2022
Health and Welfare Benefits Overview

Contract Full-Time
averaging 30 hours or more per week

Aleron sdi

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Welcome to the 2022 Open Enrollment Period

We're pleased to offer comprehensive, competitive benefits to our employees and their eligible dependents. This overview is designed to help you better understand the choices available to you and your family.

Once you make your benefit selections, they remain in effect until our next annual benefits open enrollment period—therefore, it is important to thoroughly review your choices. However, if you have a qualifying life event (e.g., get married, have a baby, get a divorce, etc.), you may be able to change certain benefits during the year. You must make any changes within 30 days of the life event.

If eligible, new hires have 30 days to enroll in benefits from their start date. Benefits become effective the 1st of the month following 60 days of employment.

Domestic Partner Coverage is available for some benefit plans. An Affidavit of Domestic Partnership will be required with proper documentation.

Questions? We're here to help!

Tel: 1.800.568.8310
Fax: 716.817.5253
Aleron: benefitsdepartment@aleroninc.com
SDI: benefitsdepartment@sdintl.com

Contents

Dependent Eligibility by Plan

Plan	Dependents Covered Up to Age	Effective Date of Plan	Termination Date of Plan	
			Employment Ends	**Date Coverage Ends**
BlueCross BlueShield of Western New York (BCBS) Medical Plans	26 New York "Age 29" law*	1st of the month following 60 days of employment	1st to 15th of the month	Employment end date
			16th to end of the month	End of month
Transamerica	26	1st of the month following 60 days of employment	End of month	
Guardian Dental	19 - Orthodontia 20 - All other dental services 26 - full-time student**	1st of the month following 60 days of employment	End of month	
Vision Service Plan (VSP)	26	1st of the month following 60 days of employment	End of month	
MetLife Benefits Group Plans	26	1st of the month following 60 days of employment	End of month	
Hartford Insurance Company	26	1st of the month following 60 days of employment	End of month	

*New York "Age 29" law—call the benefits department for details.
**If a full-time student, insurance company needs an official letter/statement of enrollment and once per semester from the accredited college, university, or technical training program, verifying the dependent's full-time status.

Determining Affordable Care Act (ACA) Eligibility

How is it Determined if I may be Eligible for the Health and Welfare Benefits Employer Contribution to the BlueCross BlueShield (BCBS) Medical Plan?

Current employees may be offered an employer contribution to the BCBS medical insurance plan during the annual benefits open enrollment period if during a "look-back" period of 12 months working for company, the employee was averaging 30 or more hours per week.

If you are a new hire, it will be determined at the time of hire if you will be a "full-time" employee (working 30 hours average per week), or if you will be a "variable" hour employee (your schedule will vary sometimes under 30 hours a week).

- Those employees determined to be **full-time employees** at the time of hire will be offered the company's BCBS medical coverage (effective the 1st of the month following 60 days).
- Those employees that are listed as a **"variable" hour employee** will have to wait until the 12 month "look-back" period is calculated before company can determine if the employee is considered a full-time employee (averaging 30 hours or more per week) or not.

Those employees determined to be "full-time" after the look-back period calculation, will be offered the company's BCBS medical coverage (no matter how many hours they work during that time period) or until termination from employment.

How to Enroll (or Decline) in the Health and Welfare Benefits

New Hires

If you are determined to be working 30 hours or more per week at the time of your hire, **after you receive your first paycheck**, you can then access your information and enroll or decline in the benefits.

You have 30 days from your start date to complete enrollment.

Annual Benefits Open Enrollment

If you are determined to be a full-time employee using the "look-back" period of 12 months, you will be able to enroll in or decline the benefits during our annual benefits open enrollment period (usually held in November). You will be notified of your eligibility and open enrollment dates by email and other methods. **Always keep your personal information up-to-date by notifying your branch office representative of any changes.**

New Hires

You have 30 days from your start date to complete your benefits enrollment or decline the benefits.

Instructions to Enroll (or Decline) in the Health and Welfare Benefits

Two Ways to Enroll or Waive Coverage

The special enrollment period for new hire employees is **30 days from your employment start date**. If you do not affirmatively elect benefit coverage during your allotted enrollment period, you will be unable to elect such coverage again until the next annual open enrollment period, unless you experience a qualifying event that entitles you to a new special enrollment period.

Here's how to enroll:

- You can self-enroll online at your own pace at https://www.employeenavigator.com/benefits (see login instructions), OR
- Call our Benefit Call Center at 1-888-592-2681, Mon – Fri, between the hours of 11 a.m. – 8 p.m. EST to speak to a benefits counselor and have them enroll for you (or waive) any coverage.

If you do not enroll or waive benefit coverage within 30 days of your start date, you will be considered to have waived all benefit coverage.

How to Decline Medical Coverage (as a New Hire)

As a new hire through the onboarding system, you will be asked to complete a Waiver of Medical Coverage form.

You will have two options:

- Tell us you need up to 30 days from your employment start date to decide what benefits you would like or to decide if you want to waive coverage. **If you do not complete enrollment or waive coverage through the Benefit Call Center within the 30 days of your employment start date, you will be considered to have waived coverage**.

OR

- Immediately decline the medical coverage and complete the medical waiver form.

You can call the Benefit Call Center to enroll in those plans after getting your first paycheck (i.e., when your employee data will be transferred to the enrollment portal.

Employee understands and agrees to the following terms:

You cannot change your benefit elections or salary reduction agreement (including stopping your deductions) as of any date prior to the next annual open enrollment, unless that change or revocation is on account of and consistent with a change in your family status as listed in the IRS regulations. Changes based on: financial reasons, not reading the provided information, not calling the insurance company's customer service department with any questions (or the company's Benefit Call Center or Benefits Department), or because you found a less expensive direct pay plan, are not allowed under IRS regulations.

BlueCross BlueShield of WNY Medical Plan Options (ACA-compliant)

Two national medical plans are offered to our full-time contract employees. Please review the detailed summaries before making a final decision.

2022	1 HDPPO 8000 Plan 1	2 HDPPO 8000 Plan 2
Benefit	**In-Network**	**In-Network**
Annual Deductible (combined with out-of-network deductible)—Single	$5,000 (Embedded)	$3,000 (True Family)
Annual Deductible (combined with out-of-network deductible)—Family	$10,000* (Embedded)	$6,000** (True Family)
Coinsurance	30% coinsurance after deductible	30% coinsurance after deductible
Out-of-Pocket Maximum—Single (includes deductible)	$6,350 (Embedded)	$6,650 (Embedded)
Out-of-Pocket Maximum—2-Party or Family (includes deductible)	$12,700 (Embedded)	$13,300 (Embedded)
Preventive Services	Covered in full not subject to deductible	Covered in full not subject to deductible
Telemedicine	30% coinsurance after deductible	30% coinsurance after deductible
Primary Office Visit (Specialist Visit)	30% coinsurance after deductible	30% coinsurance after deductible
Pediatric Visits for children up to age 19	30% coinsurance after deductible	30% coinsurance after deductible
Allergy Injections & Testing	30% coinsurance after deductible	30% coinsurance after deductible
Chiropractic	30% coinsurance after deductible	30% coinsurance after deductible
Laboratory Tests	30% coinsurance after deductible	30% coinsurance after deductible
Radiology (x-ray, MRI, CT & other high-tech imaging)	30% coinsurance after deductible	30% coinsurance after deductible
Pre & Post Natal Care (Initial visit)	30% coinsurance after deductible	30% coinsurance after deductible
Inpatient Hospital Stay	30% coinsurance after deductible	30% coinsurance after deductible
Outpatient Surgical Procedure (Facility)	30% coinsurance after deductible	30% coinsurance after deductible
Diabetic Supplies/Services	30% coinsurance after deductible	30% coinsurance after deductible
Rehabilitation Services	30% coinsurance after deductible	30% coinsurance after deductible
Mental Health and Substance Abuse	30% coinsurance after deductible	30% coinsurance after deductible
Emergency Room Visit and Urgent Care Center (waived if admitted to hospital)	30% coinsurance after deductible	30% coinsurance after deductible
Pharmacy Cost (up to 30-day supply)	$15/$50/50% after deductible	$15/$50/50% after deductible
Mail Order	2.5 copays per 90-day supply	2.5 copays per 90-day supply

*Benefits covered under the plan are payable to a family member who reaches the $5,000 single deductible even though the 2-party/family deductible of $10,000 has not yet been met.

**2-Party/Family deductible of $6,000 must be met before any covered benefits are paid.

BlueCross BlueShield (BCBS) High Deductible Health Plan (HDHP) HDPPO 8000 Plan 1 - A plan where coinsurance applies for most in-network services after the deductible is met ($5,000 for single; $10,000 for 2-party/family).

BlueCross BlueShield (BCBS) High Deductible Health Plan (HDHP) HDPPO 8000 Plan 2 - A plan where coinsurance applies for most in-network services after the deductible is met ($3,000 for single; $6,000 for 2-party/family).

To the left is a brief comparison of the medical plan options offered to our employees for the in-network benefits only. Please review the detailed summaries before making a final decision. Please note that since these are high deductible health plans you are eligible to enroll in a Health Savings Account.

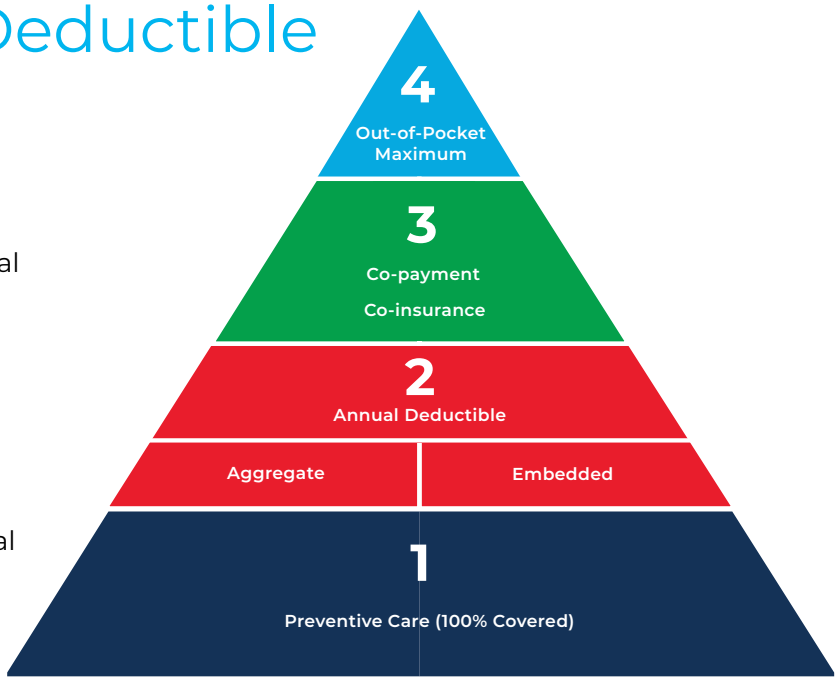
BlueCross BlueShield of WNY Medical Plan Options (ACA-compliant)

BCBS Medical Premiums

Plan	Coverage Level	Monthly Premium Cost	Your Weekly Deduction*
HDPPO 8000 Plan 1 ($5,000/$10,000)	Single	$587.60	See online
	Two Party	$1,201.11	See online
	Family	$1,641.62	See online
HDPPO 8000 Plan 2 ($3,000/$6,000)	Single	$626.07	$156.52
	Two Party	$1,252.12	$313.03
	Family	$1,824.04	$456.01

*Deductions only come out four times in the month (even if there is a month with five pay days).

How Does a High Deductible Health Plan Work?



A High Deductible Health Plan (HDHP) is a health plan product that combines a Health Savings Account (HSA) with traditional medical coverage. It provides insurance coverage and a tax-advantaged way to help save for future medical expenses. The HDHP/HSA gives you greater flexibility and discretion over how you use your health care dollars.

HDHPs have higher annual deductibles and out-of-pocket maximum limits than traditional medical plans. With an HDHP, the annual deductible must be met before plan benefits are paid for services other than in-network preventive care services, which are covered at 100%.

HDHPs also protect you against catastrophic out-of-pocket expenses for covered services. Once your annual out-of-pocket expenses for covered services from in-network providers, including deductibles, copayments and coinsurance, reaches the pre-determined catastrophic limit, the plan pays 100% of the allowable amount for the remainder of the calendar year.

Aggregate vs. Embedded Deductible — What is the Difference?

The deductible is the amount of money you will pay out of pocket before the insurance company begins to make any payments. How the family deductible is calculated and applies is what causes the difference between an embedded and an aggregate deductible. Knowing what kind of deductible your plan has can save you a lot of headaches and help you plan for medical services.

Embedded - When the health plan begins to make payments as soon as one member of the family has reached the individual deductible limit.

For example, if the individual deductible is $5,000 and the family deductible is $10,000 and one member of your family has a covered procedure that costs $6,000, the health plan begins paying for this person's covered expenses over $5,000 (for the $1,000 over the deductible amount minus any copayments or coinsurance), but not the health care expenses of other family members (unless it's preventive care).

Aggregate or True Family - The health plan doesn't begin paying for the health care expenses of anyone in the family until the entire family deductible has been met. This aggregate family deductible can be met by one individual or several covered individuals combined together.

For example, if the individual deductible is $1,500 and the family deductible is $3,000, if an individual has $1,500 in covered health care services, the insurance company does not begin to pay for that individual until the $3,000 (family deductible) is met (unless it's preventive care).

Preventive Services 100% Covered

You can proactively manage your health by using the preventive services that come with the BCBS medical plans. By using these services, your doctor may be able to identify issues which are easier to treat when detected early.

The following are just some of the in-network, routine preventive services offered to you at no charge.

Please review all the preventive services here:

Benefit (In-Network) - Routine*	Comments
Colorectal cancer screening	Age 50 or older
Depression screening	Adults
Diabetes type 2 screening	Adults over 19
Diet counseling	Adults
Immunizations - including influenza, measles, mumps, tetanus, and more	If nonparticipating doctor, facility, or pharmacy is used, you will have to pay upfront and submit a claim for reimbursement.
Mammogram	**If you are 40-49 years old, talk to your doctor about when to start and how often to get a mammogram. If you are 50-74 years old, be sure to have a mammogram at least once every two years. Tell your doctor if your mother or sister has had breast cancer. Depending on your family history and other risk factors, your doctor may have you get a mammogram before age 40 or more frequently.**
Obesity screening and counseling	Adults—up to 20 visits of behavioral intervention
Well women visits	1 per year
Pap smear	1 per year
Physical	1 per year
Smoking cessation medications	
Vision exam (additional benefits through Affinity Discount Program)	1 every 2 years; 1 per year for children under 14 with diagnosed refractive error
Well child	Subject to well child guidelines

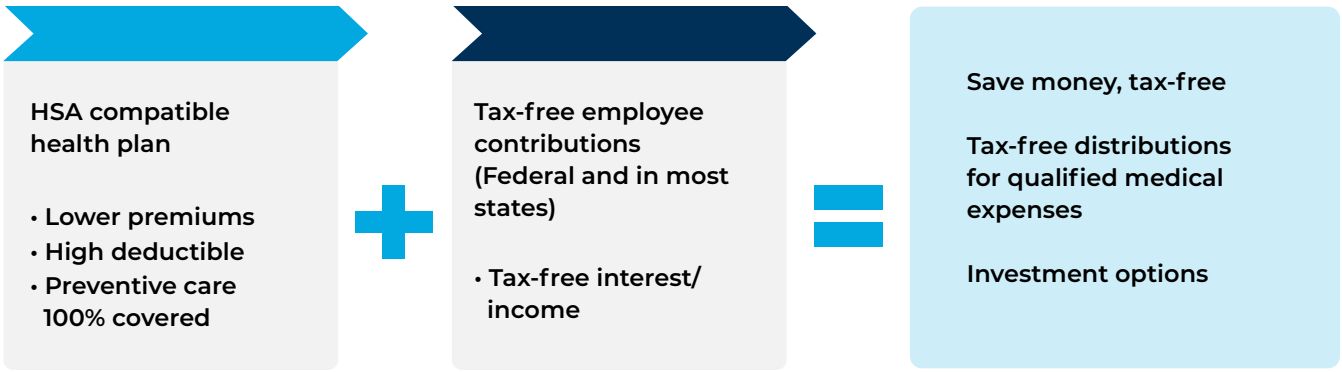
*If during a routine procedure something is found or additional tests are performed, then it is billed as a diagnosis code and would have the normal benefit cost (e.g., no longer considered preventive).

Health Savings Account - HSA Bank

If you elected to enroll in one of the BCBS medical plans, you may elect to enroll in the Health Savings Account (HSA).

An HSA gives you more control over how you spend, or save, your healthcare dollars. The HSA must be tied to a high deductible health plan (i.e., BCBS HDPPO 8000 Plans 1 or 2). With the HDPPO plans, you get the protection of a medical benefits plan with lower premiums, plus the option of opening a tax-free (Federal and most states) health savings account that can be used for qualified medical expenses (i.e., expenses such as those you can deduct if in a flexible spending account).

You can withdraw money from your HSA to reimburse yourself for qualified medical expenses (including your deductible), or you can let your HSA grow and earn interest for future or retiree health expenses. You can also invest your HSA money similar to that of a 401(k) plan. Best of all, you are entitled to keep all HSA contributions, even if you change health plans or jobs. At the end of the year, any money remaining in your account will rollover to the next year.



Health Savings Account Internal Revenue Limits for 2022

	Single	Family
Regular	$3,650	$7,300
Catch-up (age 55 or older)	$1,000	$1,000

Prorated HSA Contributions

If you do not have HSA-compatible health coverage for an entire calendar year, you must prorate your HSA contributions to avoid tax penalties.

See the Health Savings Account worksheet on the enrollment portal for more details.

Transamerica - Hospital Indemnity Plan

2022	Transamerica Plan 1	Transamerica Plan 2
	Monthly Rates	Monthly Rates
Employee Only	$77.72	$110.99
Employee + Spouse/ Domestic Partner	$165.25	$239.64
Employee + Child(ren)	$130.53	$186.04
Employee + Family	$199.58	$288.14
Hospital Indemnity Benefits		
Daily Hospital Indemnity Benefit	$300 per day / 31 days per confinement	$700 per day / 31 days per confinement
Hospital Confinement Indemnity Benefit	$500 per day / 2 days per calendar year	$1000 per day / 2 days per calendar year
Off the Job Accidental Injury Benefit	$500 / 1 day per accident / 5 accidents per calendar year	$700 / 1 day per accident / 5 accidents per calendar year
Outpatient Diagnostic Laboratory Test Indemnity Benefit	$15 / 2 days per calendar year	$25 / 2 days per calendar year
Outpatient Select Diagnostic Test Indemnity Benefit	$75 / 1 day per calendar year	$125 / 1 day per calendar year
Outpatient Advance Studies Diagnostic Test Indemnity Benefit	$300 / 1 day per calendar year	$500 / 1 day per calendar year
Intensive Care Indemnity Benefit	$400 / 30 days per calendar year	$800 / 30 day per calendar year
Ambulance Indemnity Benefit	$300 / 3 days per calendar year / 6 days per lifetime	$300 / 3 days per calendar year / 6 days per lifetime
Emergency Room Sickness Indemnity Benefit	$200 / 2 days calendar year maximum	$200 / 4 days calendar year maximum
Critical Illness Indemnity Benefit	Employee: $2500 / Dependents: 25%	Employee: $2500 / Dependents: 25%
Wellness Indemnity Benefit	$100 / 1 day per calendar year maximum	$100 / 1 day per calendar year maximum
Prescription Drug Indemnity Benefit	$10 generic / $20 brand / 36 days per calendar year	$15 generic / $30 brand / 36 days per calendar year
Ambulance Indemnity Benefit Rider	$100 / 1 day per accident / 5 accidents per calendar year	$300 / 1 day per accident / 5 accidents per calendar year
Outpatient Physician Office Visit Indemnity Benefit Rider	$100 / 6 days per calendar year	$100 / 10 days per calendar year
Surgical & Anesthesia Indemnity Benefit Rider	Inpatient Surgery: $2000 / Outpatient Surgery: $1000 Outpatient Minor Surgery: $200 If anesthesia is administered, pays an additional 20%	Inpatient Surgery: $2500 / Outpatient Surgery $1250 Outpatient Minor Surgery: $250 If anesthesia is administered, pays an additional 30%
Multiplan Network	Included	Included

Be aware that Hospital indemnity insurance is not the same as major medical insurance.

It's an affordable, standalone or supplemental medical insurance that pays fixed-dollar benefits for costs associated with health care, such as one wellness visit, doctor's office visits, prescriptions, and hospital stays. There are annual limits on how much the plan will pay.

For more information on the Multiplan Network, click here or visit:

https://www.multiplan.com/webcenter/portal/poviderSearchproviders/

Dental Plans - Guardian

Two dental plan options are offered that are 100% employee-paid. The plan premiums and the plan designs are listed below. There is a **waiting period of 12 months for Major and Orthodontia services**. This means that the plan will not pay any benefits for these services until you have been covered under the plan for at least 12 months.

Save Your Unused Claims Dollars For When You Need Them Most

Guardian will roll over a portion of your unused annual maximum into your personal Maximum Rollover Account (MRA). **You must have at least one service** during your calendar year staying under your Rollover Threshhold which will trigger your Rollover Dollars to start accumulating.

Dental Premiums

Dental Premiums by Coverage Type	Low Plan 1	Payroll Deduction 4 Times Per Month	High Plan 2	Payroll Deduction 4 Times Per Month
Employee	$30.84	$7.71	$40.40	$10.10
Employee and Spouse/Domestic Partner	$59.47	$14.87	$77.90	$19.48
Employee and Child(ren)	$61.84	$15.46	$81.01	$20.25
Family	$99.06	$24.77	$129.48	$32.37

Dental Plan Designs

Dental Benefit Design	Plan 1 - Low Plan In-Network	Plan 1 - Low Plan Out-of-Network	Plan 2 - High Plan In-Network	Plan 2 - High Plan Out-of-Network
Deductible per calendar year (waived for preventitive services)				
Per Person	$50	$75	$50	$75
Family Limit		3 per family		3 per family
Annual maximum benefit				
Per Person	$1,500	$500	$1,500	
	Combined In-Network and Out-of-Network maximum of $500, with an additional $1,000 of benefit In-Network		Combined In-Network and Out-of-Network	
Charges covered for you (co-insurance)				
Preventive Services (cleanings)	100%	100%	100%	100%
Basic Services (fillings)	80%	50%	90%	80%
Major Services (crowns, dentures)	50%	40%	60%	50%
Orthodontia (children up to age 19)	50% Combined In– and Out-of-Network		50% Combined In– and Out-of-Network	
Lifetime Orthodontia Limit				
	$1,000 Combined In– and Out-of-Network		$1,500 Combined In– and Out-of-Network	

*Note: Deferred Services (Waiting Period) of 12 Months for Major and Orthodontia Services.

Vision Plan - VSP

A stand-alone vision plan (100% employee-paid) is offered*. The plan design (glasses or contacts) is listed below. At your appointment, tell them you have VSP. There's no ID card necessary. Use an in-network provider to get the full benefit.

Find an eyecare provider who is right for you.
Visit vsp.com or call 800.877.7195.

Vision Plan Design Frequency	In-Network (VSP guarantees coverage from VSP network providers only)	Co-Pay	Out-of-Network (Visit vsp.com for details on how to use an out-of-network provider)
WellVision Exam (12 months)	Focuses on your eyes and overall wellness	$15	Up to $50
Prescription Glasses		$25	
Lenses (12 months)	· Single vision, lined bifocal, and lined trifocal lenses · Polycarbonate lenses for dependent children	Included in Prescription Glasses	Single Vision Lenses: Up to $30 Lined Bifocal Lenses: Up to $50 Lined Trifocal Lenses: Up to $65
Frames (12 months)	· $200 allowance for a wide selection of frames · $200 allowance for featured frame brands · 20% off the amount over your allowance	Included in Prescription Glasses	Up to $70
Lens Enhancements (12 months)	· UV coating · Scratch Resistant Coating · Standard progressive lenses · Premium progressive lenses · Custom progressive lenses · Average savings of 20-25% on other lens enhancements	· $0 · $0 · $55 · $95 - $105 · $150 - $175	Progressive lenses: Up to $50
Contacts instead of glasses (12 months)	· $200 allowance for contacts · Contact lens exam (fitting and evaluation)	Up to $60	Up to $105

*Please read the exclusions and limitations listed in the summary plan description.

Vision Premiums

Vision Premiums by Coverage Type	Monthly Premium	Payroll Deduction 4 Times Per Month
Employee	$7.78	$1.95
Employee + Spouse/Domestic Partner	$12.07	$3.02
Employee + Child(ren)	$12.92	$3.23
Employee + Family	$20.65	$5.17

401(k) Retirement Savings Plan

401(k) Retirement Savings Plan Enrollment

IMPORTANT
Please wait to enroll in the 401(k) Retirement Savings Plan until you have completed one (1) day of work and have met the waiting period (if any).

401(k) contributions and changes made by Friday at noon EST will go into effect for the upcoming paycheck. Any changes made after this time will go into effect the next paycheck.

You have the option to contribute (100% employee-paid) to a Traditional or Roth 401(k), or a combination of the two. The company's 401(k) plan also offers loans and hardship distributions. Once you have had your first 401(k) payroll deduction and your account is set up, you can also rollover any Traditional pre-tax or Roth balances from a previous plan. The 2022 IRS limits apply to the total sum of your Traditional and Roth 401(k) contributions—those under 50 years of age are limited to $20,500 and for those age 50 and over, an additional catch-up contribution of $6,500 is allowed for a contribution limit of $27,000.

Please go to https://panda401k.com/enrollinplan.aspx to enroll or make changes.
Temporary password for new enrollees: **ENROLL12**

Note: If there are any discrepencies with this document and the plan documents or contracts with the carriers, the plan documents or contracts apply. Benefits and premiums are subject to change and can be terminated at the employer's sole discretion.