Required Legal Notices

Direct Access to Pediatricians

You have the right to designate any primary care provider who participates in the Aetna Whole Health and Managed Choice POS and who is available to accept you or your family members. For your children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of participating primary care providers, contact Aetna at www.aetna.com.

Please note, although you are not required to select a Primary Care Physician, we encourage you to select a Primary Care Physician, or pediatrician for your child, who knows your health history.

Direct Access to Obstetricians & Gynecologists

You do not need prior authorization from any of the Aetna medical plans to obtain access to obstetrical or gynecological care from a health care professional in the applicable Aetna network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Aetna at www.aetna.com.

Women's Health and Cancer Rights Act

Special Rights Following Mastectomy: A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications of mastectomy.

Our Plans comply with these requirements. Benefits for these items generally are comparable to those provided under our Plan for similar types of medical services and supplies. The extent to which any of these items is appropriate following mastectomy, is a matter to be determined by consultation between the attending physician and the patient. Our Plans neither impose penalties (for example, reducing or limiting reimbursements) nor provides incentives to induce attending providers to provide care inconsistent with these requirements.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), there are special enrollment rights for certain individuals who earlier declined group health coverage and later wish to elect enrollment for themselves, one or more eligible dependents, or both themselves and their dependents. Group health plans and any insurer offering group health coverage must provide special enrollment periods to certain individuals eligible for group health coverage.

An employee who is eligible but not enrolled for group health coverage under the terms of the Plan (or his or her dependent if the dependent is eligible but not enrolled for coverage) is permitted to enroll for medical coverage under the Plan if:

- the employee or dependent was covered under a group health plan or had health insurance coverage at the time the Plan's medical benefits were previously offered to the employee or individual;

- the employee stated in writing at the time he or she declined coverage that the reason for declining group health coverage under the Plan during enrollment was due to coverage under another group health plan or health insurance coverage;

- the coverage of the employee or dependent who has lost the coverage was (i) under COBRA continuation coverage and the COBRA coverage was exhausted, or (ii) was not covered under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment) or employer contributions toward the coverage were terminated; and

- the employee requests enrollment not later than 30 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions (as described in (ii) above).

In addition, if the employee acquires a new dependent as a result of marriage, birth, adoption, or placement for adoption, he or she may be able to enroll himself or herself and his or her dependents, provided that the employee requests enrollment not later than 30 days after the marriage, birth, adoption or placement for adoption.

If the employee or dependent is covered under a Medicaid plan or a state children's health insurance program ("CHIP") and that coverage is terminated as a result of loss of eligibility, or the employee or dependent becomes eligible for a premium assistance subsidy for the Plan under Medicaid or a state CHIP, the employee must request enrollment in the Plan within 60 days after such loss of coverage or new eligibility. Please refer to the Notice at the end of this Guide for more details.

Newborns' and Mothers' Health Protection Act of 1996 ("NMHPA")

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This Notice is effective on November 1, 2023. Please provide this Notice to your family.
This Notice applies to the following health benefits provided under the health plans sponsored by ShopRite Supermarkets, Inc. (collectively, the "Plans"):

The Medical benefits, Dental benefits, Vision benefits, and Health Care FSA benefit

The references to "we" and "us" throughout this Notice mean the Plans.
This Notice has been drafted to comply with the "HIPAA Privacy Rules," under federal law. Any terms that are not defined in this Notice have the meaning specified in the HIPAA Privacy Rules.

How We Protect Your Privacy

The Plans will not disclose protected health information without your authorization unless it is necessary to provide your health benefits and administer the Plans, or as otherwise required or permitted by law. When we need to disclose individually identifiable information, we will follow the policies described in this Notice to protect your confidentiality.

How We May Use and Disclose Your Protected Health Information

The Plans will not use or disclose any of your protected health information for marketing purposes, nor will we make any disclosures that constitute the sale of your protected health information without your written authorization.

Any other uses and disclosures not specified in this notice require your authorization. We will not use or disclose your protected health information without your written authorization, except for the following purposes, or as otherwise permitted by law. You may revoke an authorization that you previously have given by sending a written request to ShopRite Supermarkets, Inc. but not with respect to any actions we already have taken. When required by law, we will restrict disclosures to the Limited Data Set, or if necessary, to the minimum necessary information to accomplish the intended purpose.

Treatment	We may disclose your protected health information to your health care provider for its provision, coordination or management of your health care and related services. For example, we may disclose your protected health information to a health care provider when the provider needs that information to provide treatment to you. We may also disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities or accreditation, certification, licensing or credentialing.

Payment	We may use or disclose your protected health information to provide payment for the treatment you receive under the Plans. For example, we may use and disclose your protected health information to pay and manage your claims, coordinate your benefits, and review health care services provided to you. We may use and disclose your protected health information to determine your eligibility or coverage for health benefits and evaluate medical necessity or appropriateness of care or charges. In addition, we may use and disclose your protected health information as necessary to preauthorize services to you and review the services provided to you. We may use and disclose your protected health information to adjudicate your claims. Also, we may disclose your protected health information to other health care providers or entities who need your protected health information to obtain or provide payment for your treatment.
Health Care Operations	We may use or disclose your protected health information for our health care operations. We may use or disclose your protected health information to conduct audits, for purposes of underwriting and rate-making, as well as for purposes of risk management. We may use or disclose your protected health information to provide you with customer service activities or develop programs. We may also provide your protected health information to our attorneys, accountants, and other consultants who assist us in performing our functions. We may disclose your protected health information to other health care providers or entities for certain health care operations activities, such as quality assessment and improvement activities, case management and care coordination, or as needed to obtain or maintain accreditation or licenses to provide services. We will only disclose your protected health information to these entities if they have or have had a relationship with you and your protected health information pertains to that relationship, such as with other health plans or insurance carriers in order to coordinate benefits, if you or your family members have coverage through another health plan.
Disclosures Between Health Plans	In addition to the uses and disclosures of your protected health information for purposes of treatment, payment and health care operations discussed above, the Plans may share your protected health information with each other. The Plans have entered into an "organized health care arrangement" to coordinate their operations and to better serve you and the other participants and beneficiaries of the Plans. To do this, the Plans may need to share protected health information with each other in order to manage their operations. However, the Plans will only share your protected health information with each other as is necessary for the treatment, payment or health care operations of the Plans and their common operation.
Disclosures to Sponsor of Plans	Glass Gardens Inc. is the sponsor of the Plans. We may disclose your protected health information to employees of the sponsor only to the extent necessary to administer the Plans. The sponsor is not permitted to use protected health information for any purpose other than the administration of the Plans. The sponsor must certify, among other things, that it will only use and disclose your protected health information as permitted by the Plans, restrict access to your protected health information to those individuals whose job it is to administer the Plans and it will not use protected health information for any employment-related actions or decisions.
Disclosures to Business Associates	We contract with individuals and entities (Business Associates) to perform various functions on our behalf or provide certain types of services. To perform these functions or provide these services, our Business Associates will receive, create, maintain, use or disclose protected health information. We require the Business Associates to agree in writing to contract terms to safeguard your information, consistent with federal law. For example, we may disclose your protected health information to a business associate to administer claims or provide service support, utilization management, subrogation, or pharmacy benefit management.

Disclosures to Family Members or Others	Unless you object, we may provide relevant portions of your protected health information to a family member, friend or other person you indicate is involved in your health care or in helping you receive payment for your health care. If you are not capable of agreeing or objecting to these disclosures because of, for instance, an emergency situation, we will disclose protected health information (as we determine) in your best interest. After the emergency, we will give you the opportunity to object to future disclosures to family and friends.
Other Uses and Disclosures	The law allows us to disclose protected health information without your prior authorization in the following circumstances:
Required by law	We may use and disclose your protected health information to comply with the law.
Public health activities	We will disclose protected health information when we report to a public health authority for purposes such as public health surveillance, public health investigations or suspected child abuse.
Reports about victims of abuse, neglect or domestic violence	We will disclose your protected health information in these reports only if we are required or authorized by law to do so, or if you otherwise agree.
To health oversight agencies	We will provide protected health information as requested to government agencies that have the authority to audit or investigate our operations.
Lawsuits and disputes	If you are involved in a lawsuit or dispute, we may disclose your protected health information in response to a subpoena or other lawful request, but only if efforts have been made to tell you about the request or obtain a court order that protects the protected health information requested.
Law enforcement	We may release protected health information if asked to do so by a law enforcement official in the following circumstances: (a) to respond to a court order, subpoena, warrant, summons or similar process; (b) to identify or locate a suspect, fugitive, material witness or missing person; (c) to assist the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (d) to investigate a death we believe may be due to criminal conduct; (e) to investigate criminal conduct; and (f) to report a crime, its location or victims or the identity, description or location of the person who committed the crime (in emergency circumstances).
Coroners, medical examiners & funeral directors	We may disclose protected health information to facilitate the duties of these individuals.
Organ procurement	We may disclose protected health information to facilitate organ donation and transplantation.
Medical research	We may disclose protected health information for medical research projects, subject to strict legal restrictions.

Serious threat to health or safety	We may disclose your protected health information to someone who can help prevent a serious threat to your health and safety or the health and safety of another person or the general public.
Special government functions	We may use and disclose your protected health information to comply with the law.
Workers' compensation or similar programs	We may disclose your protected health information when necessary to comply with worker's compensation laws.
Genetic information	The Plans are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes.

Your Individual Rights

Breach Notification	The Plans are required by law to notify you should a breach of your unsecured protected health information occur.
Who to contract to exercise your individual rights	You have important rights with respect to your protected health information as described below. Your enrollment and eligibility information originates with and is maintained by Glass Gardens Inc. and requests regarding that information must be in writing and directed to the Benefits Administrator. However, most of your protected health information originates with and is maintained by the Claims Administrators for the Plans. Requests relating to your claims information must be in writing and should be directed to the Claims Administrator for the particular benefit. The contact information for the Claims Administrators: Medical Plan: Aetna 1-877-461-0933 Dental Plan: MetLife 1-800-942-0854 Vision Plan: EyeMed 1-866-939-3633
Right to inspect and copy your protected health information	Except for limited circumstances, you may review and copy your protected health information. In certain situations we may deny your request, but if we do, we will tell you in writing of the reasons for the denial and explain your rights with regard to having the denial reviewed. If the information you request is in an electronic health record, you may request that these records be transmitted electronically to yourself or a designated individual. If you request copies of your protected health information, we may charge you a reasonable fee to cover the cost. Alternatively, we may provide you with a summary or explanation of your protected health information, upon your request if you agree to the rules and cost (if any) in advance.

Right to correct or update your protected health information	If you believe that the protected health information we have is incomplete or incorrect, you may ask us to amend it. To process your request, you must use the form we provide and explain why you think the amendment is appropriate. We will inform you in writing as to whether the amendment will be made or denied. If we agree to make the amendment, we will make reasonable efforts to notify other parties of your amendment. If we agree to make the amendment, we will also ask you to identify others you would like us to notify. We may deny your request if you ask us to amend information that: Was not created by us, unless the person who created the information is no longer available to make the amendment; Is not part of the protected health information we keep about you; Is not part of the protected health information that you would be allowed to see or copy; or Is determined by us to be accurate and complete. If we deny the requested amendment, we will notify you in writing on how to submit a statement of disagreement, complaint, or request inclusion of your original amendment request in your protected health information.

Questions and Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. To file a complaint with us, put your complaint in writing and send it to the Benefits Department. The Plans will not retaliate against you for filing a complaint. You may also contact the Benefits Department if you have questions or comments about our privacy practices.

Right to obtain a list of the disclosures	You have the right to get a list of protected health information disclosures, which is also referred to as an accounting. The list will not include disclosures we have made as authorized by law. For example, the accounting will not include disclosures made for treatment, payment and health care operations purposes, (except as noted in the following paragraph). Also, no accounting will be made for disclosures made directly to you or under an authorization that you provided or those made to your family or friends. The list will not include disclosures we have made for national security purposes or law enforcement personnel or disclosures made before April 14, 2004. The list we provide will include disclosures made within the last six years unless you specify a shorter period. The first list you request within a 12-month period will be free. You may be charged for providing any additional lists within a 12-month period. You may also request and receive an accounting of disclosures made for payment, treatment, or health care operations during the prior three years for disclosures made as of January 1, 2014 for electronic health records acquired before January 1, 2009, or January 1, 2011 for electronic health records acquired on or after January 1, 2009.
Right to choose how we communicate with you	You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Right to request additional restrictions on health information	You have the right to ask that we send information to you at a specific address (for example, at work rather than at home) or in a specific manner (for example, by e-mail rather than by regular mail). We must agree to your request if you state that disclosure of the information may put you in danger.

Future Changes to Our Practices and This Notice

We reserve the right to change our privacy practices and make any such change applicable to the protected health information we obtained about you before the change. If a change in our practices is material, we will revise this Notice to reflect the change. We will send or provide a copy of the revised Notice. You may also obtain a copy of any revised Notice by contacting the Benefits Administrator.

This Notice is intended as an overview of certain benefits-related requirements.

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, 2023. Contact your State for more information on eligibility.

	Website	Phone
Alabama – Medicaid	http://www.myalhipp.com	1-855-692-5447
Alaska – Medicaid	The AK Health Insurance Premium Payment Program: http://myakhipp.com/ Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: https://health.alaska.gov/dpa/Pages/default.aspx	1-866-251-4861
Arkansas – Medicaid	http://myarhipp.com/	1-855-MyARHIPP (855-692-7447)
California – Medicaid	https://www.dhcs.ca.gov/formsandpubs/laws/Pages/CaliforniStatePlan.aspx Email: publicinput@dhcs.ca.gov	916-552-9200
Colorado – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	Health First Colorado Website: https://www.healthfirstcolorado.com/ CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program	Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+ Customer Service: 1-800-359-1991/ State Relay 711 HIBI Customer Service: 1-855-692-6442
Florida – Medicaid	https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html	1-877-357-3268
Georgia – Medicaid	GA HIPP Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp GA CHIPRA Website: https://medicaid.georgia.gov/programs/third-party-liability/childrens-health-insurance-program-reauthorization-act-2009-chipra	HIPP & CHIPRA: 1-678-564-1162 Press 1
Indiana – Medicaid	Healthy Indiana Plan for low-income adults 19-64: http://www.in.gov/fssa/hip/ All other Medicaid: https://www.in.gov/medicaid/	Healthy Indiana Plan for low-income adults 19-64: 1-877-438-4479 All other Medicaid: 1-800-457-4584
Iowa – Medicaid and CHIP (Hawki)	Medicaid: https://dhs.iowa.gov/ime/members Hawki: http://dhs.iowa.gov/hawki HIPP: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp	Medicaid: 1-800-338-8366 Hawki: 1-800-257-8563 HIPP: 1-888-346-9562
Kansas – Medicaid	https://www.kancare.ks.gov/	1-800-792-4884

Kentucky – Medicaid	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Kentucky Medicaid Website: http://chfs.ky.gov	Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP): 1-855-459-6328 KCHIP Website: 1-877-524-4718
Louisiana – Medicaid	www.medicaid.la.gov or www.ldh.la.gov/lahipp	Medicaid hotline: 1-888-342-6207 LaHIPP: 1-877-697-6703
Maine – Medicaid	Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms	Enrollment Website: 1-800-442-6003,TTY: Maine relay 711 Private Health Insurance Premium Webpage: 1-800-977-6740, TTY: Maine relay 711
Massachusetts – Medicaid & CHIP	http://www.mass.gov/masshealth/pa	1-800-862-4840 TTY: 1-617-886-8102
Minnesota – Medicaid	https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp	1-800-657-3739
Missouri – Medicaid	http://www.dss.mo.gov/mhd/participants/pages/hipp.htm	1-573-751-2005
Montana – Medicaid	http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Email: HHSHIPPProgram@mt.gov	1-800-694-3084
Nebraska – Medicaid	http://www.ACCESSNebraska.ne.gov	1-855-632-7633 Lincoln: 1-402-473-7000 Omaha: 1-402-595-1178
Nevada – Medicaid	http://dhcfp.nv.gov	1-800-992-0900
New Hampshire – Medicaid	https://www.dhhs.nh.gov/programs-services/medicaid/health-insurance-premium-program	1-603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
New Jersey – Medicaid and CHIP	Medicaid: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ CHIP: http://www.njfamilycare.org/index.html	Medicaid: 1-609-631-2392 CHIP: 1-800-701-0710
New York – Medicaid	https://www.health.ny.gov/health_care/medicaid/	1-800-541-2831
North Carolina – Medicaid	https://medicaid.ncdhhs.gov/	1-919-855-4100
North Dakota – Medicaid	http://www.nd.gov/dhs/services/medicalserv/medicaid/	1-844-854-4825
Oklahoma – Medicaid and CHIP	http://www.insureoklahoma.org	1-888-365-3742
Oregon – Medicaid	https://healthcare.oregon.gov/marketplace/coverage/Pages/index.aspx	1-800-699-9075

Pennsylvania – Medicaid	https://www.dhs.pa.gov/Services/Assistance/Pages/HIPP-Program.aspx	1-800-692-7462
Rhode Island – Medicaid and CHIP	http://www.eohhs.ri.gov/	1-855-697-4347, or 1-401-462-0311 (Direct RIte Share Line)
South Carolina – Medicaid	http://www.scdhhs.gov	1-888-549-0820
South Dakota – Medicaid	http://dss.sd.gov	1-888-828-0059
Texas – Medicaid	http://www.gethipptexas.com/	1-800-440-0493
Utah – Medicaid & CHIP	Medicaid: https://medicaid.utah.gov/ CHIP: http://health.utah.gov/chip	1-877-543-7669
Vermont – Medicaid	http://www.greenmountaincare.org/	1-800-250-8427
Virginia – Medicaid & CHIP	https://www.coverva.org/en/famis-select https://www.coverva.org/en/hipp	Medicaid: 1-800-432-5924 CHIP: 1-800-432-5924
Washington – Medicaid	https://www.hca.wa.gov/	1-800-562-3022
West Virginia – Medicaid & CHIP	https://dhhr.wv.gov/bms/ http://mywvhipp.com/	Medicaid: 1-304-558-1700 CHIP: 1-855-MyWVHIPP (1-855-699-8447)
Wisconsin – Medicaid & CHIP	https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm	1-800-362-3002
Wyoming – Medicaid	https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/	1-855-294-2127

To see if any other states have added a premium assistance program since July 31, 2023, 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.

OMB Control Number 1210-0137 (expires 1/31/2024)

Notice of Creditable Coverage & Medicare Part D

Important Notice from Glass Gardens Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Glass Gardens Inc.and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription 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 drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- Glass Gardens Inc. has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays, and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th. However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Glass Gardens Inc. coverage will not be affected. You can keep your current coverage if you elect Part D coverage and your current coverage will coordinate with Part D coverage. Specific information regarding your prescription drug coverage through Glass Gardens Inc. and how this coverage coordinates with Medicare Part D, can be found in the Certificate of Coverage booklets, by

contacting Aetna directly using the contact information set forth in your Summary Plan Description or by contacting your Benefits Administrator.

See pages 7- 9 of the CMS Disclosure of Creditable Coverage To Medicare Part D Eligible Individuals Guidance available at (http://www.cms.hhs.gov/CreditableCoverage/), which outlines the prescription drug plan provisions/options that Medicare eligible individuals may have available to them when they become eligible for Medicare Part D.

If you do decide to join a Medicare drug plan and drop your current Glass Gardens Inc. coverage, be aware that because your coverage through Glass Gardens Inc.pays for other medical expenses in addition to prescription drugs, dropping it causes you to lose your medical coverage through Glass Gardens Inc.. If you drop your coverage, you and your dependents will be able to get this coverage back at the next annual open enrollment period.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Glass Gardens Inc. and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage

Contact the Benefits Administrator. NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Glass Gardens Inc. changes. You also may request a copy of this notice at notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll 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 prescription drug coverage: Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join 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).

Date: October 15, 2023
Name of Entity/Sender: Glass Gardens Inc.
Contact Person/Office: Your Benefits Administrator

COBRA CONTINUATION HEALTHCARE COVERAGE

You're getting this notice because you recently gained coverage (or soon will be gaining coverage) under a group health plan sponsored by ShopRite Supermarkets, Inc. (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of healthcare coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact your Benefits Administrator.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan healthcare coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, your civil union partner, your domestic partner and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. A child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage may also become a qualified beneficiary. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse, civil union partner or domestic partner of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse, civil union partner, or domestic partner dies;
- Your spouse's, civil union partner's or domestic partner's hours of employment are reduced;
- Your spouse's, civil union partner's or domestic partner's employment ends for any reason other than his or her gross misconduct;
- Your spouse, civil union partner, or domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or your civil or domestic partnership dissolves.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

When is COBRA continuation coverage available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Benefits Administrator has been notified that a qualifying event has occurred. The employee must notify the Benefits Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or dissolution of the civil union or domestic partnership or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Benefits Administrator in writing within 60 days after the later of the date the qualifying event occurs or the date there is a loss of coverage (or would be a loss of coverage). You must provide this notice to the Benefits Administrator using the contact information identified above. The Benefits Administrator may require copies of documents evidencing the event, such as the court order evidencing divorce or legal separation. If you do not provide this notice within the required timeframe, the qualified beneficiary will not be entitled to elect COBRA continuation coverage.

How is COBRA continuation coverage provided?
Once the Benefits Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.. If COBRA continuation coverage is not elected on a timely basis, you and your family members will lose health coverage under the Plan.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Benefits Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. This extension is available only if the Benefits Administrator is notified in writing of the disability determination before the end of the original 18-month COBRA continuation coverage period AND within 60 days of the latest of (1) a disability determination by the Social Security Administration, (2) the date of the qualifying event, and (3) the original loss of coverage date. The notice must state the identity of the covered individual determined to be disabled, the date the disability was determined to have commenced, and the identity of the person providing the notice and his or her relationship to the disabled individual. The notice must be accompanied by a copy of the Social Security disability determination.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse, civil union partner or domestic partner and dependent children in your family who are qualified beneficiaries can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse, civil union partner, or domestic partner and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated or the civil or domestic partnership dissolves; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is available only if the qualified beneficiaries were covered under the Plan at the time of the original qualifying event. Dependents acquired during COBRA continuation (other than newborns and newly adopted children) are not eligible to continue coverage as the result of a subsequent qualifying event. The second qualifying event extension is only available if the second qualifying event would have caused the spouse, civil union partner, domestic partner or dependent child to lose

coverage under the Plan had the first qualifying event not occurred. Continuation coverage after a second qualifying event is only available if you provide written notice to the Benefits Administrator within 60 days of the second qualifying event. The written notice of a second qualifying event must be sent to Benefits Administrator using the contact information indicated above.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?
In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[16] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Benefits Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Benefits Administrator.

NOTE: In response to the COVID-19 National Emergency, pursuant to and to the extent required by Department of Labor (DOL) guidance, various COBRA deadlines (i.e., the date for providing COBRA election notices, the date for qualified beneficiaries providing notice of a qualifying event or determination of disability, making a COBRA election, and paying COBRA premiums) are tolled until 60 days after the announced end of a National Emergency or such other date announced by the DOL.

[16] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.