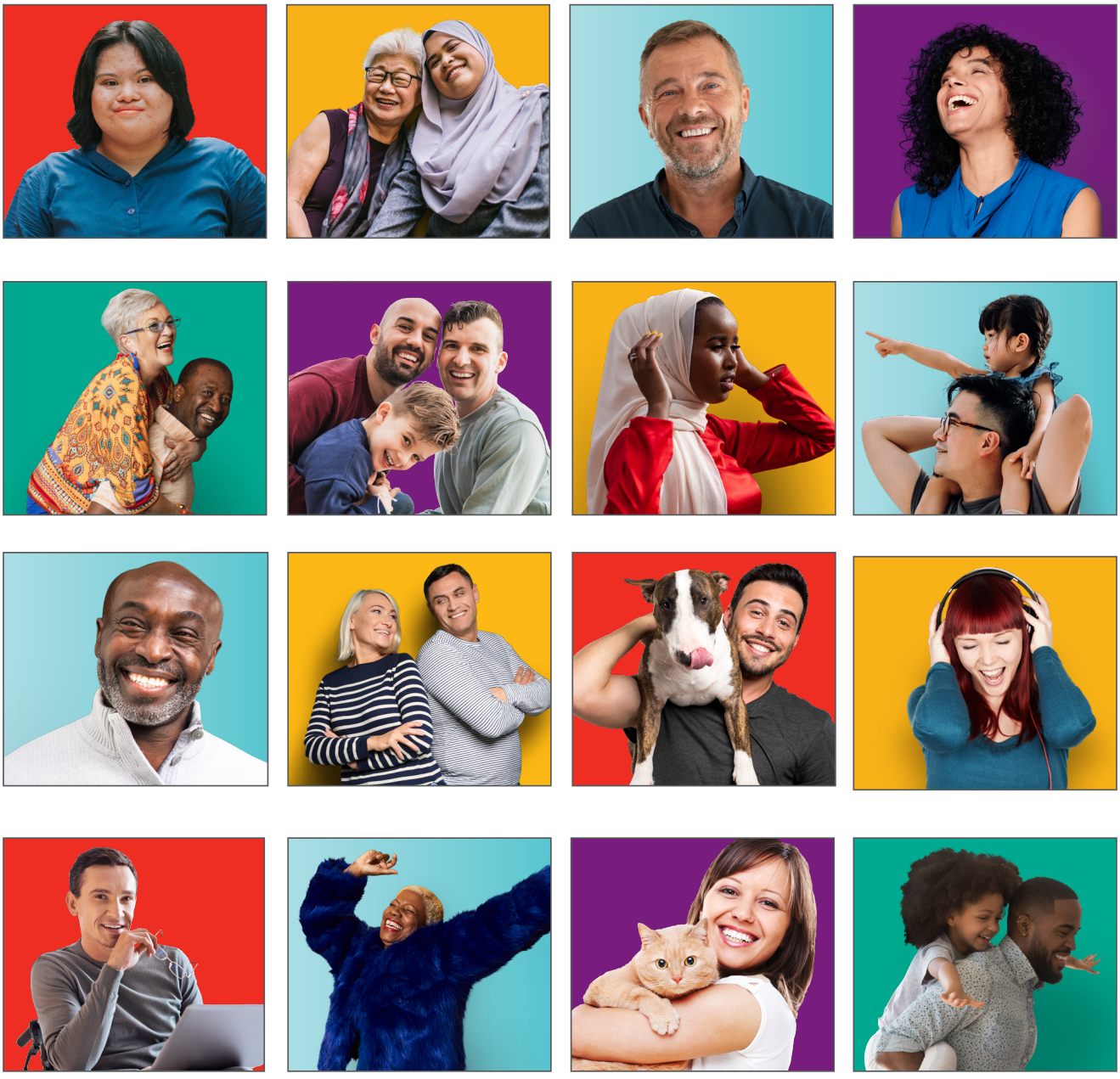
MY REWARDS EVERY DAY

2023 COBRA Benefits Guide

The **My Rewards Every Day** program provides benefits that support your health, your money, and your life — helping to make **every day** better for you and your family in all the ways that matter most.

Selecting the right health insurance for you and your family is an important decision. You have the opportunity to enroll in The Health Insurance Marketplace® (also known as the “Marketplace” or “exchange”) by visiting www.HealthCare.gov or you can enroll through the Health Equity COBRA system.

Please take the time to review this COBRA Benefits Guide as you consider your 2023 elections.



Medical

You have a choice of medical plans — all designed to help you and your family stay healthy and pay for care when you need healthcare services. All of our plans provide comprehensive coverage and a broad provider network.

Your Medical Plan Options

The Company offers these medical plan options, administered by Capital BlueCross (CBC):

- Consumer Choice $500 HSA
- Consumer Choice $300 HSA
- Consumer Choice $150 HRA
- Value Plan
- Preferred Provider Organization (PPO) Plan

Please note: The PPO Plan is only available to those who were previously eligible. To confirm your eligibility, visit **mybenefits.wageworks.com**.

If you are currently enrolled in a Health Savings Account (HSA), Health Reimbursement Account (HRA), or Flexible Spending Account (FSA), details on continuing these benefits will be provided on your enrollment form.

For more details on the HSA, contact Fidelity at 1-800-249-4015.

For more details on the FSA, contact HealthEquity at 1-888-678-4881.

HOW THE PLANS ARE THE SAME

- Comprehensive medical and prescription drug coverage from Capital BlueCross and OptumRx
- Access to a quality network of doctors, specialists, facilities, and hospitals
- In-network preventive services (e.g., physicals, mammograms, well-child care) — 100% covered
- A cap on your eligible out-of-pocket costs to protect you from excessive expenses
- Health resources to support your physical wellbeing, like Virtual Care, Nurse Line, and the Tobacco Cessation program

How the Plans Are Different

Below are some key differences among the plans.

	Consumer Choice $500 HSA Plan	Consumer Choice $300 HSA Plan	Consumer Choice $150 HRA Plan	Value Plan	PPO Plan
How **prescription drug coverage** works	You pay the full cost of prescription drugs until the annual medical plan deductible is met (except for preventive generic medications, which are covered at 100%). After you meet the annual medical plan deductible, then you pay prescription drug plan coinsurance.		You do not need to meet the annual medical plan deductible before coverage begins.	You do not need to meet the annual medical plan deductible before coverage begins.	You do not need to meet the annual medical plan deductible before coverage begins.
Tax-free account you can contribute to*	Health Savings Account		N/A	N/A	N/A

*Tax-free accounts can only be continued if currently enrolled; new elections are not eligible.

Medical Plan Comparison

	Consumer Choice $500 HSA	Consumer Choice $300 HSA	Consumer Choice $150 HRA	Value Plan	PPO Plan
Your Costs					
Preventive Doctor's Visit	No cost to you when you see in-network providers — covered at 100%				
In-Network Deductible					
Individual Coverage	$1,500	$1,500	$1,750	$2,600	$600
Family Coverage	$3,000[1]	$3,000[1]	$3,500[1]	$5,200[1]	$1,200[3]
Out-of-Network Deductible					
Individual Coverage	$3,000	$3,000	$3,500	$5,200	$1,200
Family Coverage	$6,000[1]	$6,000[1]	$7,000[1]	$10,400[1]	$2,400[3]
In-Network Out-of-Pocket Maximum					
Individual Coverage	$4,000	$4,000	$5,000	$6,550	$4,000
Family Coverage	$8,000[2]	$8,000[2]	$10,000[2]	$13,100[2]	$8,000[4]
Out-of-Network Out-of-Pocket Maximum					
Individual Coverage	$8,000	$8,000	$10,000	$13,100	$8,000
Family Coverage	$16,000[2]	$16,000[2]	$20,000[2]	$26,200[2]	$16,000[4]
Your Coinsurance					
In-Network	10% after annual medical plan deductible	20% after annual medical plan deductible	30% after annual medical plan deductible	40% after annual medical plan deductible	20% after annual medical plan deductible
Out-of-Network	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible
Virtual Care Program through Capital Blue Cross					
Medical Services before annual medical plan deductible is met	$64	$64	Covered at 100%	Covered at 100%	Covered at 100%
Behavioral Health Services before annual medical plan deductible is met	See page 13 for more details	See page 13 for more details			
After annual medical plan deductible is met	Covered at 100%	Covered at 100%			

1 You must meet the annual medical plan deductible before any family member begins to pay coinsurance. When any combination of family members meets the annual medical plan deductible, the entire covered family begins paying coinsurance.

2 No member of a covered family will pay more than a $7,350 in-network maximum, even if you have not reached your total out-of-pocket maximum for the year.

3 If you are enrolled in family coverage, each covered family member must meet their individual annual medical plan deductible before the plan begins paying coinsurance, unless the sum of all family members' expenses reaches the family annual medical plan deductible first.

4 If you are enrolled in family coverage, each family member must meet their individual out-of-pocket maximum before the plan begins paying 100% of medical/prescription drug expenses, unless the sum of all family members' expenses reaches the family out-of-pocket maximum first.

Medical Plan Comparison (continued)

	Consumer Choice $500 HSA	Consumer Choice $300 HSA	Consumer Choice $150 HRA	Value Plan	PPO Plan
Office Visit					
In-Network	10% after annual medical plan deductible	20% after annual medical plan deductible	30% after annual medical plan deductible	40% after annual medical plan deductible	$25 PCP $35 Specialist
Out-of-Network	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible
Mental Health & Substance Use Disorder Office Visits (including in-person and virtual services)					
In-Network	10% after annual medical plan deductible	20% after annual medical plan deductible	30% after annual medical plan deductible	$25	40% after annual medical plan deductible
Out-of-Network	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible	50% after annual medical plan deductible
Emergency Room Visit	10% after annual medical plan deductible	20% after annual medical plan deductible	30% after annual medical plan deductible	$200 copay	40% after annual medical plan deductible

Consumer Choice $500 and $300 HSA Plans

This chart walks you through the steps of using the Consumer Choice $500 and $300 HSA plans.

You pay nothing for **in-network preventive care** — it's covered in full. You do not need to meet the annual medical plan deductible before the plan pays for in-network eligible preventive care services.

Deductible

You **pay 100% of costs, including prescription drug costs**, until you meet an annual limit called the annual medical plan **deductible**.

If you are enrolled in dependent coverage, the family annual medical plan deductible must be met before the plan begins to pay benefits for any person. One person, or a combination of family members, can meet the family annual medical plan deductible.

Coinsurance

You **pay a percentage of the cost of covered services** after meeting the annual medical plan deductible, and **the Company pays the rest**.

You pay coinsurance until you reach the annual out-of-pocket maximum.

Out-of-Pocket Maximum

The plan protects you from high costs once you reach your annual limit — **the Company pays 100%** of any additional covered expenses for the rest of the year.

If you are enrolled in dependent coverage, no member of a covered family will pay more than a $7,350 in-network maximum, even if you have not reached your total out-of-pocket maximum for the year.

STAY IN-NETWORK

You can choose any in-network or out-of-network provider each time you receive care. But keep in mind — you will pay less out-of-pocket when you use in-network providers.

Preventive care includes annual physical exams and health screenings, such as routine tests, Pap smears, prostate screenings, mammograms, and certain other age-appropriate immunizations and health screenings.

Consumer Choice $150 HRA Plan

This chart walks you through the steps of using the Consumer Choice $150 HRA plan.

You pay nothing for **in-network preventive care** — it's covered in full. You do not need to meet the annual medical plan deductible before the plan pays for in-network eligible preventive care services.

Deductible

You **pay 100% of costs**, until you meet an annual limit called the annual medical plan **deductible**.

You pay a copay for Tier 1 generic prescription medications.

Coinsurance

You **pay a percentage of the cost of covered services** after meeting the annual medical plan deductible, and **the Company pays the rest**.

You pay coinsurance until you reach the annual out-of-pocket maximum.

Out-of-Pocket Maximum

The plan protects you from high costs once you reach your annual limit — **the Company pays 100%** of any additional covered expenses for the rest of the year.

If you are enrolled in dependent coverage, no member of a covered family will pay more than a $7,350 in-network maximum, even if you have not reached your total out-of-pocket maximum for the year.

Value Plan

This chart walks you through the steps of using the Value Plan.

You pay nothing for **in-network preventive care** — it's covered in full. You do not need to meet the annual medical plan deductible before the plan pays for in-network eligible preventive care services.

Deductible

You **pay 100% of costs**, until you meet an annual limit called the annual medical plan **deductible**.

You pay a copay for Tier 1 generic prescription medications.

Coinsurance

You **pay a percentage of the cost of covered services** after meeting the annual medical plan deductible, and **the Company pays the rest**.

You pay coinsurance until you reach the annual out-of-pocket maximum.

Out-of-Pocket Maximum

The plan protects you from high costs once you reach your annual limit — **the Company pays 100%** of any additional covered expenses for the rest of the year.

If you are enrolled in dependent coverage, no member of a covered family will pay more than a $7,350 in-network maximum, even if you have not reached your total out-of-pocket maximum for the year.

STAY IN-NETWORK

You can choose any in-network or out-of-network provider each time you receive care. But keep in mind — you will pay less out-of-pocket when you use in-network providers.

Preventive care includes annual physical exams and health screenings, such as routine tests, Pap smears, prostate screenings, mammograms, and certain other age-appropriate immunizations and health screenings.

PPO Plan

This chart walks you through the steps of using the PPO Plan.

You pay nothing for **in-network preventive care** — it's covered in full. You do not need to meet the annual medical plan deductible before the plan pays for in-network eligible preventive care services.

Copay

You pay a **copay** at the time of service for doctor visits and generic prescriptions.

Deductible

For care that doesn't charge a copay, such as lab or X-ray services, you **pay 100% of the eligible costs** until you meet the annual medical plan **deductible**.

If you are enrolled in family coverage, each covered family member must meet their individual annual medical plan deductible before the plan begins paying coinsurance, unless the sum of all family members' expenses reaches the family annual medical plan deductible first.

Coinsurance

You **pay a percentage of the cost of covered services** after meeting the annual medical plan deductible, and **the Company pays the rest**.

You pay coinsurance until you reach the annual out-of-pocket maximum.

Out-of-Pocket Maximum

The plan protects you from high costs once you reach your annual limit — **the Company pays 100%** of any further covered expenses for the rest of the year.

STAY IN-NETWORK

You can choose any in-network or out-of-network provider each time you receive care. But keep in mind — you will pay less out-of-pocket when you use in-network providers.

Preventive care includes annual physical exams and health screenings, such as routine tests, Pap smears, prostate screenings, mammograms, and certain other age-appropriate immunizations and health screenings.

Be a smart healthcare consumer

When it comes to purchasing products, people almost always look at the price tag. For larger purchases, such as a car or television, they might do hours of research to find the best fit and price for their family.

Yet with all the money spent on healthcare — from premium contributions to prescriptions to doctor's visits — many people rarely think about the price of these services. And as healthcare prices continue to rise, that ends up costing more for you and the Company. Help control health spending with these tips.

✓	**Use in-network providers.** They've agreed to charge only up to negotiated rates and bill Capital BlueCross (CBC) directly, which saves you money and time. Also, check with CBC to ensure that the services you and your dependents require are covered before you receive care.
✓	**Compare costs.** Use the price cost comparison tools through CBC to make informed medical provider/facility choices before getting healthcare services.
✓	**Keep up with preventive care.** It's covered in full and can help detect and prevent potentially costly health issues early. You pay nothing for services such as annual physicals, immunizations, routine cancer screenings, and more when you see in-network providers.
✓	**Choose the right place to get care.** Should you go to a doctor's office, go to an urgent care facility, call Virtual Care, or head elsewhere for help? Going to the most appropriate place for your healthcare needs will save you time and money!
✓	**Shop smart for prescriptions.** Using generic alternatives will almost always save you money — and in most cases they're just as effective as brand-name prescriptions. For your ongoing prescriptions, use a Company pharmacy for convenience and cost savings (where available).

CENTERS OF EXCELLENCE

Centers of Excellence are Capital BlueCross' high-performing doctors in certain specialty areas. All Centers of Excellence doctors have met nationally recognized standards for clinical performance and efficiency.

Bariatric surgery and transplant procedures are eligible for coverage only when performed at a Capital BlueCross Center of Excellence. Related travel and lodging expenses for eligible transplant services are also covered under this benefit. Find a Blue Distinction Center of Excellence by visiting capbluecross.com and using the provider finder tool, or by accessing the BlueCross BlueShield Association tool at **bcbs.com/blue-distinction-center-finder**.

Prescription Drugs

When you enroll in a Company medical plan, you automatically receive prescription drug benefits through OptumRx.

Your coverage offers up to:

- **30-day acute prescriptions** through any Company pharmacy or participating retail pharmacy more than 10 miles away from a Company pharmacy.*
- **90-day maintenance prescriptions** through a Company pharmacy* where available, or the OptumRx Mail Order drug program.*

Drug Tiers

The cost of your prescription drugs depends on the tier of the medication:

- **Tier 1 — Generic:** Generic drugs contain the same active ingredients as their brand-name equivalents and meet the same federal standards for safety, but typically cost significantly less.
- **Tier 2 — Formulary:** Formulary brand-name prescription medications are favored by a prescription plan based on drug effectiveness and cost.
- **Tier 3 — Non-formulary:** Non-formulary brand-name prescription medications are not on a prescription plan's favored list (or formulary) based on drug effectiveness and cost. Non-formulary drugs still may be covered, but may require prior authorization and cost more.

Preventive Generic Drugs: Generic drugs are covered at 100% — contact OptumRx to see which drugs are eligible for coverage at 100%.

Use Company Pharmacies*

Use a Company pharmacy whenever possible to fill 30-day acute and 30- and 90-day maintenance prescriptions and specialty drugs when available. Our Company pharmacies offer best-in-class services for a broad range of needs. Using our own pharmacies results in convenience and savings for you and the Company.

Company Pharmacies include:

- Food Lion
- Giant Martin's
- Giant Food
- Hannaford
- Stop & Shop

DIABETIC SUPPLY PROGRAM

To help meet the needs of enrolled individuals with diabetes, the Company offers the Diabetic Supply Program through the OptumRx pharmacy benefit. This program covers **Contour** and **Contour Next** brand test strips and control solutions and all brands of lancets and lancet devices at 100% when using a Company pharmacy or OptumRx mail order. Prescriptions for these items bypass the HSA Medical Plan deductible and all coinsurance and copay amounts. The OptumRx prescription plan also covers eligible insulin pumps and pods. For more information, contact OptumRx.

Mail order for maintenance medications

For ongoing maintenance medications, you can take advantage of the convenience and cost savings of using the mail order program, if a Company pharmacy is not within 10 miles. After the first two fills, all long-term maintenance medications will be required to be filled at a Company pharmacy or through the OptumRx mail order drug program. If a Company pharmacy or OptumRx mail order drug program is not utilized, the medication cost will not be covered under the plan.

Please review the Premium Formulary listing at **optumrx.com**.

* Contact OptumRx at 1-844-368-9859 to determine if you are required to use a Company pharmacy. The use of a Company pharmacy is based on plan design or for those eligible and enrolled members with limited Company pharmacy access.

Prescription Drug Plan Comparison

	Consumer Choice $500 HSA	Consumer Choice $300 HSA	Consumer Choice $150 HRA	Value Plan	PPO Plan
Up to a 30-Day Supply at a Company pharmacy or Retail Optum Network pharmacy greater than 10 miles from a Company pharmacy. Reimbursement will not be made for prescriptions filled at a Retail Optum Network pharmacy that is within 10 miles of a Company pharmacy.					
Tier 1 — Generic	$10 copay after annual medical plan deductible	$10 copay after annual medical plan deductible	$10 copay	$10 copay	$10 copay
Tier 2 — Formulary	30% after annual medical plan deductible (min. $25, max. $50)	30% after annual medical plan deductible (min. $25, max. $50)	30% (min. $25, max. $50)	30% (min. $25, max. $50)	30% (min. $25, max. $50)
Tier 3 — Non-formulary	50% after annual medical plan deductible (min. $40, max. $100)	50% after annual medical plan deductible (min. $40, max. $100)	50% (min. $40, max. $100)	50% (min. $40, max. $100)	50% (min. $40, max. $100)
Up to a 90-Day Supply at a Company pharmacy or OptumRx Mail Order after two grace fills.* **Up to a 30-Day Supply** for Specialty Drugs at a Company pharmacy or at a BriovaRx/OptumRx Specialty Services pharmacy when the Specialty drug is not available at a Company pharmacy.					
Tier 1 — Generic	$25 copay after annual medical plan deductible	$25 copay after annual medical plan deductible	$25 copay	$25 copay	$25 copay
Tier 2 — Formulary	30% after annual medical plan deductible (min. $65, max. $150)	30% after annual medical plan deductible (min. $65, max. $150)	30% (min. $65, max. $150)	30% (min. $65, max. $150)	30% (min. $655, max. $150)
Tier 3 — Non-formulary	50% after annual medical plan deductible (min. $120, max. $250)	50% after annual medical plan deductible (min. $120, max. $250)	50% (min. $120, max. $250)	50% (min. $120, max. $250)	50% (min. $120, max. $2500)
Preventive Generic	100% covered				

Please note: Coverage may differ based on eligibility. Contact OptumRx at 1-844-368-9859 to determine if you are required to use a Company pharmacy. The use of a Company pharmacy is based on plan design or for those eligible and enrolled members with limited Company pharmacy access.

Budgeting For Prescription Drug Expenses When Enrolling In A Consumer Choice HSA Medical Plan

Your prescription drug out-of-pocket costs work a little differently under the Consumer Choice $500 HSA and Consumer Choice $300 HSA plans.

Here's a quick overview when you enroll in an HSA Medical Plan:

When you fill a prescription of any type (except for preventive generic medications), you pay 100% of the negotiated cost of the drug until you and your covered dependents meet the annual medical plan deductible. So if you're taking a $500 prescription drug and you haven't met the annual medical plan deductible, you pay $500.	All prescription drug expenses apply toward the annual medical plan deductible and out-of-pocket maximum.	After you and your covered dependents meet the annual medical plan deductible,* the plan shares in the costs based on the type of prescription drug.	Once you and your covered dependents reach the annual out-of-pocket maximum, the plan pays 100% of eligible expenses.

*Tier 2 and 3 prescription medications are subject to minimum and maximum amounts AFTER the annual medical plan deductible has been met.

Save money

The cost of prescription drugs is rising faster than many other healthcare services and supplies. But there are ways for you to save on your cost of prescriptions.

- Check the prescription's cost at **optumrx.com**. Ask your doctor for a lower-cost alternative if the cost is high.
- Ask your doctor about generic medications. Generic medications are generally just as effective as brand-name medications, yet the cost of generics is substantially lower. They typically cost between 30% and 75% less than brand-name drugs.

Dental

Dentists can detect many health issues, beyond teeth and gum health, during a dental examination. Studies have shown that our mouths can show symptoms related to over 100 non-dental diseases including diabetes and heart disease.

The MetLife dental plan options (comprehensive and basic) cover eligible preventive care services and help pay for the cost of basic and major restorative treatments.

Key features at a glance:

- Free in-network preventive and diagnostic care, with no deductible.
- Affordable coverage that helps you manage the cost of dental treatment.
- Comprehensive coverage for children and adults for most conditions requiring diagnosis and treatment including preventive, restorative and orthodontia services.
- Wide network of providers who have agreed to negotiated rates, which helps you save money. When using a network provider, you receive the highest level of benefits. If you seek treatment from a provider outside the network, coverage is still provided but the out-of-pocket costs will be higher and may result in balance billing from your provider.

How it works step-by-step

You pay nothing for **eligible in-network preventive care** — it's covered in full.

The plan covers preventive services, such as oral exams, x-rays, and cleanings, at 100% (based on coverage and maximum benefit limits). You do not need to meet the deductible before the plan pays for preventive care services.

Deductible	Coinsurance	Maximum Benefits
You pay the full cost of covered services until you reach the deductible. Your deductible applies to care other than preventive care. Both plans have the same deductible.	Once you meet the annual deductible, you share in the cost of services by paying a percentage (called coinsurance) for covered basic and major restorative services.	The annual maximum benefit is the most the plan will pay each calendar year for covered services. Once you meet this limit, you pay 100% for services for the rest of the plan year. The orthodontia lifetime maximum is the total amount the plan will pay for each covered person. Once this amount is reached, you pay all additional costs. This amount does not affect your calendar year maximum benefit.

Comprehensive Option	Basic Option
Deductible: $50 individual, $150 family	Deductible: $50 individual, $150 family
Basic Services: 20% after deductible	Basic Services: 40% after deductible
Major Services: 50% after deductible	Major Services: 60% after deductible
Annual maximum per person: $1,800	Annual maximum per person: $1,500
Orthodontia lifetime max: $1,500	Orthodontia lifetime max: no coverage

Using Your Dental Benefits

Here's how to make the most of your dental benefits:

- **Choose a provider.** Each time you need dental care, you have a choice of providers. Selecting a MetLife participating dentist will ensure you receive the highest benefits from your plan. To find a provider, go to **mybenefits.metlife.com**.
- **Notify your dentist's office that MetLife is your provider.** ID cards are not required, but can be downloaded and printed from **mybenefits.metlife.com** if you prefer.
- **Flex your FSA.** You can use the tax-free money in your Health Care FSA to pay for eligible dental expenses.
- **Check your claim status and other information at mybenefits.metlife.com.** You can review Explanation of Benefits (EOB) statements, check if claims have been paid, view a list of common procedures and their in- and out-of-network fee range using the Procedure Fee Tool, and more.

Vision

To help you keep your vision strong and your eyes healthy, vision coverage includes annual exams and corrective treatment. The coverage saves you money on eligible vision care expenses such as eye exams, glasses, and contact lenses.

Key features at a glance:

- Free in-network preventive eye exam every year
- Choose from lenses or contact lenses every year
- Frames every other year
- You can choose the method of correction you prefer
- Wide network of providers (Access network) who have agreed to negotiated rates, which helps you save money
- EyeMed members also have access to affordable hearing care discounts through Amplifon, the world's largest distributor of hearing aids and services

Find the right provider

In-network providers include a large selection of optometrists and ophthalmologists, as well as the choice of either a private practice or retail setting. Even though the vision plan includes out-of-network benefits, the benefit of choosing an EyeMed Vision Care network provider is that your out-of-pocket costs are almost always lower.

You can find an EyeMed provider by calling 1-866-723-0513 or visiting **eyemed.com**. Search for a participating Access network provider by location by entering your Zip code, or by entering their name.

Health Resources

Health Resources help make it easier and more rewarding to take care of your health and financial well-being — and many of the programs are available to you and your family members enrolled in the COBRA medical plan at no cost.

Medical Plan Tools

Find a doctor easily with provider search, compare costs before you access healthcare services with the price transparency tool, manage your claims online, and much more. Capital BlueCross provides a wealth of resources and tools — at your fingertips, 24/7 — to help you live healthy. Visit **capbluecross.com**.

Prescription Drug Tools

Check the cost of a medication, view the plan formulary, find generic equivalents, and more. Visit **optumrx.com**.

Virtual Care

Seek medical advice from U.S. board-certified physicians who are available 24 hours a day, 7 days a week to consult with you by live video right from your mobile device or computer. Virtual Care physicians can provide fast, convenient diagnoses and treatments for many common conditions, such as cold and flu symptoms, allergies, respiratory infection, and more. The Virtual Care benefit is not meant to replace your current medical plan or primary care physician, but rather is an added medical benefit that provides an affordable and convenient alternative to costly urgent care or emergency room visits. See the **Medical Plan Comparison Chart** for costs.

Through Virtual Care, you also have access to behavioral health providers using the Amwell national network of psychiatrists and counselors. This feature enables you to conveniently schedule appointments with a counselor or psychiatrist by virtual visit. You can make appointments online 24/7. However, appointments are generally available only from 8 a.m. to 10 p.m. ET. Times may vary by time zone and location. You can access Virtual Care for both medical advice or behavioral health services through the Virtual Care app, available on the App Store, Google Play, on **virtualcarecbc.com**, or from the Virtual Care page on **capbluecross.com**.Medical Services — See copay on page 3.

Online Health Assessment

Whether you want to lose weight, quit smoking, add in some exercise, or stay on your current path, taking the online Health Assessment is an important step to creating and maintaining a healthy lifestyle. With Capital BlueCross, you have access to a free, convenient, confidential tool that allows you to become better acquainted with your health. The Health Assessment only takes about 15 minutes to complete, and asks you questions about your health status, medical history, and lifestyle.

When you take the online Health Assessment, you'll receive a complete summary of your health and lifestyle risk factors in a personalized report. Early detection of potential medical risks can prevent unnecessary suffering and save you thousands of dollars in future eligible out-of-pocket medical expenses. The more information you can provide, the more relevant, personal, and valuable your results will be.

To access your Health Assessment, follow these steps:

1. Go to **capbluecross.com**
2. Select "Wellness > Healthy Blue Rewards > Complete Your Health Assessment"

Behavioral Health Services Copays*:

- Therapist Visit — $90
- Psychologist Visit — $115
- Psychiatrist First Visit — $250
- Psychiatrist Follow-up Visit — 30 min $140; 15 min $95

Visit **www.virtualcarecbc.com** or call 1-833-433-5914 to enroll or learn more.

*Copays apply to the Consumer Choice $500 HSA and Consumer Choice $300 HSA plans.

Nurse Line

A Capital BlueCross registered nurse is available round the clock to answer your health questions and help you get the most out of your medical plan — confidentially and at no cost to you. The nurse can guide you to the right care for a health concern; coordinate services before, during, and after a hospital stay; or support you while you work toward a health goal. Call 1-800-452-BLUE (2583) to reach a nurse, or log on to **capbluecross.com** and start a chat session with a registered nurse anytime.

Case Management

Capital BlueCross offers Case Management support to our members with serious and complex medical conditions. Based on your health experience, Capital BlueCross may invite you to participate in the program, which helps you or an eligible family member navigate through a variety of services, including doctor visits, treatment programs, prescription drug compliance, and hospital admissions.

Condition Management

The Capital BlueCross Condition Management program aims to help people living with chronic conditions successfully manage their disease(s) by helping them to better understand their condition(s) and their doctor's prescribed treatment plan. You are provided with individual support from an experienced registered nurse or health educator, and the program is tailored to your specific needs.

The program also offers:

- Help to pull together all services and resources that can assist you with your complex healthcare needs.
- Coordination for a hospital stay, including discharge planning and at-home services.
- Answers in plain language to health-related questions.

The program outreach may include (but is not limited to) the following chronic conditions:

- Asthma
- Diabetes
- Chronic Heart Failure
- Coronary Artery Disease
- Chronic Obstructive Pulmonary Disease

All of the information you talk about with the Condition Management program nurse is kept secure and confidential. You can learn more and get started by visiting **capbluecross.com** or calling 1-800-892-3033.

Omada National Diabetes Prevention Program

Millions of American adults have prediabetes and more than 8 out of 10 of them don't even know. Without taking action, many people with prediabetes could develop Type 2 diabetes within 5 years. The Company has partnered with Omada, a lifestyle change program offered by Capital BlueCross, which provides proactive support and science-backed solutions focused on achieving long-term results. Omada includes two programs, one focused on diabetes prevention and the other on diabetes management. If you are enrolled in the Medical plan, Omada helps you to reduce your risk of developing diabetes by creating a lifestyle plan that's right for you, and helps those with diabetes manage lifestyle choices through a virtual program. For more information and to determine if you are eligible for either program, please visit **go.omadahealth.com/capitalbluecross**.

Tobacco Cessation Program with Optum

Kicking tobacco is one of the best things you can do for your health and your wallet. The Company wants to help you make this permanent lifestyle change with the Optum Quit for Life tobacco cessation program! This program is available to you and your dependents age 18 and older who are enrolled in the COBRA medical plan.

Check out the no-cost support waiting for you:

- Five phone-based coaching sessions scheduled at your convenience.
- Unlimited toll-free telephone access to coaches for the duration of treatment.
- Delivery of recommended nicotine replacement products (e.g., the patch, gum).
- A Quit Kit of materials designed to help you stay on track between calls.
- Recommendations on type, dosage, and duration of prescription medication if appropriate, in consultation with your physician. (Coverage for prescription medication, if covered at all, is in accordance with the terms of the medical portion of your plan).
- Access to Text2Quit℠, a text message feature enabling associates to connect with a Quit Coach, interact with a Web Coach, use medications correctly, manage urges, and avoid relapse — all from a supported mobile phone.
- Access to an interactive website.

SMARTCONNECT

If you are age 65 or over and/or transitioning into retirement soon, Mercer SmartConnect can help you navigate Medicare and weigh your coverage options. With SmartConnect, a Medicare concierge provides personalized recommendations and seamless enrollment to Medicare, if that's what's right for you. Plus, you'll get ongoing support to help you use your Medicare plan. For more information, visit **https://gps.smartmatch.com/go-mred** or call 1-833-438-0751.

My Resources Every Day — Employee Assistance Program (EAP)

When balancing the demands of family, job, and personal needs, the Company-provided My Resources Every Day can help. My Resources Every Day is staffed by licensed professionals who are available to guide you and get you the right resources to deal with your personal, household, and family issues. Turn to this confidential, no-cost service 24 hours a day, 365 days a year, for support provided through a wide range of resources to assist you in managing everyday concerns.

Counseling Services

My Resources Every Day provides confidential support, counseling, text, chat, telephonic or video conference (when available), and resources **at no cost to you and your household members** who are dealing with:

- Bereavement
- Legal questions or concerns
- Marital or family conflicts
- Child care and senior care
- Social development
- Education planning
- Alcohol/drug issues
- Work-related issues
- Stress/emotional issues

You can receive up to five (5) counseling sessions with a licensed professional (per 12-month period beginning with the date of your first session) for each separate issue. Counselors are also available in-person and via phone, text, chat, or video conference (when available) to assist with short-term concerns.

Financial Services

Financial consultants are ready to help you with a wide range of issues, including budgeting and debt management, tax matters, and retirement planning. A telephonic consultation of up to 60 minutes is provided at no charge for each separate issue. If help is needed beyond your first call, you receive a discount on the consultant's normal rate.

Legal Services

Legal consultants are available to provide guidance for:

- Divorce
- Bankruptcy
- Will Preparation
- Tax Issues
- Real Estate
- Adoption
- Estate Planning

If help is needed beyond your first call, you receive a 25%–35% discount on the attorney's normal rate.

Work/Life Balance

With My Resources Every Day, get assistance locating resources that your family needs, such as child care and parenting, elder care and aging, and education and college planning. This program can also save you money through the online discount center on brand-name products and services like electronics, travel, car rentals and hotels, clothes, movie tickets, restaurants, and more.

LifeMart Associate Discount Program

This program helps you save money on major purchases like cars, tickets, electronics, vacations, or on day-to-day essentials like groceries and childcare. And best of all, access is free!

Identity Theft Services

Through My Resources Every Day, you have access to unlimited telephonic fraud resolution, consultation, and assistance to help you prevent fraud and restore credit. You can also access a free Identity Theft Emergency Response Kit.

Online Resources

My Resources Every Day offers you a variety of online tools and resources designed to enable you to find the information you need to help yourself and your loved ones — all with the click of a mouse.

Digital Emotional Wellbeing

Digital Emotional Wellbeing offers free, confidential self-care programs including digital emotional wellness tools to build resiliency, manage stress, improve mood, sleep better, or simply find daily inspiration.

BetterHelp Virtual Therapy

Magellan's My Resources Every Day EAP program has partnered with BetterHelp to offer access to confidential, virtual therapy at no cost to you. You and your household members can access confidential support quickly and easily through text messaging, phone calls, video sessions, or live chat sessions.

To take advantage of this valuable benefit, visit **magellanascend.com** or call 1-800-479-9581.

Contacts

Vendor	Phone	Website
General Questions and Enrollment		
HealthEquity COBRA System	1-888-678-4881	**mybenefits.wageworks.com**
Medical and Prescription Drug		
Capital BlueCross	1-866-686-2242	**capbluecross.com**
OptumRx	1-844-368-9859	**optumrx.com**
BriovaRx Pharmacy/OptumRx Specialty Services	1-855-427-4682	**briovarx.com**
Virtual Care	1-833-433-5914	**virtualcareCBC.com**
NurseLine	1-800-452-2583	**capbluecross.com/nurseline**
Condition Management	1-800-892-3033	**capbluecross.com**
SmartConnect	1-833-438-0751	**https://gps.smartmatch.com/go-mred**
Health Resources		
My Resources Every Day (EAP)	1-800-479-9581	**magellanascend.com**
Optum Quit for Life Tobacco Cessation Program	1-866-784-8454	**quitnow.net**
Dental and Vision		
MetLife Dental	1-800-823-1475	**mybenefits.metlife.com**
EyeMed Vision Care	1-866-723-0513	**eyemed.com**
Spending Accounts		
HealthEquity (formerly WageWorks) Flexible Spending Account	1-877-924-3967	**wageworks.com**
Fidelity Health Savings Account	1-800-249-4015	**netbenefits.com**
Life Insurance		
MetLife (Life Insurance Conversion/Portability)	1-800-823-1475	**mybenefits.metlife.com**

REMINDER

COBRA questions should be directed to HealthEquity at 1-888-678-4881.

Understand Your Options

When you visit **mybenefits.wageworks.com** or call 1-888-678-4881, you can research and customize a health insurance plan that is best for you. The HealthEquity COBRA System features both an online and phone-based customer service solution to help you:

- Find out if you qualify for tax credits to help pay for your health insurance.
- Understand what plans are available.
- Enroll quickly and easily in the plan of your choice.

MAKE YOUR CHOICE!

Determine which offering better meets the health care needs of you and your family — the Public Exchange or COBRA. You make the informed choice!

Key Terms

- **Coinsurance:** How you and the plan share costs after you meet the annual medical plan deductible — you and the Company both pay a percentage of the cost of your care.
- **Copay:** The fixed dollar amount you are responsible for paying when you incur an eligible medical expense for certain services.
- **Deductible:** The amount you pay out of your pocket for covered expenses each plan year before the plan shares in the costs. The plans have different annual medical plan deductible amounts for in- and out-of-network care.
- **Emergency Care:** Treatment given in a hospital's emergency room or urgent care facility for a sudden illness, injury, or condition of recent onset and severity that would lead a person with an average knowledge of medicine and health to believe that the condition would result in the person's health being jeopardized, serious impairment to bodily function, or dysfunction of a body part or organ, or lead to serious jeopardy to the health of a fetus if immediate medical care is not obtained.
- **In-Network:** Providers and facilities that have agreed to contracted rates with the insurance carrier. These providers and facilities have been chosen based on quality of service and care.
- **Out-of-Network:** Providers and facilities that have not agreed to contracted rates with insurance carriers.
- **Out-of-Pocket Maximum:** The most you pay in a plan year for covered expenses. Your copay, annual medical plan deductible, and coinsurance count toward your out-of-pocket maximum. Once you meet it, the Company pays 100% for covered services for the rest of the year. If you have dependent coverage, you must meet the family out-of-pocket maximum (excluding the PPO medical plan).
- **Preventive Care:** Routine physical exams and health screenings (like routine tests, Pap smears, prostate screenings, and certain other age-appropriate health screenings). In-network services coded by your doctor as preventive care are generally covered at 100%. However, if the same tests are performed to diagnose an illness or treat a known condition, they are not considered preventive care and the annual medical plan deductible and coinsurance apply. If you aren't planning to pay for a non-preventive visit, make sure your doctor tells you if the care you're about to receive is covered as preventive care. If you don't ask questions, you could be charged for tests your doctor didn't mention were above and beyond the usual preventive precautions.
- **Primary Care Physician (PCP):** A doctor who supervises, coordinates, and provides initial care and basic medical services such as a general or family care practitioner, internist, or pediatrician.
- **Urgent Care:** Treatment in a medical facility that provides unscheduled medical services to treat an urgent condition if the person's physician is not available. An urgent condition does not require the level of care provided in a hospital emergency room, but is considered severe enough to require prompt medical attention.
- **Virtual Care:** Medical advice available via live video from your mobile device or computer. Virtual care physicians can provide fast, convenient diagnoses and treatments for many common conditions, such as cold and flu symptoms, allergies, respiratory infection, and more.

Legal Notices

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2022. Contact your State for more information on eligibility –

Alabama – Medicaid	Kansas – Medicaid
Website: http://myalhipp.com Phone: 1-855-692-5447	Website: https://www.kancare.ks.gov/ Phone: 1-800-792-4884
Alaska – Medicaid	**Kentucky – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov
Arkansas – Medicaid	**Louisiana – Medicaid**
Website: http://myarhipp.com Phone: 1-855-MyARHIPP (1-855-692-7447)	Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)
California – Medicaid	**Maine – Medicaid**
Website: Health Insurance Premium Payment (HIPP) Program http://dhcs.ca.gov/hipp Phone: 1-916-445-8322 Fax: 1-916-440-5676 Email: hipp@dhcs.ca.gov	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-977-6740 TTY: Maine relay 711
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**Massachusetts – Medicaid and CHIP**
Health First Colorado website: https://www.healthfirstcolorado.com Health First Colorado Member Contact Center: 1-800-221-3943/state relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/state relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442	Website: https://www.mass.gov/masshealth/pa Phone: 1-800-862-4840 TTY: 1-617-886-8102

Florida – Medicaid	Minnesota – Medicaid
Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268	Website: https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739
Georgia – Medicaid	**Missouri – Medicaid**
GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 1-678-564-1162, Press 1 GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra Phone: 1-678-564-1162, Press 2	Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 1-573-751-2005
Indiana – Medicaid	**Montana – Medicaid**
Healthy Indiana Plan for low-income adults 19–64 Website: http://www.in.gov/fssa/hip Phone: 1-877-438-4479 All other Medicaid: Website: https://www.in.gov/medicaid Phone 1-800-457-4584	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084 Email: HHSHIPPProgram@mt.gov
Iowa – Medicaid and CHIP (Hawki)	**Nebraska – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/hawki Hawki Phone: 1-800-257-8563 HIPP Website: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp HIPP Phone: 1-888-346-9562	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
Nevada – Medicaid	**South Carolina – Medicaid**
Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900	Website: https://www.scdhhs.gov Phone: 1-888-549-0820
New Hampshire – Medicaid	**South Dakota – Medicaid**
Website: https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program Phone: 1-603-271-5218 Toll-free number for the HIPP program: 1-800-852-3345, ext. 5218	Website: http://dss.sd.gov Phone: 1-888-828-0059
New Jersey – Medicaid and CHIP	**Texas – Medicaid**
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: 1-609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710	Website: http://gethipptexas.com Phone: 1-800-440-0493
New York – Medicaid	**Utah – Medicaid and CHIP**
Website: https://www.health.ny.gov/health_care/medicaid Phone: 1-800-541-2831	Medicaid Website: https://medicaid.utah.gov CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
North Carolina – Medicaid	**Vermont – Medicaid**
Website: https://medicaid.ncdhhs.gov Phone: 1-919-855-4100	Website: http://www.greenmountaincare.org Phone: 1-800-250-8427
North Dakota – Medicaid	**Virginia – Medicaid and CHIP**
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid Phone: 1-844-854-4825	Website: https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-800-432-5924 Email: HIPPcustomerservice@dmas.virginia.gov

Oklahoma – Medicaid and CHIP	Washington – Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: https://www.hca.wa.gov Phone: 1-800-562-3022
Oregon – Medicaid	**West Virginia – Medicaid and CHIP**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: https://dhhr.wv.gov/bms http://mywvhipp.com Medicaid Phone: 1-304-558-1700 CHIP Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
Pennsylvania – Medicaid	**Wisconsin – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002
Rhode Island – Medicaid and CHIP	**Wyoming – Medicaid**
Website: http://www.eohhs.ri.gov Phone: 1-855-697-4347 or 1-401-462-0311 (direct RIte Share line)	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility Phone: 1-855-294-2127 or 1-307-777-7531

To see if any other states have added a premium assistance program since July 31, 2022, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Women's Health and Cancer Rights Act (WHCRA)

The Women's Health and Cancer Rights Act of 1998 requires health plans to provide coverage for reconstructive surgery and related services that may follow a mastectomy, as determined in consultation with the attending physician and the patient. In compliance with the law, the Company's medical plans cover the following services:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Treatment of physical complications of the mastectomy, including lymphedema

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. If you would like more information on WHCRA benefits, please call your plan administrator toll free at 1-866-686-2242.

Medicare Drug Plan Notice of Creditable Coverage

This notice includes important information about the prescription coverage you are eligible to receive through Ahold Delhaize ("the Company") and the coverage you could obtain through a Medicare drug plan. It also explains the options you have under Medicare drug coverage and can help you decide whether or not you want to join. At the end of this notice is information about where you can get help to make decisions about your drug coverage.

The Medicare Prescription Plan Option

Medicare drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription coverage. This coverage is sometimes referred to as Medicare Part D prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Certain health plan or prescription vendors who are offering this drug coverage may also offer more or better coverage for a higher monthly premium, so it's important to understand what your options are and what benefits are being provided.

Please read this notice carefully and retain it for future reference. If you join a Medicare drug plan option, you may need to provide a copy of this notice to show whether or not you have maintained creditable coverage, and therefore whether or not you are required to pay a higher premium (a penalty).

You can join a Medicare Drug Plan when you first become eligible for Medicare and each year from October 15th through December 7th. If you elect to join later, you may have to pay the higher premium unless you can show you have maintained creditable prescription coverage that's at least as good as Medicare's drug coverage.

However, if you lose creditable drug coverage, through no fault of your own, you will be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

Your Company Prescription Coverage

As you know, the Company provides eligible associates and retirees with health care coverage, which includes prescription benefits. **The Company has determined that the prescription drug coverage provided through the Company health care plan is expected to pay, on average for all plan participants, at least as much as and, in most cases, more than the standard coverage that Medicare will provide and is therefore considered Creditable Coverage.** For this reason, we expect that most active associates or retirees will *not* want to enroll in a Medicare drug plan option. If you remain enrolled in the Company-sponsored plan, you will not pay a higher premium (a penalty) if you later decide to join in Medicare drug coverage. If you lose or leave your Company-sponsored coverage, you may be eligible for a Special Enrollment Period to sign up for a Medicare drug plan.

Comparing Your Options

We encourage you to compare your Company coverage (including which prescriptions are covered) with the coverage and cost of a Medicare drug plan in your area.

If you decide that you want to elect prescription coverage through a Medicare drug plan, your Medicare drug coverage and your Company-sponsored medical plan will coordinate benefits for your prescription costs. The Medicare drug plan will pay first and your Company-sponsored prescription plan will pay second. You will be responsible for paying any remaining amounts. Please contact us for more information about what happens to your coverage if you join in a Medicare drug plan.

If you are keeping the Company coverage, you need not do anything.

You should be aware that if you decide to join a Medicare drug plan and drop the Company-sponsored medical and prescription coverage, you or your dependents may not enroll back into the Company plan.

You should also know that if you drop or lose your coverage with the Company and do not join the Medicare drug coverage after your current coverage ends, you may pay a higher premium (a penalty) to enroll in Medicare drug coverage later. If you go 63 continuous days or longer without prescription coverage that is at least as good as Medicare's drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare drug coverage. In addition, you may have to wait until the following October to join.

If you have limited income and resources, you may receive extra help paying for prescriptions through Medicare drug plan. If you believe you might qualify for this special assistance, you may contact the Social Security Administration to determine whether you qualify and what assistance is available.

For More Information

About this notice or your current prescription coverage

You will receive this notice annually and at other times in the future such as before the next period you can join Medicare drug coverage, and if this coverage through this Company changes. You also may request a copy at any time. If you have questions about your health care and prescription benefits, which you receive through the Company's Plan, contact the Rewards Every Day Support Center at 800-752-8087.

About your options under Medicare drug coverage

Detailed information about Medicare plans that offer prescription coverage is in the "Medicare & You" handbook. You will get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare drug plans:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help, or
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at **www.socialsecurity.gov**, or you can call them at 1-800-772-1213 (TTY 1-800-325-0778).

Date: August 12, 2021
Name of Entity: Retail Business Services, LLC
Contact: Rewards Every Day Support Center
Address: 1149 Harrisburg Pike, Carlisle PA 17013
Phone Number: 1-800-752-8087

NOTICE OF PRIVACY PRACTICES FOR
RETAIL BUSINESS SERVICES, LLC WELFARE BENEFIT PLAN
DELHAIZE AMERICA, LLC WELFARE BENEFIT PLAN
AHOLD USA, INC. MASTER WELFARE BENEFIT PLAN

Effective Date: April 1, 2019

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Retail Business Services, LLC Welfare Benefit Plan, the Delhaize America, LLC Welfare Benefit Plan, and the Ahold USA, Inc. Master Welfare Benefit Plan (the "Plans") are each required under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") to maintain the privacy of your Protected Health Information ("PHI") for medical, dental and other health benefits offered under the Plans. The Plans are committed to protecting the privacy of your PHI and to providing you with a notice of their legal duties and privacy practices with respect to your PHI, pursuant to HIPAA. The Plans are required by law to maintain the privacy of PHI, to provide you with notice of the Plans' legal duties and privacy practices with respect to PHI and to notify affected individuals if a breach of unsecured PHI occurs. PHI is information about you, including basic demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices ("Notice") describes how the Plans may use and disclose PHI about you to carry out treatment, payment or health care operations and for other specified purposes that are permitted or required by law. The Notice also describes your rights with respect to your PHI. **PLEASE REVIEW THE INFORMATION IN THIS NOTICE CAREFULLY**.

The Plans are required to follow the terms of this Notice. The Plans will not use or disclose PHI about you without your written authorization, except as described in this Notice. The Plans reserve the right to change their practices and to modify this Notice and to make the modified Notice effective for all PHI that the Plans already have about you, as well as any of your PHI that the Plans may receive, create or maintain in the future. If changes are made to the policies and procedures, you will be provided an updated notice.

How to Contact the Plans
If you have any questions or need further information about this Notice, you can either write to or call:

HIPAA Privacy Officer
c/o Retail Business Services, LLC
P.O. Box 1000
Mail Sort 9805
Portland, ME 04104
1-800-442-6049 or 1-207-885-2957

Your Health Information Rights
You have the following rights with respect to PHI about you:

- *Obtain a paper copy of the Notice upon request.* At any time, you may request a copy of this Notice, as it may be modified from time to time. To obtain a paper copy, please contact the Plans using the contact information provided above.
- *Request a restriction on certain uses and disclosures of PHI.* You have the right to request additional restrictions on the Plans' use or disclosure of your PHI by sending a written request to the HIPAA Privacy Officer at the address provided above. Please clearly and concisely identify: (a) the information you wish to be restricted; (b) how you want the information restricted; and (c) to whom you want the limits to apply. The Plans are not required to agree to any such restrictions. The Plans will not use or disclose your PHI in violation of any restrictions the Plans agree to, other than as required by law, in an emergency or when the information is necessary to treat you.

- *Inspect and obtain a copy of PHI.* You have the right to access and copy your PHI that may be used to make decisions about you — a "designated record set" — for as long as the Plans maintain the PHI. This right is limited to enrollment, payment, claims adjudication, and case or medical management record systems maintained by the Plans, as well as records used to make decisions about individuals. The Plans generally are required to provide you with access to your PHI within thirty (30) days after receipt of your request. To inspect or copy your PHI, you must send a written request to the HIPAA Privacy Officer at the address noted above. You also may request that copies of your health information be sent to another entity or person, so long as that request is clear, specific and directs where the copies are to be sent. You may be charged a reasonable fee for the costs of copying, transmitting and/or mailing your PHI. The Plans may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your PHI, you may request that the denial decision be reviewed by sending a written request to the HIPAA Privacy Officer at the address noted above.
- *Request an amendment of PHI.* If you feel that PHI the Plans maintain about you is incomplete or incorrect, you may request that the Plans amend the PHI. You may request an amendment for as long as the Plans maintain the PHI. To request an amendment, you must send a written request to the HIPAA Privacy Officer at the address provided above. In addition, you must include with your written request a specific reason that supports your request. In certain cases, the Plans may deny your request for amendment. If your request for an amendment is denied, you have the right to file a statement of disagreement with the decision by sending your statement to the HIPAA Privacy Officer at the address provided above and the Plans may provide a rebuttal to your statement.
- *Receive an accounting of disclosures of PHI.* You have the right to receive an accounting of certain disclosures of your PHI made by the Plans for the six (6) years prior to the date you request the accounting. This right applies to most disclosures that are made for purposes other than treatment, payment or health care operations. The accounting will exclude disclosures the Plans have made directly to you, disclosures to friends or family members involved in your care, and disclosures for notification purposes. The right to receive an accounting is subject to certain other exceptions, restrictions and limitations, all of which are set out in HIPAA. To request an accounting, you must submit your request in writing to the HIPAA Privacy Officer at the address provided above. Your request must specify the time period for which you want an accounting, but that time period may not exceed six (6) years. The first accounting you request within a twelve (12) month period will be provided free of charge, but you may be charged for the cost of providing additional accountings within the same twelve (12) month period. Following your request for an accounting, you will be notified of the cost associated with providing the accounting and you may choose to withdraw or modify your request at that time.
- *Request communications of PHI by alternative means or at alternative locations.* You may request that the Plans contact you about medical matters only in writing or at a different residence or post office box than the one at which you receive your other mail. To request confidential communication of your PHI, you must submit your request in writing to the HIPAA Privacy Officer at the address provided above. Your request must specify how or where you would like to be contacted, but you do not need to provide a reason for your request. The Plans will accommodate all reasonable requests for communicating via alternative means or locations.

Examples of How The Plans May Use and Disclose PHI

The following categories describe and provide examples of different ways that the Plans may use and disclose PHI about you. Note that the examples listed do not constitute an exhaustive list but merely illustrate some of the ways PHI may be used and disclosed.

Treatment: The Plans may use or disclose your PHI in coordinating or managing your health care and its related services with your health services providers. For example, the Plans' third-party administrator may be required to review your medical information to assist you in obtaining pre-certification of certain health services or hospital admissions. During that pre-certification process, the third-party administrator may disclose the reasons you have requested treatment to your health services provider. The Plans also may use or disclose your PHI when providing information regarding health-related services that may be available to you under the Plans, or describing treatment alternatives.

Payment: The Plans may use or disclose PHI submitted by you or your health care provider in making determinations concerning coverage or eligibility, such as when itemized medical bills are submitted to the Plans or their third-party administrators for reimbursement. The submitted medical bills will usually include information that identifies you, as well as the services or procedures provided and supplies used.

Health care operations: The Plans may use or disclose your PHI in a number of ways involving plan administration. The Plans may use your PHI to provide you and your dependents with customer service in resolving Plan claims. Your information could also be used in arranging or conducting medical or legal review of Plan claims. The Plans also may disclose your PHI to plan sponsor personnel in connection with these activities. If you are covered under an insured health plan, the insurer also may disclose PHI to the plan sponsor in connection with payment, treatment or health care operations. Although the Plans may use or disclose your PHI for health care operations, the Plans cannot use or disclose PHI that is genetic information for underwriting purposes (generally, eligibility determinations, premium computations, application of pre-existing condition exclusions, and any other activities related to the creation, renewal, or replacement of health benefits). Genetic information includes information regarding genetic tests for you and your family members, information regarding the manifestation of a disease or disorder in your family members, and any request for (or receipt of) genetic services, including participation in clinical research trials that involve genetic services.

Business associates: The Plans may share your PHI with certain business associates who contract with the Plans to provide services. Examples of possible business associates include attorneys, software vendors, consultants, communication service providers and third-party benefits administrators. When these services are contracted for, the Plans may disclose PHI about you to the Plans' business associates so the business associates can perform those services. To protect your PHI, the Plans require each business associate to sign an agreement that obligates it to appropriately safeguard your PHI.

Communication with individuals involved in your care or payment for your care: The Plans may, using the Plans' professional judgment, disclose your PHI to a family member, other relative, close personal friend or any person you identify, if the PHI is relevant to that person's involvement in your care or payment related to your care.

As required by the Secretary of Health and Human Services: The Plans may be required to disclose your PHI to the Secretary of Health and Human Services so that the Secretary may investigate or determine the Plans' compliance with HIPAA.

Food and Drug Administration (FDA): The Plans may disclose to the FDA or its agents PHI that relates to adverse events with respect to drugs, foods, supplements, products and product defects or post-marketing surveillance information to enable product recalls, repairs or replacement.

Workers' compensation: The Plans may disclose PHI about you to the extent authorized by and to the extent necessary to comply with state laws relating to workers' compensation or other similar programs established by law.

Public health: The Plans may disclose PHI about you to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Law enforcement: The Plans may disclose PHI about you for law enforcement purposes as required by law or in response to a validly issued subpoena or other legal process. This includes state and federal prescription use monitoring programs.

National security and intelligence activities: The Plans may release PHI about you to authorized federal officials for intelligence, counterintelligence and other national security activities when required to do so and such disclosure is authorized by law.

As required by law: The Plans must disclose PHI about you when required to do so by law.

Health oversight activities: The Plans may disclose PHI about you to an oversight agency for activities authorized or monitored by law. These oversight activities include audits, investigations and inspections as needed for the Plans' licensure and for the government to monitor the health care system and government programs, as well as compliance with civil rights laws.

Judicial and administrative proceedings: If you are involved in a lawsuit or a dispute, the Plans may disclose PHI about you in response to a court or administrative order. The Plans may also disclose PHI about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the requested PHI.

Research: The Plans may disclose PHI about you to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, medical examiners, and funeral directors: The Plans will not release PHI about you to a coroner, medical examiner or funeral director without your authorization unless required to do so by law. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plans may also disclose PHI to funeral directors to assist them in carrying out their responsibilities, provided such disclosure is consistent with applicable law.

Organ or tissue procurement organizations: The Plans may, consistent with applicable law, disclose PHI about you to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Fundraising: The Plans will not disclose your PHI for fundraising purposes.

Correctional institution: If you are or become an inmate of a correctional institution, the Plans may disclose to the institution or its agents PHI necessary for your health and the health and safety of others.

To avert a serious threat to health or safety: The Plans may use and disclose PHI about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Specialized government functions: The Plans may disclose PHI for purposes related to the military or national security concerns, such as for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits. The Plans may also release PHI about foreign military personnel to the appropriate military authority.

Victims of abuse, neglect or domestic violence: The Plans may disclose PHI about you to a government authority, such as a social service or protective services agency, if the Plans reasonably believe you are a victim of abuse, neglect or domestic violence. The Plans will only disclose this type of information to the extent required by law, if you agree to disclosure or if the disclosure is allowed by law and the Plans believe it is necessary to prevent serious harm to you or someone else, or if the law enforcement or public official that is to receive the report represents that it is necessary and will not be used against you.

Other Uses and Disclosures of PHI

The Plans will obtain your written authorization before using or disclosing PHI about you for purposes other than those provided for above or as otherwise permitted or required by law. Your authorization is required for any use or disclosure of PHI for marketing communications or sales of PHI that involve financial remuneration to the Plans. You may revoke an authorization at any time by submitting a written revocation to the HIPAA Privacy Officer at the address provided above. As soon as reasonably possible following receipt of the written revocation, the Plans will stop using or disclosing PHI about you, except to the extent that the Plans have already taken action in reliance on the authorization. Please note that the Plans may be required by applicable law to retain certain PHI about you.

Other Restrictions on Uses and Disclosures of PHI

The uses and disclosures of your PHI described above are permitted or required by federal law. Whenever the Plans use, disclose or request medical information, the Plans will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose for the use, disclosure or request, taking into consideration practical and technological limitations. In general, until regulations are issued, disclosure will be limited to limited data set information unless more information is needed.

To Report a Problem

If you have questions or would like additional information about the Plans privacy practices, you may contact the HIPAA Privacy Officer at the address provided above. If you believe your privacy rights have been violated, you can file a written complaint with the HIPAA Privacy Officer at the address provided above or with the Secretary of the United States Department of Health and Human Services. There will be no retaliation against you for filing a complaint.

This guide contains details of the company's benefit programs. It is not intended to be a Summary Plan Description (SPD) or, except as otherwise stated elsewhere in the guide, serve as a Summary of Material Modifications (SMM). If there are differences between the guide and the plan document, the terms of the plan document will control. In addition, if there are differences between the guide and the SPD, the SPD will control (except to the extent the guide serves as an SMM for the SPD). The company may amend or terminate its plans at any time by its sole discretion.
The descriptions of these programs, the plans themselves, or participation in the plans is not an employment contract or any type of employment guarantee and should not be considered as such.

Summary Plan Descriptions and Summary of Benefits Coverage (SBC) are located on **mybenefits.wageworks.com**.