2022

Mead Lumber

BENEFITS GUIDE

HEALTH • FINANCIAL • WORK-LIFE

January 1 - December 31, 2022

Welcome

Your benefits are an important part of your overall compensation. We are pleased to offer a comprehensive array of valuable benefits to protect your health, your family and your way of life. This guide answers some of the basic questions you may have about your benefits. Please read it carefully, along with any supplemental materials you receive.

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 biological 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 31 days of your date of hire. If you enroll on time, coverage is effective on the first of the month (not coinciding with) following a 60-day eligibilitywaiting period.

  NOTE: Please be sure to return all enrollment forms to Human Resources even if you are waiving coverage.

  If you fail to enroll on time, you will **NOT** have benefits coverage (except for company-paid benefits).

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.*

Inside

Medical

We are proud to offer you a choice of medical plans that provide comprehensive medical and prescription drug coverage. The plans also offer many resources and tools to help you maintain a healthy lifestyle. Following is a brief description of each plan.

BCBSNE PPO

This plan gives you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a provider who participates in the network.

- The plan pays the full cost of qualified in-network preventive health care services.
- You pay the full cost of non-preventive health care services until you meet the **annual deductible**. You may also have to pay a fixed dollar amount (**copay**) for certain services.
- Once you meet the deductible, you pay a percentage of certain health care expenses (**coinsurance**) and the plan pays the rest.
- Once your deductible, copays and coinsurance add up to the **out-of-pocket maximum**, the plan pays the full cost of all qualified health care services for the rest of the year.

Following is a high-level overview of the coverage available. For complete coverage details, please refer to the Summary Plan Description (SPD).

Key Medical Benefits	BCBSNE Medical PPO Plan PPO	
	In-Network	Out-of-Network[1]
Deductible (per calendar year)		
Individual / Family	$1,500 / $3,000	$3,000 / $6,000
Out-of-Pocket Maximum (per calendar year)		
Individual / Family	$5,000 / $10,000	$10,000 / $20,000
Covered Services		
Office Visits (physician/specialist)	$30	40%*
Virtual Visits	$20	Not covered
Routine Preventive Care	No charge	40%*
Outpatient Diagnostic (lab/X-ray)	20%*	40%*
Complex Imaging	20%*	40%*
Chiropractic	$30 copay[2]	40%*[2]
Ambulance	20%*	20%*
Emergency Room	20%*	20%*
Urgent Care Facility	20%*	40%*
Inpatient Hospital Stay	20%*	40%*
Outpatient Surgery	20%*	40%*
Prescription Drugs (Tier 1 / Tier 2 / Tier 3)		
Retail Pharmacy (30-day supply)	$10 / $30 / $60 / $90[3]	50% coinsurance
Mail Order (90-day supply)	$30 / $90 / $180	Not covered

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. Limited to 20 sessions per calendar year.
3. Specialty drugs must be purchased throug a designated specialty pharmacy after two fills.

Dental

We are proud to offer you a choice between two dental plans.

Ameritas DPPO: High Plan Option and Low Plan Option

Both plans offer you the freedom and flexibility to use the dentist of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose a dentist who participates in the Ameritas network.

Following is a high-level overview of each plan option available.

Key Dental Benefits	Ameritas DPPO High Plan		Ameritas DPPO Low Plan	
	In-Network	Out-of-Network[1]	In-Network	Out-of-Network[1]
Deductible (per calendar year)				
Individual / Family	$50 / $150		$50 / $150	
Benefit Maximum (per calendar year; preventive, basic, and major services combined)				
Per Individual	$1,500	$1,000	$750	
Covered Services				
Preventive Services	No charge		No charge	
Basic Services	20%*		50%*	
Major Services	50%*		50%*	
Orthodontia (Child Only)	50%		50%	

Coinsurance percentages 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.

Vision

We are proud to offer you a choice between two vision plans.

Both vision plans give you the freedom to seek care from the provider of your choice. However, you will maximize your benefits and reduce your out-of-pocket costs if you choose an in-network provider.

Following is a high-level overview of the coverage available.

Key Vision Benefits	Ameritas-EyeMed Access Network		Ameritas-VSP Network	
	In-Network	Out-of-Network Reimbursement	In-Network	Out-of-Network Reimbursement
Exam (once every 12 months)	$10	Up to $35	$10	Up to $50
Lenses (once every 12 months)	Covered in full after $25 copay		Covered in full after $25 copay	
Single Vision		Up to $25		Up to $50
Bifocal		Up to $40		Up to $75
Trifocal		Up to $55		Up to $100
Frames (once every 24 months)	$150	Up to $75	$150	Up to $70
Contact Lenses (once every 12 months; in lieu of glasses)	$150	Up to $120	$150	Up to $120

Flexible Spending Accounts

We provide you with an opportunity to participate in our flexible spending accounts (FSAs) administered through gente. FSAs allow you to set aside a portion of your income, before taxes, to pay for qualified health care and/or dependent care expenses. Because that portion of your income is not taxed, you pay less in federal income, Social Security and Medicare taxes.

Health Care FSA

For 2022, you may contribute up to $2,850 to cover qualified health care expenses incurred by you, your spouse and your children up to age 26. Some qualified expenses include:

- Coinsurance
- Copayments
- Deductibles
- Prescriptions and Over-the-Counter Drugs
- Menstrual Care Products
- Dental treatment
- Orthodontia
- Eye exams, materials, Lasik

NOTE: If you enroll in the HSA medical plan, you may not participate in a Health Care FSA.

Dependent Care FSA

For 2022, you may contribute up to $5,000 (per family) to cover eligible dependent care expenses ($2,500 if you and your spouse file separate tax returns). Some eligible expenses include:

- Care of a dependent child under the age of 13 by babysitters, nursery schools, pre-school or daycare centers
- Care of a household member who is physically or mentally incapable of caring for him/herself and qualifies as your federal tax dependent

For a complete list of eligible expenses, visit www.irs.gov/pub/irs-pdf/p503.pdf.

FSA Rules

YOU MUST ENROLL EACH YEAR TO PARTICIPATE.

Because FSAs can give you a significant tax advantage, they must be administered according to specific IRS rules:

Health Care FSA: Unused funds of up to $570 from one year can carry over to the following year. Carryover funds will not count against or offset the amount that you can contribute annually. Unused funds over $570 will **NOT** be returned to you or carried over to the following year.

You must file claims by March 31, 2023.

Maximum contribution amount is established by the IRS and your employer each year. See plan document for details.

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 Principal.

Benefit Amount	
Employee	$50,000
Spouse	$5,000
Child over 6 months old	$2,500
Child under 6 months old	$1,000

Supplemental Life/AD&D (Employee-paid)

If you determine you need more than the basic coverage, you may purchase additional coverage through Principal for yourself and your eligible family members.

Benefit Option		Guaranteed Issue[1]
Employee	$10,000 increments up to $100,000*	If you're under 70: $100,000. If you're 70 or older: $10,000
Spouse	$5,000 increments up to $50,000*	If your spouse is under 70: $50,000. If your spouse is 70 or older: $10,000
Child(ren)	$10,000	$10,000

*Benefit reductions begin at age 65

1. 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.

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Employee Insurance Rates

January 1, 2022 through December 31, 2022

MEDICAL COVERAGE

	Monthly Rates* **
Employee Only	$137.00
Employee + Spouse	$409.00
Employee + Child(ren)	$353.00
Family	$591.00

***NOTE:** If your spouse is employed and has medical insurance available under his/her employer's plan but enrolls for Medical coverage with Mead Lumber, there will be a $125 per month surcharge added to the above EMP/SP & FAMILY rates.

DENTAL COVERAGE

	Monthly Rates**	
	High Plan	Low Plan
Employee Only	$31.80	$26.96
Employee + Spouse	$67.56	$55.84
Employee + Child(ren)	$93.68	$76.92
Family	$119.84	$102.04

VISION COVERAGE

	Monthly Rates**	
	VSP Network	EyeMed Network
Employee Only	$9.76	$9.76
Employee + Spouse	$16.44	$16.44
Employee + Child(ren)	$16.76	$16.76
Family	$26.52	$26.52

****Insurance premiums will be deducted across 24 rather than 26 pay periods for the calendar year. In the months with three pay periods, no premium deductions will be taken in the third payroll.**