STRUCTURAL MODULARS, INC.
www.smihomes.com

2022-2023 BENEFITS GUIDE

DECEMBER 1 - NOVEMBER 30, 2023

Health · Financial · Work-Life

ELIGIBILITY

You are eligible for benefits if you work 30 or more hours per week. You may also enroll your eligible family members under certain plans you choose for yourself. Eligible family members include:

- Your legally married spouse
- Your children who are your natural children, stepchildren, adopted children or children for whom you have legal custody (age restrictions may apply). Disabled children age 26 or older who meet certain criteria may continue on your health coverage.

WHEN COVERAGE BEGINS

- **New Hires:** You must complete the enrollment process within 60 days of your date of hire. If you enroll on time, coverage is effective on the first of the month following 60 days of employment.

  If you fail to enroll on time, you will **NOT** have benefits coverage (except for company-paid benefits).
- **Open Enrollment:** Changes made during Open Enrollment are effective December 1 - November 30, 2023.

CHOOSE CAREFULLY!

Due to IRS regulations, you cannot change your elections until the next annual Open Enrollment period, unless you have a qualified life event during the year. Following are examples of the most common qualified life events:

- Marriage or divorce
- Birth or adoption of a child
- Child reaching the maximum age limit
- Death of a spouse or child
- You lose coverage under your spouse's plan
- You gain access to state coverage under Medicaid or CHIP

MAKING CHANGES

To make changes to your benefit elections, you must contact Human Resources within 31 days of the qualified life event (including newborns). Be prepared to show documentation of the event such as a marriage license, birth certificate or a divorce decree. If changes are not submitted on time, you must wait until the next Open Enrollment period to make your election changes.

Required Information—*When you enroll, you will be required to enter a Social Security number (SSN) for all covered dependents. The Affordable Care Act (ACA), otherwise known as health care reform, requires the company to report this information to the IRS each year to show that you and your dependents have coverage. This information will be securely submitted to the IRS and will remain confidential.*

Medical

We are proud to offer you a choice of medical plans. Following is a high-level overview of the coverage available.

Key Medical Benefits	Highmark Blue Cross Blue Shield/Difference Card Performance Blue PPO Sharing $5000		Highmark Blue Cross Blue Shield/Difference Card Performance Blue PPO Sharing $2,000	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per plan year)				
Individual / Family	$5,000 (Employee responsible for first $500/Difference Card reimburses remaining $4,500) / $10,000 (Employee responsible for first $1,000/Difference Card reimburses remaining $9,000)	$10,000 / $20,000	$5,000 (Employee responsible for first $2,00/Difference Card reimburses remaining $3,000) / $10,000 (Employee responsible for first $4,000/Difference Card reimburses remaining $6,000)	$10,000 / $20,000
Out-of-Pocket Maximum (per plan year)				
Individual / Family	$6,450 / $12,900	N/A / N/A	$6,450 / $12,900	N/A / N/A
Covered Services				
Office Visits (physician/specialist)	$10 / $30 copay (Difference Card pays remaining $10 copay)	20%*	$10 / $30 copay (Difference Card pays remaining $10 copay)	20%*
Routine Preventive Care	No charge	20%*	No charge	20%*
Outpatient Diagnostic (lab/X-ray)	0%* (Difference Card reimburses remaining deductible after employee share)	20%*	0%* (Difference Card reimburses remaining deductible after employee share)	20%*
Complex Imaging	0%* (Difference Card reimburses remaining deductible after employee share)	20%*	0%* (Difference Card reimburses remaining deductible after employee share)	20%*
Chiropractic	$30 copay (Difference Card pays remaining $10 copay)	20%*	$30 copay (Difference Card pays remaining $10 copay)	20%*
Ambulance	0%* (Difference Card reimburses remaining deductible after employee share)	20%*	0%* (Difference Card reimburses remaining deductible after employee share)	20%*
Emergency Room	$150 (Waived if admitted)	$150 copay (Waived if admitted)	$150 (Waived if admitted)	$150 copay (Waived if admitted)
Urgent Care Facility	$50 copay (Difference Card pays additional $25 copay)	20%*	$50 copay (Difference Card pays additional $25 copay)	20%*
Inpatient Hospital Stay	0%* (Difference Card reimburses remaining deductible after employee share)	20%*	0%* (Difference Card reimburses remaining deductible after employee share)	20%*
Outpatient Surgery	0%* (Difference Card reimburses remaining deductible after employee share)	20%*	0%* (Difference Card reimburses remaining deductible after employee share)	20%*
Prescription Drugs (Generic / Brand / Non-Formulary / Specialty)				
Retail Pharmacy (30-day supply)	$15 / $30 / $50 / $50	$15 / $30 / $50 / $50	$15 / $30 / $50 / $50	$15 / $30 / $50 / $50
Mail Order (90-day supply)	$30 / $60 / $100	$30 / $60 / $100	$30 / $60 / $100	$30 / $60 / $100

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**

1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. Waived if admitted

Dental

We are proud to offer you a dental plan. Following is a high-level overview of the coverage available.

Key Dental Benefits	Guardian Life Insurance Company DPPO	
	In-Network	Out-of-Network[1]
Deductible (per plan year)		
Individual / Family	$25 [2] / $25 per person up to three family members maximum 1	
Benefit Maximum (per plan year; preventive, basic, and major services combined)		
Per Individual	$1,000 [3]	$1,000 [3]
Covered Services		
Preventive Services	No charge	No charge
Basic Services	No charge*	80%*

Coinsurance percentages and copay amounts shown in the above chart represent what the member is responsible for paying.
***Benefits with an asterisk (*) require that the deductible be met before the Plan begins to pay.**
1. If you use an out-of-network provider, you will be responsible for any charges above the maximum allowed amount.
2. Waived for preventive
3. Combined for both in and out of network services

Vision

We are proud to offer you a vision plan through Vision Benefits of America.

Key Vision Benefits	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$0	Reimbursed $30
Materials Copay	$0	N/A
Lenses (once every 12 months)	Covered 100%	
Single Vision		Reimbursed $30
Bifocal		Reimbursed $40
Trifocal		Reimbursed $60
Frames (once every 24 months)	Covered 100% [1]	Reimbursed $40
Contact Lenses (once every 12 months months; in lieu of glasses)	Covered up to $100 [2 4]	Reimbursed $100 [3]

1. Up to the program's $50 wholesale allowance
2. The allowance is applied to all services/materials associated with contact lenses, including, but not limited to, contact exam, fitting, dispensing, cost of lenses, etc. No guarantee the allowance will cover the entire cost of services and materials.
3. Reimbursed $250 if medically necessary
4. Requires prior approval if medically necessary to be covered 100%. May only be selected in lieu of all other material benefits listed herein.

Life and AD&D

Life insurance provides your named beneficiary(ies) with a benefit in the event of your death.

Accidental Death and Dismemberment (AD&D) insurance provides specified benefits to you in the event of a covered accidental bodily injury that directly causes dismemberment (i.e., the loss of a hand, foot or eye). In the event that your death occurs due to a covered accident, both the life and the AD&D benefit would be payable.

Basic Life/AD&D (Company-paid)

This benefit is provided at NO COST to you through Guardian Life Insurance Company.

Benefit Amount	$15,000

Supplemental Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage through **Guardian Life Insurance Company** for yourself and your eligible family members.

Benefit Option		Guaranteed Issue*
Employee	See summary of benefits	$10,000
Spouse	50% of the employee's volume to a maximum of $50,000	N/A
Child(ren)	10% of employee's volume to a maximum of $10,000 1	No guaranteed issue. All amounts are approved.

*During your initial eligibility period only, you can receive coverage up to the Guaranteed Issue amounts without having to provide Evidence of Insurability (EOI, or information about your health). Coverage amounts that require EOI will not be effective unless approved by the insurance carrier.

1. Ages 14 days to 6 months flat $500

Cost of Benefits

Your contributions toward the cost of benefits are automatically deducted from your paycheck before taxes. The amount will depend upon the plan you select and if you choose to cover eligible family members. **Please refer to the separate rate sheet for your contributions.**

Contact Information

Coverage	Carrier	Phone #	Website/Email
Medical	Highmark Blue Cross Blue Shield	(800) 241-5704	www.highmarkbcbs.com
Dental	Guardian Life Insurance Company	(888) 482-7342	www.guardianlife.com
Vision	Vision Benefits of America	(800) 432-4966	www.vbaplans.com
Life and AD&D	Guardian Life Insurance Company	(888) 482-7342	www.guardianlife.com
HRA (MERP) Coverage	The Difference Card	(888) 343-2110	customercare@differencecard.com www.DifferenceCard.com

Questions?

If you have additional questions, you may also contact:

Cindy King - Hub International
(814) 844-6646
cynthia.king@hubinternational.com

Lori Miller
(814) 764-5555
smi@penn.com

HUB