S. Freedman & Sons, Inc.

PAPER, MAINTENANCE, PACKAGING & RESTAURANT SUPPLIES

2022 Benefits Guide

January 1, 2022 - December 31, 2022

Contacts

Carrier	Web / Email	Phone
Medical and Prescription United Healthcare	myuhc.com	1-866-673-6293
Health Savings Account **Flexible Spending Accounts** Optum Financial	www.optum.com/financial	1-877-292-4040
Dental United Healthcare	myuhc.com	1-800-445-9090
Vision United Healthcare	www.myuhc.com (if you are also enrolled in the Medical Plan) www.myuhcvision.com (if you have Vision but not Medical)	1-866-673-6293
Voluntary Life **Short-Term Disability** **Long-Term Disability** Principal	www.principal.com	1-800-843-1371
S. Freedman & Sons Lynn Hobbs	lhobbs@sfreedman.com	301-386-7874

QUESTIONS, PROBLEMS OR CONCERNS

Our goal is to make certain that you receive the correct coverage under the benefits plan. We are here to help with any issues that may arise. If you require assistance, have your ID number or Social Security Number available and follow these steps:

- ✔ **For claims assistance** call the applicable insurance carrier. Have your ID number, date of service, and provider name available.
- ✔ **If you require further assistance** contact Lynn Hobbs at lhobbs@sfreedman.com or 301-386-7874.
- ✔ **Do you need an ID card?** If you do not have an ID card, please contact the insurance carrier to order your ID card or go online to the carrier's site to download an ID card.

Table of Contents

PLEASE NOTE: This booklet provides a summary of the benefits available, but is not your Summary Plan Description (SPD). The Company reserves the right to modify, amend, suspend, or terminate any plan at any time, and for any reason without prior notification. The plans described in this book are governed by insurance contracts and plan documents, which are available for examination upon request. We have attempted to make the explanations of the plans in this booklet as accurate as possible. However, should there be a discrepancy between this booklet and the provisions of the insurance contracts or plan documents, the provisions of the insurance contracts or plan documents will govern. In addition, you should not rely on any oral descriptions of these plans, since the written descriptions in the insurance contracts or plan documents will always govern.

Eligibility

Employee

Full-time employees with a regular schedule of **30 hours per week** are eligible for the benefits described in this guide, unless otherwise stated.

Eligible Dependents*

- A spouse to whom you are legally married.
- A dependent child under age 26. Coverage will terminate at the end of the month of the dependent's 26th birthday. Coverage may be extended past the age of 26 for disabled dependents. Dependent children include natural, adopted children, and stepchildren.

Coverage for eligible dependents generally begins on the same day your coverage is effective. Completed enrollment serves as a request for coverage and authorizes any payroll deductions necessary to pay for that coverage.

**Additional carrier conditions may apply and may vary by state.*

Newly Hired/Eligible Employees

New hires and newly eligible employees **MUST** complete enrollment even if choosing to waive coverage.

When Benefits Become Effective

Coverage for most benefit plans are effective on the first day of the month after 30 days.

Benefit Changes

The benefit elections you make during open enrollment or as a new hire will remain in effect for the entire plan year. You will not be able to change or revoke your elections once they have been made unless a life event status change occurs.

For purposes of health, dental, vision and flexible spending accounts, you will be deemed to have a life event status change if:

- your marital status changes through marriage, the death of your spouse, divorce, legal separation, or annulment;
- your number of dependents changes through birth, adoption, placement for adoption, or death of a dependent;
- you, your spouse or dependents terminate or begin employment;
- your dependent is no longer eligible due to attainment of age;
- you, your spouse or dependents experience an increase or reduction in hours of employment (including a switch between part-time and full-time employment; strike or lock-out; commencement of or return from an unpaid leave of absence);
- gain or loss of eligibility under a plan offered by your employer or your spouse's employer;
- a change in residence for you, your spouse or your dependent resulting in a gain or loss of eligibility.

In order to be permitted to make a change of election relating to your health, dental or vision coverage due to a life event status change, the change must result in you, your spouse or dependent gaining or losing eligibility for health, dental or vision coverage under this plan or a plan sponsored by another employer by whom you, your spouse or dependent are employed. The election change must correspond with that gain or loss of eligibility.

You may also be permitted to change your elections for health coverage under the following circumstances:

- a court order requires that your child receive accident or health coverage under this plan or a former spouse's plan;
- you, your spouse or dependent become entitled to Medicare or Medicaid;
- you have a Special Enrollment Right;
- there is a significant change in the cost or coverage for you or your spouse attributable to your spouse's employment.

For purposes of all other benefits under the plan, you will be deemed to have a life event status change if the change is on account of and consistent with a change in status, as determined by the plan administrator, in its discretion, under applicable law and the plan provisions.

IF YOU EXPERIENCE A LIFE EVENT STATUS CHANGE

You must update your elections within 30 days of your life event status change or you will not be able to make changes until the next annual open enrollment. If adding or removing dependents, you are required to submit specific documents to Human Resources. The change will be inactive until proper documentation is received and approved.

Medical Plan Comparison

S. Freedman & Sons is proud to offer you a choice of three Health Maintenance Organizations (HMOs). All plans offer in-network coverage only through United Healthcare. **The Choice $3,000 plan does NOT require you to select a Primary Care Physician nor do you need a referral to visit a specialist.**

	OCI $5,000	OCI $3,000	CHOICE $3,000
Annual Deductible Individual / Family	**$5,000 / $10,000**	**$3,000 / $6,000**	**$3,000 / $6,000**
Annual Out-of-Pocket Limit Individual / Family	**$6,650 / $13,300**	**$6,000 / $12,000**	**$6,000 / $12,000**

Once you've met your deductible, you start sharing costs with your plan - coinsurance. You continue paying a portion of the expense until you reach your out-of-pocket limit. From there, your plan pays 100% of allowed amounts for the rest of the plan year.

In-Network Coverage Only, You Pay:			
Preventive Care	No charge	No charge	No charge
Virtual Visits	0% coinsurance after Deductible	0% coinsurance after Deductible	0% coinsurance after Deductible
Office Visits PCP Specialist	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Emergency Services Urgent Care Center Emergency Room Ambulance	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Labs and Testing	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Hospitalization Inpatient Outpatient	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Mental Health & Substance Disorder Services Inpatient Outpatient	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Skilled Nursing Facility 60 days/year	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Home Health Care 60 visits/year	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Hospice Care	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Physical, Speech, Occupational Therapy Services 60 visits combined/year	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
Durable Medical Equipment	10% coinsurance after Deductible	10% coinsurance after Deductible	10% coinsurance after Deductible
PHARMACY BENEFITS - Retail up to 31-day supply; Mail Order up to 90-day supply			
The following copays are applicable in addition to your annual deductible.			
Tier 1 Retail / Mail Order	$10 / $25	$10 / $25	$10 / $25
Tier 2 Retail / Mail Order	$35 / $87.50	$35 / $87.50	$35 / $87.50
Tier 3 Retail / Mail Order	$60 / $150	$60 / $150	$60 / $150

This summary is for informational purposes only. For specific benefit information, please refer to the Summary Plan Description.

How It Works

1 At the start of your plan year...

You are responsible for paying 100% of your covered health services until you reach your **deductible**, which is the amount you pay before your health plan pays a portion.

YOU PAY 100%

2 Once you reach your deductible...

Your health plan starts to share a percentage of costs for covered health care services with you – this is your **coinsurance**.

YOU PAY 10%

YOUR PLAN PAYS 90%

3 When you reach your out-of-pocket limit...

Your plan covers your costs (the allowed amount) at 100%. Your **out-of-pocket limit** is the most you'll pay for covered health services in a plan year – copays and coinsurance count toward this.

YOUR PLAN PAYS 100%

Stay In The Loop

Search the network to find doctors.

You can go to providers in and out of our network — but when you stay in network, you'll likely pay less for care. To get started:

- Go to ***welcometouhc.com > Benefits > Find a Doctor or Facility***.
- Choose ***Search for a health plan***.
- Choose ***OCI*** or ***Choice*** (depending on which plan you are enrolled) to view providers in the health plan's network.

Manage your meds.

Look up your prescriptions using the Prescription Drug List (PDL). It places medications in tiers that represent what you'll pay, which may make it easier for you and your doctor to find options to help you save money.

- Go to ***welcometouhc.com > Benefits > Pharmacy Benefits***.
- Select ***Advantage*** to view the medications that are covered under your plan.

Access your plan online.

With **myuhc.com®**, you've got a personalized health hub to help you find a doctor, manage your claims, estimate costs and more. When you're out and about, the **UnitedHealthcare® app** puts your health plan at your fingertips. Download to find nearby care, video chat with a doctor 24/7, access your health plan ID card and more.

Pre-Tax Benefits: Section 125

The Company's benefit plans utilize Section 125. This enables you to elect to pay premiums for health, dental, vision and flexible spending account coverage on a pre-tax basis. When you use pretax dollars, you will reduce your taxable income and have fewer taxes taken out of your paycheck. Under Section 125, you can actually have more spendable income than if the same deductions were taken on an after tax basis.

Pre-tax Note: When you pay for your dependent's benefits on a pre-tax basis you are certifying that the dependent meets the IRS' definition of a dependent. [IRC §§ 152, 21 (b)(1) and 105(b)]. Children/spouses that do not satisfy the IRS' definition will result in a tax liability to you, such as changing that dependent's election to a post-tax election, or receiving imputed income on your W-2 for the dependent's coverage that should not have been taken on a pre-tax basis.

Dental Plan

UHC Dental DPPO

The dental plan offers flexibility to see the provider of your choice each time you seek dental care. You can find a network dentist online at **www.myuhc.com**, or by calling **1-800-445-9090**. **Note that providers that do not participate with our insurance plan can "balance bill" you for any difference between their charge and what the plan pays. Therefore, using non-participating providers may result in significant patient liability.**

UHC Dental PPO Options PPO 20 network	You pay:
Annual Deductible Individual / Family	**$50 / $150**
Annual Maximum	**$1,500**
Preventive Care Cleanings, Sealants, Space Maintainers	No charge
Basic Care Restorations, Simple Extractions, Oral Surgery, Periodontics, Endodontics	20% coinsurance after Deductible
Major Care Inlays/Onlays/Crowns, Dentures, Bridges	50% coinsurance after Deductible
Orthodontia *(Up to age 19)* Orthodontia Lifetime Maximum	50% coinsurance $1,000

This summary is for informational purposes only. For specific benefit information, please refer to the Summary Plan Description.

Vision Plan

UHC Vision PPO

UnitedHealthcare vision has been trusted for more than 50 years to deliver affordable, innovative vision care solutions to the nation's leading employers through experienced, customer-focused people and the nation's most accessible, diversified vision care network.

UHC Vision PPO UHC Vision network	In-Network, you pay:	Out-of-Network, Reimbursement
Exam Copay *(Every 12 months)*	$10 copay	Up to $40.00 (copay does not apply)
Materials Copay	$25 copay	N/A
Frames *(Every 24 months)*	$130 allowance + 30% discount on amount over allowance	Up to $45.00
Lenses *(Every 12 months)* Single Vision Lined Bifocal and Progressive Lined Trifocal Lenticular	Included with frames	 Up to $40.00 Up to $46.00 Up to $80.00 Up to $80.00
Contact Lenses *(Every 12 months)* Elective Necessary	$105 allowance Covered 100%	Up to $80.00 Up to $210.00

This summary is for informational purposes only. For specific benefit information, please refer to the Summary Plan Description.

Health Savings Accounts

If you enroll in one of the medical plans offered, a Health Savings Account (HSA) will be opened for you through Optum Financial. HSA's are financial accounts that you can use to accumulate tax-free funds to pay for qualified health care expenses, as defined by the Internal Revenue Service.

The account acts like a regular savings account with a debit card and accrues interest. The money in the account is owned by you and is fully portable. Funds can accumulate over time and roll over each year. If you use the funds for qualified health care expenses, you will pay no taxes. If you use the money for other expenses, you will pay a tax and a penalty fee.

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. The employer contribution of $1,000 for individual coverage or $1,500 for all other coverage tiers is included in the 2022 IRS maximum of $3,650 / $7,300 making the maximum amounts you can contribute to your HSA $2,650 for individual coverage or $5,800 for all other coverage tiers.

If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Qualifying for an HSA

To be an eligible individual and qualify for an HSA, you must meet the following requirements:

- You must be covered under a high deductible health plan (HDHP).
- You have no other health coverage or Health Care Flexible Spending Account.
- You are not enrolled in Medicare Part A or Part B.
- You cannot be claimed as a dependent on someone else's tax return.
- You are not active in the military and not receiving health benefits under TRICARE.
- You are a U.S. resident and not a resident of Puerto Rico or American Samoa.
- You have not participated in Veterans benefits within the last 3 months.(Employee must wait at least three (3) months after last receiving VA benefits before they are eligible to elect and open an HSA account.)

2022 HSA Annual Contribution Limits *(Total combined Employee and Employer contribution limit)*

$3,650 for individual coverage **$7,300 for all other coverage tiers**

You can choose to contribute to your HSA on a before-tax basis, up to the IRS annual maximums. If you are or will be age 55 or over during the calendar year, you may also make a "catch-up" HSA contribution of an additional $1,000 each year.

Note: As a taxpayer, it is your responsibility to ensure that your HSA contributions do not exceed the maximum possible for your specific tax situation. Please consult your attorney, CPA or tax adviser about your specific tax situation before deferring monies to your Health Savings Account. The benefits of an HSA, who is qualified to have an HSA, etc. can be found in IRS Publication 969, beginning on page 2. https://www.irs.gov/pub/irs-pdf/p969.pdf

Employee Assistance Program

Your Well-Being is What Matters Most

If you're struggling with a relationship, depression, stress at work, or seeking financial or legal advice, we're here for you. The Employee Assistance Program (EAP) is designed to give you and your family personal and confidential support — 24 hours a day, 7 days a week.

As part of your EAP benefit, these services are available at **no extra cost**.

- Call or web chat with a registered nurse, master's-level counselor, or legal or financial professional 24/7
- Help coping with grief, stress, relationship issues, and more
- Financial management information
- Legal support

Liveandworkwell.com

From your desktop, mobile device or smartphone, you can easily and securely find a provider, discover community and work-life resources near you, and quickly and confidentially connect to expert guidance. You can also access news, events and thousands of expert articles and advice.

Maintaining your privacy and confidentiality is of the greatest importance. All records, referrals and evaluations are kept private and confidential in accordance with federal and state laws.

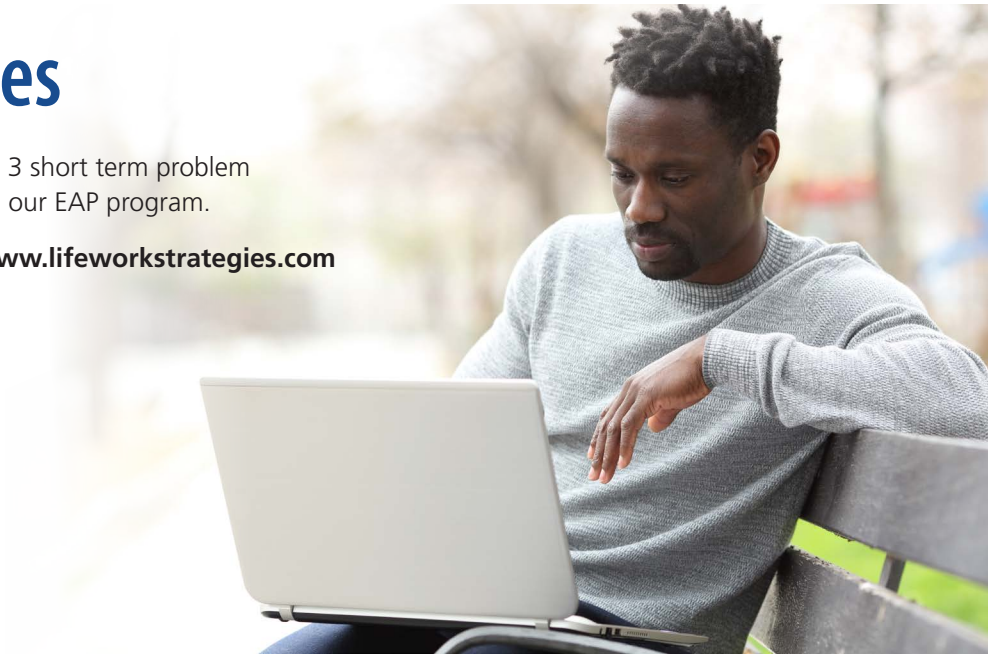
ACCESS: Call 888-887-4114 or access online via myuhc.com

Life Work Strategies

You and your household members will receive 3 short term problem resolution sessions per issue, per year through our EAP program.

You can call **877-252-8550** or go online to **www.lifeworkstrategies.com**

User name: sfseap Password: Employee



Rally Health and Wellness

Our voluntary wellness program, Rally, is available at **no additional cost** to you through UnitedHealthcare. Rally supports and motivates you to meet your health targets and maximize your well-being.

What is Rally?

Rally is a fun and easy-to-use web and mobile app. Designed to help you improve your health, this interactive web and mobile experience recommends simple actions you can take every day and rewards you as you make progress.

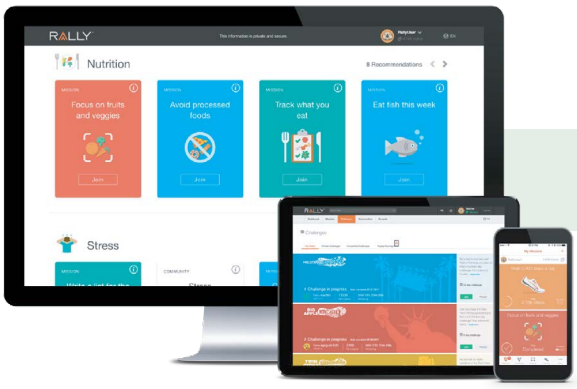
The focus of Rally is to help improve your health and well-being. Rally goes beyond your physical health and factors in emotional, financial, social and community connections. Combining these aspects of your well-being may help you better manage your health.

Get started and you'll get a custom-created program designed to help you live healthier.

- **See your Rally age** - start by taking a health survey to see your Rally age - a measure of your overall health
- **Accept your Missions** - based on your Rally age, you'll get a list of easy, fun custom-picked missions to try - all designed to help you eat better, lift your fitness level and even improve your mood.
- **Take on a Challenge** - use the Rally app to track your activity and compete with other Rally members to earn extra rewards.
- **Connect with a Coach** - talk on the phone and work together to create a personalized healthy-living plan that works with your lifestyle.

Enjoy the Rewards

You'll earn Rally coins when you complete your missions, complete a challenge or even just for logging in once a day. You can use the coins to enter to earn rewards for all that good work: it's a great way to experience the rewards of healthy living every day.



RALLY®

GET STARTED TODAY AT MYUHC.COM

Fitness Activity Tracker - For every month a member logs a fitness activity through the Rally App, at least 12 days, they earn $20. Activities include:

- Running
- Walking
- Boxing
- Climbing
- Cycling
- Yoga and Pilates
- Traditional gyms

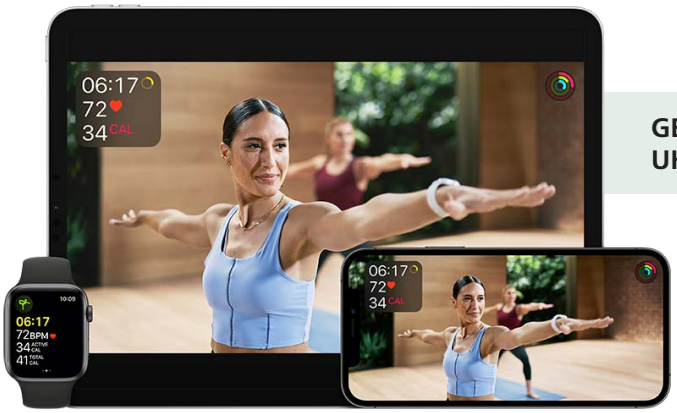
Fitness Apps

Make your move with Apple Fitness+

Get 12 months of Apple Fitness+ at **no additional cost** to you as part of your health plan.* That's a $79.99 value.

The first fitness service powered by Apple Watch® includes:

- 11 workout types (from HIIT to core to yoga)
- New workouts every week (from 5–45 minutes)
- Handpicked music to keep you going
- A subscription for up to 5 family members



GET STARTED AT UHC.COM/APPLE-FITNESS-PLUS

Stronger with the Peloton App

Get a 1-year Peloton Digital Membership—which gives you access to the Peloton® App—at **no additional cost** to you. That's a value of $155 per year for you and each covered family member age 18 and over.

Here's what the Peloton App includes:

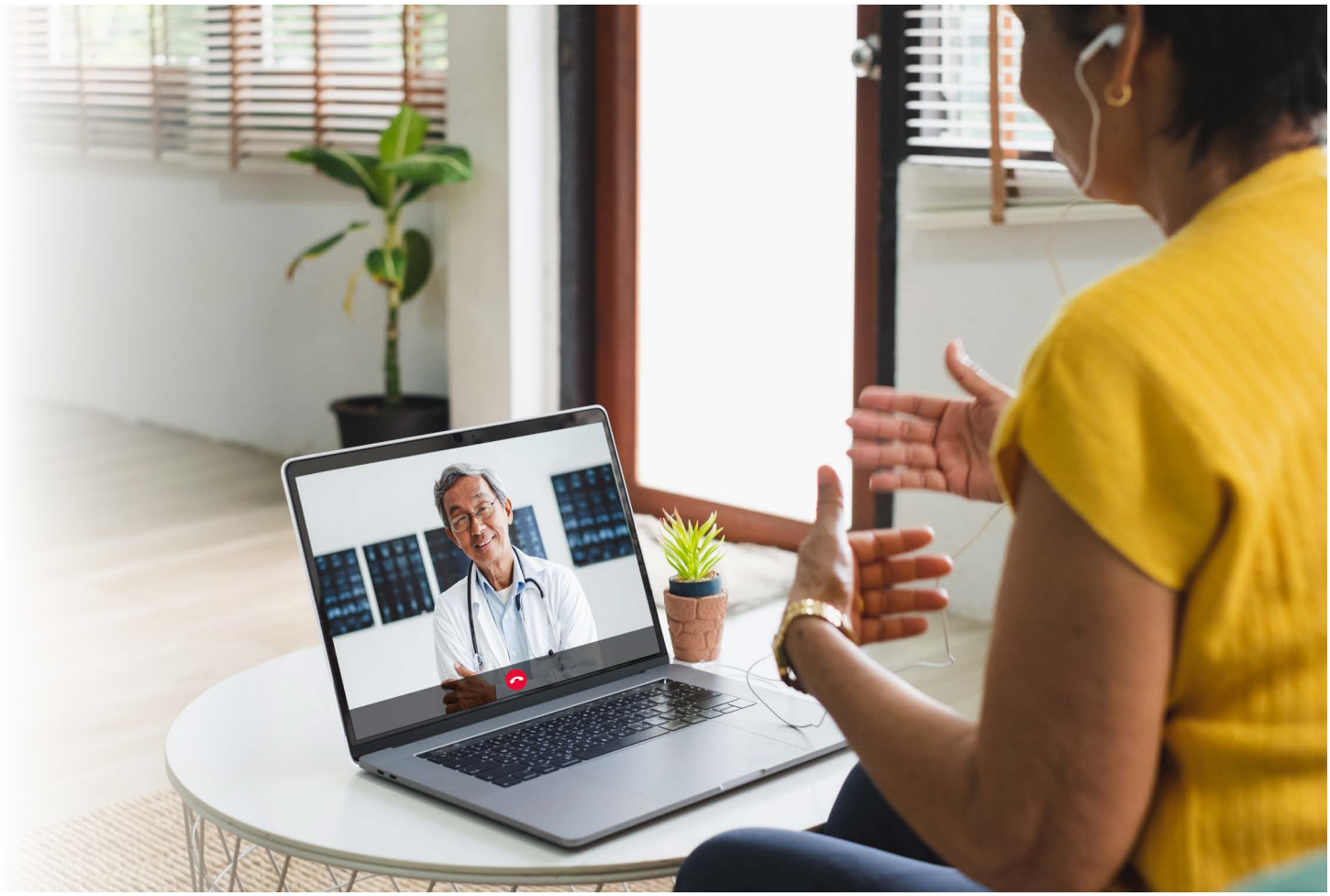
- Thousands of fitness classes
- The flexibility to get active anywhere, anytime
- Ways to help you have fun and stay motivated

LEARN MORE AT UHC.COM/PELOTON

Virtual Visit/Doctor on Demand

Online access to care with no copay after your deductible. A virtual visit lets you see a doctor using the camera on your smartphone, tablet or computer. You can even get a prescription sent to your local pharmacy, all in 30 minutes or less.

- Cost: No Charge, after your annual medical plan deductible has been met.
- No driving or crowded waiting rooms
- 24/7 access
- How to access: Log into **MyUHC.com** or the UnitedHealthcare smartphone app to access
  - Allergies
  - Bladder infections
  - Bronchitis
  - Cough/colds
  - Diarrhea
  - Fever
  - Pinkeye
  - Rashes
  - Seasonal flu
  - Sinus problems
  - Sore throat
  - Stomach aches



Dependent Care Flexible Spending Account

You may use pre-tax dollars from your Dependent Care Flexible Spending Account (DCFSA) to pay expenses for care when the services enable you and your spouse to work. These include expenses for the custodial care of a dependent child, spouse or elderly parent (provided they are your tax dependents). Also included are baby-sitters, nursery schools, and day care centers.

Only the portion of expenses which enable you to remain employed are eligible. Educational expenses are not eligible.

2022 DCFSA CONTRIBUTION LIMIT
$5,000

Or $2,500 if you are married and file a separate tax return.

Making Changes

Federal regulations prohibit you from changing your enrollment or the amount of your election during the plan year. You are only eligible to change your elections during the year if you have a life event status change. Only benefit changes consistent with the change in status are permitted. Life event status changes that may warrant a change in benefit elections are described elsewhere in this guide.

Eligible Dependents

In regards to your Dependent Care FSA, the IRS defines an eligible dependent as:

- A child under the age of 13 and may be claimed as a deduction for personal exemption under Code Section 151(c).
- A spouse who is physically or mentally incapable of selfcare.
- A disabled person who is physically or mentally incapable of self-care who you provide more than 50% support, and who qualifies as your dependent under Code Section 152.

Voluntary Life and Disability

Life and AD&D Insurance

Life insurance provides financial protection for your family in the event of your passing. You have the option to purchase life and accidental death and dismemberment insurance at affordable group rates through Principal.

Benefit Reduction Schedule: 35% benefit reduction at age 65, with an additional 15% reduction at age 70

Employee: $10,000 increments to $500,000 max.

Spouse: $5,000 increments to $50,000 max. (not to exceed 50% of employee coverage amount)

Child(ren): $5,000 OR $10,000. Under 14 days old: $1,000

Short-Term Disability

To ensure your income will continue if you are unable to work due to a disability, you have the option to purchase short-term disability (STD) through Principal. Benefits are payable for a non-occupational injury or illness that keep you from performing the normal duties of your job. If a medical condition is job-related, it is considered Workers' Compensation rather than STD.

Benefits Begin: after 14 days

Benefit Amount: 60% of pre-disability earnings

Maximum Benefit: $1,000 per week

Benefit Duration: 24 weeks

EMPLOYER PAYS $2.30 BI-WEEKLY TOWARDS THE STD COST

Long-Term Disability

Long-term disability (LTD) insurance helps replace a portion of your income if you are disabled for an extended period of time. You have the option to purchase long-term disability through Principal.

Benefits Begin: after 180 days

Benefit Amount: 60% of pre-disability earnings

Maximum Benefit: $10,000 per month

Benefit Duration: 5 years

YOU PAY 75%
EMPLOYER PAYS 25%

Portability Options for Voluntary Life

Portability is available when an Insured Person's employment terminates for a reason other than sickness or injury or retirement at the Social Security Normal Retirement Age (SSNRA). The Insured Person's coverage must be enforce for at least 12 months in a row just prior to the date employment ends.

This person has the option to continue all or part of his or her insurance enforce when employment ends without Evidence of Insurability. To continue insurance, application and the first premium payment must be made within the time period specified in the policy. Coverage can continue until the earlier of the date the master policy terminates or up to 36 Months.

2022 Employee Contributions

Plan Cost Per Pay	Medical			Dental	Vision
	OCI $5,000	OCI $3,000	CHOICE $3,000		
Employee Only	$92.47	$138.46	$165.21	$7.14	$3.06
Employee + Spouse	$386.28	$449.39	$527.57	$14.29	$5.08
Employee + Child(ren)	$230.92	$281.04	$339.58	$16.70	$5.34
Family	$457.98	$550.45	$650.51	$25.13	$7.42

Plan Cost Per Pay — Voluntary Term Life

Employee Age	Employee									
	$10,000	$20,000	$30,000	$40,000	$50,000	$60,000	$70,000	$80,000	$90,000	$100,000
29 and under	$0.46	$0.93	$1.39	$1.84	$2.31	$2.77	$3.23	$3.69	$4.16	$4.61
30-34	$0.53	$1.07	$1.59	$2.12	$2.66	$3.19	$3.71	$4.24	$4.78	$5.31
35-39	$0.69	$1.40	$2.09	$2.79	$3.49	$4.18	$4.88	$5.57	$6.27	$6.97
40-44	$0.96	$1.92	$2.88	$3.84	$4.80	$5.76	$6.72	$7.68	$8.64	$9.60
45-49	$1.47	$2.95	$4.42	$5.89	$7.37	$8.84	$10.30	$11.77	$13.25	$14.72
50-54	$2.32	$4.66	$6.98	$9.30	$11.64	$13.96	$16.28	$18.60	$20.94	$23.26
55-59	$3.66	$7.33	$10.99	$14.66	$18.33	$21.99	$25.65	$29.31	$32.98	$36.65
60-64	$4.76	$9.52	$14.28	$19.03	$23.80	$28.55	$33.31	$38.06	$42.83	$47.58
	$6,500	$13,000	$19,500	$26,000	$32,500	$39,000	$45,500	$52,000	$58,500	$75,000
65-69	$4.82	$9.64	$14.46	$19.27	$24.10	$28.91	$33.73	$38.54	$43.37	$100.95
	$5,000									
70 & Over	$6.47									

Voluntary Term Life

Employee Age	Spouse				
	$5,000	$10,000	$15,000	$20,000	$25,000
29 and under	$0.23	$0.46	$0.69	$0.93	$1.16
30-34	$0.26	$0.53	$0.79	$1.07	$1.33
35-39	$0.35	$0.69	$1.04	$1.40	$1.74
40-44	$0.48	$0.96	$1.44	$1.92	$2.40
45-49	$0.73	$1.47	$2.20	$2.95	$3.68
50-54	$1.16	$2.32	$3.48	$4.66	$5.82
55-59	$1.83	$3.66	$5.49	$7.33	$9.16
60-64	$2.38	$4.76	$7.13	$9.52	$11.90
	$3,250	$6,500	$9,750	$13,000	$16,250
65-69	$2.41	$10.10	$7.23	$9.64	$12.04
	$2,500	$5,000			
70 & Over	$3.24	$10.76			

Dependent Child(ren) - $0.46 for $5,000 or $0.92 for $10,000

Plan Cost Per Pay	Short-Term Disability	Long-Term Disability
Employee Age	Rate	
24 and under	0.0221538	0.0025846
25-29	0.0221538	0.0025846
30-34	0.0216923	0.0025846
35-39	0.0216923	0.0025846
40-44	0.0216923	0.0026769
45-49	0.0184615	0.0028615
50-54	0.0235385	0.0029077
55-59	0.0235385	0.0030000
60-64	0.0263077	0.0030000
65-69	0.0240000	0.0030000
70 & Over	0.0240000	0.0030462

To determine your estimated bi-weekly deduction, multiply your covered monthly earnings by your **LTD** age rate from the above chart.

$ _____ X _____ X 75% = $ _____

Covered Monthly Earnings | Age Rate | Employee Contribution Percentage | Estimated Bi-weekly Deduction

To determine your estimated bi-weekly deduction, multiply your estimated weekly benefit amount by your **STD** age rate from the above chart.

$ _____ X _____ - $2.30 = $ _____

Estimated Weekly Benefit Amount | Age Rate | Employer Contribution Percentage | Estimated Bi-weekly Deduction

Glossary of Terms

This glossary has many commonly used terms, but it isn't a full list. These are not contract terms. Those can be found in your insurance policy or certificate.

Allowed Amount: Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Appeal: A request for your health insurer or plan to review a decision or a grievance again.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may not balance bill you.

Co-insurance: Your share of the costs of a covered health care service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay co-insurance plus any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your co-insurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount. (Jane pays 20%, her plan pays 80%.)

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency cesarean section aren't complications of pregnancy.

Co-payment: A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

Deductible: The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your deductible is $1000, your plan won't pay anything until you've met your $1000 deductible for covered health care services subject to the deductible. The deductible may not apply to all services. (Jane pays 100%, her plan pays 0%.)

Durable Medical Equipment (DME): Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches or blood testing strips for diabetics.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm. Emergency Medical Transportation Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services received in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Excluded Services: Health care services that your health insurance or plan doesn't pay for or cover.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Health care services a person receives at home.

Hospice Services: Services to provide comfort and support for persons in the last stages of a terminal illness and their families.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

In-network Co-insurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network co-insurance usually costs you less than out-of-network co-insurance.

In-network Co-payment: A fixed amount (for example, $15) you pay for covered health care services to providers who contract with your health insurance or plan. In-network co-payments usually are less than out-of-network co-payments.

Medically Necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, disease or its symptoms and that meet accepted standards of medicine.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Non-Preferred Provider: A provider who doesn't have a contract with your health insurer or plan to provide services to you. You'll pay more to see a non-preferred provider. Check your policy to see if you can go to all providers who have contracted with your health insurance or plan, or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers.Out-of-Network Co-insurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do not contract with your health insurance or plan. Out-of-network co-insurance usually costs you more than in-network co-insurance.

Out-of-Network Co-payment: A fixed amount (for example, $30) you pay for covered health care services from providers who do not contract with your health insurance or plan. Out-of-network co-payments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit. (Jane pays 0%, her plan pays 100%.)

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan: A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide services to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating" providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Premium: The amount that must be paid for your health insurance or plan. You and or your employer usually pay it yearly.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Prescription Drugs: Drugs and medications that by law require a prescription.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Reconstructive Surgery: Surgery and follow-up treatment needed to correct or improve a part of the body because of birth defects, accidents, injuries or medical conditions.

Rehabilitation Services: Health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: Services from licensed nurses in your own home or in a nursing home. Skilled care services are from technicians and therapists in your own home or in a nursing home.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

UCR (Usual, Customary and Reasonable): The amount paid for a medical service in a geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

Urgent Care: Care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require emergency room care.

Annual Notices

Health Insurance Portability and Accountability Act (HIPAA)

For purposes of the health benefits offered under the Plan, the Plan uses and discloses health information about you and any covered dependents only as needed to administer the Plan. To protect the privacy of health information, access to your health information is limited to such purposes. The health plan options offered under the Plan will comply with the applicable health information privacy requirements of federal Regulations issued by the Department of Health and Human Services. The Plan's privacy policies are described in more detail in the Plan's Notice of Health Information Privacy Practices or Privacy Notice. Plan participants in the Company-sponsored health and welfare benefit plan are reminded that the Company's Notice of Privacy Practices may be obtained by submitting a written request to the Human Resources Department. For any insured health coverage, the insurance issuer is responsible for providing its own Privacy Notice, so you should contact the insurer if you need a copy of the insurer's Privacy Notice.

Newborns' and Mothers' Health Protection Act

Group health plans and health issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours if applicable).

Notice Regarding Special Enrollment

If you are waiving enrollment in the Medical plan for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Medical plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

States with Individual Mandate

Taxpayers in CA, DC, MA, NJ, RI, and VT (this list is neither complete nor exhaustive) are reminded that your state imposes an individual mandate penalty (tax) should you, your spouse, and children choose to not have (and keep) medical/rx coverage for each tax year. Please consult your tax advisor for how a non-election for health coverage may affect your tax situation.

Special Enrollment Rights CHIPRA – Children's Health Insurance Plan

You and your dependents who are eligible for coverage, but who have not enrolled, have the right to elect coverage during the plan year under two circumstances:

- You or your dependent's state Medicaid or CHIP (Children's Health Insurance Program) coverage terminated because you ceased to be eligible.
- You become eligible for a CHIP premium assistance subsidy under state Medicaid or CHIP (Children's Health Insurance Program).
- You must request special enrollment within 60 days of the loss of coverage and/or within 60 days of when eligibility is determined for the premium subsidy.

Genetic Nondiscrimination

The Genetic Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting, or requiring, genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Company asks Employees not to provide any genetic information when providing or responding to a request for medical information. Genetic information, as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Qualified Medical Child Support Order

QMCSO is a medical child support order issued under State law that creates or recognizes the existence of an "alternate recipient's" right to receive benefits for which a participant or beneficiary is eligible under a group health plan. An "alternate recipient" is any child of a participant (including a child adopted by or placed for adoption with a participant in a group health plan) who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant. Upon receipt, the administrator of a group health plan is required to determine, within a reasonable period of time, whether a medical child support order is qualified, and to administer benefits in accordance with the applicable terms of each order that is qualified. In the event you are served with a notice to provide medical coverage for a dependent child as the result of a legal determination, you may obtain information from your employer on the rules for seeking to enact such coverage. These rules are provided at no cost to you and may be requested from your employer at any time.

Annual Notices *continued*

Notice of Required Coverage Following Mastectomies

In compliance with the Women's Health and Cancer Rights Act of 1998, the plan provides the following benefits to all participants who elect breast reconstruction in connection with a mastectomy, to the extent that the benefits otherwise meet the requirements for coverage under the plan:

- reconstruction of the breast on which the mastectomy has been performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- coverage for prostheses and physical complications of all stages of the mastectomy, including lymphedemas. The benefits shall be provided in a manner determined in consultation with the attending physician and the patient. Plan terms such as deductibles or coinsurance apply to these benefits

Women's Preventive Health Benefits

The following women's health services are considered preventive. These services generally will be covered at no cost share, when provided in network:

- Well-woman visits (annually and now including prenatal visits)
- Screening for gestational diabetes
- Human papilloma virus (HPV) DNA testing
- Counseling for sexually transmitted infections
- Counseling and screening for human immunodeficiency virus (HIV)
- Screening and counseling for interpersonal and domestic violence
- Breast-feeding support, supplies and counseling
- Generic formulary contraceptives are covered without member cost-share (for example, no copayment). Certain religious organizations or religious employers may be exempt from offering contraceptive services.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you leave your job to perform military service, you have the right to elect to continue your existing employer-based health plan coverage for you and your dependents (including spouse) for up to 24 months while in the military. Even if you do not elect to continue coverage during your military service, you have the right to be reinstated in your employer's health plan when you are reemployed, generally without any waiting periods or exclusions for pre-existing conditions except for service-connected injuries or illnesses.

Mental Health Parity and Addiction Equity Act of 2008

This act expands the mental health parity requirements in the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Services Act by imposing new mandates on group health plans that provide both medical and surgical benefits and mental health or substance abuse disorder benefits. Among the new requirements, such plans (or the health insurance coverage offered in connection with such plans) must ensure that: the financial requirements applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance abuse disorder benefits.

COBRA

Under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, COBRA qualified beneficiaries (QBs) generally are eligible for group coverage during a maximum of 18 months for qualifying events due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

COBRA coverage is not extended for those terminated for gross misconduct. Upon termination, or other COBRA qualifying event, the former employee and any other QBs will receive COBRA enrollment information.

Qualifying events for employees include voluntary/involuntary termination of employment, and the reduction in the number of hours of employment. Qualifying events for spouses or dependent children include those events above, plus, the covered employee becoming entitled to Medicare; divorce or legal separation of the covered employee; death of the covered employee; and the loss of dependent status under the plan rules.

If a QB chooses to continue group benefits under COBRA, they must complete an enrollment form and return it to the Plan Administrator with the appropriate premium due. Upon receipt of premium payment and enrollment form, the coverage will be reinstated. Thereafter, premiums are due on the 1st of the month. If premium payments are not received in a timely manner, Federal law stipulates that your coverage will be canceled after a 30-day grace period. If you have any questions about COBRA or the Plan, please contact the Plan Administrator.

Please note, if the terms of the Plan and any response you receive from the Plan Administrator's representatives conflict, the Plan document will control.

Health Insurance Marketplace

The Patient Protection Affordability Care Act ("PPACA") was signed into law on March 23, 2010. Under PPACA, individuals are required to have creditable health insurance coverage or pay a penalty to the Internal Revenue Service. This is known as the Individual Mandate. For more information on the details of PPACA please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-workers-and-families.

PPACA created a new way to buy health insurance which is called the Health Insurance Marketplace ("Marketplace"), also known as Exchanges. These Marketplaces are established by each individual state, the federal government or as a partnership between the state and the federal government. Through the Marketplaces, individuals can compare and purchase coverage (with a possible premium subsidy for those qualifying as low income; subsidies are made available as a federal tax credit through the Marketplace for individuals that are not eligible for coverage through their employer.

If you are enrolled in the Company's medical plan, then PPACA may have little effect on you. The Company's medical plans meet or exceed the minimum coverage requirements set by PPACA. If you are eligible for our plans, you will not be eligible for federal tax credits. You still have the option to visit the Marketplace to see the coverage options available. If you purchase a health plan through the Marketplace instead of purchasing health coverage offered by the Company, you will lose any contribution your employer makes for your health coverage, and your payments for coverage through the Marketplace will be made on an after-tax basis. (See https://www.healthcare.gov/have-job-based-coverage/).

If you are not eligible to enroll in the Company's medical plan, you may have a few options to purchase medical coverage. These options, if applicable, may include but are not limited to: your spouse's medical plan, your parent's medical insurance plan (if you are under age 26), or from several insurance companies offered though the Marketplace. If you shop for coverage through the Marketplace, you may be eligible for a federal tax credit and/or subsidy if you qualify as low income. (See also: healthcare.gov).

How Can I Get More Information?

For more information about purchasing medical coverage through the Marketplace please visit healthcare.gov or call 800-318-2596.