Understanding Your Health Benefits and Options

2024 Annual Open Enrollment Guide

Price Rite MARKETPLACE

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.

Open Enrollment 2024

As a Price Rite Team Member, 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: Full Time Team Members 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.

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

How: Go to **www.priceritebenefits.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 Team Member 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

What you need to know

Introducing a new network: APCN Plus
Aetna Premier Care Plus Network is designed to simplify your life and put your mind at ease. That means better quality of care and a better experience for you and your family — plus the savings that come with staying in the network.

You have access to a network of primary care doctors, specialists, hospitals, walk-in clinics and urgent care centers in your area. You may also have access to a special network of doctors working as a team to manage your care needs. This can make everything more convenient and cost effective.

Aetna has chosen a network of doctors and health care centers based on clearly defined cost and quality standards. Many of the specialists and hospitals have proven track records, including lower readmission rates, fewer complications and more successful treatments. And staying in the network almost always reduces your out-of-pocket costs. Plus, there's no guesswork about which doctors are covered, and no worries about unneeded tests or procedures. You'll enjoy quality health care from a network of doctors and other providers you can trust.

And it's possible you may be using a provider that is already in the APCN Plus network. If you, take advantage of a lower premium by choosing this network without any (or little) disruption of providers.

What isn't changing for 2024?

- We will continue to offer four Aetna medical plans.
- There are no plan design changes to the dental plan.
- There are no plan design changes to the vision plan.
- We will continue our current health care pricing for all medical plans when selecting the Aetna Premier Care Network (APCN) Plus.
- We will continue our current Dental and Vision pricing.

What are the benefit plan changes for 2024?

- There are plan design changes across all medical plan offerings.
- Weekly contributions for all medical plans have increased when selecting the Aetna Broad Network.
- With all four medical plan offerings, you must select a network when you enroll or change your medical plan.

Your network options include:

- **Aetna Broad Network**, our current network
- **Aetna Premier Care Network (APCN) Plus**

Whichever network you choose during Open Enrollment will be your in-network providers for the year.

As a reminder, we encourage you to get additional information about this year's Open Enrollment online at **www.priceritebenefits.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 also access your contributions and enrollment forms directly from the password protected website. See your Benefits Administrator for details.

A New Network Option

All medical plans offer a choice of two network options.

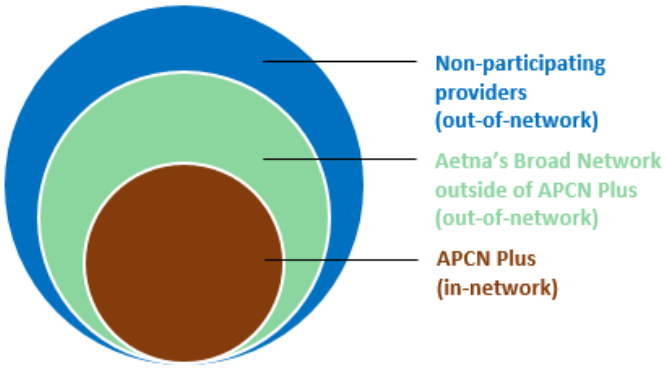
When you enroll for medical coverage during Open Enrollment, you'll select your plan (choice of four Aetna plans) and your network (choice of two networks). For all four plans, the network options include:

Aetna Premier Care Network (APCN) Plus is a smaller group of providers chosen from the Aetna Broad network. These providers have a proven track record with excellent health outcomes at a lower cost. If you select this network when you enroll, your weekly contributions will be lower.

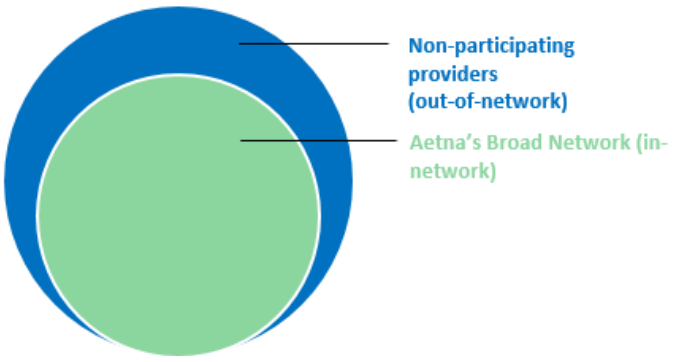
Important: If you choose APCN Plus when you enroll, you must use providers in the APCN Plus network, or benefits will be paid at the out-of-network level (even if you use a provider in the Aetna Broad network).

Aetna Broad Network is all of the providers that participate with Aetna. If you see a non-participating provider, benefits will be paid at the out-of-network level. Your weekly contributions if you choose the Aetna Broad Network will be higher than if you choose APCN Plus.

If you choose **Aetna Premier Care Network (APCN) Plus**



If you choose **Aetna's Broad Network**



Once you select your network during Open Enrollment, you may not change it until the next year's Open Enrollment.

Who Is Eligible?

The Price Rite benefit plans described in this guide are available to full-time, non-union Team Members and their eligible dependents.

Your eligible dependents include:

- Your spouse to whom you are legally married.
- Your same sex domestic partner (contact your Benefits Administrator for more details).
- 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 Price Rite 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 Price Rite medical plan. Please refer to the Legal Notices on your benefits website for more details.

Individuals Planning to Retire or Leave Price Rite
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 if you 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, 2nd.MD 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.

Life Insurance
Price Rite Team Members are eligible for 1.5 times their annualized salary in basic life insurance. Team Members can also purchase additional financial protection for their family at very competitive prices (subject to the insurance company's underwriting requirements).

Optional Life Insurance
Optional Life Insurance and AD&D is offered through The Hartford and are offered on an Team Member Paid Basis.

Short-Term Disability
Price Rite Team Members are eligible for up to 100% of their pre-disability weekly earnings for the first 12 weeks.

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

Your Medical Plan

You can choose from the Aetna medical plans listed on the next page. Each plan offers the following options:

Your medical plans are 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 2nd.MD 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 Price Rite 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 Care (Bronze) (You Pay)	Managed Care (Silver Plus) (You Pay)	HCRA Plan (You Pay)	Premium Managed Care (You Pay)
Comparison to Marketplace plans	Bronze	Silver Plus	Gold	Gold Plus
In-network preventive care covered at 100%	Yes	Yes	Yes	Yes
Well-being resources & special programs	Yes	Yes	Yes	Yes
Provider network	Broad or APCN Plus	Broad or APCN Plus	Broad or APCN Plus	Broad or APCN Plus
Use of in- and out-of-network providers	Yes	Yes	Yes	Yes
Must select a Primary Care Physician (PCP)	No	Yes	No	Yes
PCP referrals needed for specialty care	No	Yes	No	Yes
HCRA Funded	No	No	Yes	No
In-network deductible	Yes	Yes	Yes	Yes
Out-of-pocket maximum for in-network care	$6,500 single $13,000 family	$3,000 single $6,000 family	$3,750 single $7,500 family	$1,500 single $3,000 family

How the Plans Work

In-network Medical Services

Benefits	Basic Managed Care (Bronze) (You Pay)	Managed Care (Silver Plus) (You Pay)	HCRA Plan (You Pay)	Premium Managed Care (You Pay)
Preventative Services	$0	$0	$0	$0
Office Visits Primary Care Physician (PCP)/Specialist (SPC)	$30 PCP copay (after deductible) $45 SPC (after deductible)	$25 PCP copay $40 SPC	Deductible and Coinsurance	$30 PCP copay $45 SPC copay
Emergency Room	$150 copay (after deductible)	$150 copay	Deductible and Coinsurance	$150 copay
Urgent Care Facility	$45 copay (after deductible)	$40 copay	Deductible and Coinsurance	$45 copay
Deductible	$2,750 single $5,500 family	$750 single $1,500 family	$2,250 single $4,500 family	$750 single $1,500 family
HCRA Fund	N/A	N/A	$1,500 single $3,000 family	N/A
Deductible after HCRA Fund	N/A	N/A	$750 single $1,500 family	N/A
Coinsurance	35%	10%	10%	10%
Annual Out-of-Pocket Maximum	$6,500 single $13,000 family	$3,000 single $6,000 family	$3,750 single $7,500 family	$1,500 single $3,000 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 Care (Bronze) (You Pay)	Managed Care (Silver Plus) (You Pay)	HCRA Plan (You Pay)	Premium Managed Care (You Pay)
Office Visits and Preventive Care	Deductible & Coinsurance	Deductible & Coinsurance	Deductible & Coinsurance	Deductible and Coinsurance
Emergency Room	$150 copay (after deductible)	$150 copay	Deductible & Coinsurance	$150 copay
Deductible	$7,500 single $15,000 family	$1,250 single $2,500 family	$4,000 single $8,000 family	$1,000 single $2,000 family
Coinsurance*	50%	30%	40%	40%
Annual Out-of-Pocket Maximum	$12,500 single $25,000 family	$5,000 single $10,000 family	$8,000 single $16,000 family	$4,500 single $9,000 family

*The plan pays out-of-network benefits based on Medicare reimbursement levels of 140% of Medicare replacement. In addition to your coinsurance, you are responsible for amounts that exceed these levels.

How the Plans Work

A closer look at the HCRA Plan.

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 Price Rite 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 before- tax 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 cost-conscious 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 $2,250 single or $4,500 family and the out-of-network deductible is $4,000 single or $8,000 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 90% for in-network medical services and 60% for out-of-network medical services (up to the Medicare reimbursement level).

- You will pay 10% for in-network services.
- You will pay 40% plus any amount that exceeds the reimbursement level for out-of-network services.
- Prescriptions 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 $1,500 single and $3,000 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 $1,700.

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 Price Rite 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 Price Rite 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 Price Rite 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 Care, HCRA, & Premium Managed Care*

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	$10	$10
Preferred Brand**	Drug marketed under a specific trademark or name by specific drug manufacturer and included on Aetna's drug list	$30	$30
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	$50	$50
Specialty Brand***	High-cost prescription medications used to treat complex, chronic conditions	$100	Contact a ShopRite pharmacy for more information.

*The cost of prescriptions under the Basic Managed Care 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.

***Specialty Brand drugs must be filled at CVS Specialty Pharmacy.

Prescription Drugs

The PrudentRx Copay Optimization program helps reduce or eliminate the member cost share for specialty medications.

PrudentRx Copay Optimization Minimizes the Impact of Specialty Medications

While most medicines are available at your local ShopRite Pharmacy, there are an estimated 400 limited distribution medicines that are only available through CVS Health's specialty pharmacy. These medicines are often costly and therefore the PrudentRx Copay Optimization program, offered by CVS Health, is an innovative specialty copay plan design that enables payors to help reduce or eliminate member cost share for specialty medications. If you currently take a specialty medication, PrudentRx will be reaching out to you directly to coordinate this benefit where you can receive a $0 copay on the specialty medication.

Take control of your health with the ShopRite Pharmacy App

The ShopRite Pharmacy Mobile App lets you find pharmacies, manage your family's medications, refill prescriptions, and transfer prescriptions from one pharmacy to another using your mobile device.

Features include:

- Refill your prescriptions by entering the Rx number or scanning the bottle using your camera phone
- Manage the prescriptions of your entire family with a secure biometric login
- See your prescription history
- Transfer prescriptions from any pharmacy to your preferred ShopRite location
- Use the GPS on your phone to find the nearest ShopRite location
- Filter your ShopRite location search
- Find information on a variety of health topics and medications
- Schedule an Immunization Appointment

To find the app, search "ShopRite Pharmacy App" or **visit https://www.shoprite.com/rxapp/**

ShopRite Pharmacy Auto Refill Program

Quick & easy signup!

ShopRite Pharmacists play an important role in helping our associates properly adhere to their prescription medication. Your ShopRite Pharmacy will automatically refill your prescription before your supply runs out. They will even contact your doctor for you when your prescription expires or your refill runs out.... Automatically! Speak with your local ShopRite Pharmacist to determine which of your prescriptions are eligible or visit **https://www.shoprite.com/pharmacy**.

*The ShopRite Pharmacy Auto Refill program is optional and available for most maintenance medications.

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 Team Members and Price Rite. 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 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)

Meru Health
This is a 12-week program is clinically proven to reduce anxiety, stress, depression, and long-term burnout. In addition, you can access the entire program from the convenience of your smartphone. Visit **www.meruhealth.com/aetna** to get started today.

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.

2nd.MD Advisory Services
Feel confident about your medical decisions. As part of your employer provided benefits, you can get an expert second opinion from a leading specialist at no additional cost to you. Connect directly with experts by video from the comfort of your home. Ask questions, get answers and feel empowered to make the best healthcare decisions.

PrudentRx
The PrudentRx Copay Optimization program, offered by CVS Health, is an innovative specialty copay plan design that enables payors to help reduce or eliminate member cost share for specialty medications while saving the plan money. If you currently take a specialty medication, PrudentRX will be reaching out to you directly to coordinate this benefit where you can receive a $0 copay on the specialty medication.

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 Price Rite gift card for each enrolled Team Member 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.

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, Price Rite 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

Get Rewarded for Participation
The number of Team Members and spouses completing the Health Assessment continues to increase each year. Last year, most of our Team Members and eligible spouses received rewards for completing a Health Assessment. We encourage everyone to complete the Health Assessment again this year and receive the following incentives:

- Complete/Update the Health Assessment in 2024 and receive a $100 Price Rite gift card for an enrolled Team Member's spouse.
- Complete/Update the Health Assessment from November 1, 2023–May 31, 2024 and pay NO health care contributions for up to 13 weeks, as indicated in the chart below.

Number of Weeks You Pay No Contribution for Medical Coverage if You Complete your Health Assessment from November 1, 2023 — May 31, 2024		
	Team Member Only Coverage	**Family Coverage**
Basic Managed Care Plan	13 weeks	9 weeks
Managed Care Plan	13 weeks	9 weeks
HCRA Plan	13 weeks	9 weeks
Premium Managed Care Plan	4 weeks	2 weeks

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 **$10** 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? Price Rite 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. For 2024, there are no changes to your dental benefits.

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 copay- ments, 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	In-Network Member Cost	Out-of-Network Reimbursement
Exam (one every 12 months)	No copay	Up to $28
Frames (one every 24 months)	No copay; $180 allowance + 20% off balance over $180	Up to $90
Lenses (one every 12 months)		
Single Vision Bifocal Trifocal	No copay No copay No copay	Up to $25 Up to $39 Up to $63
Contact Lenses (one order every 12 months)		
Conventional	No copay; $180 allowance + 15% off balance over $180	Up to $144
Disposable	No copay; $180 allowance	Up to $144
Medically Necessary	No copay; Paid in full	Up to $200

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.

Team Members 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 Team Member's salary at a maximum of $500,000. It is company paid, at no cost to the Team Member. On January 1st following the day the participant turns age 70, the benefit reduces to 50% of 1.5x the Team Member 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 Team Member 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.

Team Members are offered:

- Optional Life for the Team Member
- 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:

Team Member Optional Life Insurance

- Team Members can opt for 1, 2 or 3x's salary to a maximum coverage amount of $750,000.
- Guaranteed Issue for the Team Member — 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 Team Member 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			
Team Member/Spouse Age	**Rate per $1,000**	**Team Member/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.
- 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 Team Member only (single) coverage; identify all eligible dependent(s) on the enrollment forms.

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.

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 Price Rite?
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 Price Rite 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 **www.priceritebenefits.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
2nd.MD health advisory services	www.2nd.MD/activate	1-866-841-2575
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)

About This Guide
This guide describes the benefit plans and policies available to you as a Team Member of Price Rite. 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 Team Member 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 Price Rite.