Understanding Your Health Benefits and Options

2024 Annual Open Enrollment Guide

Inserra Supermarkets

Inside

Your well-being is important to you — and it's important to us. We are here to support you during the moments that matter the most. That is why we are committed to providing a flexible, comprehensive benefits package for you and your family.

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Open Enrollment 2024

As a ShopRite Associate, you have access to benefit plans for you and your family. Understanding your options is the first step to making a decision for the next calendar year.

What: Open Enrollment is upon us once again. This is your annual opportunity to review your current benefit plans and make any changes for the upcoming year.

Who: Non-union full-time ShopRite associates who are eligible for benefits. If this is your first year enrolling, please take the time to review your options to ensure you are making the best choice for you and your family. If you are currently enrolled, it's always a good practice to review and confirm your information. If you choose not to take action, your current coverage elections will roll over into the next year, with the exception of the Flexible Spending Accounts (FSAs). FSAs require you to enroll/ re-enroll each year.

When: Open Enrollment begins Monday, November 6, 2023, and ends at midnight on Saturday, November 25, 2023.

How: Go to **inserra.shopritebenefits.com** and download the enrollment forms which are located at the bottom of the home page under "Enrollment Forms". These password protected forms contain your weekly associate contributions. See your Benefits Administrator for access. Once you have completed the forms, please submit them to your Benefits Administrator no later than November 25, 2023 to receive the coverage of your choice in 2024.

If you have any questions along the way, please contact your Benefits Administrator.

What's New for 2024

A New Network Option for 2024
We will continue to offer the current plans. However, to maximize your medical benefits, we are adding a new network offering that may lower your costs. Aetna Whole HealthSM is an ACO (Accountable Care Organization) Network. This is a group of healthcare providers that provide coordinated care to patient populations, including incentives to improve the quality of patient care and health outcomes while controlling costs. Aetna and providers leverage strengths to create a product offering with a shared patient focus. That focus is on delivering quality and efficiency that drives improved patient and provider engagement levels and, ultimately, better health outcomes.

No Changes to Your Plan Design

- There are no plan design changes (such as copays, coinsurance, deductibles, etc.) to the medical, dental, or vision plans.
- Although not a new benefit, we've included your Long Term Disability and Life Insurance options in this guide to help you learn more.
- Each enrolled associate and spouse/partner may still qualify for a $100 ShopRite gift card for completing an annual physical. We also encourage you to take advantage of our well-being activities (e.g., the Aetna Health Assessment and Tobacco Cessation Program), which are important to your overall health.

Take Advantage of These Special Programs
Also check out our special programs such as Aetna Concierge Customer Service, PinnacleCare health advisory services, Memorial Sloan Kettering (MSK) and more. They are designed to help you get great care and save money too.

Enhanced Website for Open Enrollment and More
As a reminder, we encourage you to get additional information about this year's Open Enrollment online at **inserra.shopritebenefits.com**. It is a self service benefits website that provides resources to help you make informed decisions about your benefits. On this website, you will also find details on your benefits, Summary of Benefits and Coverage (SBCs), important eligibility, enrollment information, and Legal Notices. You can now access your contributions and enrollment forms directly from the password protected website. See your Benefits Administrator for details.

A New Network Option

We are adding a new network offering that may improve the quality of healthcare for you and your family.

A New Network Option for 2024
We will continue to offer the current plans. However, to maximize your medical benefits, we are adding a new network offering that may lower your costs. Aetna Whole HealthSM is an ACO (Accountable Care Organization) Network. This is a group of healthcare providers that provide coordinated care to patient populations, including incentives to improve the quality of patient care and health outcomes while controlling costs. Aetna and providers leverage strengths to create a product offering with a shared patient focus. That focus is on delivering quality and efficiency that drives improved patient and provider engagement levels and, ultimately, better health outcomes.

How do I know if my doctor(s) participate in the ACO Network?
To help members determine which doctors are associated with an Accountable Care Organization (ACO), participating providers are flagged in the online provider search. Participating ACO providers associated with an Aetna Whole Health ACO are identified with an Aetna Whole Health logo. Download the Aetna Whole Health Provider Search document to learn how to search for a provider in your network.

How is the ACO network different from the current network?
Aetna teams up with systems of doctors, hospitals, and other health care providers to help these organizations manage risk, improve clinical care management, and implement data and technology to connect providers, health plans, and patients.

ACO providers accept responsibility for caring for a population of patients and work together to coordinate care. The goal of an ACO is to:

- Improve the health of the population using evidence-based medicine and greater integration and collaboration
- Enhance the member experience of care (including quality, access, and reliability) while encouraging member engagement
- Manage health care costs while focusing on health outcomes

How are provider's selected to participate within the ACO network?
Aetna Whole Health plans are designed to:

- Reward doctors for improving patient care quality
- Lower medical cost growth over time by reducing waste, improving care coordination and closing care gaps
- Encourage members to stay in network which is intended to help them experience improved quality of care at a lower total cost of care
- Support effective patient and primary care doctor relationships

ACO providers have to meet certain quality measures which are monitored ongoing. Some examples include:

- Impactable bed days per 1000 members
- 30 day re-admission rate
- Potentially avoidable ER visits per 1000 members
- Outpatient surgery steerage to a lower-cost place of service
- Outpatient lab steerage to a lower-cost place of service
- Outpatient radiology steerage to a lower-cost place of service
- Generic prescribing rate
- Total cost of care

A New Network Option

Which providers are part of the ACO network?
By using an ACO, you and your family will have access to all of your care, coordinated by your primary care physician and a care team. Within the ACO network, you will have access to hospitals, ancillary providers (lab, x-ray) and physicians (primary care and specialists) employed by the system. Your provider will assist with referrals to other in-network providers if there is care you need outside of the ACO.

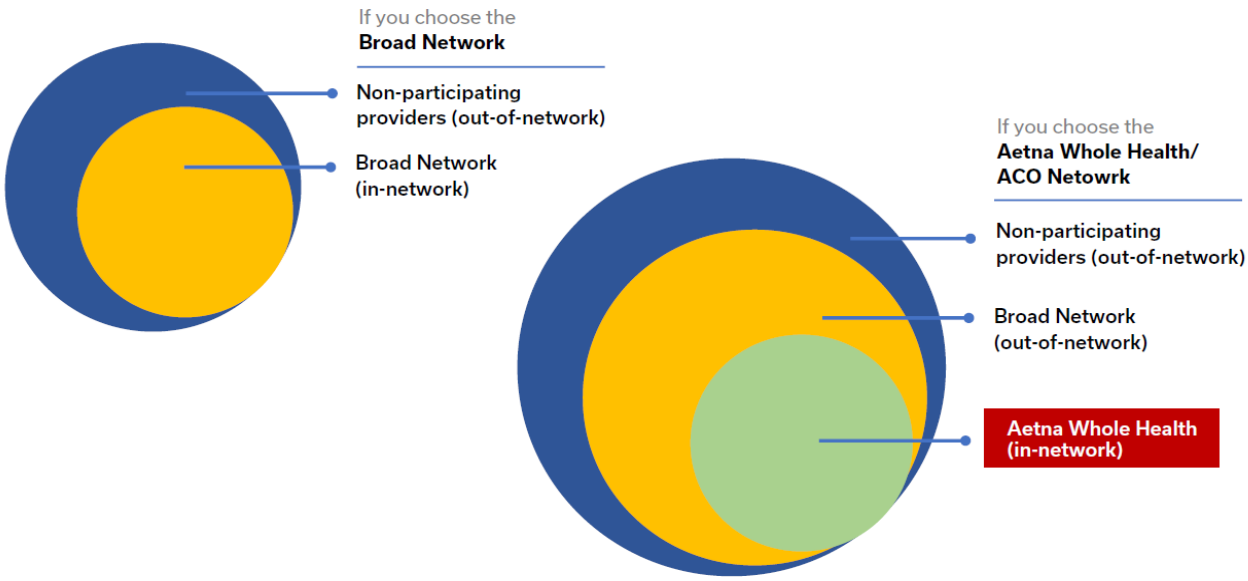
What if my provider is not part of the ACO network?
If your provider is not part of the ACO network you have several options:

- You can look for a provider who is in the ACO network and switch providers
- If you elect to visit a Non participating ACO provider, your out-of-network benefits will apply. For example, a lab test performed by a Non ACO provider will be applied to your out-of-network benefits which is subject to your deductible, co-insurance, and any amount that exceeds Aetna's Usual & Customary rate.

How will my out-of-network benefits be applied to services with Non ACO providers?
If members utilize an out-of-network provider, they would receive the out-of-network benefits. So an out-of-network lab test for example, would follow the out-of-network lab benefit.

I am in the middle of treatment with a provider who is not part of the ACO network. Can I still visit my provider?
In certain circumstances, where it is not feasible for someone to switch providers due to being in the midst of treatment, a transition of care request can be granted. In the event you receive a balance bill from the provider, please contact Aetna Concierge at 1-877-461-0933 for assistance.

What if I am traveling out of my home zip code and have an emergency? Am I covered?
If you are traveling outside of your ACO service area, and have an emergency, you would receive the highest level of coverage which would be in-network coverage. In the event you receive a balance bill from the provider, please contact Aetna Concierge at 1-877-461-0933 for assistance.



Who is Eligible?

The ShopRite benefit plans described in this guide are available to full-time, non-union associates and their eligible dependents.

Your eligible dependents include:

- Your spouse to whom you are legally married. If your spouse is eligible for medical coverage through his/her employer, then he/she is not eligible for primary medical coverage through ShopRite.
- Your same sex domestic partner (contact your Benefits Administrator for more details). If your domestic partner is eligible for medical coverage through his/her employer, then he/she is not eligible for primary medical coverage through ShopRite.
- Your dependent child(ren) until the end of the month he/she turns age 26. For example, if your child was born March 2, 1998, your child is eligible for medical, dental, and vision coverage until March 31, 2024.
- Eligible dependent child(ren):
  - Does not need to be a full-time student
  - Is not required to live with you
  - Does not need to be an eligible dependent on the parent's tax return
  - May be married or unmarried (your child's spouse and children are not eligible)
- Your unmarried children of any age who are permanently and totally disabled physically or mentally for whom you provide financial support. You must periodically provide medical documentation of such disability.

Individuals Eligible for Medicare

If you have Medicare, or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please refer to the Notice of Creditable Coverage & Medicare Part D information located in the Legal Notices on your benefits website.

Individuals Not Eligible for ShopRite Medical Coverage

If you have a qualifying event and are offered continued coverage through COBRA, you may want to consider buying an individual health insurance plan through your state's Marketplace. The Marketplace may offer you additional choices to better fit your budget and needs.

Notify your Benefits Administrator if You Lose Medicaid/CHIP Eligibility

If you or your dependents lose eligibility for Medicaid or the Children's Health Insurance Program (CHIP) coverage, or become eligible for a state's premium assistance subsidy under Medicaid or CHIP, you will have 60 days from the date of that Medicaid/eligibility change to request enrollment in a ShopRite medical plan. Please refer to the Legal Notices on your benefits website for more details.

Individuals Planning to Retire or Leave ShopRite

If you are planning to retire, please contact your Benefits Administrator for information about your benefit options.

Who is Eligible?

After Open Enrollment, you cannot change your elections during the year unless you have a "qualified change in family status".

Making Changes During the Year
After the Open Enrollment period ends, you cannot change your elections during the year unless you have a "qualified change in family status" and you notify your Benefits Administrator within 30 days of the event. Qualified life events (QLE) are defined by the IRS and include:

- Marriage, divorce or legal separation
- Birth or adoption of a child or placement of a child for adoption
- Death of a dependent
- Child is no longer eligible due to reaching limiting age
- Change in spouse's employment status that results in a gain or loss of coverage, such as beginning or terminating employment, or changing status from full-time to part-time

Important Note
If you experience any of the life events mentioned here or have questions, please contact your Benefits Administrator.

- The medical plan may include annual deductibles and out-of-pocket maximums for individuals and families. In addition, when you enroll in the Health Care Reimbursement Account (HCRA) Plan, you receive a fund with an amount based on whether you are an individual or family.
- If you change your medical plan election due to a qualified change in family status, your deductibles, out-of- pocket maximums, and HCRA Fund amount (if applicable) are also subject to change based on the specific life event. For example, if you get married and add your spouse, you will change from Single to Family, and your deductibles, out-of-pocket maximums, and HCRA Fund (if applicable) will increase.

Please contact your Benefits Administrator for more information about how this may impact you based on your current election and potential change.

After the Open Enrollment period ends, you cannot change your elections during the year unless you have a "qualified change in family status."

Your Benefit Options

Understanding your options is the first step in making a decision for the next calendar year.

Medical and Prescription Drug
Various medical options designed to help you manage your health and budget.

Well-being Programs
Resources and tools to help you get and stay healthy; 100% coverage for preventive care and free resources for living a healthy lifestyle. Special programs to help you get great care and save money too, such as Aetna Concierge Customer Service, MSK Direct, PinnacleCare health advisory services, and more.

Dental
Benefits to help pay for preventive, basic, and major dental services.

Vision
Benefits to help pay for eye exams and glasses/contacts.

Flexible Spending Accounts
Make tax-free contributions to pay for eligible dependent care and health care expenses such as medical, dental, vision, and prescription drug copays, deductibles, and coinsurance.

Basic Life Insurance
ShopRite associates are eligible for 1.5 times their annualized salary in basic life insurance.

Long-Term Disability
Benefits that provide a portion of your salary in the event you become disabled and cannot work.

Additional Optional Life Insurance
Associates are eligible for up to 3 times their annualized salary in optional life insurance. They can purchase additional financial protection for their family at very competitive prices (subject to the insurer's underwriting approval).

Your Medical Plan

You can choose from various Aetna Medical Plan offerings for 2024.

Your medical plan is offered through Aetna and includes:

- **Well-being programs** — with 100% coverage for preventive care, free resources for tobacco cessation programs and medication, and other resources for living a healthy lifestyle.
- **Aetna discounts** on well-being programs and services — such as weight management, fitness equipment, vision, and hearing services.
- **Special programs** — to help you get great care and save money too, such as Aetna Concierge Customer Service and PinnacleCare health advisory services.
- **Flexibility to use in- or out-of-network providers** — with higher benefits when you use in-network providers.
- **Ability to select a Primary Care Physician (PCP)** — to manage your overall health care (required for some plans).
- **Tools and Resources** — available through Aetna Health at **www.aetna.com** to help you estimate costs, explore savings, view claims, and access health information to make more informed decisions.

The weekly contributions can be found on your enrollment forms.

Summary of Benefits and Coverage (SBC)
As part of the Patient Protection and Affordable Care Act (PPACA), SBCs are designed to help you understand and compare the key features of your ShopRite medical plan options. Each includes coverage examples, a glossary of common health insurance terms, and contact information for each medical plan. They are available for all individual plans through the Marketplace. The SBCs for the medical plans available to you can be found on your benefits website.

How the Plans Work

Your medical plans are offered through Aetna and in-network preventative care is covered at 100%.

Benefits	**Basic Managed Choice (Bronze)** (You Pay)	**Managed Choice (Silver Plus)** (You Pay)	**HCRA (Aetna Healthfund)** (You Pay)
In-network preventive care covered at 100%	Yes	Yes	Yes
Well-being resources & special programs	Yes	Yes	Yes
Provider network	Broad or ACO	Broad or ACO	Broad or ACO
Use of in- and out-of-network providers	Yes	Yes	Yes
Must select a Primary Care Physician (PCP)	No	Yes	No
PCP referrals needed for specialty care	No	Yes	No
HCRA Funded	N/A	N/A	Yes
In-network deductible	Yes	Yes	Yes
Out-of-pocket maximum for in-network care	$6,000 single $12,000 family	$4,750 single $9,500 family	$5,600 single $11,200 family

How the Plans Work

In-network Medical Services

Benefits	**Basic Managed Choice (Bronze)** (You Pay)	**Managed Choice (Silver Plus)** (You Pay)	**HCRA (Aetna Healthfund)** (You Pay)
Preventative Services	$0	$0	$0
Office Visits Primary Care Physician (PCP)/Specialist	$30 PCP copay (after deductible) $45 Specialist copay (after deductible)	$30 PCP copay $40 Specialist copay	Deductible & Coinsurance
Emergency Room	$100 copay (after deductible)	$100 copay	Deductible & Coinsurance
Urgent Care Facility	$45 copay (after deductible)	$40 copay	Deductible & Coinsurance
Deductible	$2,500 single $5,000 family	$1,250 single $2,500 family	$2,000 single $4,000 family
HCRA Fund	N/A	N/A	$1,000 single $2,000 family
Deductible after HCRA Fund	N/A	N/A	$1,000 single $2,000 family
Coinsurance	35%	35%	30%
Annual Out-of-Pocket Maximum	$6,000 single $12,000 family	$4,750 single $9,500 family	$5,600 single $11,200 family

Note: Prescription drug coverage, described later in this guide, is included in the medical plan. Prescription drug expenses are not subject to the medical plan deductible.

How the Plans Work

Out-of-network Medical Services

Benefits	Basic Managed Choice (Bronze) (You Pay)	Managed Choice (Silver Plus) (You Pay)	HCRA (Aetna Healthfund) (You Pay)
Office Visits and Preventive Care	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance
Emergency Room	$100 copay (after deductible)	$100 copay	Deductible & Coinsurance
Deductible	$7,000 single $14,000 family	$3,000 single $6,000 family	$6,000 single $12,000 family
Coinsurance*	50%	50%	50%
Annual Out-of-Pocket Maximum	$12,000 single $24,000 family	$10,000 single $20,000 family	$10,000 single $20,000 family

*The plan pays out-of-network benefits based on Medicare reimbursement levels (up to 110% of Medicare for professional services and 140% for facility charges). In addition to your coinsurance, you are responsible for amounts that exceed these levels.

How the Plans Work

A closer look at the HCRA.

The HCRA is a unique medical plan that combines the essential elements of traditional plans with an important innovative feature, the HCRA Fund, a health reimbursement account. If you haven't yet considered this plan, take time during this year's Open Enrollment to review this option.

The HCRA provides you with medical and prescription drug coverage like all of the ShopRite plans — including the same extensive network of providers through Aetna. You will pay more when you need care (higher deductible and larger share of coinsurance). In addition, the HCRA Fund can be used to pay for qualified health care expenses with beforetax dollars. And, you receive an annual contribution to your HCRA Fund to help offset your out-of-pocket expenses.

The HCRA, together with the HCRA Fund, encourages you to take a more active role in your health care spending, and to be a more costconscious health care consumer. The plan involves three features working together:

1. Deductible

You pay this amount before your medical plan begins to pay for eligible expenses. (Please note: prescription drug expenses are not subject to the deductible).

- The in-network deductible is $2,000 single or $4,000 family and the out-of-network deductible is $6,000 single or $12,000 family.
- The full out-of-network deductible (depending on coverage level) must be met before the medical plan begins to pay.

2. Health Plan

Once you meet your deductible, your medical plan pays 70% for in-network medical services and 50% for out-of-network medical services (up to the Medicare reimbursement level).

- You will pay 30% for in-network services.
- You will pay 50% plus any amount that exceeds the reimbursement level for out-of-network services.
- Prescription drug expenses are subject to the applicable copays.

3. The HCRA Fund

Helps you pay for eligible out-of-pocket expenses, such as your deductible.

- The HCRA Fund amount is $1,000 single and $2,000 family, and is paid by the Company.
- The remaining balance rolls over each year. This means if you were enrolled for single coverage in 2023 and have a balance of $200 at the end of the year, your 2024 HCRA Fund would increase by this amount and would be $1,200.

How the Plans Work

The HCRA

Know Before You Go
Planning ahead can help you be an informed health care consumer — saving you time and money! When you enroll in the HCRA, you have an HCRA Fund funded by ShopRite that is used to pay for a portion of your deductible. By finding out the facts before you go for medical treatment, you can compare doctor's rates and clinical performance to help you:

- Understand your cost for the medical services you need;
- Be prepared for out-of-pocket costs before you visit the doctor;
- Plan for health care expenses so you can manage your funds; and
- Make health care purchasing decisions based on overall value.

Other Features
Since you are responsible for paying some or all of your health care expenses, it's important to do your research and review your options — both price and quality — before you go! Compare doctor's rates, specialist's quality indicators, and more at **www.aetna.com**.

Maximize Your Benefits

It's important to establish an ongoing relationship with a Primary Care Physician for your ongoing routine care.

Use Your Primary Care Physician
You may be thinking, why bother with a Primary Care Physician (PCP) when you can easily be seen at a local medical clinic or the emergency room (ER). While your walk-in-clinic or local ER may be ideal for urgent medical conditions, it's important to establish an ongoing relationship with a Primary Care Physician. They know you and your medical history, allowing them to recognize changes in your health. A Primary Care Physician cares for you as an entire person—physically, mentally, and emotionally—in addition to overseeing all of your routine care.

Your Primary Care Physician can provide education about preventive care which helps you take charge of your health, save money, and help you navigate through chronic or complex illnesses. They also act as your advocate and refer you to specialists as needed.

Your PCP's office is the best place for:

- Routine care: annual physicals, prescription refills, and immunizations.
- Chronic and complex conditions: diabetes, high blood pressure, thyroid, high cholesterol.
- Minor injuries: sprains, back pain, cuts and burns or eye injuries.

Get the Facts About Your Doctor in 3 Simple Steps
You can find the rates doctors have agreed to charge for up to 30 commonly used services provided by primary care and specialty care physicians and certain health care professionals, such as chiropractors and physical therapists. You also can access details about clinical performance.

- Visit your member website on Aetna Health through **www.aetna.com** or the Aetna Health app.
- Go to Find Care & Pricing and look up your doctor or search by the type of service.
- You can compare up to three doctors, view a breakdown of cost for a specific doctor, and read reviews for a specific doctor.

Maximize Your Preventive Benefits
The medical plans pay 100% for in-network preventive services for adults and children when the main purpose of the visit is for preventive care. Covered services are determined based on your age, gender, and risk status. There is no copay, deductible, or coinsurance for in-network preventive services such as office visits, screenings, counseling, and appropriate immunizations.

- Remind your physician's office to code your visit as "wellness," if appropriate, so you can take full advantage of the 100% in-network well-being benefit. In the event your visit is not for wellness, it is not eligible for the 100% benefit.
- Make sure your screenings and tests are sent to an in-network lab. It's your responsibility to make sure the lab is in the network before you have your tests done or sent for processing. If the lab is NOT in the network, even if recommended by your network physician, your claim will be paid at the lower out-of network benefit level.
- Our preferred laboratory services providers are Quest Diagnostics and LabCorp.

Maximize Your Benefits

Consider using an urgent care facility before the emergency room. ERs should be used only for true emergencies.

Did you know that you will wait longer and pay more for non-emergency care in an emergency room (ER) than in an Urgent Care Facility or Walk-In Clinic? It costs a lot of money for hospitals to support all the equipment and staff that an ER requires. So, visits to the ER generally cost much more than those to a doctor's office or an Urgent Care Facility. Plus, your medical plan copays for ER visits will be higher than the copays for doctor's or Urgent Care Facility visits. In addition to the ER copay, in some cases, you may receive a separate bill from your emergency room physician. There is generally only one charge for your Urgent Care bill.

Your wait time may be longer too. Emergency rooms treat the patients with the most serious conditions first, so patients with less urgent needs will often wait longer to see a doctor. An Urgent Care Facility will only see patients with routine conditions, and it's usually on a first-come, first-served basis.

Simply put, when it's not a true emergency, an Urgent Care Facility or Walk-In Clinic is the better choice.

Locating an Urgent Care Facility

- Visit your member website on Aetna Health through **www.aetna.com** or the Aetna Health app
- Go to Find Care & Pricing
- Scroll down to Clinics and Hospitals
- Click Urgent Care Centers

Maximize Your Benefits

Most health care costs are tied to decisions and behaviors we can control and improve.

Be A Wise Consumer
As partners in health, we have a shared responsibility to manage health care costs by being informed and engaged health care consumers. Most health care costs are tied to decisions and behaviors we can control and improve. That's why making smart choices every day is so important. Here are 10 ways to save:

1. Think ahead — Don't just automatically keep the same benefits every year. Take a little time and research the benefit options before making a selection.

2. Know what the medical plan covers — Understand your plan before you need to use it. Find out about pre-approvals, emergency room visits, copays for doctor visits, and coinsurance for procedures.

3. Get physically fit and practice preventive care
- Take prescribed medications.
- Keep up a healthy lifestyle and complete the Health Assessment every year.
- Schedule your annual physical with an in-network doctor (Covered at 100% – Plus $100 ShopRite Gift Card!).
- Take advantage of free resources to get and stay healthy.

4. Remember to NETWORK — Always use an Aetna in-network doctor or facility; not doing so may result in paying more from your own pocket.

5. Pick the right facility — If your condition isn't life-threatening, don't go to the emergency room. A persistent cough or a broken finger may be better treated by Teladoc or an urgent care facility at a much lower cost.

6. Be a smart shopper — Look up prices for medical procedures in your area using FAIR Health's "Consumer Cost Lookup" tool. This can help you plan for out-of-pocket health costs, or, contact other providers and ask for a quote to see if they offer a lower price for a specific procedure.

7. Use Teladoc — Consult with a doctor online or over the phone for minor conditions. It's a convenient treatment option that saves time and stress by not having to leave home or work.

8. Check bills and insurance EOBs for errors — A mistake in coding can mean the difference between a procedure with no copay and one that costs you money.

9. Cut your prescription costs
- Ask your provider if you can take a generic medication instead of an expensive brand.
- Fill your prescriptions using your local ShopRite pharmacy or through the Spotswood mail-order program. This also includes your specialty medication needs. Get a three-month supply of maintenance prescriptions for the cost of one!

10. Ask questions
- Ask your doctor whether making lifestyle changes can achieve the same results as costly prescriptions or a medical procedure.
- Get a second opinion before undergoing surgery.
- Clearly understand the goal of a procedure. Is it meant to cure or manage a condition? What are the long-term success rates, and how do they compare to other options?

Prescription Drugs

When you use a ShopRite pharmacy or Spotswood mail order for maintenance prescriptions, you'll get a three-month supply for the cost of one!

When you enroll in a ShopRite medical plan, you receive prescription drug coverage. Your copays are based on the type of drug and where you purchase your prescription. To lower your costs, request generic, use a ShopRite pharmacy or Spotswood mail order for maintenance medications (for conditions that usually require regular use, such as high blood pressure, heart disease, asthma, and diabetes).

Prescription Drug Benefits — Managed Choice and HCRA*

Type of Drug	Definition	Retail Pharmacy (NonShopRite)	ShopRite Pharmacies or Spotswood Mail Order
		For a 30 day supply	For a 90-day supply
Generic	Drug with same active ingredients as brand name, with lower cost	$15	$15
Preferred Brand**	Drug marketed under a specific trademark or name by specific drug manufacturer and included on Aetna's drug list	$40	$40
Non Preferred Brand (no generic available)**	Drug marketed under a specific trademark or name by specific drug manufacturer and NOT on Aetna's drug list	$60	$60
Specialty Brand	High-cost prescription medications used to treat complex, chronic conditions	$60	Contact your local pharmacy for more information.

*The cost of prescriptions under the Basic Managed Choice uses coinsurance. You pay 30% of the cost for Generic and Preferred Brand and 50% of the Non-Preferred Brand (not subject to the medical plan deductible).

**If you or your physician requests a brand-name medication when a generic is available, you will pay the applicable copay plus the difference between the cost of the generic and brand-name drug.

Prescription Drugs

Have your local ShopRite Pharmacy handle all of your prescription needs, including services under our Specialty Pharmacy.

How the Specialty Drug Market Impacts Health Care Costs

Drug prices in the United States continue to skyrocket. Prescription spending is growing faster than any other part of the health care dollar. The increase in FDA approvals for specialty drugs have increased access to higher costing prescription options. Higher prices and increased use are generating a significant increase in health care costs.

According to a recent AARP report, the annual retail cost of widely-used specialty prescription drug therapies averaged more than the median U.S. household income for the same time period.

ShopRite Pharmacy provides support for patients taking Specialty Medications for chronic and complex conditions

Let ShopRite Pharmacy help you along your treatment journey — from facilitating prior authorizations to helping you remember to take and refill your medications.

We deliver high-quality, accessible pharmacy services. Our experienced team can help you get and find ways to pay for the medication you need, so you can focus on you.

Our program offers:

- Assistance with prior authorizations.
- Guidance with co-pay reimbursement programs to help lower costs whenever possible.
- Refill management.
- The convenience of scheduling specialty medication pick up with non-specialty medications at a local ShopRite Pharmacy.

Take control of your health with the ShopRite Rx App

- Refill prescriptions
- View your prescription profile
- Transfer a prescription
- Get drug information
- Find a ShopRite Pharmacy near you

To find the app, search "ShopRite Pharmacy App".

ShopRite Specialty Pharmacy has a Pharmacist available 24/7 for patients:

- Medication therapy education by a licensed clinician.
- Side effect management.
- Self injection technique guidance.

Assistance with medication refills:

- ShopRite Specialty Pharmacy will notify your prescriber via fax when their specialty medications have expired, have no refills available or have changed.
- We will contact patients seven days before their next scheduled fill to verify and confirm their refill. We will reach out to new patients to explain the benefits of our program to help manage their complex medical condition. This program is voluntary, not all patients must enroll.

For more details, contact your local ShopRite pharmacy.

Well-being Programs

Your medical plan includes special programs to help you get great care and save money.

An important part of your medical plan is improving long-term health and managing the cost for both our associates and ShopRite. That's why we provide programs and resources that encourage healthy actions at no additional cost to you. Through Aetna, our medical plan administrator, we offer a wide variety of programs and services, from Health Assessments to help you identify opportunities for improvement, to a robust well-being portal that includes health tools, resources, services, and information.

Aetna Concierge Customer Service
Your Aetna Concierge is like your personal health care assistant, helping you to understand your medical plan and answering questions, such as:

- How can I find the right specialist?
- I have my diagnosis, but what do I do now?
- Is this covered by my plan?
- How much is this going to cost?

Your concierge can even make appointments for you. Just log in at **www.aetna.com** and chat online or call the toll-free number on the back of your Aetna member ID card.

Aetna Drug Savings Review Program
This review of pharmacy claims helps increase safety, save money, and improve quality of care. Drug reviews are done after prescriptions are filled and coordinated directly with your medical provider, so you won't experience any disruptions.

Aetna One Choice Solution
This program provides ongoing nurse support and coaching. Whether you're managing a chronic condition or have an upcoming surgery, Aetna nurses can help you put together a plan, understand your benefits, and answer your questions.

Aetna Pharmacy Advisory Program
If you have certain conditions (listed below), Aetna's Care Support team will contact you directly when you fill your first prescription to treat your conditions, if you are not taking your medication as directed, and if you miss one or more refills. The conditions included in this program are:

- Diabetes
- Cardiovascular Suite (Hypertension, Dyslipidemia, Coronary Artery Disease, Congestive Heart Failure)

MSK Direct
Through a partnership with Memorial Sloan Kettering Cancer Center (MSK), MSK Direct is your resource for prevention through diagnosis and ongoing treatment in cancer care, providing practical and emotional support. An MSK Direct Care Advisor helps find the best cancer care possible, either through on-site care at MSK (in certain states), or remotely, where MSK doctors guide your treatment in partnership with your local doctor.

PinnacleCare Health Advisory Services
If you need surgery or have complex medical conditions, you may call PinnacleCare to access your personal health advisor. Supported by physicians and researchers, your advisor will coordinate an expert medical review, guide you through health care challenges, and help you save time and avoid unnecessary or inappropriate procedures.

Well-being Programs

An annual physical is important to your overall wellness and helps prevent health issues down the road.

Get Your Annual Physical — and Get Rewarded!
Even if you feel perfectly healthy, it's important to get an annual physical for your overall wellness. A physical is an opportunity to check in with your primary care physician on your health, get tips on living a healthy lifestyle, and discuss prevention and treatment options.

Complete an annual physical – and receive a $100 ShopRite gift card for each enrolled associate and spouse/partner.*

***Note:** Payment of the $100 incentive for obtaining an age-appropriate physical exam from your physician is not conditioned on you or your spouse providing any genetic information (e.g., family medical history) to your employer or to your employer's medical plan.

Why Get an Annual Physical?

- **Prevent health problems.** Annual physicals allow your doctor to review any changes that have occurred over the last year and encourage healthy choices and lifestyle. Also, your doctor can help identify risk factors that could lead to future health problems and offer expert advice on how to manage them.
- **Establish baselines.** Getting a routine physical will help establish a baseline (e.g., blood pressure and cholesterol) that will help you and your doctor in making future healthcare decisions.
- **Stay on track with important screenings,** such as a mammogram, colonoscopy, or bone density test. Your doctor can help coordinate the recommended screenings.
- **Manage your medications.** Reviewing medications with your physician will ensure you are treating your medical concerns the best way available and will help prevent medication interactions.
- **Save money.** If a doctor can detect a problem before it gets serious, you'll save money on medical bills down the road.
- **Build a solid relationship with your doctor.** Having one-on-one time with your doctor when you're not sick or in the midst of a medical issue allows you to connect, establish rapport, trust, and discuss your personal health care needs.

Well-being Programs

A Health Assessment can give you valuable insight into your overall health and potential risk factors.

Aetna Health Assessment
The Aetna Health Assessment is a simple, confidential questionnaire to be completed on the Aetna website. This is available to you because it's a great tool for helping you to stay healthy; however, note there is no premium discount or gift card for completing the Health Assessment in 2024.

A Health Assessment can give you valuable insight into your overall health and potential risk factors.
Once you complete the questionnaire, you will receive a full assessment of your current health status, including potential risk factors and tips to modify your behavior for better health. You can print the report for your files and share it with your doctor.

Accessing the Assessment
To complete the Aetna Health Assessment, simply:

1. Visit **www.aetna.com** to access the Health Assessment or by using your smartphone, open the camera and aim the phone at the QR code.
2. Enter basic health information and habits.
3. Receive an online Action Plan and select programs and resources to help improve your health.

Get Help to Quit the Habit
Smoking is the number one cause of preventable deaths in the United States, and is a contributing cause to many chronic health conditions. Your medical plan includes **FREE** resources to help you stop smoking, including Aetna's Tobacco Cessation Program.

Aetna's Tobacco Cessation Program
If you meet the eligibility requirements and complete the program, ShopRite will pay the full cost of the program which includes:

- Personal support from an Aetna health coach who can help you set goals you can handle, plan quitting strategies, and stay motivated to quit for good
- Weekly coaching sessions with your health coach
- 8 weeks of nicotine replacement therapy
  To get started, visit **www.aetna.com** or call **1-866-213-0153**.

100% Coverage for Smoking Cessation Medications
If you need smoking cessation medications to help you quit, the medical plan will reimburse 100% of the cost for eligible over- the-counter and prescription medications.

- Contact Aetna at the number on the back of your ID card to make sure the item is eligible.
- In certain cases you may be asked to pay the full cost for the medication at the pharmacy. Send a claim form with your receipt to Aetna for 100% reimbursement.

Well-being Programs

Teladoc is a convenient treatment option that saves you time and stress by not having to leave home or work!

Talk to a doctor anytime and for as long as you need! Teladoc gives you 24/7/365 access to a board certified doctor through the convenience of phone or video consults. It's a quick and affordable option for quality medical care — with $0 copay for general medical care; specialty care (e.g., mental and behavioral health care, therapy, dermatology, and other specialty services) is subject to a fee schedule.

When can you use Teladoc?

- When you need care now
- If your doctor is unavailable
- If you're considering the ER or Urgent Care Facility for a non- emergency issue
- On vacation or away from home
- For short-term prescription refills

Why Teladoc?

There are many things in this world that are valuable... work, family, health, and so forth. But it could be argued that the most valuable thing you'll ever have, after your health, is your time. What if there was a way you could get health care for minor issues while saving you time and money? ShopRite has a possible solution.

Consider these questions...

- What if you could avoid waiting several hours in the ER or sitting in a room with other patients in an urgent care facility or doctor's office?
- Where should you go for care if it's a weekend or after hours?
- Once you see the doctor, how long do you normally spend talking about your illness?
- What if we told you, you could speak to a doctor in less than 10 minutes?
- What if you never had to leave your house or office?
- Would it be convenient for you to have your prescription sent to the pharmacy of your choice? Teladoc may be the best solution for you!

How to access Teladoc

- Online at **www.teladoc.com** or
- Download the Teladoc App on your smart phone, iPad or another compatible device. Just search "Teladoc" in the AppStore or Google play store.

You may also call **1-855-TELADOC** to get started. Then fill out a brief medical history like you would at the doctor's office.

Common non-emergency conditions Teladoc can treat include:

- Colds and flus
- Simple infections
- Fever
- Stomach flus, diarrhea or constipation
- Bronchial, upper respiratory, and ear infections
- Insect bites and unknown rashes
- Sore or strep throat
- Conjunctivitis and similar bacterial infections
- Headaches
- Temporary joint aches

Manageable chronic conditions:

- Arthritis
- Asthma
- Allergies
- IBS

Dental

Preventative oral care can prevent unexpected costs and pain that often come with oral surgery and emergency procedures.

The dental plan is administered by MetLife. You may choose any licensed dental provider, but you benefit from discounted fees when you use network providers.

Highlights of the Plan

- When you use a dentist participating in MetLife's network, you are only responsible for the difference between the in-network fee for the service provided and the plan's payment for the approved service.
- When you use out-of-network providers, your cost is based on the Reasonable and Customary (R&C) cost, instead of a discounted fee. You are responsible for any amounts that exceed the R&C, in addition to the deductible and coinsurance.

For more information or to locate in-network dental providers, visit **www.metlife.com/dental** or call **1-800-942-0854**.

Benefit	**In-Network** (You Pay)	**Out-of-Network** (You Pay)
Deductible (Individual/Family)[1]	$25/$75 (waived for preventive services)	
Annual Benefit Maximum	$2,000 per person	
Orthodontia Lifetime Maximum	$1,500 per person	$1,000 per person
Type A — (cleanings, oral exams and other maintenance type procedures)	0% of PDP Fee[2]	0% of R&C Fee[3]
Type B — (fillings and other standard dental procedures)	After deductible, 15% of PDP Fee[2]	After deductible, 20% of R&C Fee[3]
Type C — (bridges, dentures and other complex procedures)	After deductible, 35% of PDP Fee[2]	After deductible, 40% of R&C Fee[3]
Type D — Orthodontia	50% of PDP Fee[2]	50% of R&C Fee[3]

[1] Applies only to type B and C services combined.

[2] PDP Fee refers to the fees that participating PDP dentists have agreed to accept as payment in full, subject to any copayments, deductibles, cost sharing, and benefit maximums.

[3] R&C Fee refers to the Reasonable and Customary (R&C) charge, which is based on the lowest of (1) the dentist's actual charge, (2) the dentist's usual charge for the same or similar services, or (3) the charge of most dentists in the same geographic area for the same or similar services as determined by MetLife.

Vision

Vision benefits are so much more than an eye exam. They help you save money, stay healthy and see everything life has to offer.

Importance of Eye Exams
Annual eye exams not only help correct vision problems, but comprehensive exams can also reveal the warning signs of more serious undiagnosed problems, such as high blood pressure, heart disease, and diabetes.

The vision plan is administered by EyeMed. With this plan, you pay less when you visit a provider that participates in the EyeMed Select network.

Highlights of the Plan

- When you visit an EyeMed network provider, you pay a copay for eye exams and materials.
- When you visit an out-of-network provider, you generally pay the provider directly and submit an itemized bill to EyeMed. You will receive reimbursement up to the scheduled amount for each covered service and supply.

For more information or to locate EyeMed vision providers, visit **www.eyemedvisioncare.com** or call **1-866-939-3633**.

Benefit	EyeMed Option 1		EyeMed Option 2	
	In-Network Member Cost	**Out-of-Network Reimbursement**	**In-Network Member Cost**	**Out-of-Network Reimbursement**
Exam (one every 12 months)	$10 copay	Up to $35	No copay	Up to $28
Frames (one every 24 months)	No copay; $120 allowance + 20% off balance over $120	Up to $48	No copay; $180 allowance + 20% off balance over $180	$90
Lenses (one every 12 months)				
Single Vision	$25 copay	Up to $25	No copay	Up to $25
Bifocal	$25 copay	Up to $40	No copay	Up to $39
Trifocal	$25 copay	Up to $60	No copay	Up to $63
Contact Lenses (one order every 12 months)				
Conventional	No copay; $135 allowance + 15% off balance over $135	Up to $95	No copay; $180 allowance + 15% off balance over $180	Up to $144
Disposable	No copay; $135 allowance	Up to $95	No copay; $180 allowance	Up to $144
Medically Necessary	No copay: Paid in full	Up to $200	No copay: Paid in full	Up to $200

Flexible Spending Accounts

A flexible spending account (FSA) allows you to save pre-tax dollars and use them toward your medical and dependent care expenses.

Another way you can save money is by participating in Health Care and/or Dependent Care Flexible Spending Accounts (FSAs). Your contributions are made with pre- tax dollars from your pay – before federal income taxes and Social Security taxes are calculated. As a result, your taxable income is lower, so you pay less taxes in each paycheck. Then, when you have an eligible expense, you reimburse yourself with tax-free money from your account.

Eligible Expenses

- **Health Care FSA —** Use this account to pay for expenses not covered by any medical, prescription drug, dental, vision, or any other applicable and eligible plans, as well as copays, deductibles, and charges that exceed any benefit maximum limits, the plan's reimbursement level, or reasonable and customary allowance.
- **Dependent Care FSA —** Use this account to pay for day care expenses for your dependent child(ren) under the age of 13 or other eligible dependents so you and your spouse, if married, can work or look for work.

Note: The Health Care FSA offers an extra 2½ month grace period to incur expenses for reimbursement from your 2024 account. This grace period does not apply to the Dependent Care FSA. See the chart, How FSAs Work, on the next page.

Important Facts About the FSAs

In exchange for tax advantages, the IRS requires eligible expenses are incurred and submitted timely, so you will not forfeit any unused balances. The following rules apply to FSAs:

- **You must use it or lose it.** Estimate carefully. You will forfeit any balance left in your FSA(s) after all your incurred expenses are submitted and paid (according to the timeframes in the chart on the following page). You cannot roll it over to the next year.
- **You must enroll for the entire plan year.** Your election (payroll deduction amount) may not be changed during the year, unless you have a qualified status change.
- **The two Accounts are separate.** You cannot use the money in your Health Care FSA to pay for Dependent Care expenses, and vice versa.
- **You must complete an enrollment form each year.** If you participated in 2023, you still must complete an enrollment form to enroll for 2024. Your election may not be changed during the year unless you have a qualified status change.

FSA Decision Guidelines

Before participating in an FSA, ask yourself:

- How much did I spend on out-of-pocket health care and dependent care expenses last year?
- Do I expect to pay for some health care costs that are not totally covered by my benefits?
- Do I pay someone to care for my dependents while I work?
- Am I eligible for a tax credit for any health care or dependent care-related expenses? If so, will the tax credit or FSA participation be better for me?
- Does my spouse have FSAs available through an employer? If so, how do we want to coordinate our accounts?

Flexible Spending Accounts

How FSAs work

Step	Health Care FSA	Dependent Care FSA
Estimate your out-of-pocket expenses. Examples of eligible expenses* include:	• Deductibles, copays, and co-insurance for medical, prescription drug, dental, and vision care that are not paid under any health plan • Expenses that exceed plan limits • Over-the-counter medications used to treat personal injuries or sickness are NOT eligible unless for insulin or with a prescription • Expenses for domestic partners are not eligible	• Childcare centers, private providers, nursery schools, summer day camps, and after school care provided for your eligible dependent children up to age 13 • Care provided for your eligible elderly or disabled, tax-qualified dependent
How much you can contribute:	Up to $3,050 per year	Up to $5,000 per year ($2,500 if married and filing separately)
Payroll deductions are taken:	January 1, 2024 – December 31, 2024	
Enroll by:	**Enroll by November 25, 2023. If you participated in 2023, you must re-enroll. Your 2023 election will not carry over.**	
Incur expenses by:	January 1, 2024 – March 15, 2025	January 1, 2024 – December 31, 2024
Submit claims by:	April 30, 2025	April 30, 2025
Receive reimbursement up to:	**Annual elected amount**	**Account balance**

***Note:** Although it's easy to participate in the FSAs, the IRS places some rules on their use. For details, such as exclusions for both the Health Care and Dependent Care FSAs, visit **www.mypayflex.com**.

Flexible Spending Accounts

How much to contribute.

Use it, Don't Lose it!
The most challenging part of an FSA is determining how much to contribute. Be sure to estimate your expenses carefully because you will forfeit any unused funds at the end of the plan year. The Health Care FSA has the additional grace period of 2½ months to incur expenses. Keep in mind, money can't be transferred between accounts for reimbursement. You may want to contribute a bit less than you estimate in your FSA to be safe.

Questions & Online Resources
Aetna is the administrator for the FSAs. If you have any questions, contact Aetna at **1-800-284-4885** or visit **www.aetna.com** or **www.mypayflex.com**. Note that you may sign up for direct deposit/electronic funds transfer (EFT) for faster reimbursement on the Aetna website.

Sample Savings With an FSA*

	Without FSA	With FSA
Annual Salary	$25,000	$25,000
Pre-tax FSA Contribution		– $1,000
Taxable Income	$25,000	$24,000
Taxes: 28% (estimated)	– $7,000	– $6,720
After-Tax Eligible Expenses	– $1,000	–
Spendable Income	$17,000	$17,280
Annual Savings!	–	**$280**

*This example shows how you can save money by using an FSA. Using a 28% tax rate, this person saved $280 by using an FSA for $1,000 of eligible expenses. Your own situation would depend on your salary, tax rate, FICA and State taxes, and expenses.

Consult your tax advisor before making any financial decisions.

Long Term Disability

Long-term disability insurance pays a portion of your income if you're unable to work due to illness or injury.

The Hartford is the LTD provider.
LTD benefits provide you with a portion of your salary in the event you become disabled and cannot work. If you are rendered disabled by a licensed physician, for 90 days or more, you can apply and be considered for the LTD benefit. If approved, you would be eligible to receive 60% of your monthly earnings, up to $15,000 depending on the class defined.

Associates are provided with two LTD tax options:

Option 1 — Employee Paid/Weekly Contribution
If you pay the LTD premium with after-tax dollars, and you become disabled, the benefit of 60% (of your predisability wages) is NOT subject to Federal Tax. Therefore, you would receive the full 60% benefit.

Option 2 — Company Paid
If you become disabled, any disability benefit paid to you would be subject to Federal taxes. So, if the benefit paid is 60% of your pre-disability wages, and you are in the 21% tax bracket, your net benefit check would be about 48% of your normal gross wages.

If you are currently enrolled, during the annual Open Enrollment period, you have the opportunity to review your current participation in LTD and can make changes to your current LTD tax election.

Note: LTD contributory plans are governed by IRS regulations. The IRS has a three-year "look back" on LTD plans. If you contribute from the inception of the policy and continue to contribute throughout the policy years, any benefit paid to you will not be subject to Federal Tax. If, however, you change your mind during the policy period, you will have to pay the premium for 3 full years before the benefit is not subject to tax. If you pay the premium for 1 or 2 years in the 3 year period, the taxable portion is prorated accordingly.

Life Insurance and AD&D

Life insurance and Accidental Death and Dismemberment (AD&D) is offered through The Hartford.

Basic Life Insurance and AD&D is offered through The Hartford and is 1.5x the associate's salary at a maximum of $500,000. It is company paid, at no cost to the associate. On January 1st following the day the participant turns age 70, the benefit reduces to 50% of 1.5x the associate's salary.

Your designated beneficiary/beneficiaries will be the recipient of this benefit. It's important to ensure the beneficiary/beneficiaries are up to date.

Optional Life Insurance and AD&D is offered through The Hartford.

The products will be offered on an Associate Paid Basis. This payment will be facilitated via a weekly payroll deduction. You have greater purchasing power because of your employer rather than purchasing the product as an individual.

Associates are offered:

- Optional Life for the associate
- Dependent Life for your Spouse/Partner and Children
- Accidental Death & Dismemberment

New hires have 30 days from their date of hire to enroll in these products on guaranteed issue basis. This means you and your dependents can enroll for the maximum amounts of insurance (as stated below) and you do not have to provide any statement/proof with regard to your own or your dependent's current health status.

If you do not enroll when initially eligible, you will still be able to enroll for these products at any time during the year, but both you and your dependents will be required to provide a current statement of health status and coverage is "pending" until The Hartford approves this information.

Below is the coverage offered:

Associate Optional Life Insurance

- Associates can opt for 1, 2 or 3x's salary to a maximum coverage amount of $750,000.
- Guaranteed Issue for the associate — up to $300,000 (no medical proof will be required for coverage amounts up to this amount - only for amounts in excess of $300,000 to the $750,000 maximum).

Spouse Optional Life Insurance

- Total coverage amount is up to 50% of associate election to a max of $375,000.
- Guaranteed Issue for the Spouse — up to $50,000 (no medical proof will be required for coverage amounts up to this amount - only for amounts in excess of $50,000 to the $375,000 maximum).

Life Insurance and AD&D

Dependent Optional Life Insurance

- Dependent child coverage to age 26 - coverage amount is a flat $5,000.

Optional Accidental Death & Dismemberment

- Accidental Death & Dismemberment coverage is also an optional benefit available to you, if you elect this coverage; the amount usually mirrors the Voluntary Optional Life base election.

See table below for the current rates.

This coverage is age band rated. The rate you pay will change when you move to a different age group.

As always we encourage you to comparison shop any product you may be interested in. Your main goal is to purchase the best coverage for you and your family at the best price.

The Hartford — The rates are per $1,000 of coverage per month			
Associate/Spouse Age	**Rate per $1,000**	**Associate/Spouse Age**	**Rate per $1,000**
Age < 25	$0.044	55-59	$0.357
25-29	$0.044	60-64	$0.602
30-34	$0.060	65-69	$1.139
35-39	$0.074	70-74	$1.845
40-44	$0.089	75-79	$2.019
45-49	$0.125	80+	$2.019
50-54	$0.208		
Child Rate	$0.113	AD&D	$0.026

How to Enroll

Consider these important steps when making your benefit decisions. And remember, your decisions don't end here. We are counting on you to be a smart consumer throughout the year as you use your benefits.

Understand your benefit options

- Review your enrollment materials and Summary of Benefits and Coverage (SBCs) on your benefits website.
- Consider your benefit needs and compare your options for 2024.
- Contact your Benefits Administrator if you have any questions.

Make your benefit decisions

- Choose your benefits carefully.
- Decide if you want to add or delete dependents from your coverage. If you're adding a dependent, you are required to provide dependent documentation, such as a marriage certificate and/or a birth certificate.
- Review your life insurance needs and update your beneficiary designation, if changes are necessary.
- Consider making pre-tax contributions to the Health Care and/or Dependent Care Flexible Spending Account(s) (FSA).
- Review your LTD needs and update your tax election, if changes are necessary.

Complete the enrollment forms by November 25, 2023, if you want to:

- Enroll in, change, or drop your medical, dental, and/or vision coverage.
- Elect anything other than Associate only (single) coverage; identify all eligible dependent(s) on the enrollment forms.
- Participate in a Flexible Spending Account; sign up for direct deposit/electronic funds transfer (EFT) for faster reimbursement by visiting **www.aetna.com**.

If you do not elect to make any changes by November 25, 2023:

- Your medical, dental, and/or vision coverage will continue with the 2024 plans and contributions.
- Your dependents will remain the same.
- Your participation in the Flexible Spending Account(s) will end on December 31, 2023.

Frequently Asked Questions

What is an annual Open Enrollment period?
It's the time of year that you may add, drop or change your level of coverage for certain pre-tax benefit options. This year's Open Enrollment period is from **November 6 – 25, 2023**.

How do I obtain detailed information about the plans offered by ShopRite?
Refer to your "Summary of Benefits and Coverage" (SBC), available on your benefits website.

Why should I see a Network Provider?
Network Doctors have agreed to a discount of their fees. You may pay lower out-of-pocket expenses when you use an in-network provider.

How do I know if my provider is in the network?
Check the website or call the insurance provider directly.

What is an Explanation of Benefits (EOB)?
A statement provided to the member explaining how and why a claim was or wasn't paid. Always review your EOB statements for accuracy. If you have a question about an EOB, or see an error, contact the provider directly.

When can I continue coverage under COBRA?
You and/or your dependents are eligible to continue group health care under COBRA if coverage is lost because:

- You leave ShopRite for any reason other than "gross misconduct".
- Your work hours are reduced.
- You die.
- You become entitled to and enroll in Medicare prior to electing COBRA.
- You divorce.
- Your dependent loses dependent status.

How can I receive additional or replacement ID cards?
Call the benefit providers directly.

How do I add my dependents?
Contact your Benefits Administrator.

What if I get married, divorced or have a new child in my family during the plan year?
You must contact your Benefits Administrator within 30 days of any Qualified Life Event. Otherwise, you will have to wait until the next enrollment period to change your benefit options or coverage levels. You are also required to show official documentation as proof of the change such as a marriage certificate, birth certificate or court documents.

Why do I pay for some benefits with pre-tax money?
Paying for certain optional benefits with pre-tax money lowers the amount of your pay that is taxable; therefore, you pay less in taxes.

Important Terms

We know that benefits can be confusing, especially with all of the terms that are used to describe them. To help you better understand your options, we put together a listing of commonly used benefit terms used throughout this Guide.

Coinsurance — percentage of covered expenses you pay after the plan's applicable deductible.

Consumerism features — choices you make to save money, such as using network providers instead of out-of-network providers, or requesting a generic drug instead of a brand-name drug alternative.

Contributions — the amount that is deducted from your paycheck to pay for your share of benefits.

Copayment — the fixed dollar amount you pay to the provider for some services, such as office visits and prescription drugs.

Deductible — the amount you pay each calendar year before the plan reimburses you for covered expenses.

Exchange — another name for the Health Insurance Marketplace that has been available since October 1, 2013 to help individuals and small employers compare and purchase health insurance.

Health Assessment — online questionnaire that you complete to help you identify potential health risks.

Health Care Reimbursement Account (HCRA) — a company-funded account that can be used to pay for a portion of your deductible or coinsurance. (Only available with the Health Care Reimbursement Account Plan).

Health Insurance Marketplace — a way for individuals and small employers to compare and purchase health insurance.

In-network — service received from a participating medical, dental or vision care network provider. Also, can be used to define the level of benefits paid when you use a network provider.

Out-of-network — service received from a provider that does NOT participate in the applicable Aetna, MetLife and/or EyeMed networks. The medical plan pays out-of-network benefits based on Medicare reimbursement levels (up to 110% of Medicare for professional services and 140% for facility charges). In addition to your coinsurance, you are responsible for amounts that exceed these levels.

Out-of-pocket maximum — maximum expense limit you are responsible for paying such as your deductible, coinsurance, and copays in a given plan year - this does not include your contributions. After this limit is reached, the plan reimburses 100% for most remaining covered medical expenses (excluding prescription drugs and the amount above the reimbursement level.).

Primary care physician (PCP) — the network doctor, generally a family practice, internist or pediatrician, you choose to provide care for you and to help you coordinate your overall health care, and make referrals to specialists, when appropriate.

Reasonable and Customary (R&C) Charges (for Dental Plan) — the negotiated fee your network dentist and the insurance provider have agreed on to perform certain services. If you visit an out-of-network provider, you will be required to pay any charges that exceed the R&C charge.

Important Contacts

To learn more about a specific benefit plan, please visit **inserra.shopritebenefits.com**, or contact the individual company/provider listed here. We also invite you to speak with your Benefits Administrator when you have questions.

Benefit Plan	Website	Telephone
Medical and Prescription Drugs		
Aetna medical plan and prescription drugs	www.aetna.com	1-877-461-0933
PinnacleCare health advisory services	www.pinnaclecare.com/support	1-888-442-7380
MSK Direct	www.mskcc.org/gs-well-being	1-833-986-1757
Aetna Health Assessment	www.aetna.com	1-800-225-3375
Healthy Lifestyle Coaching Tobacco Free Program	www.aetna.com	1-866-213-0153
Dental		
MetLife	www.metlife.com/dental	1-800-942-0854
Vision		
EyeMed	www.eyemedvisioncare.com	1-866-9EYEMED (939-3633)
Flexible Spending Accounts		
Aetna	www.aetna.com www.mypayflex.com	1-800-284-4885

About This Guide

This guide describes the benefit plans and policies available to you as an associate of ShopRite. The details of these plans and policies are contained in the official plan and policy documents, including some insurance contracts. This guide is meant only to cover the major points of each plan or policy. It doesn't contain all of the details that are included in your Summary Plan Descriptions (as required by ERISA) found in your other associate benefit materials. If there is ever a question about one of these plans and policies, or if there is a conflict between the information in this guide and the formal language of the plan or policy documents, the formal wording in the plan or policy documents will govern.

Note: The benefits highlighted and described in this guide may be changed at any time and don't represent a contractual obligation – either implied or expressed – on the part of ShopRite.