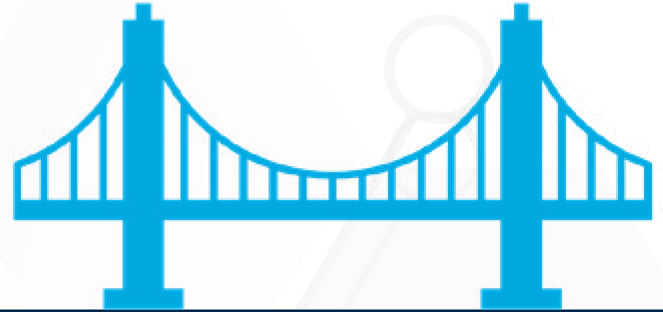

# 2022
# Health and Welfare Benefits Overview

San Francisco Contract Full-Time
working 8 hours or more per week

Aleron sdi

# 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

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## 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 | 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 |
| Guardian Dental | 19 - Orthodontia<br>20 - All other dental services<br>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 | |

**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 Am Eligible for Medical Benefits?

If you are determined to be working 8 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 two ways:

- You can self-enroll at your own pace via the benefits portal at **employeenavigator.com/benefits** (see login instructions)

**OR**

- Call our **Benefits Call Center** at 1-888-592-2681 between the hours of 11 a.m. to 8 p.m. EST Monday to Friday to speak to a benefits counselor and have them enroll (or waive) any coverage. You have 30 days from your start date to complete enrollment. **If you do not enroll or waiver benefit coverage within 30 days of your start date or during our annual open enrollment period, you will be considered to have waived all benefit coverage**.

## San Francisco's "Employee Voluntary Waiver Form"

The *Employee Voluntary Waiver Form* verifies you are receiving health care through another employer and that you knowingly and voluntarily waive the right to enroll in the company's medical coverage and to accept the subsidy for single coverage on the BCBS HDPPO 8000 Plan 2. You have a right to revoke your voluntary waiver at any time; the revocation must be submitted in writing to: benefitsdepartment@aleroninc.com or benefitsdepartment@sdintl.com.

### New Hires

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

You are advised that the premium amounts outlined in this brochure are subject to your meeting the following eligibility requirements:

- Is entitled to be paid the minimum wage;
- Has been employed by the company for at least 90 calendar days; and
- Performs at least eight (8) hours of work per week within the geographic boundaries of San Francisco.

The following employees are **excluded** from coverage:

- If employee waives their right to enroll in the company's medical coverage (see below);
- Managers, supervisors, and confidential employees earning an annual base salary more than $109,643 annually (or $52.71 per hour) in 2022; or
- Employees who receive health care benefits pursuant to the San Francisco Health Care Accountability Ordinance.

## 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.**

# 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 have two options:

1. 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
2. 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)

This national medical plan is offered to our full-time contract employees in San Francisco.

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

*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 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).

Please review the detailed summary to the left. Please note that since this is a high deductible health plan 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 Monthly Premium Cost | Your Weekly Deduction* |
|---|---|---|---|---|
| HDPPO 8000 Plan 2 ($3,000/$6,000) | Single | $626.07 | $0.00 | $0.00 |
| | Two Party | $626.05 | $626.06 | $156.51 |
| | Family | $1,824.04 | $1,197.97 | $299.49 |

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

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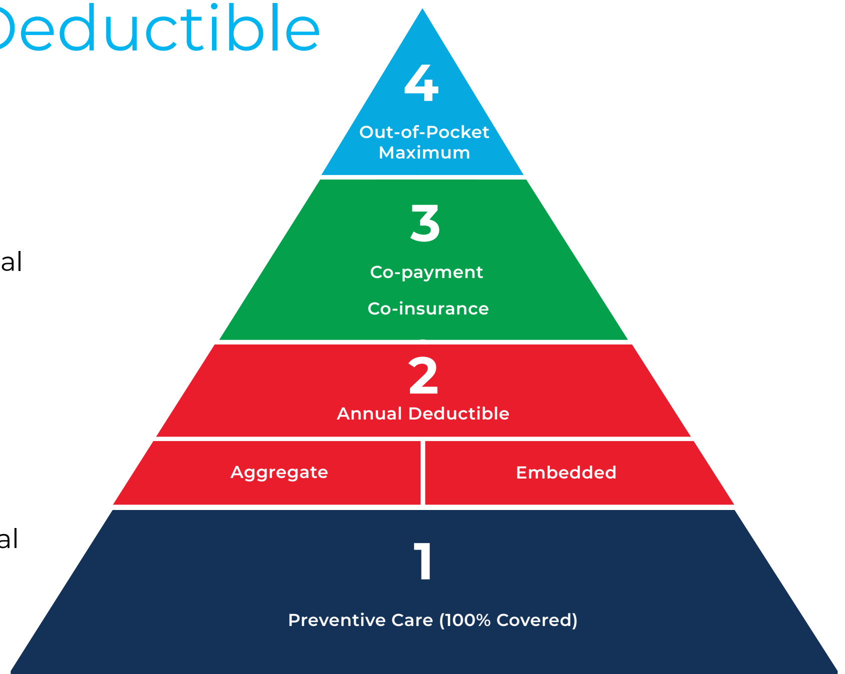
## MetLife Benefits Group Plans

(see MetLife brochures for more information)

Some additional group benefits offered through the MetLife Benefits Group are:

- Accident Insurance
- Hospital Indemnity Insurance
- Critical Illness Insurance
- Optional Life Insurance
- Short-term Disability Insurance

# 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 |

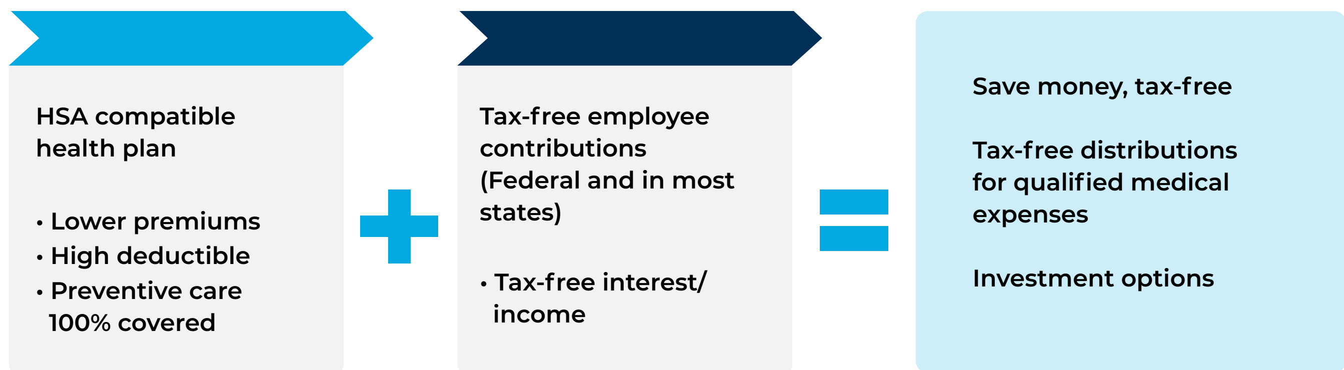
*If during a routine procedure something is found or additional tests are performed, then it is billed as a diagnosis code and would have the normal benefit cost (e.g., no longer considered preventive).

# 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. 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.

# 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 | $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<br>· Polycarbonate lenses for dependent children | Included in Prescription Glasses | Single Vision Lenses: Up to $30<br>Lined Bifocal Lenses: Up to $50<br>Lined Trifocal Lenses: Up to $65 |
| Frames (12 months) | · $200 allowance for a wide selection of frames<br>· $200 allowance for featured frame brands<br>· 20% off the amount over your allowance | Included in Prescription Glasses | Up to $70 |
| Lens Enhancements (12 months) | · UV coating<br>· Scratch Resistant Coating<br>· Standard progressive lenses<br>· Premium progressive lenses<br>· Custom progressive lenses<br>· Average savings of 20-25% on other lens enhancements | · $0<br>· $0<br>· $55<br>· $95 - $105<br>· $150 - $175 | Progressive lenses: Up to $50 |
| Contacts instead of glasses (12 months) | · $200 allowance for contacts<br>· 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.

# Health Care Security Ordinance Employee Voluntary Waiver Form (for San Francisco requirements)

Each year, the city of San Francisco requires the company to provide you with a "Health Care Security Ordinance Employee Voluntary Waiver Form" (referred to as the San Francisco Medical Waiver form). This is a form in addition to the Waiver of Medical Coverage you will find in our eStaff onboarding system (which is for the Affordable Care Act purposes). The San Francisco Medical Waiver form is provided in our eStaff onboarding system and through our enrollment website (referred to as the Benefits Portal).

We may request that you waive the company's legal obligation to spend money on health care services for you if you are currently receiving health care services from another employer (i.e., your other job, your spouse/domestic partner/ parent's job).

Even if you receive health care services through another employer, you are entitled to receive health care services from THIS company. If you sign the Health Care Security Ordinance Employee Voluntary Waiver Form, you are telling us we can stop making a mandatory health care expenditure on your behalf (i.e., making an employer contribution for the amount of single coverage to a medical plan through our company).

Even if you choose to sign this form, you have the right to revoke or cancel it any time. If you have questions about whether you are eligible to sign this waiver, please call San Francisco Office of Labor Standards Enforcement at 415-554-7892.

**HEALTH CARE SECURITY ORDINANCE EMPLOYEE VOLUNTARY WAIVER FORM**

*Updated November 1, 2017*

**ATTENTION EMPLOYEES: IF YOU COMPLETE THIS FORM, YOU ARE GIVING UP YOUR RIGHT TO RECEIVE HEALTH CARE SERVICES FROM THIS EMPLOYER**

- **You do not have to sign this form. It is unlawful for your employer to pressure you to sign this form. Signing this form may make you ineligible for health benefits you would otherwise be entitled to.**
- **Read the form carefully. If you have any questions about this form or your employer's obligations under the Health Care Security Ordinance, please call 415-554-7892 or visit www.sfgov.org/olse/hcso. Para asistencia en español, llame al 415-554-7892. 需要中文幫助，請電 554-7892**

**The San Francisco Health Care Security Ordinance requires this employer to make health care expenditures on your behalf, even if you already have health insurance and/or receive health care services from another employer.** A health care expenditure is an amount of money paid by your employer to provide you with access to health care services. For example, your employer may:

- make payments to enroll you in a health insurance program,
- make payments on your behalf to the City Option program (MRA or Healthy San Francisco), and/or
- establish and maintain a reimbursement account for your health care expenses.

Your employer may request that you waive its legal obligations to spend money on health care services for you if you are currently receiving health care services from another employer. Your employer must obtain an updated and signed Voluntary Waiver Form from you each year that you agree to waive its legal obligations. **Even if you receive health care services through another employer** (ie, your other job, your spouse/domestic partner/parent's job)**, you are entitled to receive health care services from THIS employer.** If you sign this form, you are telling this employer it can stop making a mandatory health care expenditure on your behalf **Even if you choose to sign this form, you have the right to revoke or cancel it at any time.**

**ARE YOU ELIGIBLE TO WAIVE HEALTH CARE SERVICES?**

**Examples of Employees who should not sign this waiver are:**

- Employees who do not receive healthcare services from another employer
- People who pay for their own insurance out of pocket, or whose families pay for their insurance;
- People who are uninsured;
- Medi-Cal recipients;
- Participants in county-run medical programs (ie, San Mateo County Health Plan, Health PAC (Alameda Co.), etc.

**If you have questions about whether you are eligible to sign this waiver, please call 415-554-7892.**

**I acknowledge that I have read the above statement.**

Employer Name: ________________________________

Employee Name: ________________________________ Today's Date: ____________________________

SF OFFICE OF LABOR STANDARDS ENFORCEMENT WWW.SFGOV.ORG/OLSE

**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 benefits department), or because you found a less expensive direct pay plan, are not allowed under IRS regulations.