours per week**.

Benefits begin **on the first of the month following 30 days of employment.**

Eligible dependents include:

- Your legal spouse or domestic partner
- Children under age 26, regardless of student, dependency, or marital status
- Children age 26 or older who are fully dependent on you due to a mental or physical disability

Making Changes to Your Benefits:

You may enroll in or make changes to your benefits during your initial eligibility period or during the annual Open Enrollment period. Changes during the year are only allowed if you experience a qualifying life event.

Qualifying life events include:

- Marriage, divorce, or legal separation
- Birth, adoption, or placement of a child
- Change in dependent status
- Death of a dependent
- Change in employment or residence
- Change in spouse's benefits or employment

If you experience a qualifying life event, you must submit your change request within 30 days. For Medicaid or CHIP-related events, you have up to 60 days to submit your request.

When Coverage Ends:

Coverage ends on the **last day of the month** in which your employment ends.

Important Medicare Notice:

If you (and/or your dependents) have or become eligible for Medicare, you may have additional rights related to your prescription drug coverage. If you do not enroll in Medicare Part D when first eligible, you may pay a higher premium later.

Please refer to the Medicare Part D Creditable Coverage Notice on page 33 for more information.





Changes effective 06/01/26:

As an employee of **ProTech Services Group**, enjoying your work and making valuable contributions to business are equally vital. The health, satisfaction and security of you and your family are important, not only to your wellbeing, but ultimately, in terms of achieving the goals of our organization.

For the 2026 plan year, your benefits team has worked hard to offer a competitive, total rewards package that includes valuable and competitive benefits plans.

Each year, we research new plan designs and insurance companies to ensure that we are offering the best plans to our employees at the best rates available to us, and after careful consideration, we have determined that the group medical plans will be moving to **Cigna Healthcare**, dental and vision will move to **Delta Dental**, and ancillary lines will move to **Unum**.

You will now have 3 medical plans to choose from and we have included an option that is Health Savings Account (HSA) compatible for anyone who would like to utilize that benefit. You can also choose to contribute to an HSA through a paycheck deduction.

These programs reflect our commitment to keeping our staff healthy and secure. We understand that your situation is unique, which is why this is a benefits package that can be shaped and molded by you to fit your needs.



MEDICAL GLOSSARY

Allowed Amount:

The maximum amount your plan will pay for a covered service. If your provider charges more than this amount, you may be responsible for the difference.

Balance Billing:

When a provider bills you for the difference between their charge and the allowed amount. This typically applies to out-of-network providers. In-network providers cannot balance bill you for covered services.

Coinsurance:

The percentage of costs you pay for covered services after you meet your deductible. Your plan pays the remaining portion.

Copayment (Copay):

A fixed amount you pay for certain covered services, such as doctor visits or prescriptions.

Deductible:

The amount you must pay each year before your plan begins to pay for covered services.

Domestic Partnership:

A relationship between two individuals who meet specific criteria to qualify for benefits coverage. Coverage may be available for a domestic partner and their eligible dependents. Tax implications may apply if the partner is not recognized as a tax dependent under IRS rules.

In-Network:

Providers who have a contract with your insurance plan. Using in-network providers usually costs less.

Out-of-Network:

Providers who do not have a contract with your insurance plan. Using out-of-network providers typically costs more, and you may be responsible for charges above the allowed amount.

Out-of-Pocket Maximum:

The most you will pay for covered services in a plan year. Once you reach this limit, the plan pays 100% of eligible expenses for the rest of the year.

Prior Authorization:

Approval required by your health plan before certain services or prescriptions will be covered.

Your health has met its app.

Access your health plan anytime and just about anywhere you go.



Life can be busy and complicated. So we created a simple-to-use tool that can help make your life easier (and healthier) while you're on the go. **myCigna**® helps you personalize, organize and access your important plan information on your phone or tablet. Use the **myCigna** app to:*

- **View**, fax or email ID card information
- **Access** virtual care directly from your phone or tablet**
- **Manage** and track claims
- **Find** in-network doctors and compare cost and quality information
- **Review** your coverage
- **Track** your account balances and deductibles
- **Submit** receipts for reimbursement from your Cigna Healthcare℠ HRA and/or FSA
- **Order** your prescriptions from Express Scripts® Pharmacy, a Cigna Healthcare company, and get home delivery, the ability to view your order history online and more
- **Compare** prescription drug prices for retail and home delivery pharmacies***

Download the myCigna App for your mobile device. Disponible en español.

Scan the QR code with your mobile phone and download the app today.

GET IT ON Google Play

Download on the App Store

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cigna healthcare

* Actual myCigna features may vary by plan and individual security profile. The downloading and use of the myCigna App is subject to the terms and conditions of the app and the online stores from which it is downloaded. Standard mobile phone carrier and data usage charges apply.

** Cigna Healthcare provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs.

*** Prescription savings opportunities may not be available for some medications.

Product availability may vary by location and plan type and is subject to change. All group health insurance policies and health benefit plans contain exclusions and limitations. For costs and details of coverage, contact a Cigna Healthcare representative.

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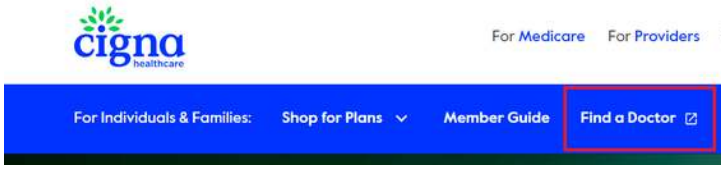
WELCOME TO CIGNA

Make the most of your plan by utilizing in-network providers

Steps to finding a Cigna OAP Network Provider

Through ProTech's group health plan, you have access to the Cigna network of doctors, hospitals, and facilities. Cigna is a national network with over 1 million healthcare professionals and more than 6,300 facilities, offering you a range of quality choices to help you stay healthy. With this access, you will be guaranteed lower copays and coinsurance when you receive care from an in-network provider versus one that is out-of-network.

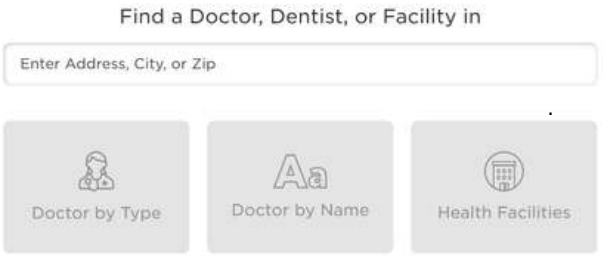
1 Visit www.cigna.com and click "Find a Doctor"



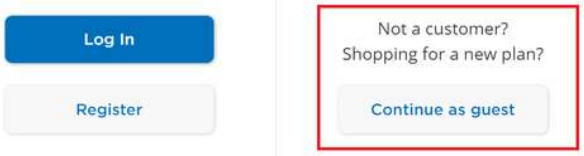
2 Select Employer or School



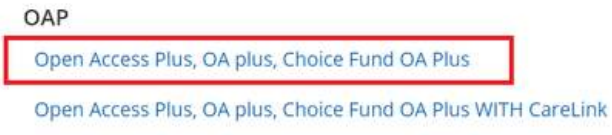
3 Enter zip code and search as you'd like



4 Continue as guest



5 Select Open Access Plus



PROTECH SERVICES GROUP

HEALTH CARE THAT'S THERE FOR YOU WHEN AND WHERE YOU NEED IT

Head-to-toe virtual care[1] from MDLIVE.®



It's not always easy to find time for the health care you need. After all, doctors' appointments traditionally involve time and travel. That can lead to putting off care until problems become more serious, and potentially more expensive.

That's why Cigna has partnered with MDLIVE to offer a comprehensive suite of convenient virtual care options — available by phone or video whenever it works for you. MDLIVE board-certified doctors, dermatologists, psychiatrists and licensed therapists have an average of over 10 years of experience, and provide personalized care for hundreds of medical and behavioral health needs.

Now you don't have to wait — or travel — for the care you need.

Connect with video or phone, whenever it's convenient for you. Best of all, virtual care from MDLIVE board-certified doctors is available to you and your eligible dependents as part of your health benefits.

MDLIVE®

Primary Care

Preventive care, routine care, and specialist referrals

- Preventive care checkups/wellness screenings available at no additional cost[2] to identify conditions early
- Routine care visits allow you to build a relationship with the same primary care provider (PCP) to help manage conditions
- Prescriptions available through home delivery or at local pharmacies, if appropriate
- Receive orders for biometrics, blood work and screenings at local facilities[3]

Urgent Care

On-demand care for minor medical conditions

- On-demand 24/7/365, including holidays
- Care for hundreds of minor medical conditions
- A convenient and affordable alternative to urgent care centers and the emergency room
- Prescriptions available, if appropriate

Behavioral Care

Talk therapy and psychiatry from the privacy of home

- Access to psychiatrists and therapists
- Schedule an appointment that works for you
- Option to select the same provider for every session
- Care for issues such as anxiety, stress, life changes, grief and depression

Dermatology[4]

Fast, customized care for skin, hair and nail conditions — no appointment required

- Board-certified dermatologists review pictures and symptoms; prescriptions available, if appropriate
- Care for common skin, hair and nail conditions including acne, eczema, psoriasis, rosacea, suspicious spots and more
- Diagnosis and customized treatment plan, usually within 24 hours

Cigna®

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Offered by: Cigna Health and Life Insurance Company or its affiliates.

3 easy steps to connect to care

Virtual care visits are convenient and easy.
To schedule an appointment:

Access MDLIVE by logging into myCigna.com and clicking on "Talk to a doctor." You can also call MDLIVE at 888.726.3171. (No phone calls for virtual dermatology.)

Select the type of care you need: medical care or counseling; cost will be displayed on both myCigna.com and MDLIVE

Follow the prompts for an on-demand urgent care visit, to make an appointment for primary or behavioral care, or to upload photos for dermatology care

Appointments are available via video or phone, whenever it's most convenient for you. Virtual dermatology does not require an appointment.



Visit myCigna.com to make an appointment for virtual care today.

Together, all the way.®

Cigna®

1. Cigna provides access to virtual care through national telehealth providers as part of your plan. This service is separate from your health plan's network and may not be available in all areas or under all plans. Referrals are not required. Video may not be available in all areas or with all providers. Refer to plan documents for complete description of virtual care services and costs. Virtual primary care through MDLIVE is only available for Cigna medical members aged 18 and older.
2. For customers who have a non-zero preventive care benefit, MDLIVE virtual wellness screenings will not cost $0 and will follow their preventive benefit.
3. Limited to labs contracted with MDLIVE for virtual wellness screenings.
4. Virtual dermatological visits through MDLIVE are completed via asynchronous messaging. Diagnoses requiring testing cannot be confirmed. Customers will be referred to seek in-person care. Treatment plans will be completed within a maximum of 3 business days, but usually within 24 hours.

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Healthy choices that really pay off

Start saving today with Cigna Healthy Rewards®*

When it comes to getting your money's worth, there's more to your Cigna plan than you might realize. **Get to know Cigna Healthy Rewards and discover discounts on trusted brands that support your goals for better overall health and well-being.**

With Healthy Rewards, you can save time and money on a wide variety of health products, wellness programs and other services, including:

- **Fitness and exercise****
- **Nutrition**
- **Hearing and vision care**

So, don't wait. Make the most of your benefits. After all, Cigna is here to help protect your health — and your budget. Discover Healthy Rewards today.

Ready. Set. Save!

To get started with Healthy Rewards now, scan the code with your smartphone.

Or visit cigna.com/discoverhealthyrewards

*Healthy Rewards is a discount program. Some Healthy Rewards programs are not available in all states and programs may be discontinued at any time. If your health plan includes coverage for any of these services, this program is in addition to, not instead of, your plan benefits. Healthy Rewards programs are separate from your plan benefits. A discount program is NOT insurance, and you must pay the entire discounted charge. All goods, services and discounts offered through Healthy Rewards are provided by third parties who are solely responsible for their products, services and discounts.

**Fitness membership and devices, along with virtual workouts, can only be accessed by login into myCigna.com and navigating to Healthy Rewards Discount Program.

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MEDICAL BENEFIT SUMMARY

Coverage Level:	$6,000 Deductible HSA	$0 Deductible	$3,000 Deductible
Employee Only	$85.48	$113.99	$116.40
Employee + Spouse	$206.86	$275.84	$281.67
Employee + Child(ren)	$181.39	$241.88	$246.99
Employee + Family	$285.93	$381.28	$389.34

The rates shown are per paycheck deductions based on 24 pay periods and your employer's monthly contribution. Please ask your benefit manager for more details.

Please refer to the carrier policy for a complete benefit overview.

Benefits: OAP Network	$6,000 HSA	$0	$3,000
Individual / Family Deductible	$6,000 / $12,000	$0 / $0	$3,000 / $6,000
Coinsurance	80%	100%	80%
Individual / Family Maximum Out-of-Pocket	$8,000 / $16,000	$7,500 / $15,000	$6,000 / $12,000
Telehealth	Deductible then Coinsurance	Covered at 100%	Covered at 100%
Office Visits	Deductible then Coinsurance	Primary Care: $35 Copay Specialist: $60 Copay	Primary Care: $35 Copay Specialist: $55 Copay
Inpatient Services	20% After Deductible	$2,000 Copay/Admission	20% After Deductible
Outpatient Services	20% After Deductible	$1,000 Copay	20% After Deductible
ER Services	20% After Deductible	$750 Copay	$500 Copay
Urgent Care	20% After Deductible	$60 Copay	$55 Copay
Mental Health	20% After Deductible	Inpatient: $2,000 Copay Outpatient: $35 Copay	Inpatient: 20% After Deductible Outpatient: $35 Copay
Prescription Drug Coverage	20% After Deductible	Tier 1: $20 Copay Tier 2: $50 Copay Tier 3: $100 Copay Tier 4: $250 Copay	Tier 1: $10 Copay Tier 2: $35 Copay Tier 3: $50 Copay Tier 4: $150 Copay

Boring helps you cover healthcare expenses — now and in the future.

PNC BeneFit Plus Health Savings Account



Discover a brilliant way to take control of your healthcare spending and save for qualified medical expenses on a tax-advantaged basis.[1]

Health Savings Account (HSA)

- Enjoy tax advantages on contributions, earnings and withdrawals for qualified medical expenses[1,2]
- Your account and all contributions stay with you, no matter where life or work takes you
- Help build financial security with long-term savings as unused funds roll over year to year

Managing Your HSA Is Easy

- Simple steps to activate your account in your welcome email
- Manage your account via the consumer portal and mobile app
- Flexible contributions options through payroll deductions, online transfers or mail
- Diversified investment opportunities available upon reaching the minimum account balance[3,4]
- Convenient methods to pay for or reimburse yourself for qualified medical expenses[1] include debit card, mobile wallet or online bill pay
- Link your bank account to make contributions or reimburse yourself

Learn More Today

pnc.com/benefitplushsainfo

PNC BeneFit Plus Consumer Services

844-356-9993

Monday–Friday
8 a.m. to 10 p.m. ET

1 To view a partial list of qualified medical expenses, see IRS Publication 502 available at http://www.irs.gov/pub/irs-pdf/p502.pdf

2 Contributions are tax-deductible on your federal tax return. Some states do not recognize HSA contributions or earnings as a deduction. Your own HSA contributions are either pre-tax (if made by payroll deduction) or tax-deductible. For more information, see IRS Publication 969.

3 PNC does not provide legal, tax or accounting advice. Consult your tax advisor about tax benefits applicable to Health Savings Accounts.

4 Shares of mutual funds are not deposits or obligations or guaranteed or endorsed by any bank, nor are they federally insured or otherwise supported by the Federal Deposit Insurance Corporation or other government agency. Investments in mutual funds may lose value, including possible loss of principal. Please read the prospectus carefully before you invest.

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A supported mobile device is needed to use mobile banking. Standard message and data rates may apply.

Investments: Not FDIC Insured. Not Bank Guaranteed. Not A Deposit. Not Insured By Any Federal Government Agency. May Lose Value.

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DELTA DENTAL®

DENTAL PLAN

Why Choose Us?

As a client of **Delta Dental of Tennessee**, *ProTech Services Group* employees will have access to the nation's largest dental networks: Delta Dental PPO and Delta Dental Premier. With 4 out of 5 dentists participating nationwide, these two networks provide superior access to care as well as reduced fees through our agreements with participating dentists.

Lower claims costs means lower rates! Plus, using in-network dentists means you cannot be balance billed - giving you added savings.

You could even opt to visit nonparticipating dentists, but may be balance billed and have to pay more.

DEDUCTIBLE

Applies to Coverage B and C Only:
Individual: $50 / Family: $150

BENEFIT MAXIMUMS

Applies to A, B and C: **$2,000 / Year**
Orthodontia: Not Covered

	PPO	Premier	Non-participating
A: Diagnostic & Preventative			
Exams, cleanings, fluoride, space maintainers	100%	100%	100%
Sealants, radiographs, periodontal maintenance, brush biopsy	100%	100%	100%
B: Basic Services			
Emergency palliative treatment, minor restorative, endodontics, periodontics, oral surgery, other basic services, adjustments & repairs	90%	80%	80%
C: Major Services			
Major restorative, prosthodontics, reline & rebases	60%	50%	50%

More Options, Lower Costs

The power of two networks

When it comes to pearly whites, everyone wants to save a little green. Delta Dental offers two provider networks to help cover your smile while keeping costs as low as possible. The Delta Dental PPOSM Network provides maximum cost savings, while the Delta Dental Premier® Network—which is the largest network in Tennessee—provides a safety net for additional access when you need it.

Delta Dental PPO	→ More than 269,000 office locations nationwide → Average savings of 30% on submitted fee → No balance billing and no paperwork to file
Delta Dental Premier	→ More than 339,000 office locations nationwide → Average savings of 18% on submitted fee → No balance billing and no paperwork to file
Out-of-Network	→ May need to file your own claims → May be balance billed → No discounts

Save when you see a network dentist

*Example: You have met your deductible and visit a dentist for a Basic Service, which your plan covers at 80%. The estimated charge for the service is $120.^*

Set by Delta Dental

NETWORK	ESTIMATED CHARGE	MAXIMUM ALLOWED FEES	AMOUNT DELTA DENTAL PAYS	AMOUNT YOU PAY
Delta Dental PPO	$120	$84 x 80% =	$67.20	$16.80
Delta Dental Premier	$120	$113 x 80% =	$90.40	$22.60
Out-of-Network Dentist	$120	$100 x 80% =	$80	$40.00

Best Deal!

^This example is an estimate. Fees and reimbursments can vary by state.

20% + $20 balance billing

What is balance billing?

Our network dentists agree to accept maximums on what they charge for each service. An out-of-network dentist hasn't agreed to those maximums. When you visit a Delta Dental network dentist, you won't have to pay the difference between what the dentist charges and what Delta Dental will pay, *aka balance billing*.

As you can see, it pays to visit Delta Dental network dentists - especially those in our PPO network. To find a Delta Dental network dentist near you:

→ Visit **DeltaDentalTN.com**, click on "FIND A DENTIST," and then choose your network.
→ Download our free **Delta Dental mobile app**, available for Apple and Android devices.
→ Call toll-free **(800) 223-3104.**



Looking After You

Your **DeltaVision 130** plan in association with VSP provides the right mix of independent and retail providers — including popular national chains and regional favorites, as well as online options. Members can pick an in-network eye doctor with the brands, hours and location to fit. Sprinkle in members-only savings and helpful tools, and you've got a winning experience designed to help you see life to the fullest.

Provider Network: Choice

Your Benefits

Exams

Exam with Dilation as Necessary: **$10 Copay**
Contact Lens Exam:
Up to $60 Copay

Materials

$25 Copay, Plus Any Additional Copays or Fees for Add-On Options

Frequencies

Exams: **12 Months**
Frames: **24 Months**
Lenses: **12 Months**
Contact Lenses (*In Lieu of Glasses*): **12 Months**

Frames

- Retail Frame Allowance: $130
- Costco Frame Allowance: $70
- Featured Frame Allowance: $150
- Additional Pair of Glasses or Sunglasses: 20% Off

Lenses

- Covered Lens Options: Polycarbonate for Children, Standard Progressive Lenses
- Lens Enhancements: 20-25% Savings

Contacts

- Contact Lens Fit and Evaluation: Up to a $60 Copay
- Elective Contact Lens Allowance: $130

Other

- Value Added Programs: Primary Eyecare, TruHearing Discounts, Eye Health Management and Diabetic Exam Reminder Letters.
- Laser Vision Correction Discount: Average 15-20% Off
- Out of Network Allowances Available

Stay informed about your DeltaVision® benefits on vsp.com

Learn more about your vision benefits and access claims on vsp.com.

It's easy to create an account.

Just follow these steps:

1. Visit **vsp.com**
2. Click CREATE AN ACCOUNT at the top of the page.
3. Enter the last 4 digits of the primary member's SSN or Member ID Number.
4. Continue to complete all required fields.
5. Click CREATE MY ACCOUNT to complete process.

It's that simple! Once you create an account, you can review your benefit information, access personalized eligibility and plan coverage details, and print a Member Vision Card.

How to find a VSP network provider

Search under the VSP Choice Network for any DeltaVision plan:



Online

Visit vsp.com and request the information by city, state, zip code, provider's name or specialty.



Mobile App

Download the mobile app for Apple or Android. To download, visit the App Store (Apple) or Google Play (Android) and search for VSP.



Customer Service

Call VSP customer service representatives at 800-877-7195 and ask if your provider is participating in the VSP Choice Network.



Provider Office

Call your provider's office and ask if he/she participates in the VSP Choice network.

It is important that you verify a provider's status each time you seek care as a provider contract may change. It is your responsibility to verify that the provider you use is contracted with the Delta Dental or VSP network associated with the plan that you have chosen. If you receive treatment from a non-network provider, your benefits may be paid at a lower percentage or you may be balance billed.

EMPLOYEE DEDUCTIONS

PROTECH ASSIGNED EMPLOYEES

ProTech Services Group *contributes a majority percentage of your benefit costs each month. The rates shown below are employee deductions* ***per paycheck*** *(over 24 pay periods) after your employer's monthly contribution. Please ask your benefit manager for more details.*

PAYCHECK DEDUCTIONS: MEDICAL			
COVERAGE LEVEL:	**$6,000** DEDUCTIBLE HSA COMPATIBLE	**$0** DEDUCTIBLE	**$3,000** DEDUCTIBLE
NO COVERAGE	**$0.00**	**$0.00**	**$0.00**
EMPLOYEE ONLY	**$85.48**	**$113.99**	**$116.40**
EMPLOYEE + SPOUSE	**$206.86**	**$275.84**	**$281.67**
EMPLOYEE + CHILD(REN)	**$181.39**	**$241.88**	**$246.99**
EMPLOYEE + FAMILY	**$285.93**	**$381.28**	**$389.34**

PAYCHECK DEDUCTIONS: DENTAL & VISION		
COVERAGE LEVEL:	DELTA **DENTAL**	DELTA **VISION**
NO COVERAGE	**$0.00**	**$0.00**
EMPLOYEE ONLY	**$4.52**	**$1.04**
EMPLOYEE + 1 DEPENDENT	**$21.71**	**$3.55**
EMPLOYEE + 2 OR MORE DEPENDENTS	**$45.51**	**$5.88**

Please Note*: Your plan enrollment and administration is managed electronically through your benefits enrollment team and Employee Navigator. To make your 2026 plan year elections, see your full benefit summary and costs, or manage your plans and/or dependents, please use the instructions provided by your benefits team.*

PROTECH SERVICES GROUP INC.

Employer-paid and Voluntary Term Life Insurance with Accidental Death and Dismemberment

How does it work?

Term Life Insurance allows you to keep coverage for a set amount of time, or term. If you die during that term, the money can help your family pay for basic living expenses, final arrangements, tuition and more. Accidental Death and Dismemberment (AD&D) Insurance pays a benefit if you survive an accident but have certain serious injuries. It can pay an additional amount if you die from a covered accident.

Your employer is providing you with the following amount of Term Life and AD&D coverage. You are eligible for coverage if you are working a minimum of 30 hours per week.

Employee	A flat $50,000 of coverage. You can receive $50,000 of coverage without answering medical questions.

You can purchase the following Voluntary Term Life and AD&D coverage for you and your family during this enrollment. You are eligible for coverage if you are working a minimum of 30 hours per week.

You may purchase AD&D at a different amount from Term Life or purchase AD&D without the Term Life coverage.

Employee	A maximum of the lesser of 5 times your annual earnings or $500,000, in $10,000 increments. The minimum purchase amount is $10,000. You can purchase up to $100,000 of Life coverage without answering medical questions.
Spouse	A maximum of $500,000 in $5,000 increments. Your spouse can get $25,000 of coverage without medical underwriting. You must be insured under the plan in order to elect coverage for your spouse.
Child	Live birth to 14 days is $1,000 14 days to 6 months is $1,000 6 months and older is $10,000 in $2,000 increments Dependent children are eligible up to age 26. You must be insured under the plan in order to purchase coverage for your children.

Accelerated Death Benefit

If you are diagnosed with a terminal illness with less than 12 months to live, you can request 50% of your life insurance benefit (up to $750,000) while you are still living. This amount will be taken out of the death benefit. **These benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements, and may be taxable.** You should seek assistance from a personal tax advisor prior to requesting an accelerated payment of death benefits.

Portability

You may be able to keep coverage if you leave the company, retire or change the number of hours you work. Employees or dependents cannot port coverage if they are confined to a hospital or home at the time of application and/or age 70 or older at time of application. State restrictions may apply.

Life Planning and Financial Resources

Provides expert financial and legal counseling as well as planning to the beneficiary of a deceased insured employee or a terminally ill employee or spouse.

How much voluntary coverage can I get?

Calculate your costs

1. Enter the coverage amount you want.
2. Divide by the amount shown.
3. Multiply by the rate. Use the rate table (at right) to find the rate based on age.
   (Choose the age you will be when your coverage becomes effective on 06/01/2026.)
   (To determine your spouse rate, choose the age the spouse will be when coverage becomes effective on on 06/01/2026.)
4. Enter your cost.

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

Employee monthly rate		Spouse monthly rate	Child monthly rate
Age	Per $1,000 of coverage	Per $1,000 of coverage	$0.300 per $1,000 of coverage
	Cost	Cost	
15-24	$0.049	$0.049	
25-29	$0.056	$0.056	
30-34	$0.080	$0.080	
35-39	$0.112	$0.112	
40-44	$0.162	$0.162	
45-49	$0.256	$0.256	
50-54	$0.361	$0.361	
55-59	$0.557	$0.557	
60-64	$0.708	$0.708	
65-69	$0.868	$0.868	
70-74	$1.590	$1.590	
75+	$5.620	$5.620	

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

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

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

Billed amount may vary slightly.

PROTECH SERVICES GROUP INC.

Long Term Disability Insurance



How does it work?

This employer-paid coverage provides a monthly benefit if you have a covered illness or injury and you can't work for a few months — or even longer. You're generally considered disabled if you're unable to do important parts of your job — and your income suffers as a result.

Why is this coverage so valuable?

Your employer is paying the cost of this coverage. You can use the benefits however you choose. It can help you pay for your rent or mortgage, groceries, out-of-pocket medical expenses and more.

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week. Cover 60% of your monthly income, up to a maximum payment of $7,500. *See the Legal Disclosures for more information.

The monthly benefit may be reduced or offset by other sources of income. The IRS may require you to pay taxes on certain benefit payments. See your tax advisor for details.

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

Elimination period (EP)

Your elimination period is 180 days. This is the number of days that must pass after a covered accident or illness before you can begin to receive benefits.

Benefit duration (BD)

This is the maximum length of time you can receive benefits while you're disabled. You can receive benefits up to the Social Security (SS) normal retirement age. If you become disabled after your normal retirement age, check with your employer for the maximum length of time applicable to you.

Full-time Employees

What else is included?

Work-life balance employee assistance program

Get access to professional help for a range of personal and work-related issues, including counselor referrals, financial planning and legal support.

Worldwide emergency travel assistance

One phone call gets you and your family immediate help anywhere in the world, as long as you're traveling 100 or more miles from home. However, a spouse traveling on business for his or her employer is not covered.

Survivor benefit

If you die while you've been disabled and receiving benefits for at least 180 days, your family could get a benefit equal to 3 months of your gross disability payment.

Help, when you need it most

With your Employee Assistance Program and work-life balance services, confidential assistance is as close as your phone or computer.



Employee Assistance Program (EAP)

Your EAP is designed to help you lead a happier and more productive life at home and at work. Call for confidential access to a Licensed Professional Counselor* who can help you.

A Licensed Professional Counselor can help you with:

- Stress, depression, anxiety
- Relationship issues, divorce
- Anger, grief, loss
- Job stress, work conflicts
- Family, parenting problems
- And more

Work-life balance

You can also reach out to a specialist for help with balancing work and life issues. Just call and one of our work-life Specialists can answer your questions and help you find resources in your community.

Ask our work-life Specialists about:

- Child care
- Elder care
- Financial services, debt management, credit report issues
- Identity theft
- Legal questions**
- Even reducing your medical/dental bills
- And more

Who is covered?

EAP services are available to all eligible partners and employees, their spouses or domestic partners, dependent children, parents and parents-in-law.

Always by your side

- Expert support 24/7
- Convenient website
- Short-term help
- Referrals for additional care
- Monthly webinars
- Medical Bill Saver® — helps you save on medical bills

Help is easy to access:

Phone support: 1-800-854-1446

Online support: unum.com/lifebalance

In-person: You can get up to three visits available at no additional cost to you with a Licensed Professional Counselor. Your counselor may refer you to resources in your community for ongoing support.

Better benefits at work.™

unum.com

*The counselors must abide by federal regulations regarding duty to warn of harm to self or others. In these instances, the consultant may be mandated to report a situation to the appropriate authority.

**State mandated limitations apply for work-life balance employee assistance program services in WA.

Work-life balance employee assistance programs may not be available in New York. Other state-specific restrictions may apply based on the product offering.

The Employee Assistance Program and Work/Life Balance services, provided by HealthAdvocate, are available with select Unum insurance offerings. Terms and availability of service are subject to change. Service provider does not provide legal advice; please consult your attorney for guidance. Services are not valid after coverage terminates. Please contact your Unum representative for details.

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PROTECH SERVICES GROUP INC.

Short Term Disability Insurance



How does it work?

If a covered illness or injury keeps you from working, Short Term Disability Insurance replaces part of your income while you recover. As long as you remain disabled, you can receive payments for up to 25 weeks.

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

Why is this coverage so valuable?

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

How much coverage can I get?

You*	You are eligible for coverage if you are an active employee in the United States working a minimum of 30 hours per week. Cover 60% of your weekly income, up to a maximum benefit of $1,500 per week. The weekly benefit may be reduced or offset by other sources of income. *See the Legal Disclosures for more information.

Full-time Employees

What else is included?

Cesarean section benefit

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

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

This plan does not cover pre-existing conditions. See the disclosure section to learn more.

Elimination period (EP)

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

Your benefits would begin after you become disabled for 7 days.

Benefit duration (BD)

The maximum number of weeks you can receive benefits while you're disabled. You have a 25 week benefit duration.

Disability worksheet

1 Calculate your weekly disability benefit.

$_____	÷ 52 =	$_____	x	60%	=	$_____
Your annual earnings		Your weekly earnings		(Max % of income covered)		Max weekly benefit available (if the amount exceeds the plan max of $1,500, enter $1,500.

2 Calculate your cost per paycheck.

$_____	÷ 10 =	$_____	x	$_____	=	$_____	x	12 =	$_____	÷	12	=	$_____
Your weekly benefit amount				Your rate		Your monthly cost			Your annual cost		Number of paychecks per year		Your cost per paycheck

Age	Rates
15-24	$0.097
25-29	$0.223
30-34	$0.307
35-39	$0.249
40-44	$0.184
45-49	$0.207
50-54	$0.280
55-59	$0.349
60-64	$0.481
65+	$0.582

PROTECH SERVICES GROUP INC.

Group Accident Insurance



How does it work?

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

Why is this coverage so valuable?

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

Who can get coverage?

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

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

What's included?

Be Well Benefit

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

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

Organized Sports Benefit

Each family member that has Accident coverage is eligible for a 10% increase in payable benefits within the Injury and Treatment schedule of benefit categories. See disclosures and schedule of benefits for more information.

Personal Safety Benefit

Every year, each family member who has Accident coverage can also receive $50 for completing a covered safety program. This benefit is available in the Treatment category. See disclosures and schedule of benefits for more information.

How much does it cost?

Your monthly premium	
You	$9.31
You and your spouse	$17.26
You and your children	$24.17
Family	$32.12

SCHEDULE OF BENEFITS

Hospitalization

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

Injury

Burns	
2nd Degree Burns - At least 5%, but less than 20% of skin surface	$500
2nd Degree Burns - 20% or greater of skin surface	$1,000
3rd Degree Burns - Less than 5% of skin surface	$2,000
3rd Degree Burns - At least 5%, but less than 20% of skin surface	$5,000
3rd Degree Burns - 20% or greater of skin surface	$10,000
Concussion	
Concussion	$200
Connective Tissue Damage	
One Connective Tissue (tendon, ligament, rotator cuff, muscle)	$90
Two or more Connective Tissues (tendon, ligament, rotator cuff, muscle)	$150
Dislocations	
Ankle bone or bones of the foot (other than toes)	$1,650
Collarbone (acromioclavicular and separation)	$325
Collarbone (sternoclavicular)	$825
Finger or Toe (Digit)	$150
Hand (other than Fingers)	$500
Elbow joint	$500
Wrist joint	$500
Shoulder	$500
Hip joint	$3,375
Knee joint (other than patella)	$1,650
Kneecap (patella)	$500
Lower Jaw	$500
Incomplete Dislocation - Payable as a % of the applicable Dislocations benefit	25%
Eye Injury	
Eye Injury	$200
Fractures	
Ankle (lower tibia or fibula)	$450
Foot or Heel (other than Toes)	$450
Bones of the Face or Nose (other than Lower Jaw, Mandible or Upper Jaw, Maxilla)	$675
Collarbone (clavicle, sternum) or Shoulder Blade (scapula)	$450

Injury

Finger or Toe (Digit)	$225
Forearm (olecranon, radius, or ulna), Hand, or Wrist (other than Fingers)	$450
Hip or Thigh (femur)	$3,375
Kneecap (patella)	$450
Leg (mid to upper tibia or fibula)	$1,350
Lower Jaw, Mandible (other than alveolar process)	$450
Pelvis	$1,350
Rib	$450
Tailbone (coccyx), Sacrum	$450
Vertebral Processes	$450
Skull (except bones of Face or Nose), Depressed	$4,500
Skull (except bones of Face or Nose), Non-depressed	$2,250
Upper Arm between Elbow and Shoulder (humerus)	$675
Upper Jaw, Maxilla (other than alveolar process)	$675
Vertebrae, body of (other than Vertebral Processes)	$1,350
Chip Fracture - Payable as a % of the applicable Fractures benefit	25%
Same bone maximum incurred per accident	1 Fracture
Maximum payable multiplier for multiple bones	2 Times
Internal Injuries	
Internal Injuries	$200
Lacerations	
No Repair	$50
Repair Less than 2 inches	$150
Repair At least 2 inches but less than 6 inches	$300
Repair 6 inches or greater	$600
Loss of a Digit	
One Digit (other than a Thumb or Big Toe)	$750
One Digit (a Thumb or Big Toe)	$1,125
Two or more Digits	$1,500
Knee Cartilage	
Knee Cartilage (Meniscus) Injury	$150
Ruptured or Herniated Disc	
One Disc	$150
Two or more Discs	$250
Other	
Injury due to felony & sexual assault	$150
Organized Sports	10%

Recovery

At-Home Care	$100

Recovery

Physician Follow-Up Visits	$75
Physician Follow-Up Maximum Visits	2 Visits
Prescription Drug	$25
Prescription Benefit Incidence per covered accident	1 Per Insured
Rehabilitation or Subacute Rehabilitation Unit	$100
Behavior Health Therapy	$20
Behavior Health Therapy visits	15 Days
Therapy Services (chiro, speech, PT, occ, acupuncture/alternative)	$20
Therapy Services Maximum Days	15 Days

Surgery

Dislocations	
Dislocation, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Anesthesia	
Epidural or Regional Anesthesia	$100
General Anesthesia	$250
Connective Tissue	
Exploratory without Repair	$100
Repair for One Connective Tissue	$800
Repair for Two or more Connective Tissues	$1,200
Eye Surgery	
Eye Surgery, Requiring Anesthesia	$300
Fractures	
Fractures, Surgical Repair - Payable as a % of the applicable Injury benefit	100%
Surgical Repair same bone maximum incurred per accident	1 Fracture
Surgical Repair same bone maximum payable multiplier for multiple bones	2 Times
General Surgery	
Abdominal, Thoracic, or Cranial	$1,500
Exploratory	$150
Incidence per covered accident	1 Per Insured
Hernia Surgery	
Hernia Surgery	$150
Knee Cartilage	
Knee Cartilage (Meniscus) Exploratory without Repair	$150
Knee Cartilage (Meniscus) with Repair	$750
Outpatient Surgical Facility	
Outpatient Surgical Facility	$300
Ruptured or Herniated Disc Surgery	
Exploratory without Repair	$125
One Disc	$675

Surgery

Two or more Discs	$1,000

Treatment

Organized Sports	10%
Ambulance	
Air	$1,000
Ground	$300
Durable Medical Equipment	
Tier 1 (arm sling, cane, medical ring cushion)	$50
Tier 2 (bedside commode, cold therapy system, crutches)	$100
Tier 3 (back brace, body jacket, continuous passive movement, electric scooter)	$200
Emergency Dental Repair	
Dental Crown	$350
Dental Extraction	$115
Filling or Chip Repair	$90
Imaging	
Tier 1 - X-rays or Ultrasound	$50
Tier 2 - Bone Scan, CAT, CT, EEG, MR, MRA, or MRI	$200
Medical Imaging Incidence allowance covered accident per Tier	1 Per Insured Per Tier
Lodging	
Lodging (per night)	$150
Prosthetic Device	
One Device or Limb	$750
Two or more Devices or Limbs	$1,500
Skin Grafts	
For Burns - Payable as a % of the applicable Burn benefit	50%
Not Burns - Less than 20% of skin surface	$250
Not Burns - 20% or greater of skin surface	$500
Treatment	
Emergency Room Treatment	$100
Injections to Prevent or Limit Infection (tetanus, rabies, antivenom, immune globulin)	$50
Pain Management Injections (epidural, cortisone, steroid)	$100
Transfusions	$400
Transportation (per trip)	$100
Family Care	$50
Pet Boarding (per day)	$30
Treatment in a Physician's Office or Urgent Care Facility (initial)	$75
Personal Safety	$50

PROTECH SERVICES GROUP INC.

FULL-TIME EMPLOYEES

Group Critical Illness Insurance



How does it work?

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

Why should I buy coverage now?

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

Be Well Benefit

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

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

Who can get coverage?

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

Why is this coverage so valuable?

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

What's covered?

Critical Illnesses

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

Cancer conditions

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

Progressive diseases

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

Supplemental conditions

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

Paid at 25%:

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

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

Benefits may be subject to a pre-existing condition provision

Monthly costs		
Age	Employee coverage: $10,000 Spouse coverage: $5,000 Be Well benefit: $50	
	Employee	Spouse
under 25	$4.10	$2.90
25 - 29	$4.80	$3.25
30 - 34	$5.70	$3.70
35 - 39	$6.90	$4.30
40 - 44	$9.00	$5.35
45 - 49	$12.70	$7.20
50 - 54	$17.80	$9.75
55 - 59	$24.00	$12.85
60 - 64	$40.70	$21.20
65 - 69	$54.70	$28.20
70 - 74	$74.30	$38.00
75 - 79	$101.30	$51.50
80 - 84	$136.30	$69.00
85+	$199.10	$100.40

Monthly costs		
Age	Employee coverage: $20,000 Spouse coverage: $10,000 Be Well benefit: $75	
	Employee	Spouse
under 25	$8.20	$5.80
25 - 29	$9.60	$6.50
30 - 34	$11.40	$7.40
35 - 39	$13.80	$8.60
40 - 44	$18.00	$10.70
45 - 49	$25.40	$14.40
50 - 54	$35.60	$19.50
55 - 59	$48.00	$25.70
60 - 64	$81.40	$42.40
65 - 69	$109.40	$56.40
70 - 74	$148.60	$76.00
75 - 79	$202.60	$103.00
80 - 84	$272.60	$138.00
85+	$398.20	$200.80

Monthly costs		
Age	Employee coverage: $30,000 Spouse coverage: $15,000 Be Well benefit: $100	
	Employee	Spouse
under 25	$12.30	$8.70
25 - 29	$14.40	$9.75
30 - 34	$17.10	$11.10
35 - 39	$20.70	$12.90
40 - 44	$27.00	$16.05
45 - 49	$38.10	$21.60
50 - 54	$53.40	$29.25
55 - 59	$72.00	$38.55
60 - 64	$122.10	$63.60
65 - 69	$164.10	$84.60
70 - 74	$222.90	$114.00
75 - 79	$303.90	$154.50
80 - 84	$408.90	$207.00
85+	$597.30	$301.20

Active employment: You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees may have a waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date. If enrolling, and eligible for Medicare (age 65+; or disabled) the Guide to Health Insurance for People with Medicare is available at https://www.medicare.gov/publications/02110-choosing-a-medigap-policy-a-guide-to-health-insurance-for-people-with-medicare.pdf

PROTECH SERVICES GROUP INC.

Group Hospital Insurance



How does it work?

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

Why is this coverage so valuable?

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

Be Well Benefit

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

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

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

Who can get coverage?

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

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

How much does it cost?

Your monthly premium	
You	$17.00
You and your spouse	$37.29
You and your children	$25.30
Family	$45.59

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

Hospital		
Hospital Admission	Payable for a maximum of 1 day per year	$1,500
ICU Admission (added to Admission)	Payable for a maximum of 1 day per year	$1,500
Hospital Daily Stay	Payable per day up to 365 days	$100
ICU Daily Stay (added to Daily Stay)	Payable per day up to 30 days	$100

Exclusions and Limitations

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

Active employment
You are considered in active employment if, on the day you apply for coverage, you are being paid regularly for the required 20 hours each week and you are performing the material and substantial duties of your regular occupation. Insurance coverage will be delayed if you are not in active employment because of an injury, sickness, temporary layoff, or leave of absence on the date that insurance would otherwise become effective. New employees may have a waiting period to be eligible for coverage. Please contact your plan administrator to confirm your eligibility date.

Continuity of coverage
We will provide coverage for an Insured if the Insured was covered by a similar prior policy on the day before the Policy Effective Date of this certificate.
Coverage is subject to payment of premium and all other terms of the certificate. If an employee is on a temporary Layoff or Leave of Absence on the Policy Effective Date of this certificate, we will consider your temporary Layoff or Leave of Absence to have started on that date and coverage will continue for the period provided temporary Layoff or Leave of Absence under Continuation of your Coverage During Extended Absences in the certificate.
If you have not returned to Active Employment before any Insured's covered loss, any benefits payable will be limited to what would have been paid by the prior carrier.
If the Employer replaces a Supplemental health policy with this Policy, or the employee becomes insured due to a merger, acquisition or affiliation, and the prior carrier's pre-existing condition requirement has been satisfied, the Pre-existing Condition requirement under this coverage will not apply. However, if the Unum certificate provides a higher level of coverage at the time it becomes effective, its Pre-existing Condition requirement will apply to any increase in coverage. If the prior carrier's pre-existing condition requirement has not been satisfied, periods of coverage applicable to the prior carrier's Pre-existing Condition will count towards satisfying the Pre-existing Condition requirement under this coverage.

Pre-existing Condition
We will not pay benefits for a claim when the Covered Loss occurs in the first 12 months following an Insured's Coverage Effective Date and the Covered Loss is caused by, contributed to by, or resulting from any of the following:
• a Pre-existing Condition; or
• complications arising from treatment or surgery for, or medications taken for, a Pre-existing Condition.
An Insured has a Pre-existing Condition if, within the 12 months just prior to their Coverage Effective Date, they have an Injury or Sickness, whether diagnosed or not, for which:
• medical treatment, consultation, care or services, or diagnostic measures were received or recommended to be received during that period; or
• drugs or medications were taken, or prescribed to be taken during that period; or
• symptoms existed
Pre-existing Condition requirements are not applicable to:
• Children who are newly acquired after your Coverage Effective Date.
The Pre-existing Condition provision applies to any Insured's initial coverage and any increases in coverage.
Coverage Effective Date refers to the date any initial coverage becomes effective.

Exclusions and limitations
We will not pay benefits for a claim that is caused by, contributed to by, or resulting from any of the following:
• committing or attempting to commit a felony;
• being engaged in an illegal occupation or activity;
• injuring oneself intentionally or attempting or committing suicide, whether sane or not;
• active participation in a riot, insurrection, or terrorist activity. This does not include civil commotion or disorder, Injury as an innocent bystander, or Injury for self-defense;
• participating in war or any act of war, whether declared or undeclared;
• Combat or training for combat while serving in the armed forces of any nation or authority, including the National Guard, or similar government organizations;
• being intoxicated;
• a Covered Loss that occurs while an Insured is legally incarcerated in a penal or correctional institution;
• elective procedures, cosmetic surgery, or reconstructive surgery unless it is a result of organ donation, trauma, infection, or other diseases;
• treatment for dental care or dental procedures, unless treatment is the result of a Covered Accident;
• any Admission or Daily Stay of a newborn Child immediately following Childbirth unless the newborn is Injured or Sick;
• voluntary use of or treatment for voluntary use of any prescription or non-prescription drug, alcohol, poison, fume, or other chemical substance unless taken as prescribed or directed by the Insured's Physician; and
• Mental or Nervous Disorders. This exclusion does not include dementia if it is a result of:
• stroke, Alzheimer's disease, trauma, viral infection; or
• other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment.
Additionally, no benefits will be paid for a Covered Loss that occurs prior to the Coverage Effective Date.

End of employee coverage
If you choose to cancel your coverage under this certificate, your coverage will end on the first of the month following the date you provide notification to your Employer.
Otherwise, your coverage under this certificate ends on the earliest of:
• the date the Policy is cancelled by us or your Employer;
• the date you are no longer in an Eligible Group;
• the date your Eligible Group is no longer covered;
• the date of your death;
• the last day of the period any required premium contributions are made; or
• the last day you are in Active Employment.
However, as long as premium is paid as required, coverage will continue in accordance with the Continuation of your Coverage During Absences provision or if you elect to continue coverage for you under Portability of Hospital Indemnity Insurance.
We will provide coverage for a Payable Claim that occurs while you are covered under this certificate.

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

Underwritten by: Unum Insurance Company, Portland, Maine
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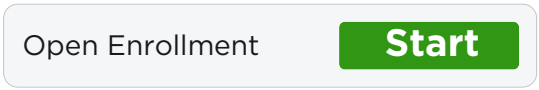
8 Easy steps to employee enrollment.

employee NAVIGATOR

Company Identifier:ProSerGro2026

1. **Let's begin your open enrollment!** Log in to **employeenavigator.com*** per the instructions you have received from your HR. **You will need to create a new username and password this year!**

2. Click **Start**.



Then click **Begin Enrollment**

3. You will need to verify and/or enter some personal information for you and your dependents — Click **Get Started** then complete all required fields.

Verify all information is correct — Click **Save & Continue** when you are ready to proceed to the next section.

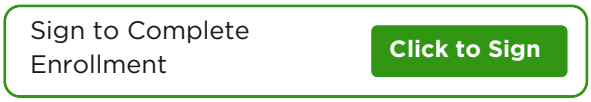
4. Add your dependents and their information.

5. If requested, provide any emergency contacts, employment documents, Medicare status, previous/current coverage and/or health information.

6. Take a moment to compare and view details of your available benefits. To select your prefered choice, click **Select** or **Dont Want This Benefit?** to decline the benefit — Click **Save & Continue** when you are ready to proceed to the next benefit.

7. Finally, you will be shown a summary of your elected benefits and the total cost to you per pay period.

When you have reviewed and approve the enrollment summary, sign to complete your enrollment.



Elections will be finalized only after you sign and authorize your elections.

8. If you have any questions about your enrollment or would like to make changes, please contact HR.

PROTECH SERVICES GROUP

SHOEMAKER INSURANCE SOLUTIONS

* We recommend using either Google Chrome or Firefox as your browser for optimal experience.



BENEFIT CONTACTS

If you have questions about your benefits, need help with claims, or want to learn more about your coverage, your benefit carriers are here to help. Each provider offers dedicated customer service and online resources to support you throughout the year.

Use the contact information below to reach the appropriate carrier for your specific benefit. Many carriers also offer mobile apps and online portals where you can access ID cards, check claims, find providers, and manage your benefits anytime.

Coverage	Carrier	Phone	Website or Email
Insurance Broker / General Questions	**Shoemaker Insurance Solutions**	**901-757-5757** *Emily Breen: Ext. 1155* *Amanda Brace: Ext. 1160*	**ebreen@shoemakerins.com** **abrace@shoemakerins.com**
Medical/Pharmacy	Cigna	(800) 997-1654	www.my.cigna.com
Home Delivery Pharmacy	Cigna	(800) 835-3784	www.my.cigna.com
Behavioral Health	Cigna	(800) 433-5768	www.my.cigna.com
Telemedicine	Cigna / MD Live	(888) 726-3171	www.mdlive.com
Basic/Voluntary Life/ AD&D Insurance	Unum	(866) 679-3054	www.unum.com
Long Term Disability	Unum	(866) 679-3054	www.unum.com
Short Term Disability	Unum	(866) 679-3054	www.unum.com
Accident	Unum	(866) 679-3054	www.unum.com
Critical Illness	Unum	(866) 679-3054	www.unum.com
Hospital Indemnity	Unum	(866) 679-3054	www.unum.com
General ProTech Questions	**Human Resources**	**(901) 257-3272** *Beth Yobak*	**byobak@psgi.net**

Your Health Plan Rights & Notices

This handout gives you important information about your group health plan. These notices explain your rights, protections, and options if you lose or change coverage. They are written in plain language to help you understand your benefits. Please read carefully and keep this for your records.

Medicare Part D Creditable Coverage Notice

ProTech Services Group's prescription drug coverage is considered Creditable Coverage, meaning it is expected to pay, on average, as much as standard Medicare prescription drug coverage.

Because your coverage is creditable, you may keep it and delay enrolling in a Medicare Part D plan without paying a penalty later. However, if you go 63 consecutive days or longer without creditable coverage, you may be subject to a late enrollment penalty if you choose to enroll in a Medicare drug plan in the future.

You may enroll in a Medicare drug plan when you first become eligible and during the annual enrollment period (October 15 – December 7).

For additional information, visit www.medicare.gov or call 1-800-MEDICARE (TTY 1-877-486-2048).

HIPAA Special Enrollment Rights

If you decline coverage for yourself or your dependents due to other coverage, you may be eligible to enroll later if certain events occur, including:

- Loss of other group health coverage
- Employer contributions toward other coverage ending
- Marriage, birth, adoption, or placement for adoption
- Eligibility for Medicaid or CHIP or loss of such coverage

Enrollment must be requested within:

- 30 days of most qualifying events
- 60 days for Medicaid or CHIP-related events

HIPAA Privacy Practices (Summary)

ProTech Services Group's health plan complies with HIPAA privacy requirements to protect your Protected Health Information (PHI). This includes information related to your health condition, treatment, and payment for care.

Your information may be used or disclosed for:

- Treatment and care coordination
- Payment of claims
- Health plan operations

You have important rights regarding your PHI, including the right to:

- Access and request copies of your information
- Request corrections
- Receive an accounting of certain disclosures
- Request restrictions or confidential communications

A full Notice of Privacy Practices is available upon request or through your benefits administrator.

Women's Health and Cancer Rights Act (WHCRA) Notice

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998.

For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical benefits.

Newborns' and Mothers' Health Protection Act (NMHPA) Notice

Group health plans generally may not restrict benefits for a hospital stay in connection with childbirth to less than:

- 48 hours following a vaginal delivery
- 96 hours following a cesarean section

However, the plan may pay for an earlier discharge if the attending provider (such as a physician or nurse midwife), in consultation with the mother, determines that an earlier discharge is appropriate.

Mental Health Parity Notice

The plan provides coverage for mental health and substance use disorder services in accordance with federal law. Financial requirements and treatment limitations for these services are applied in a manner comparable to those for medical and surgical benefits.

COBRA Continuation Coverage

COBRA continuation coverage is a temporary extension of group health coverage that allows you and your eligible dependents to continue coverage when it would otherwise end due to a qualifying event..

Qualifying events may include:

- Termination of employment or reduction in hours
- Divorce or legal separation
- Death of the employee
- A dependent child no longer meeting eligibility requirements

COBRA coverage generally lasts:

- Up to 18 months for employees and dependents due to employment-related events
- Up to 36 months for dependents due to other qualifying events

You or your dependents must notify the Plan Administrator within the required timeframes after certain qualifying events (such as divorce or loss of dependent status) to elect COBRA coverage. You may be required to pay the full cost of coverage plus a small administrative fee.

Surprise Billing / No Surprises Act Notice

Under federal law, you are protected from balance billing for certain services, including:

- Emergency services
- Services provided by out-of-network providers at in-network facilities

In these situations, you are only responsible for your in-network cost-sharing amounts, such as copayments, coinsurance, and deductibles.

Medicaid and CHIP Premium Assistance Notice

If you or your dependents are eligible for Medicaid or the Children's Health Insurance Program (CHIP), your state may offer a premium assistance program that can help pay for employer-sponsored health coverage.

If you or your dependents are already enrolled in Medicaid or CHIP and live in a state that offers premium assistance, you may be eligible for assistance with your employer health plan premiums. If you or your dependents are not currently enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if you qualify.

If you or your dependents become eligible for premium assistance under Medicaid or CHIP, you may enroll in the employer plan. You must request enrollment within 60 days of the date you or your dependent is determined eligible for assistance.

To learn more about premium assistance under Medicaid or CHIP, visit: www.healthcare.gov

If you or your dependents live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. Contact your state for more information:

Family and Medical Leave Act (FMLA) Notice

Eligible employees may take:

- Up to 12 weeks of unpaid, job-protected leave for qualifying family or medical reasons
- Up to 26 weeks to care for a covered service member

During FMLA leave, group health coverage is maintained under the same terms as if you had continued working. Upon return, you will generally be restored to your same or an equivalent position.

Health Insurance Marketplace Notice

You may have the option to purchase health coverage through the Health Insurance Marketplace. If your employer-sponsored coverage meets affordability and minimum value requirements, you may not qualify for a premium tax credit through the Marketplace.

For more information, visit www.healthcare.gov

USERRA Notice

If you leave employment to perform military service, you have the right under USERRA to:

- Continue your health coverage for up to 24 months
- Be reinstated in your job with the same or similar benefits upon return
- Be protected from discrimination based on military service



901-767-7550

https://psgi.net

THANK YOU!

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