KNOW and maximize! YOUR BENEFITS

2021

Human Technologies Corporation

The following is a general overview of our employee benefits program. If you have questions about the benefits included in this overview, please contact HR:

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Provided By:

GILROY KERNAN & GILROY

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CONTACT INFORMATION

Below is the contact information for the various insurance carriers and vendors:

Benefit	Carrier/Vendor	Website	Phone Number
Health/Medical	UMR A UnitedHealthcare Company	https://www.umr.com	1-800-826-9781
Child Health Plus	nystateofhealth The Official Health Plan Marketplace	https://nystateofhealth.ny.gov	1-800-698-4KIDS TTY 1-877-898-5849
FSA	UMR A UnitedHealthcare Company	https://www.umr.com	1-800-826-9781
HRA	UMR A UnitedHealthcare Company	https://www.umr.com	1-800-826-9781
Dental	Guardian	Guardiananytime.com	1-888-600-1600
Vision	Guardian	Guardiananytime.com	1-888-600-1600
LTD (Long Term Disability)	Guardian	Guardiananytime.com	1-888-600-1600
College Tuition Benefit	Guardian	Guardian.collegetuitionbenefit.com	1-215-839-0119
Short Term Disability	Guardian	Guardiananytime.com	1-215-839-0119
Specified Disease	Guardian	Guardiananytime.com	1-215-839-0119

Glossary of Health Coverage and Medical Terms

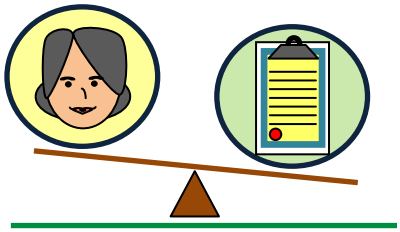
- This glossary has many commonly used terms, but isn't a full list. These glossary terms and definitions are intended to be educational and may be different from the terms and definitions in your plan. Some of these terms also might not have exactly the same meaning when used in your policy or plan, and in any such case, the policy or plan governs. (See your Summary of Benefits and Coverage for information on how to get a copy of your policy or plan document.)
- Bold blue text indicates a term defined in this Glossary.
- See page 4 for an example showing how deductibles, co-insurance and out-of-pocket limits work together in a real life situation.

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 for covered services.

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.



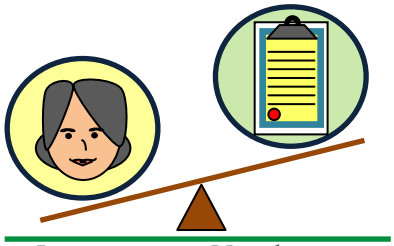
Jane pays 20% | Her plan pays 80%

(See page 4 for a detailed example.)

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 caesarean 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%

(See page 4 for a detailed example.)

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 you get 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, condition, disease or its symptoms and that meet accepted standards of medicine.

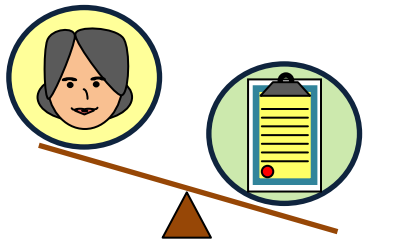
Network
The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

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 co-payments.

Out-of-Pocket Limit
The most you pay during a 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.



(See page 4 for a detailed example.)

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 monthly, quarterly or 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.

HEALTH/MEDICAL

Health Plan Option Overview

Option 1 - HYBRID		
Insurance Company	UMR/United Healthcare	
Plan Network	In-Network	Out-of-Network
Deductible (Individual/Family)	$1,000/$3,000 (combined in and out)	
Coinsurance	20%	40%
Out-of-Pocket Max	$4,200/$12,600 (combined in and out)	
Prescription Coverage (In Network) Tier 1/Tier 2/Tier 3	$5/$35/$70 $0 Generic for Kids	No Coverage
Are Prescription Drugs subject to the deductible first?	No	No
Hybrid Plan Details	SEE ADDENDUM FOR MORE DETAILS	

Cost

Great news! If you participate in our wellness program, your annual premium will be reduced by $1,000 for single or $2,000 for 2 person or family. See your details below:

Plan #1 Name: Hybrid – Non-wellness

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$788.74	$300.58	$488.16	$138.73	$225.30
Employee + Spouse	$1,641.69	$1,083.36	$558.33	$500.01	$257.69
Employee + Child	$1,641.69	$1,083.36	$558.33	$500.01	$257.69
Family	$2,264.68	$1,706.35	$558.33	$787.55	$257.69

Plan #1 Name: Hybrid - Wellness

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$788.74	$217.25	$571.49	$100.27	$263.76
Employee + Spouse	$1,641.69	$916.69	$725.00	$423.09	$334.62
Employee + Child	$1,641.69	$916.69	$725.00	$423.09	$334.62
Family	$2,264.68	$1,539.68	$725.00	$710.62	$334.62

HEALTH/MEDICAL

Health Plan Options Overview

Option 2 – 2600 HDHP		
Insurance Company	UMR/United Healthcare	
Plan Network	In-Network	Out-of-Network
Deductible (Individual/Family)	$2,600/$5,200	$5,200/$10,400
Coinsurance	0%	10%
Out-of-Pocket Max	$5,500/$11,000 (Ind Max of $6,650)	$11,000/$22,000
Prescription Coverage (In Network) Tier 1/Tier 2/Tier 3	$5/$35/$70 $0 Generic for Kids Preventive Drug Rider Included	No Coverage
Are Prescription Drugs subject to the deductible first?	Yes, unless the drug is on the Preventive Drug Rider List. If so, copays apply immediately.	Not Applicable
2600 HDHP Plan Details	SEE ADDENDUM FOR MORE DETAILS	

Cost

Great news! If you participate in our wellness program, your annual premium will be reduced by $1,000 for single or $2,000 for 2 person or family. See your details below:

Plan #1 Name: 2600 HDHP - Non-Wellness

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$625.29	$141.36	$483.93	$65.24	$223.35
Employee + Spouse	$1,301.45	$743.12	$558.33	$342.98	$257.69
Employee + Child	$1,301.45	$743.12	$558.33	$342.98	$257.69
Family	$1,795.38	$1,237.05	$558.33	$570.95	$257.69

Plan #1 Name: 2600 HDHP - Wellness

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$625.29	$58.03	$567.26	$26.78	$261.81
Employee + Spouse	$1,301.45	$576.45	$725.00	$266.05	$334.62
Employee + Child	$1,301.45	$576.45	$725.00	$266.05	$334.62
Family	$1,795.38	$1,070.38	$725.00	$494.02	$334.62

HEALTH/MEDICAL

Health Plan OptionsOverview

Option 3 – 5500 HDHP		
Insurance Company	UMR/United Healthcare	
Plan Network	In-Network	Out-of-Network
Deductible (Individual/Family)	$5,500/$11,000 (Ind Max of $6,650)	$11,000/$22,000
Coinsurance	0%	10%
Out-of-Pocket Max	$5,500/$11,000 (Ind Max of $6,650)	$11,000/$22,000
Prescription Coverage (In Network) Tier 1/Tier 2/Tier 3	$5/$35/$70* $0 Generic for Kids Preventive Drug Rider Included	No Coverage
Are Prescription Drugs subject to the deductible first?	Yes, Unless the drug is on the Preventive Drug List. *Copays apply only to drugs on the Preventive Drug Rider List.	Not Applicable
5500 HDHP Plan Details	SEE ADDENDUM FOR MORE DETAILS	

Cost

Great news! If you participate in our wellness program, your annual premium will be reduced by $1,000 for single or $2,000 for 2 person or family. See your details below:

Plan #1 Name: 5500 HDHP - Non-Wellness

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$509.37	$121.24	$388.13	$55.96	$179.14
Employee + Spouse	$1,060.22	$501.89	$558.33	$231.64	$257.69
Employee + Child	$1,060.22	$501.89	$558.33	$231.64	$257.69
Family	$1,462.55	$904.22	$558.33	$417.33	$257.69

Plan #1 Name: 5500 HDHP - Wellness

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$509.37	$37.91	$471.46	$17.50	$217.60
Employee + Spouse	$1,060.22	$335.22	$725.00	$154.72	$334.62
Employee + Child	$1,060.22	$335.22	$725.00	$154.72	$334.62
Family	$1,462.55	$737.55	$725.00	$340.41	$334.62

CHILD HEALTH PLUS

Free or low-cost health insurance for your child(ren)!

Child Health Plus (CHP) is a New York State sponsored health insurance program. Your child will receive health care at a low premium cost, or no cost at all, depending on your income level, for these and other services:

- Regular well child doctor check - ups and immunizations
- Inpatient hospital care
- Prescription drugs and over-the-counter-drugs
- Dental care (does not include braces)

There are some eligibility requirements to enroll in the coverage. Your child is eligible for Child Health Plus if:

- Your child is a New York State resident
- Your child is less than 19 years of age
- Your child is not eligible for Medicaid
- Your child has little or no other health insurance

For more information on the program, please visit:
http://www.health.state.ny.us/nysdoh/chplus/index.htm

For more information about eligibility and pricing, visit:
https://www.health.ny.gov/health_care/child_health_plus/eligibility_and_cost.htm

To apply for this program, please contact your local community organization can help you enroll in Child Health Plus:
http://www.health.state.ny.us/nysdoh/chplus/where_do_i_apply.htm

Please call this toll-free number to ask about Child Health Plus:
1-800-698-4543

TTY users please call:
1-877-898-5849

Note: before enrolling please check with your primary care provider to see if they accept Child Health Plus.

FLEXIBLE SPENDING ACCOUNT

Paying for health expenses can be stressful but by planning ahead and putting money in a health flexible spending account (FSA) will help you save on taxes while keeping a reserve of money available for health care costs.

Setting Up An FSA

If you have questions about setting up an FSA, contact Human Resources.

Contributions

Employee Contribution: your contribution amount is to be determined by you!

The FSA operates with a use-or-lose rule, meaning if you don't use the money in your FSA by the end of the plan year, you will lose it. However, there is a "Roll Over" which allows you to carry over up to $500 of any unused funds into the next year.

After your initial contribution election, you ordinarily cannot change your election for a plan year during the year. Your elected contribution amount can only be changed if you experience a permitted election change event, such as a change in family status and your FSA permits you to change your election.

The amount you choose to transfer into your FSA should be based on the amount of qualifying medical expenses you anticipate your family incurring during the plan year. Start by looking at your family's medical expenses for the past year and then determine whether your family will likely have those same expenses again and whether there will likely be any new expenses. Use this estimate to help you choose what amount you would like to contribute to your FSA, remembering that it is typically best to underestimate by a little than to overestimate and lose that money at the end of the year.

Note: In 2021, the maximum amount that can be contributed to your Health FSA is $2,750.

Using Your FSA Funds

When you are paying for a qualified medical expense that you would like to use your FSA funds for, you will use the following method:

Health Payment Card

This is very similar to a debit or credit card. You can pay for eligible medical services or products by swiping the card as you would a debit or credit card. The money will then be deducted from your FSA account. Health care payment cards may be used only on eligible medical expenses that are not reimbursed or covered by another source. Over-the-counter (OTC) medications are only eligible for reimbursement if they are prescribed to you and if you present the prescription at the time of purchase. The only OTC medication that can be reimbursed without a prescription is insulin.

Note: Funds do not need to be available in the account in order to be reimbursed; however, health care payment cards may not be used to cover more than your annual elected amount.

As a general rule, every claim paid with a health care payment card must be reviewed and substantiated. The IRS guidance allows automatic adjudication for certain card transactions, meaning that receipts do not need to be submitted for verification of expenses for which a health care payment card is used. This applies in three situations at medical providers and 90-percent pharmacies (drug stores and pharmacies where at least 90 percent of the store's gross receipts during the prior taxable year consisted of medical expenses):

- When the total cost of the transaction is equal to the standard copayment for the service(s) received
- When the transaction is for recurring expenses that have previously been approved
- When the merchant provides expense verification to the employer when the transaction takes place

HEALTH REIMBURSEMENT ARRANGEMENT

A health reimbursement arrangement (HRA) can be a great way to take advantage of employer contributions for your health care expenses. An HRA is entirely employer-funded, essentially boosting your salary with tax-free money for health care expenses.

Contributions

Employee Contribution: Employees are NOT able to contribute toward an HRA.

Employer Contribution:

	HRA HDHP 2,600/5,200 Contribution	HRA HDHP 5,500/11,000 Contribution
Single	$1,300	$2,500
Employee + Spouse	$2,600	$5,000
Employee + Child	$2,600	$5,000
Family	$2,600	$5,000

Employer contributions to the HRA are made on a quarterly basis.

Applicable Expenses

The funds in your HRA can be used toward the following expenses only:

- Medical Deductible
- Rx Expenses

Using Your HRA Funds

When you are paying for a qualified medical expense that you would like to use your HRA funds for, you will use the following method:

Health Payment Card

This is very similar to a debit or credit card. You can pay for eligible medical services or products by swiping the card as you would a debit or credit card. The money will then be deducted from your HRA account.

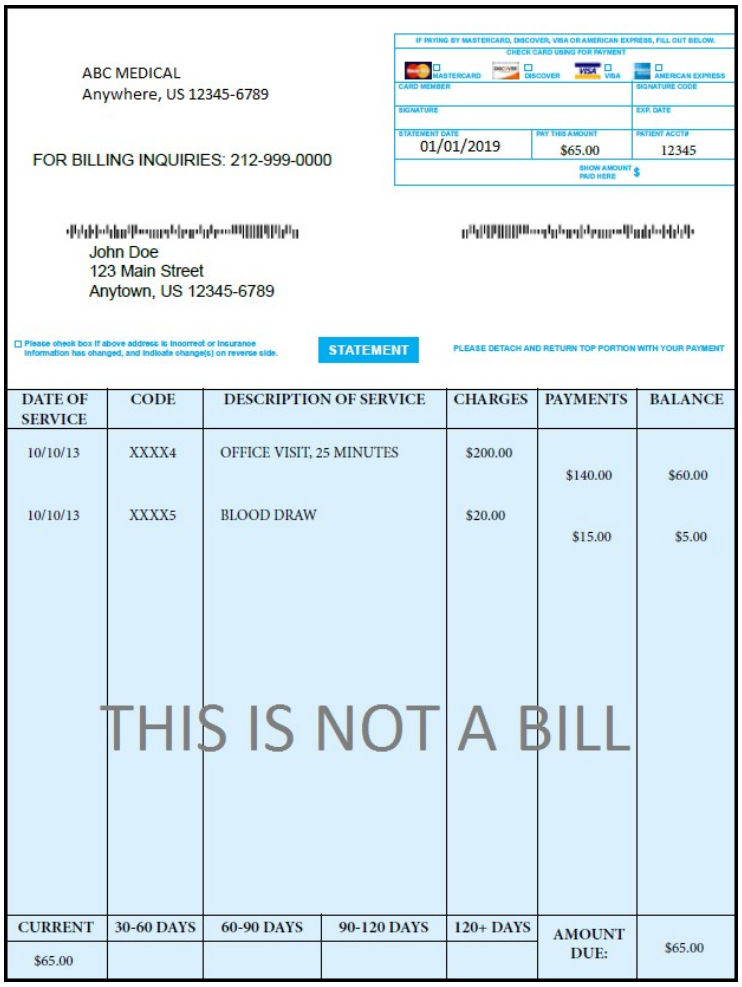
Health care payment cards may be used only on eligible medical expenses that are not reimbursed or covered by another source. Over-the-counter (OTC) medications are only eligible for reimbursement if they are prescribed to you and if you present the prescription at the time of purchase. The only OTC medication that can be reimbursed without a prescription is insulin. Health care payment cards may not be used to cover more than the maximum dollar amount of coverage available in your HRA.

RECORD KEEPING

Recordkeeping

In most cases, you will have to submit receipts and other proof that you purchased an eligible medical service or product in order to receive reimbursement. Make sure you retain all receipts, Explanation of Benefits (EOBs) and other documents to ensure that you have the necessary proof to obtain reimbursement from your FSA.

KEEP YOUR RECEIPTS!! Find a folder, a drawer or even a shoebox and keep all your receipts for prescriptions, medical products and/or services!



ABC MEDICAL
Anywhere, US 12345-6789

FOR BILLING INQUIRIES: 212-999-0000

IF PAYING BY MASTERCARD, DISCOVER, VISA OR AMERICAN EXPRESS, FILL OUT BELOW.
CHECK CARD USING FOR PAYMENT
MASTERCARD DISCOVER VISA AMERICAN EXPRESS
CARD MEMBER | SIGNATURE CODE
SIGNATURE | EXP. DATE
STATEMENT DATE: 01/01/2019 | PAY THIS AMOUNT: $65.00 | PATIENT ACCT#: 12345
SHOW AMOUNT PAID HERE $

John Doe
123 Main Street
Anytown, US 12345-6789

☐ Please check box if above address is incorrect or insurance information has changed, and indicate change(s) on reverse side.

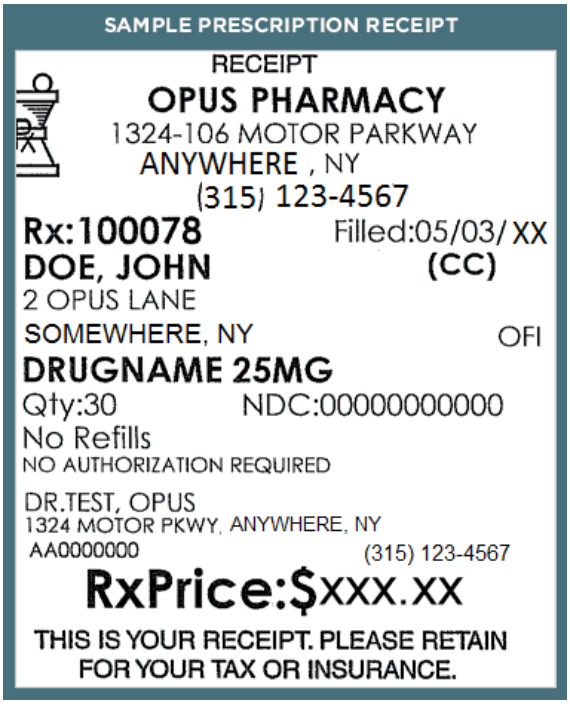
STATEMENT

PLEASE DETACH AND RETURN TOP PORTION WITH YOUR PAYMENT

DATE OF SERVICE	CODE	DESCRIPTION OF SERVICE	CHARGES	PAYMENTS	BALANCE
10/10/13	XXXX4	OFFICE VISIT, 25 MINUTES	$200.00	$140.00	$60.00
10/10/13	XXXX5	BLOOD DRAW	$20.00	$15.00	$5.00

THIS IS NOT A BILL

CURRENT	30-60 DAYS	60-90 DAYS	90-120 DAYS	120+ DAYS	AMOUNT DUE:	$65.00
$65.00						



DENTAL

Dental Plan Option

	Dental Plan	
Insurance Company	Guardian	
Plan Network	In-Network	Out-of-Network
Plan Deductible	$50 – Waived for Preventive	
Annual Plan Maximum	$1,500	
Coinsurance Preventive/Basic/Major	Covered at 100%/Covered at 80%/Covered at 50%	
Claim Payment Basis	Fee Schedule No Balance Billing	UCR 90% Balance Billing
Dental Plan Details	SEE ADDENDUM FOR MORE DETAILS	

Cost

Plan #1 Name: Guardian Dental Plan

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$30.01	$15.00	$15.01	$6.92	$6.93
Family	$85.88	$70.87	$15.01	$32.71	$6.93

VISION

Vision Plan Option

	Vision Plan	
Insurance Company	Guardian	
Plan Network	In-Network	Out-of-Network
Exam Copay	$10	$10
Materials Copay	$20	$20
Exam Allowance	100%	$50
Base Lenses, Contact Lenses, Frames (Frequency: 12 mos/12 mos/24 mos)	100%/$130/$130	$48/$105/$48
Vision Plan Details	SEE ADDENDUM FOR MORE DETAILS	

Cost

Guardian Vision Plan

	Monthly Plan Cost ($)	Monthly Employee Cost Share ($)	Monthly Employer Cost	Employee Cost Per Pay Period	Employer Cost Per Pay Period
Single	$7.53	$7.53	$0.00	$3.48	$0.00
Family	$16.19	$16.19	$0.00	$7.47	$0.00

DISABILITY

Benefit

	NYS Disability	Long-Term Disability
Is This Provided By My Employer?	Yes	Yes, for Leadership Team Only
Benefits Begin (when)	Date of Hire	Date of Hire
Waiting Period	7 Days	180 Days
Percentage of Income Replaced	50% up to $300/week	60% to $5,000/month
Maximum Benefit	26 Weeks	To Age 65

Note: You are not eligible for Disability Benefits if you are receiving Workers' Compensation.

Cost

Human Technologies covers the cost of this benefit, with the exception of a $0.60 weekly payroll deduction.

NYS PAID FAMILY LEAVE

As of January 1, 2018, most employees who work in New York State for private employers are eligible to take Paid Family Leave.

New York's Paid Family Leave provides job-protected, paid time off, so you can:

- bond with a newly born, adopted or fostered child;
- care for a close relative with a serious health condition; or
- assist loved ones when a family member is deployed abroad on active military service.

You can continue your health insurance while on leave and are guaranteed the same or a comparable job after your leave ends. If you contribute to the cost of your health insurance, you must continue to pay your portion of the premium cost while on Paid Family Leave.

BENEFIT

Paid Family Leave benefits phase in over four years. During 2021, you can take up to 12 weeks of Paid Family Leave and receive 67% of your average weekly wage (AWW), capped at 67% of the New York State Average Weekly Wage (SAWW).

Leave can be taken either all at once or in full-day increments. You may take the maximum time-off benefit in any given 52-week period. The 52-week clock starts on the first day you take Paid Family Leave.

PAID FAMILY LEAVE HELPLINE

Questions? Call the Paid Family Leave Helpline at 844-337-6303 from 8:30am – 4:30pm ET, Monday - Friday

PAID FAMILY LEAVE: FAMILY MATTERS

Helping New Yorkers in Need

For more information, visit:

https://paidfamilyleave.ny.gov/paid-family-leave-information-employees

Voluntary Benefits

Benefit

	Specified Disease	Supplemental Short-Term Disability
Benefits Begin (when)	Upon verified diagnosis of Covered Condition	8th day after accident/sickness
Waiting Period	Varies Depending on Condition	8th day after accident/sickness
Percentage of Income Replaced	Employee may choose a lump sum of $5,000 to $20,000, in increments of $5,000	40% to $1,000/week
Maximum Benefit		26 Weeks

Please see addendum for further plan details on both voluntary benefits offered.

Cost

Specified Disease

Bi-weekly Premiums Displayed

Election Cost Per Age Bracket

	< 30	*30-39*	*40-49*	*50-59*	*60-69*	*70+*
Employee						
$5,000	$0.69	$1.06	$2.29	$4.75	$8.61	$15.46
$10,000	$1.39	$2.12	$4.57	$9.51	$17.22	$30.92
$15,000	$2.08	$3.19	$6.85	$14.26	$25.82	$46.39
$20,000	$2.77	$4.25	$9.14	$19.02	$34.43	$61.85
Benefit Amount Up To 50% of Employee Amount to a Maximum of $10,000						
Spouse						
$2,500	$0.35	$0.53	$1.15	$2.38	$4.30	$7.73
$5,000	$0.69	$1.06	$2.29	$4.75	$8.61	$15.46
$7,500	$1.04	$1.59	$3.43	$7.13	$12.91	$23.19
$10,000	$1.39	$2.12	$4.57	$9.51	$17.22	$30.92

Short Term Disability

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
Your premium rate (estimated example salaries)	$0.540	$0.620	$0.940	$0.860	$0.700	$0.700	$0.940	$1.190	$1.460
				Election Cost Per Age Bracket					
	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
$20,000 Annual Salary $154 Weekly Benefit	$3.84	$4.41	$6.68	$6.11	$4.98	$4.98	$6.68	$8.46	$10.38
$40,000 Annual Salary $308 Weekly Benefit	$7.68	$8.81	$13.36	$12.23	$9.95	$9.95	$13.36	$16.92	$20.75
$60,000 Annual Salary $462 Weekly Benefit	$11.51	$13.22	$20.04	$18.34	$14.93	$14.93	$20.04	$25.37	$31.13
$80,000 Annual Salary $615 Weekly Benefit	$15.33	$17.60	$26.68	$24.41	$19.87	$19.87	$26.68	$33.78	$41.44
$100,000 Annual Salary $769 Weekly Benefit	$19.17	$22.01	$33.36	$30.52	$24.85	$24.85	$33.36	$42.24	$51.82
$120,000 Annual Salary $923 Weekly Benefit	$23.00	$26.41	$40.04	$36.64	$29.82	$29.82	$40.04	$50.69	$62.20
$140,000 Annual Salary $1,000 Weekly Benefit	$24.92	$28.62	$43.39	$39.69	$32.31	$32.31	$43.39	$54.92	$67.39

ADDENDUM

Human Technologies Health Plan

Hybrid Summary of Benefits

A UnitedHealthcare Company

All claims must be filed within 12 months from the date the claim is incurred or the claim will be denied.

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible Per Person Family *Deductibles are combined for in and out-of-network Providers, except where noted.	$1,000.00 $3,000.00	
Out-of-Pocket Maximum Per Calendar Year Per Person Family *Maximums are combined for in and out-of-network Providers, except where noted.	$4,200.00 $12,600.00	
Primary Care Physician Office Visits	$25.00 copay; $0.00 copay for Children under age 19.	60% after deductible
Specialist Office Visits	$40.00 copay	60% after deductible
Urgent Care Visit	$40.00 copay	60% after deductible
Emergency Room *Copay waived in-network if admitted within 24 hours	$150.00 copay, no deductible	$150.00 copay, no deductible
Ambulance *Ground, water or air ambulances that are Medically Necessary and appropriate are covered.	$150.00 copay	
Durable Medical Equipment	80% after deductible	60% after deductible
Outpatient Diagnostic X-Ray and Lab	$40.00 copay	60% after deductible
Outpatient Hospital Services	80% after deductible	60% after deductible
Inpatient Hospital Services *Prior Authorization requested	80% after deductible	60% after out-of-network deductible
Physical Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	$40.00 copay per visit	60% after out-of-network deductible
Speech, Occupational Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	$40.00 copay per visit	60% after deductible
Preventive/Routine Exams	100%; deductible waived	60% after deductible
Immunizations	100%; deductible waived	60% after deductible
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	60% after deductible
Mammograms	100%; deductible waived	60% after deductible
Preventive/Routine Pap Test	100%; deductible waived	60% after deductible
Preventive/Routine PSA and Prostate Screening	100%; deductible waived	60% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	60% after deductible
Preventive/Routine Hearing Exams *Limited to one exam per calendar year (Adult & Child)	$40 copay	60% after deductible
Women's Preventive Health Care	100%; deductible waived	60% after deductible

Prescription Drug Benefits

Retail Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (up to a 30-day supply)	
For Generic Drugs	$5.00 *Copay waived for children under age 19/Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$35.00
For Non-Preferred Brand Drug	$70.00
Retail 90 RX Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (up to a 90-day supply)	
For Generic Drugs	$10.00 *Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$70.00
For Non-Preferred Brand Drugs	$140.00
Mail Order Option – Optum RX	
Co-Pay Per Prescription (up to a 90-day supply)	
For Generic Drugs	$10.00
For Preferred Brand Drugs	$70.00
For Non-Preferred Drugs	$140.00

Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification card.

Optum RX Member Services: 1-877-559-2955

This is a summary of benefits and not a guarantee. Benefit payments are subject to all plan provisions and eligibility requirements at the time services are rendered. The plan document and summary plan description are the official sources of information. In the event of a discrepancy, the plan document and summary plan description will prevail.

UMR℠

A UnitedHealthcare Company

Human Technologies Health Plan

2600 HDHP Plan Option Coverage Summary

All claims must be filed within 12 months from the date the claim is incurred or the claim will be denied.

A UnitedHealthcare Company

Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible Per Person Family *Deductibles are combined for in and out-of-network Providers, except where noted. On a family contract the entire family deductible must be satisfied before copay and co-insurance benefits apply.	$2,600.00 $5,200.00	$5,200.00 $10,400.00
Out-of-Pocket Maximum Per Calendar Year Per Person Family *Maximums are combined for in and out-of-network Providers, except where noted.	$5,500.00 $11,000.00 *An individual enrolled in a family contract will not be required to meet more than a $6,650.00 embedded Out-of-Pocket maximum.	$11,000.00 $22,000.00
Primary Care Physician Office Visits	100% after deductible	90% after deductible
Specialist Office Visits	100% after deductible	90% after deductible
Urgent Care Visit	100% after deductible	90% after deductible
Emergency Room *Out-of-Network is subject to in-network deductible.	100%; subject to $2,600 deductible	
Ambulance *Ground, water or air ambulances that are Medically Necessary and appropriate are covered.	100% after deductible	Ground Ambulance 100%, subject to $2,600 deductible. Air Ambulance 90% subject to out-of-network deductible.
Durable Medical Equipment *Prior Authorization requested over $2,500.00	100% after deductible	90% after deductible
Outpatient Diagnostic X-Ray and Lab	100% after deductible	90% after deductible
Outpatient Hospital Services	100% after deductible	90% after deductible
Inpatient Hospital Services *Prior Authorization requested	100% after deductible	90% after deductible
Physical Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy	100% after deductible	90% after deductible
Speech, Occupational Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy	100% after deductible	90% after deductible
Preventive/Routine Exams	100%; deductible waived	90% after deductible *well child care 100% no deductible
Immunizations	100%; deductible waived	90% after deductible *well child care 100% no deductible
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	90% after deductible
Mammograms	100%; deductible waived	90% after deductible
Preventive/Routine Pap Test	100%; deductible waived	90% after deductible
Preventive/Routine PSA and Prostate Screening	100%; deductible waived	90% after deductible
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	90% after deductible
Preventive/Routine Hearing Exams *Limited to one exam per calendar year (Adult & Child)	100%; deductible waived	90% after deductible
Women's Preventive Health Care	100%; deductible waived	90% after deductible

Prescription Drug Benefits

Deductible must be satisfied before copays are applicable. Note: The deductible is waived for certain preventive drugs.

Retail Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (up to a 30-day supply)	
For Generic Drugs	$5.00 *Copay waived for children under age 19/Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$35.00
For Non-Preferred Brand Drug	$70.00
Retail 90 RX Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (up to a 90-day supply)	
For Generic Drugs	$10.00 *Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	$70.00
For Non-Preferred Brand Drugs	$140.00
Mail Order Option – Optum RX	
Co-Pay Per Prescription (up to a 90-day supply)	
For Generic Drugs	$10.00
For Preferred Brand Drugs	$70.00
For Non-Preferred Drugs	$140.00

Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. The Plan Out-of-Pocket maximum does apply to prescription drug benefits. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.

Optum RX Member Services: 1-877-559-2955

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Human Technologies Health Plan

5500 HDHP Plan Option Coverage Summary

All claims must be filed within 12 months from the date the claim is incurred or the claim will be denied.

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Medical Benefits

Covered Services	In-Network Providers	Non-Network Providers
Calendar Year Deductible/Out-Of-Pocket maximum Per Person Family *Maximums are combined for in and out-of-network Providers, except where noted. On a family contract the entire family deductible must be satisfied before copay and co-insurance benefits apply.	$5,500.00 $11,000.00 *An individual enrolled in a family contract will not be required to meet more than a $6,650.00 embedded Out-of-Pocket maximum.	$11,000.00 $22,000.00
Primary Care Physician Office Visits	100% after deductible	100% after deductible
Specialist Office Visits	100% after deductible	100% after deductible
Urgent Care Visit	100% after deductible	100% after deductible
Emergency Room	100%; after $5,500.00 deductible applies	
Ambulance *Ground, water or air ambulances that are Medically Necessary and appropriate are covered.	100%; after $5,500.00 deductible applies	
Durable Medical Equipment *Prior Authorization requested over $2,500.00.	100% after deductible	100% after deductible
Outpatient Diagnostic X-Ray and Lab	100% after deductible	100% after deductible
Outpatient Hospital Services	100% after deductible	100% after deductible
Inpatient Hospital Services *Prior Authorization requested.	100% after deductible	100% after deductible
Physical Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	100% after deductible	100% after deductible
Speech, Occupational Therapy *Maximum of 45 visits per Calendar Year. Maximum includes physical, speech and occupational therapy.	100% after deductible	100% after deductible
Preventive/Routine Exams	100%; deductible waived	100%; deductible waived
Immunizations	100%; deductible waived	100%; deductible waived
Preventive/Routine Diagnostic Lab and X-Rays	100%; deductible waived	100%; deductible waived
Mammograms	100%; deductible waived	100%; deductible waived
Preventive/Routine Pap Test	100%; deductible waived	100%; deductible waived
Preventive/Routine PSA and Prostate Screening	100%; deductible waived	100%; deductible waived
Preventive/Routine Colonoscopy, Sigmoidoscopy and Other Similar Procedures	100%; deductible waived	100%; deductible waived
Preventive/Routine Hearing Exams *Limited to one exam per calendar year (Adult & Child)	100%; deductible waived	100%; deductible waived
Women's Preventive Health Care	100%; deductible waived	100%; deductible waived

Prescription Drug Benefits

Deductible must be satisfied before co-insurance is applicable. Note: The deductible is waived for certain preventive drugs.

Retail Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (30-day supply)	
For Generic Drugs	0% Copay *Copay waived for Generic oral contraceptives
For Preferred Brand Drugs	0% Copay
For Non-Preferred Brand Drug	0% Copay
Retail 90 RX Pharmacy Option – Participating Pharmacy	
Co-Pay Per Prescription (90-day supply)	
For Generic Drugs	0% Copay
For Preferred Brand Drugs	0% Copay
For Non-Preferred Brand Drugs	0% Copay
Mail Order Option – Optum RX	
Co-Pay Per Prescription (90-day supply)	
For Generic Drugs	0% Copay
For Preferred Brand Drugs	0% Copay
For Non-Preferred Drugs	0% Copay

Contact your Pharmacy Benefit Manager for prescription drug coverage inquiries. The Plan Out-of-Pocket maximum does apply to prescription drug benefits. Your Pharmacy Benefit Manager's contact information is located on your Benefit Identification Card.

Optum RX Member Services: 1-877-559-2955

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Welcome to UMR

Take a few minutes to learn more about your plan

At UMR, our job is to support you and your employer as you engage in the health plan available to you and your dependents. We're here to guide you in your health care experience and help you live a healthier life.

Enclosed is your new membership card. Try to carry it with you wherever you go and present it at your next health care visit or trip to the pharmacy.

Your card tells you your member ID number, along with your toll-free customer service number and important information your health care providers need to file claims for services you receive.

It will ensure you get discounted rates when you receive services from in-network doctors, clinics and hospitals.

If you have any questions along the way, simply call the member services number on the back of your card. You'll be connected to a team of individuals assigned to answer your questions about eligible services or how your claim was paid.

Use your card to create an account on umr.com. Log in anytime. We're open 24/7 to:

- Look up in-network providers
- View your benefits and claims information
- Access commonly used forms
- Review your financial activity
- Find other tools for improving your health

After you set up your account online, you can also visit **umr.com** on the go with your smart phone or mobile device. To access our mobile Web site, simply visit **umr.com** on your mobile device and you'll be automatically directed to our mobile site. Get quick and easy access to your claim and benefit information anytime, anywhere.

Start using your benefits today!

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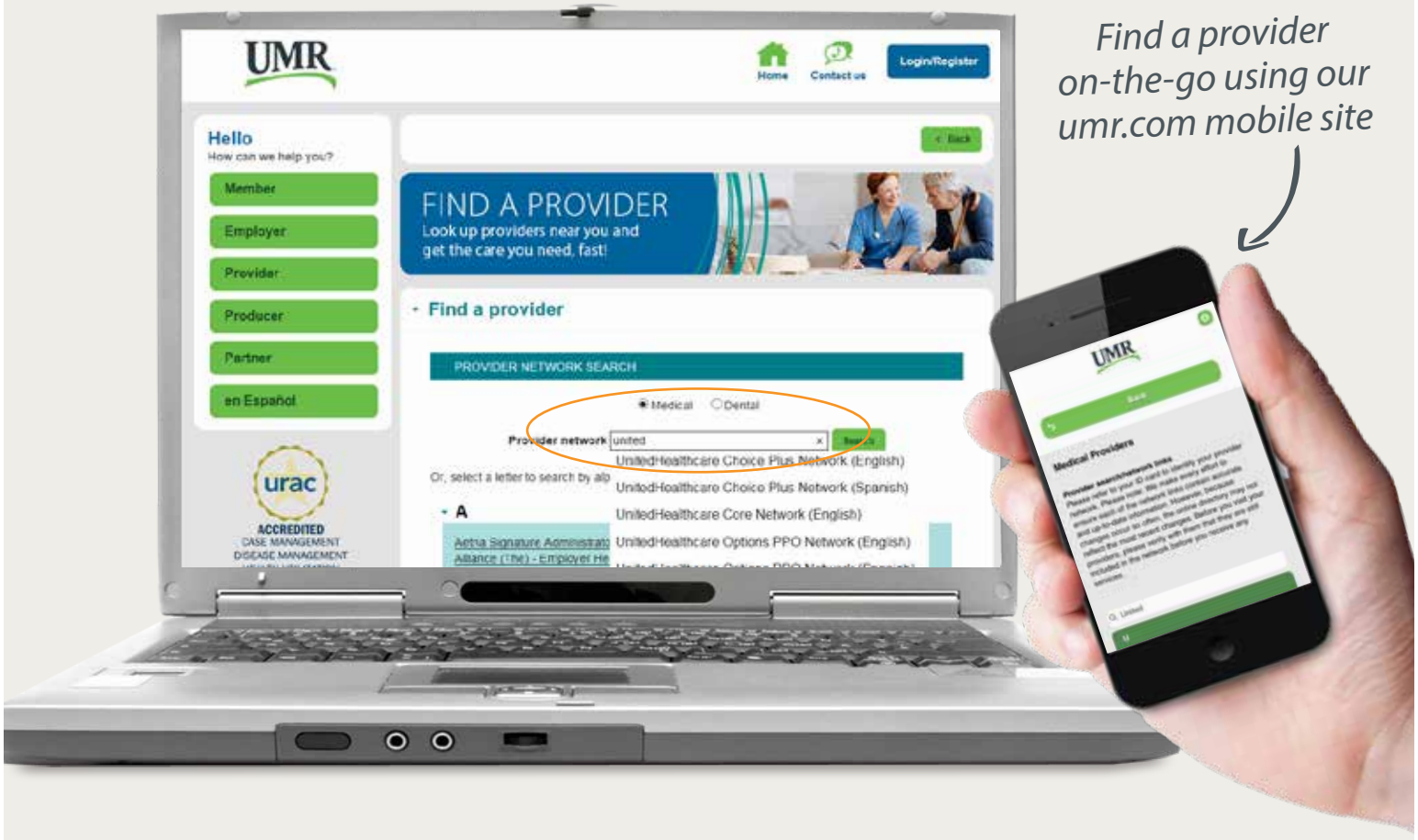
Find a provider

Your new preferred provider networks will be the UnitedHealthcare Choice Plus Network and the POMCO Select Medical Network.

1 Go to **umr.com** and select **"Find a provider"**

2 Search by using our alphabet navigation or type **UnitedHealthcare Choice Plus Network** or **POMCO Select Medical Network** into the search box and follow the prompts



Find a provider on-the-go using our umr.com mobile site

Questions?

Call UMR Customer Service at **1-800-826-9781**.

UMR℠

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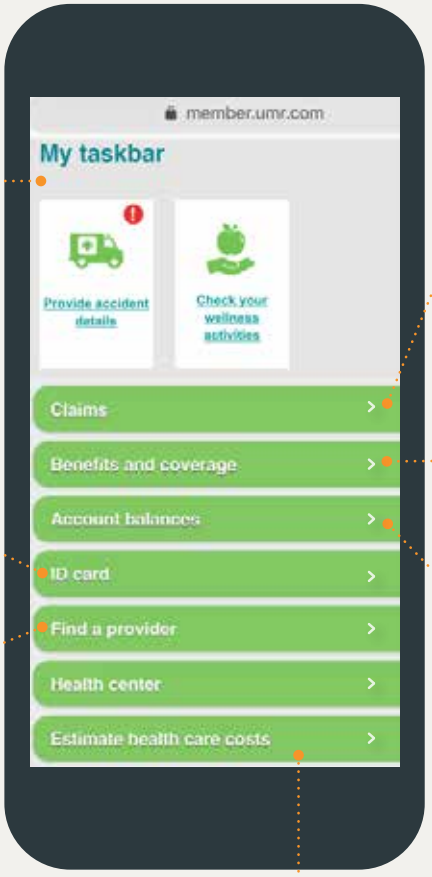
Welcome to
umr.com on the go

As a UMR member you can access your benefits and claims information anytime, anywhere using your mobile device. There's no app to download. Simply log in to **umr.com**



My Taskbar
View upcoming tasks right from the homepage.

Look up claims
Look up a claim for yourself or an authorized dependent.

Share your ID card with your provider
Now, there's no need to carry it with you, it's at your finger tips

Check your benefits
View medical/dental benefits. And, see who's covered under your plan.

Find a provider
Find an in-network provider while you are "**on the go**."

Access account balances
Look up balances for your special accounts including HRAs and FSAs.

Estimate health care costs
See what you can expect to pay before receiving care with the Health Cost Estimator tool.

Want to bookmark umr.com on your mobile device?

iPhone: Touch and hold the open book icon to add **umr.com**

Android: Tap on the menu. Then select "Add Bookmark."

Note: The images above reflect available features within our mobile site. These features may or may not be available to all users depending on your individual and company benefits. If you are having trouble accessing or logging into our mobile site, contact the 800 number on the back of your ID card for fastest service. You can click the "Contact us" link on the home screen.

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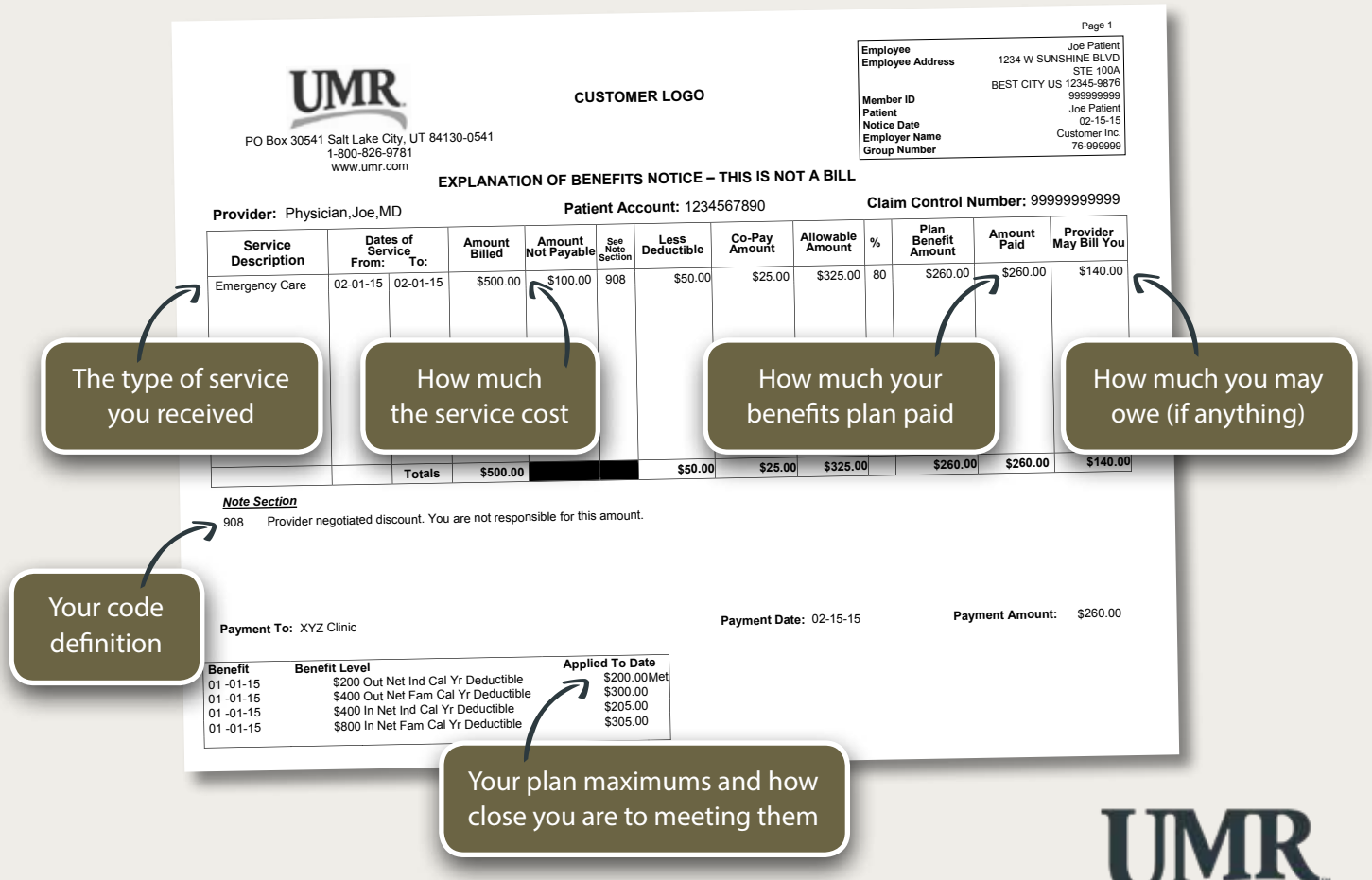
You deserve an explanation

An explanation of benefits (EOB) is not a bill. It simply tells you everything you might want to know about your claims.

Among the more important things included on your EOB are:

- The service you received
- How much the service cost
- How much you may owe, if anything
- A notes section that explains the meaning of any special codes
- A section that shows how close you are to meeting any plan maximums

There is a second page that includes contact numbers if you have questions. It also tells you how to file an appeal if you want a claim decision reviewed.



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24/7 doctor visits via phone or mobile app

TELADOC

Teladoc gives you access 24 hours, 7 days a week to a U.S. board-certified doctor through the convenience of phone, video or mobile app visits. It's an affordable option for quality medical care.

Talk to a doctor anytime, anywhere you happen to be

Receive quality care via phone, video or mobile app

Prompt treatment, median call back, in 10 minutes

A network of doctors that can treat every member of the family

Prescriptions sent to pharmacy of choice if medically necessary

Teladoc is less expensive than the ER or urgent care

Talk to a doctor anytime!

visit **Teladoc.com**
or call
1-800-Teladoc

Google play

Get the care you need

Teladoc doctors can treat many medical conditions, including:

- Cold & flu symptoms
- Allergies
- Pink eye
- Respiratory infection
- Sinus problems
- Skin problems
- And more

With your consent, Teladoc is happy to provide information about your Teladoc visit to your primary care physician.

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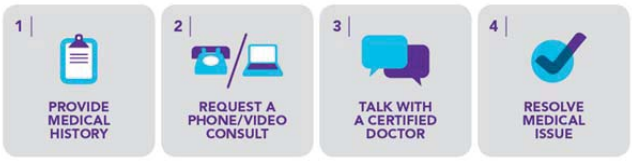
How To Register For Teladoc

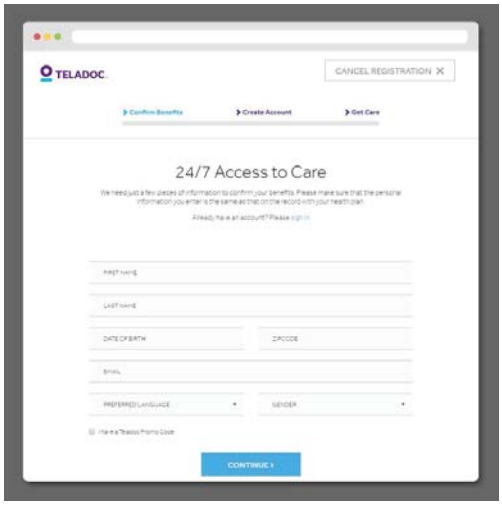
Registering for Teladoc is a quick and easy process. Once registered, you are four steps away from being well!

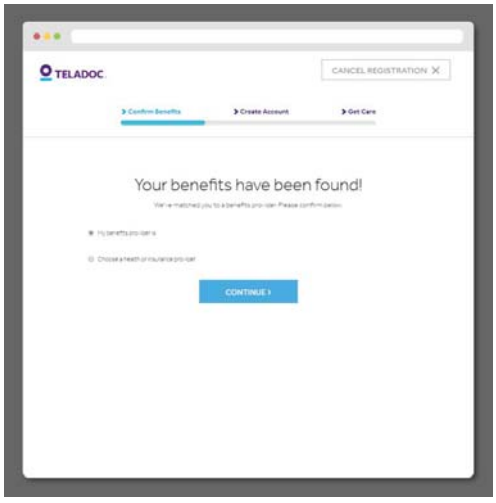


We suggest registering once you have access to the Teladoc service. Registration takes less than 10 minutes and saves vital time when you're not feeling well.

To register, follow these easy steps:

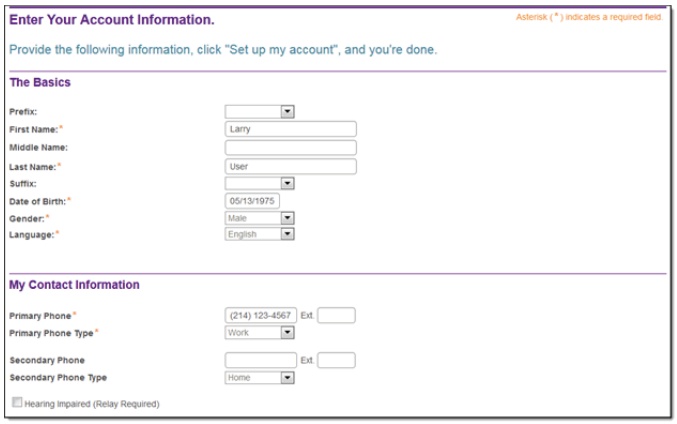
1. Go to Teladoc.com
2. Select *Set Up Account* and enter all required fields (Ex: First/Last Name, DOB, Zip, etc). When you're found, simply select your benefit provider (UMR). If you're not found, click on *Look me up using my health or insurance provider.* Search and highlight UMR. Once UMR is selected from the drop down, a field will appear to enter your *Insurance Card ID* information.





If you ever need help or have questions, you can call our call center 24/7/365 at 800-Teladoc (835-2362)

3. From there, the registration page will appear. You will be prompted to enter your basic information (Ex: Contact, Address, Login). Lastly, it will ask for you to electronically accept the terms, conditions, and privacy policy



4. After accepting the terms, you will then be presented with the option to complete your medical history, go to the home page to register eligible dependents, or perform any other account functions.

***Helpful Hint:** If scheduling a consult, have your credit card handy (if copay applies) and make sure your medical history is completed.

Current Dental Plan Information

PLAN BENEFITS SUMMARY		
	In-Network	**Out-of-Network**
Network	DentalGuard Preferred	None
Coinsurance		
Preventive	100%	100%
Basic	80%	80%
Major	50%	50%
Deductible	$50	$50
Waived for preventive?	Yes	Yes
Claim Payment Basis	Fee Schedule	UCR 90%
Maximum	$1,500	$1,500
Orthodontia	Included	
Lifetime Maximum	$2,000	
Coinsurance	50%	
Maximum Rollover		
Threshold	$700	
Rollover Amount	$350	
In-network only rollover	$500	
Max Rollover Limit	$1,250	
Dependent Age Limit	20/26	

Current Voluntary Vision Plan Information

PLAN BENEFITS SUMMARY			
	In-Network	**Out-of-Network**	**Frequency**
Exam Copay	$10	$10	Once per Calendar Year
Exam Allowance	100%	$50	Once per Calendar Year
Materials Copay	$20	$20	
Base Lenses			
Single Vision Allowance	100%	$48	Once per Calendar Year
Bifocal Allowance	100%	$67	Once per Calendar Year
Trifocal Allowance	100%	$86	Once per Calendar Year
Lenticular Allowance	100%	$126	Once per Calendar Year
Contact Lenses			
Elective Allowance	$130	$105	Once per Calendar Year
Therapeutic Allowance	100%	$210	Once per Calendar Year
Frame Retail Allowance	$130	$48	Every Other Calendar Year
Materials Allowance	N/A	N/A	N/A

The Guardian Tuition Benefit

COLLEGE TUITION BENEFIT

It's true. Your Guardian coverage can help pay for college.

Included with your Guardian coverage is a college tuition benefit. As the cost of college continues to rise faster than inflation and medical costs,[1] Guardian is helping families keep up by providing this benefit in arrangement with SAGE College Tuition Benefit.

- Members enrolled in a Guardian plan earn $2,000 in annual Tuition Rewards®.
- One Tuition Reward point = $1 in tuition reduction.
- Tuition Rewards can be used at over 375 institutions, with 80% ranked among "America's Best" by US News and World Report in 2016.
- Members can share the benefit with eligible relatives, including children, nieces, nephews, step-children and grandchildren, subject to certain restrictions.
- Colleges participate as a way to boost their student recruitment.

See how Guardian plan participants can earn even more rewards to help them save with multiple Guardian products:

Guardian Insurance Product	Sign-up Bonus	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	TOTAL
Dental *Year 4 = Bonus year with dental	500 per child	2,000	2,000	2,000	4,500*	2,000	2,000	2,000	16,500
Life		2,000	2,000	2,000	2,000	2,000	2,000	2,000	14,000
Hospital Indemnity		2,000	2,000	2,000	2,000	2,000	2,000	2,000	14,000
Critical Illness		2,000	2,000	2,000	2,000	2,000	2,000	2,000	14,000
TOTAL	500	8,000	8,000	8,000	10,500	8,000	8,000	8,000	58,500

Please visit https://guardian.collegetuitionbenefit.com for more information

Guardian

HUMAN TECHNOLOGIES CORP.

Short-Term Disability Benefit Summary

Group Number: 00507708

A Disability insurance plan through Guardian provides:

- Income protection while you are unable to work
- Affordable group rates
- Fast claim payments paid directly to you that can help pay for expenses while you recover
- Extensive resources and support to help you get back to work and a productive life

About Your Benefits:

	Short-Term Disability
Coverage amount	40% of salary to maximum $1000/week
Maximum payment period: Maximum length of time you can receive disability benefits.	26 weeks
Accident benefits begin: The length of time you must be disabled before benefits begin.	Day 8
Illness benefits begin: The length of time you must be disabled before benefits begin.	Day 8
Evidence of Insurability: A health statement requiring you to answer a few medical history questions.	Health Statement may be required
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when applicant signs up for coverage during the initial enrollment period.	We Guarantee Issue $1000 in coverage
Minimum work hours/week: Minimum number of hours you must regularly work each week to be eligible for coverage.	Planholder Determines
Pre-existing conditions: A pre-existing condition includes any condition/symptom for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	3 months look back; 12 months after full limitation.
Premium waived if disabled: Premium will not need to be paid when you are receiving benefits.	Yes

UNDERSTANDING YOUR BENEFITS—DISABILITY (Some information may vary by state)

- **Earnings definition:** Your covered salary excludes bonuses and commissions.

Short-Term Disability Plan Bi-weekly Cost Illustration:

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses. To help you assess your needs, you can also go to Guardian Anytime and view a video:
https://www.guardiananytime.com/gafd/wps/portal/fdhome/employees/products-coverage/disability

Policy amounts shown based on sample salary amounts only.

	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
Your premium rate	$0.540	$0.620	$0.940	$0.860	$0.700	$0.700	$0.940	$1.190	$1.460
					Election Cost Per Age Bracket				
	< 25	*25–29*	*30–34*	*35–39*	*40–44*	*45–49*	*50–54*	*55–59*	*60+*
$20,000 Annual Salary $154 Weekly Benefit	$3.84	$4.41	$6.68	$6.11	$4.98	$4.98	$6.68	$8.46	$10.38
$40,000 Annual Salary $308 Weekly Benefit	$7.68	$8.81	$13.36	$12.23	$9.95	$9.95	$13.36	$16.92	$20.75
$60,000 Annual Salary $462 Weekly Benefit	$11.51	$13.22	$20.04	$18.34	$14.93	$14.93	$20.04	$25.37	$31.13
$80,000 Annual Salary $615 Weekly Benefit	$15.33	$17.60	$26.68	$24.41	$19.87	$19.87	$26.68	$33.78	$41.44
$100,000 Annual Salary $769 Weekly Benefit	$19.17	$22.01	$33.36	$30.52	$24.85	$24.85	$33.36	$42.24	$51.82
$120,000 Annual Salary $923 Weekly Benefit	$23.00	$26.41	$40.04	$36.64	$29.82	$29.82	$40.04	$50.69	$62.20
$140,000 Annual Salary $1,000 Weekly Benefit	$24.92	$28.62	$43.39	$39.69	$32.31	$32.31	$43.39	$54.92	$67.39

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00507708

A SUMMARY OF DISABILITY PLAN LIMITATIONS AND EXCLUSIONS

- Evidence of Insurability is required on all late enrollees. This coverage will not be effective until approved by a Guardian underwriter. This proposal is hedged subject to satisfactory financial evaluation. Please refer to certificate of coverage for full plan description.
- You must be working full-time on the effective date of your coverage; otherwise, your coverage becomes effective after you have completed a specific waiting period.
- Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding one year; or (b) in an area under travel warning by the US Department of State. Subject to state specific variations.
- For Short-Term Disability coverage, benefits for a disability caused or contributed to by a pre-existing condition are limited, unless the disability starts after you have been insured under this plan for a specified period of time. We do not pay short term disability benefits for any job-related or on-the-job injury, or conditions for which Workers' Compensation benefits are payable.
- We do not pay benefits for charges relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane. We do not pay benefits for charges relating to legal intoxication, including but not limited to the operation of a motor vehicle, and for the voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless it has been prescribed by a doctor and is used as prescribed. We limit the duration of payments for long term disabilities caused by mental or emotional conditions, or alcohol or drug abuse. We do not pay benefits during any period in which a covered person is confined to a correctional facility, an employee is not under the care of a doctor, an employee is receiving treatment outside of the US or Canada, and the employee's loss of earnings is not solely due to disability.
- This policy provides disability income insurance only. It does not provide "basic hospital", "basic medical", or "medical" insurance as defined by the New York State Insurance Department.
- If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. State variations may apply.
- When applicable, this coverage will integrate with NJ TDB, NY DBL, CA SDI, RI TDI, Hawaii TDI and Puerto Rico DBA, DC PFML and WA PFML.

Contract # GP-1-STD-15-1.0 et al.

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

Guardian

BENEFITS OFFSET NOTICE

Your Guardian Group Disability Policy (Policy) may provide that any Guardian Disability benefits you receive may be offset by Other Income/ Benefits you or your dependents receive while you are receiving Guardian Disability Benefits. This means that Guardian may deduct the amount of any Other/Income Benefit payments made to you or your dependents from your weekly or monthly Guardian Disability Benefit prior to issuing payment. Examples of Other Income Benefits described in your Policy include:

- U.S. Social Security Disability Income or Retirement Benefits
- Disability or Retirement Benefits payable from any other source, including state mandated disability plans, U.S. Railroad Retirement plan or similar U.S./Canadian plan
- Salary earned or paid during your disability period, including sick leave, paid time off, severance payments, bonuses and commissions
- Workers' Compensation benefits
- No-fault motor vehicle coverage benefits
- Distributions, profit sharing, royalties

Upon enrollment, please review your certificate booklet for the full definition of Other Income Benefits and provisions pertaining benefit offsets and overpayment recovery. If you or your dependents are awarded any Other Income Benefits, including lump sum payments while you are receiving Guardian Disability benefits, you should contact Guardian promptly to calculate the appropriate offset amount and prevent an overpayment of benefits.

Guardian

HUMAN TECHNOLOGIES CORP.

Specified Disease Benefit Summary

Group Number: 00507708

A Specified Disease insurance plan through Guardian provides:

- A cash benefit for a range of covered serious illnesses such as Cancer, Stroke and Heart Attack, in addition to whatever your medical insurance may cover
- Payments are made directly to you and can be used for any purpose

About Your Benefits:

	SPECIFIED DISEASE	
Benefit Amount(s)	Employee may choose a lump sum benefit of $5,000 to $20,000 in $5,000 increments.	
CONDITIONS		
Cancer	**1st OCCURRENCE**	**2nd OCCURRENCE**
Invasive Cancer	100%	50%
Carcinoma In Situ	30%	0%
Skin Cancer	$250 per lifetime	Not Covered
Vascular		
Heart Attack	100%	50%
Stroke	100%	50%
Heart Failure	100%	50%
Coronary Arteriosclerosis	30%	0%
Other		
Organ Failure	100%	50%
Kidney Failure	100%	50%
Spouse/Domestic Partner Benefit	May choose a lump sum benefit of $2,500 to $10,000 in $2,500 increments up to 50% of the employee's lump sum benefit.	
Child Benefit- children age Birth to 26 years	25% of employee's lump sum benefit	
Guarantee Issue: The 'guarantee' means you are not required to answer health questions to qualify for coverage up to and including the specified amount, when you sign up for coverage during the initial enrollment period.	We Guarantee Issue up to: $20,000 For a spouse: $10,000 For a child: All Amounts **Health questions are required if the elected amount exceeds the Guarantee Issue.**	
Portability: Allows you to take your Specified Disease coverage with you if you terminate employment.	Included	
Pre-Existing Condition Limitation: A pre-existing condition includes any condition for which you, in the specified time period prior to coverage in this plan, consulted with a physician, received treatment, or took prescribed drugs.	6 months prior, 6 months after	
WELLNESS BENEFIT		
Employee Per Year Limit	$50	
Spouse Per Year Limit	$50	
Child Per Year Limit	$50	

Condition Definitions

- Heart Failure: An insured must be placed on an organ transplant list in order to be eligible for the Heart failure benefits.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis must be severe enough to require a coronary artery bypass graft.
- Coronary Arteriosclerosis: Coronary Arteriosclerosis referred to as [Coronary Heart Disease]
- Organ Failure: Organ failure includes both lungs, liver, pancreas or bone marrow and requires the insured to be placed on an organ transplant list.
- Kidney Failure: An insured must be placed on an organ transplant list in order to be eligible for the Kidney failure benefits.

Specified Disease Cost Illustration

To determine the most appropriate level of coverage, you should consider your current basic monthly expenses and expected financial needs during a Specified Disease.

Spouse/DP coverage premium is based on Employee age

Child cost is included with employee election.

	Bi-weekly Premiums Displayed *Election Cost Per Age Bracket*					
	< 30	*30-39*	*40-49*	*50-59*	*60-69*	*70+*
Employee						
$5,000	$0.69	$1.06	$2.29	$4.75	$8.61	$15.46
$10,000	$1.39	$2.12	$4.57	$9.51	$17.22	$30.92
$15,000	$2.08	$3.19	$6.85	$14.26	$25.82	$46.39
$20,000	$2.77	$4.25	$9.14	$19.02	$34.43	$61.85
Benefit Amount Up To 50% of Employee Amount to a Maximum of $10,000						
Spouse						
$2,500	$0.35	$0.53	$1.15	$2.38	$4.30	$7.73
$5,000	$0.69	$1.06	$2.29	$4.75	$8.61	$15.46
$7,500	$1.04	$1.59	$3.43	$7.13	$12.91	$23.19
$10,000	$1.39	$2.12	$4.57	$9.51	$17.22	$30.92

Manage Your Benefits:

Go to www.GuardianAnytime.com to access secure information about your Guardian benefits. Your on-line account will be set up within 30 days after your plan effective date.

Need Assistance?

Call the Guardian Helpline (888) 600-1600, weekdays, 8:00 AM to 8:30 PM, EST. Refer to your member ID (social security number) and your plan number: 00507708.

EXCLUSIONS AND LIMITATIONS

A SUMMARY OF PLAN LIMITATIONS AND EXCLUSIONS FOR SPECIFIED DISEASE:

We will not pay benefits for the First Occurrence of a Specified Disease if it occurs less than 3 months after the First Occurrence of a related Specified Disease for which this Plan paid benefits. By related we mean either: (a) both Specified Diseases are contained within the Cancer Related Conditions category; or (b) both Specified Diseases are contained within the Vascular Conditions category. We will not pay benefits for a Second occurrence (recurrence) of a Specified Disease unless the Covered Person has not exhibited symptoms or received care or treatment for that Specified Disease for at least 12 months in a row prior to the recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

We do not pay benefits for claims relating to a covered person: taking part in any war or act of war (including service in the armed forces) committing a felony or taking part in any riot or other civil disorder or intentionally injuring themselves or attempting suicide while sane or insane.

Employees must be legally working in the United States in order to be eligible for coverage. Underwriting must approve coverage for employees on temporary assignment: (a) exceeding 1 year; or (b) in an area under travel warning by the US Department of State, subject to state specific variations.

If the plan is new (not transferred): During the exclusion period, this Specified Disease plan does not pay charges relating to a pre-existing condition. If this plan is transferred from another insurance carrier, the time an insured is covered under that plan will count toward satisfying Guardian's pre-existing condition limitation period. A pre-existing condition includes any condition for which an employee, in a specified time period prior to coverage in this plan, consults with a physician, receives treatment, or takes prescribed drugs. Please refer to the plan documents for specific time periods. State variations may apply.

Guardian's Specified Disease plan does not provide comprehensive medical coverage. It is a basic or limited benefit and is not intended to cover all medical expenses. It does not provide "basic hospital," "basic medical," or " medical" insurance as defined by the New York State Insurance Department.

Health questions are required on late enrollees. This coverage will not be effective until approved by a Guardian underwriter.

This policy will not pay for a diagnosis of a listed critical illness that is made before the insured's Critical Illness effective date with Guardian.

The policy has exclusions and limitations that may impact the eligibility for or entitlement to benefits under each covered condition. See your certificate booklet for a full listing of exclusions & limitations..

If Specified Disease insurance premium is paid for on a pre tax basis, the benefit may be taxable. Please contact your tax or legal advisor regarding the tax treatment of your policy benefits..

Contract # GP-1-CI-14

This document is a summary of the major features of the referenced insurance coverage. It is intended for illustrative purposes only and does not constitute a contract. The insurance plan documents, including the policy and certificate, comprise the contract for coverage. The full plan description, including the benefits and all terms, limitations and exclusions that apply will be contained in your insurance certificate. The plan documents are the final arbiter of coverage. Coverage terms may vary by state and actual sold plan. The premium amounts reflected in this summary are an approximation; if there is a discrepancy between this amount and the premium actually billed, the latter prevails.

GUARDIAN LIFE INSURANCE COMPANY
10 HUDSON YARDS
NEW YORK, NEW YORK 10001
212-598-8000

SPECIFIED DISEASE COVERAGE ONLY
REQUIRED DISCLOSURE STATEMENT

For Members under age 65: This certificate is a group certificate. This certificate provides specified disease coverage ONLY. This certificate does NOT provide basic hospital, basic medical or major medical insurance, as defined by the New York State Insurance Department. Benefits provided are a supplement, and not a substitute for, medical coverage. You must have medical coverage in place in order to enroll for this insurance.

For Members over age 65: This certificate is a group certificate. This certificate provides specified disease coverage ONLY. This policy or certificate does NOT provide Medicare supplement insurance, long term care insurance, nursing home insurance only, home care insurance only or nursing home and home care insurance as defined by the New York State Insurance Department. You may also contact your local social security office or this company and obtain a copy of the Guide to Health Insurance for People with Medicare.

READ YOUR CERTIFICATE CAREFULLY – This outline of coverage provides a very brief and general description of the important features of the group insurance coverage provided by the group policy. This is not the insurance contract and only the actual policy provisions will control. The policy and certificate set forth in detail the specific conditions covered under the policy, the applicable benefit amounts, limitations, exclusions and the rights and obligations of both you and Guardian. It is, therefore, important that YOU READ YOUR CERTIFICATE CAREFULLY.

The expected benefit ratio for this policy or certificate is 70%. This ratio is the portion of future premiums which the company expects to return as benefits, when averaged over all people with this policy or certificate.

Specified Disease coverage is designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of a Specified Disease. Coverage is not provided for other diseases or accidents or for basic hospital, basic medical-surgical, or major medical expenses.

Subject to all of the Certificate's terms, this plan will pay a benefit based on the benefit amount for which a person is insured. The Specified Disease must occur while the person is insured by this plan. All covered Specified Diseases are listed in the Certificate. The benefit amount is payable for each condition. All benefit amounts are shown in the Schedule of Benefits.

This plan may pay a different level of benefits for the First Occurrence and for the Recurrence of a Specified Disease. For some Specified Diseases we pay no benefits for a Recurrence. The benefit levels are shown in the Schedule of Benefits.

This following is an **EXAMPLE** of what the plan may pay:

For you	$5,000
For your spouse or domestic partner	$2,000
For your covered dependent child	$1,000

Benefit Levels	Specified Disease	$ or % of Benefit Amount for First Occurrence	% of Benefit Amount for Recurrence
	Cancer Related Conditions:		
	Carcinoma in Situ	30%	Not Covered
	Invasive Cancer	100%	50%
	Skin Cancer	$250	Not Covered
	Vascular Conditions:		
	Arteriosclerosis	30%	Not Covered
	Heart Attack	100%	50%
	Heart Failure	100%	50%
	Stroke	100%	50%
	Neurological Conditions:		

Alzheimer's Disease for Covered Person	50%	Not Covered
ALS (Lou Gehrig's Disease)	100%	Not Covered
Other Conditions:		
Kidney Failure	100%	50%

Cancer Vaccine $50 per lifetime

The complete list of Benefits that applies to your Plan appears in your Certificate. Please Read your Certificate.

LIMITATIONS

Proof of Insurability: The covered person's benefit amount, a part of it, or increases in it may not become effective until he or she submits proof of insurability to us. We must approve such proof in writing. These requirements are shown in the schedule.

Pre-Existing Conditions: If your Certificate has a pre-existing condition exclusion, it will not pay benefits for a Specified Disease that is caused by, or results from, a pre-existing condition if the Specified Disease occurs during the first 6 months that the person is insured by this Certificate. A pre-existing condition is a sickness or injury, for which in the 6 months before a person becomes insured by this Certificate he or she: (a) received medical advice or diagnosis or (2) care or treatment was recommended or received from a doctor.

EXCLUSIONS

We will not pay benefits for a diagnosis of a Specified Disease that occurs as a result of the following: participating in a riot or insurrection; committing or attempting to commit a felony; self-inflicted injury; committing or attempting to commit suicide while sane or insane; that is caused by the covered person's voluntary use of any prescription or non-prescription drug or controlled substance; engaging in any illegal occupation; or war or act of war.

The complete list of exclusions appears in the Certificate. Please Read Your Certificate.

The information in this Benefits Overview is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Overview was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Overview and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.