Employee Benefits Plan: January 1, 2019

Insurance Benefits for Full Time Employees
Dear Employees,

As you continue to deliver quality care at Preferred Therapy Solutions, we are committed to providing you, our most valuable asset, with a comprehensive, cost effective benefits program that will provide YOU with quality healthcare.

In order to accomplish this, we evaluate each benefit program on a yearly basis to determine how we can continue to deliver this package that you and your family have come to rely on while maintaining our shared costs at an affordable level. As a result, we have made some changes to the offerings which are explained under the section of this booklet, “Important Medical Plan Changes”.

This year, we are announcing the addition of the following Benefits: RX Manage, an optional Rx program (for the Premium plan) which allows for select branded medications with no copay cost to you, a discounted mail order incentive for the H.S.A plans, and a new Liberty Mutual Home/Auto group discount. In addition, depending on increased costs, you may see a minor increase to the employee contribution, which worked out to about a 1.6% increase in employee contribution. We are very happy to report that increase is approximately 70% less than the standard plan increases for healthcare companies in 2019 which averaged 7%. We are also adding a fourth tier to delineate employee plus spouse from employee plus child/children coverage.

Open enrollment is online and begins in November for the plan year commencing on January 1, 2019. Please review the materials carefully for important plan changes and utilize our website www.preftherapybenefits.com or use our benefits helpline at 1-800-201-7898 if you have any questions. We hope that you find benefit offerings to be comprehensive and market competitive for you and your family.

Sincerely,

Liz Almeida-Sanborn

Liz Almeida-Sanborn, MS, PT
President, Preferred Therapy Solutions
Benefit Overview for January 1, 2019

Medical Plans
In order to continue to be able to offer affordable healthcare, we have modified the medical plan designs. Please review the Important Medical Plan Changes on page 2 and the health plan comparison chart on pages 17-18 for the changes to the medical plans for 2019.

Teladoc
No Changes.

Dental Plans
No Changes.

Vision Plan
No Changes.

Pharmacy Plans
Optum Rx
New Mail Order Service Saver plan for Maintenance Medications

RxManage
Introducing an optional alternative for Maintenance Medications with a $0.00 Copayment.

Group Life/AD&D Insurance
No Changes.

Group Voluntary Life/AD&D Insurance
No Changes.

Group Short Term Disability Insurance
No Changes.

Group Short Term Disability Buy-Up Insurance
No Changes.

Group Voluntary Long Term Disability Insurance
No Changes.

Flexible Spending Accounts
Health Care FSA
Dependent Care FSA

Health Savings Account
No Changes.

CCA Work/Life Assistance Program
A program for employees and their families.

Liberty Mutual
Discounts on Auto and Home Insurance.
Important Medical Plan Changes

**Mail Order Prescription Drug Incentives**
We are introducing a discounted Mail Order pharmacy benefit to plan members (except those enrolled in the Bronze plan). This discounting applies to all Non-Specialty, Maintenance Medications. The program benefits are detailed on pages 11 and 12 of this booklet.

**Opportunity to Purchase Medications at No Cost through RxManage**
Individuals enrolled in the Premium plan are able to purchase selected medications at NO COST through our international outsourced vendor, RxManage. A listing of available medications is available at our benefits website, www.preftherapybenefits.com. We will also be outreaching to members currently taking these medications to ensure everyone has the opportunity to take advantage of this plan enhancement.

**Deductible, Co-Insurance Changes**
We are raising some deductibles and co-insurance amounts in order to mitigate employee premium increases. Specifically, deductibles are increasing by $250/$500 for all plans except the Bronze. We have increased the Emergency Room copay to $250 on the Premium plan.

**Out-of-Pocket Maximum Changes for In-Network Services**
We are adjusting the In-Network Out-of-Pocket maximums to $7,900 for individuals and $15,800 for families on the Premium Plan. The HSA Out-of-Pocket maximum will be $6,750/$13,500 and Bronze Out-of-Pocket maximum will be $6,600/$13,200.

As always, please consult the Summary of Benefits and Coverages for clarification of any items. Additionally, the Certificates of Coverage for each plan contain the exact legal language governing benefit coverage.
Open enrollment begins
November 12, 2018 - December 5, 2018

24 Hour Access through our Employee Benefits Portal –
www.preftherapymenefits.com
We have developed a customized benefits portal for Preferred Therapy Solutions employees where you will be able to find information on your plan options, contact information, claim forms, enrollment information and many other topics.

Just go to www.preftherapymenefits.com and navigate to the area of the site that you wish to view.

In addition to our employee website, you also have access to our dedicated benefit advocates at our benefit advisory firm, The Hilb Group of New England.

Need help?
Call the Preferred Therapy Solutions Benefits Help Line – 1-800-201-7898
Simply dial the Preferred Therapy Solutions Help Line at 1-800-201-7898 and follow the prompts to get access to an advocate that can answer your questions or help you to enroll in a plan.

During open enrollment, Benefit Educators from The Hilb Group of New England will be available to discuss your benefits with you and explain the benefit options. Please review the information in this Benefits Guide carefully so you are familiar with your options.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Provider</th>
<th>Department</th>
<th>Phone &amp; Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Insurance</td>
<td>AETNA</td>
<td>Customer Service</td>
<td>1-800-533-8436 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Optum</td>
<td>Customer Service</td>
<td>1-844-265-1719 <a href="http://www.optumrx.com/mycatamaranrx">www.optumrx.com/mycatamaranrx</a></td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>Payflex</td>
<td>Customer Service</td>
<td>1-888-678-8242</td>
</tr>
<tr>
<td>Dental Insurance</td>
<td>Delta Dental</td>
<td>Customer Service</td>
<td>1-800-452-9310 <a href="http://www.deltadentalnj.com">www.deltadentalnj.com</a></td>
</tr>
<tr>
<td>Vision Insurance</td>
<td>AETNA</td>
<td>Customer Service</td>
<td>1-800-533-8436 <a href="http://www.aetna.com">www.aetna.com</a></td>
</tr>
<tr>
<td>Teladoc</td>
<td>AETNA</td>
<td>Customer Service</td>
<td>1-855-835-2362 <a href="http://www.teladoc.com/Aetna">www.teladoc.com/Aetna</a></td>
</tr>
<tr>
<td>Colonial Plans</td>
<td>Colonial</td>
<td>Customer Service</td>
<td>1-800-607-7949</td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>AETNA</td>
<td>Customer Service</td>
<td>1-866-326-1380</td>
</tr>
<tr>
<td>Flexible Spending Account</td>
<td>Optum</td>
<td>Customer Service</td>
<td>1-800-243-5543</td>
</tr>
<tr>
<td>401(k)</td>
<td>Principal</td>
<td>Customer Service</td>
<td>1-800-547-7754</td>
</tr>
</tbody>
</table>
Eligibility / Online Enrollment Instructions

Eligible Employees are defined as follows:
Employees who are regularly scheduled to work at least 30 hrs/wk and have satisfied the waiting period are eligible for Medical, Dental, Vision, Life, Voluntary Life, STD, LTD Insurance, the Colonial Group Accident, Cancer, Critical Illness, and Hospital Confinement coverage, Health Savings Account, and Flexible Spending Accounts.

STEP 1
Go to www.preftherapybenefits.com. Click on Preferred Therapy Solutions logo. On the top menu bar, click on Online Enrollment, this will link you to Benefits Connect, our online enrollment platform.

STEP 2
Enter Username/Password
Enter the first 6 characters of your last name, followed by the first letter of your first name, followed by the last 4 digits of your Social Security Number. Password: Enter your full Social Security number without any dashes. Once you log in, you will be prompted to go through the 6 step enrollment process.

STEP 3
Confirm your personal information and make any necessary changes to your profile.

STEP 4
Review your dependents and make any necessary corrections or add a dependent.

STEP 5
Select your benefits. Be sure to select any family member to be added to your benefits as well. Continue through until you have selected or waived all benefits.

STEP 6
Complete or Update the Beneficiary Information. You may add more than one beneficiary. Indicate percentage amount for each beneficiary.

STEP 7
Review Consolidated Enrollment Form and Benefit Selections. Please note: you do not need to sign and return this form; it is for your records.

Should you need assistance with this process, please call the Preferred Therapy Benefits Help Line at 1-800-201-7898.
Pre-Tax (Section 125) Plan

Preferred Therapy Solutions, Inc. has offered and continues to offer a valuable benefit that allows you to take advantage of the tax benefits available under Section 125. This program is designed to allow pre-tax withholdings of your share of the medical, dental, vision, health savings account, flexible spending account deductions; therefore, reducing your income tax liability. Please see the example that illustrates the savings you can achieve.

We have adopted an automatic enrollment feature for this plan. Automatic enrollment means that we will be taking any eligible premiums from your paycheck pre-tax unless you tell us that you don’t want them taken out pre-tax. Preferred Therapy Solutions has implemented a pre-tax premium payment program under IRC Section 125. Pursuant to the plan document and summary plan description, all eligible employees will be automatically enrolled in the pre-tax premium payment program unless said employee declines enrollment by written notice to their center’s human resources manager. Please understand that once you make an election in the pre-tax plan, it is irrevocable and cannot be changed for the balance of the plan year unless you have a qualifying event like a marriage, birth, death or divorce.

<table>
<thead>
<tr>
<th>Income Before Pre-Tax Plan</th>
<th>Income After Pre-Tax Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adjusted Monthly Salary</strong></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Before-tax Insurance Premiums</strong></td>
<td>- $0</td>
</tr>
<tr>
<td><strong>Taxable Salary</strong></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Taxes - Federal &amp; Social Security (25%)</strong></td>
<td>- $500</td>
</tr>
<tr>
<td><strong>After-tax Insurance Premiums</strong></td>
<td>- $400</td>
</tr>
<tr>
<td><strong>Net Monthly Salary</strong></td>
<td>$1,100</td>
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<tr>
<td><strong>MONTHLY SAVINGS</strong></td>
<td>$0</td>
</tr>
<tr>
<td><strong>YEARLY SAVINGS</strong></td>
<td>$0</td>
</tr>
</tbody>
</table>
Take advantage of all your health plan has to offer

Finding a PCP or network doctor is easy
Use the DocFind® online directory. The new one-step search lets you find the right doctor in a snap. Just enter a name, ZIP code, condition, procedure or specialty in the search box. You’ll also find maps, directions and more. Try DocFind at www.aetna.com. Or get a printed directory. If you are already an Aetna member, call Member Services to get one. The toll-free number is on your Aetna ID card. If you’re not an Aetna member yet — or haven’t received your ID card — call 1-800-533-8436.

Sign up for your members-only website
When you’re an Aetna member, you get tools and resources to help you manage your health and your benefits. All of your plan information and cost-savings tools are in one place — your Aetna Navigator® member website. When you sign up and use it, you’re not just a member, you’re a navigator. Navigators are smart about their health care. Sign up at www.aetna.com.

Meet Ann, your virtual assistant
Ann can help you sign up for Aetna Navigator. She can even help you find a doctor, estimate the cost of services, answer questions about claims, ID cards and more. She never sleeps, so chat with her anytime.

Here’s a way to estimate costs once you enroll
Our Member Payment Estimator lets you compare and estimate costs for office visits, tests, surgeries and more. You can see how much you’ll have to pay and how much Aetna will pay. To use Member Payment Estimator, log in to Aetna Navigator.

Questions? Give us a call.
When you have a coverage question, Member Services is ready to take your call. The toll-free number is 1-800-533-8436. Or use our automated phone system. You can order an ID card or ask for a claim form and mailing address. The system works with your voice and your phone’s touch tone (when you need privacy).

You’re mobile — so are we.
So use your smartphone when you’re on the go.
The Aetna Mobile app puts our most popular online features at your fingertips. It’s available for iPhone®, Android™ and BlackBerry® mobile devices. Scan this code now to download. Or visit www.aetna.com/mobile.
Preferred Therapy Solutions: Preventative Services

**Preventive care covered with no cost sharing**
Get checkups, screenings, vaccines, prenatal care, contraceptives and more with no out-of-pocket costs.

This includes routine screenings and checkups. It also includes counseling you get to prevent illness, disease or other health problems.

Many of these services are covered as part of physical exams. These include regular checkups, and routine gynecological and well-child exams. You won’t have to pay out of pocket for these preventive visits, when provided in network.

![Stethoscope Image]
Have questions about your benefits or health care services? Your Aetna Concierge has the answers.

There’s a great big world of health care out there. Sometimes you need help to make sense of it all, whether you have a question about a diagnosis, are looking for a doctor or would like to know more about your wellness benefits. Your employer doesn’t just want to offer you great health care benefits. They want to make sure you get more out of each one of them.

That’s where Aetna Concierge comes in. Think of the concierge as your personal assistant for health care … one who will help you make the most of your Aetna insurance benefits and get the best health and wellness services available.

It’s all about you
We’ve all been there: hunting down health records, trying to find a specialist or struggling to locate a diagnostic study.

Your concierge is a real live person who believes that you deserve a simpler, hassle-free health care experience.

The concierge is also an expert on Aetna’s many online tools, including your Aetna Navigator® secure member website and our Member Payment Estimator, which helps you estimate your out-of-pocket costs before you schedule a doctor’s visit. Let your concierge help you use these resources to find what you need and make better-informed health care decisions.

How can we help you?
With Aetna Concierge, you have an advocate who will listen to you, understand your needs and find the solutions that are right for you.

Your Aetna Concierge is ready to speak with you at our toll-free number from 8 a.m. to 6 p.m., Monday through Friday. Simply call 1-800-533-8436.

Your Aetna Concierge can help you:
• Better understand all the health and wellness benefits provided to you
• Use Aetna’s online tools, like Aetna Navigator, to find a doctor, check your coverage or look up a claim
• Make good health care decisions and get preventive screenings
• Better understand how to get the most out of your benefits and use the various member tools and resources available to you

Aetna Concierge
Personal assistance call 1-800-533-8436

Your Aetna Concierge is available Monday through Friday, 8 a.m. to 6 p.m.*

* Calls made before 8 a.m. and after 6 p.m. will be answered by non-concierge customer service representatives.
Clinical quality and efficiency standards
Specialists in the Aexcel® or Employer Preferred Network (EPN)

Aexcel specialists are doctors who meet standards for both clinical quality and efficiency. To be included in the Aexcel network, these high-performing doctors and doctor groups must meet certain minimum criteria.

For instance, they must meet one or more of the following:
• Show lower complication rates for their patients during hospital stays
• Use treatments shown to help improve outcomes
• Get recognition in health care quality and safety, from medical societies and health care quality industry groups
• Retain their medical board certification by taking part in activities made available through medical and specialty boards
• Use technology to make their delivery of health care services more efficient

No referrals, lower costs
Plus, with these doctors, you can usually avoid referrals. To make sure, check your Aetna ID card once you become a member. Or call Member Services to ask. You may also be able to lower the costs you pay out of pocket.

12 specialty areas
You can choose doctors in 12 areas:
• Cardiology (heart and blood)
• Cardiothoracic (heart and chest) surgery
• Gastroenterology (digestive system)
• General surgery
• Neurology (nervous system)
• Neurosurgery (spinal column, spinal cord, brain and nerves)
• Obstetrics and gynecology (pregnancy and women’s reproductive system)
• Orthopedics (bones and joints)
• Otolaryngology (ENT — ear, nose, throat; head and neck)
• Plastic surgery
• Urology (urinary tract and urogenital system)
• Vascular (vein and artery) surgery

*Aexcel is not available to residents of NH, PA, RI & VT*
How to find an Aexcel or an EPN-designated doctor

Once you’ve become an Aetna member, log in to your secure member website at www.aetna.com. Select “Find a Doctor, Dentist or Facility” and search for the type of specialist you are looking for. Aexcel-designated doctors have a blue star ☼ and EPN-designated doctors have a next to their name.

How to use the Aexcel network for lower out-of-pocket costs

You might have to use Aexcel-designated doctors to pay the least out of pocket. It depends on your health insurance plan.

For some plans with an Aexcel network, health care received from non-designated specialists may be paid at the out-of-network benefits level. Even if the non-designated specialist is in the broader Aetna network. And in some cases, the care from non-designated specialists might not be covered at all.

In other health plans with an Aexcel network, you may be allowed to visit non-designated specialists. But your out-of-pocket costs will be higher than if you saw an Aexcel-designated doctor in that same specialty.

See your health plan documents for more information.

Check your doctor’s status

Sometimes, a doctor’s Aexcel status can change during your treatment. We look at a doctor’s performance every two years. Check your doctor’s status before making an appointment.

NCQA (National Committee for Quality Assurance) background and why it’s important

NCQA is an independent nonprofit group. It accredits and evaluates many health care organizations and recognizes doctors in key clinical areas. Its mission is to improve the quality of health care.

NCQA serves as an independent examiner for Aetna, reviewing how the Aexcel program meets criteria required by the State of New York and national principles of the Patient Charter established by the Consumer-Purchaser Disclosure Project.


If you want to register a complaint with Aetna about Aexcel and/or doctor measurement activities, either:
• Call Member Services using the phone number on your Aetna ID card.
• Or send a request in writing to the Appeals Resolution Team address shown on your Explanation of Benefits (also called an EOB), or use the Member Complaint and Appeal form at www.aetna.com.

If you live in the State of New York, you can also register your complaint with NCQA. Send it in writing to customersupport@ncqa.org or to NCQA Customer Support, 1100 13th Street, NW, Suite 1000, Washington, DC.

Get the right balance of quality and cost. Choose a health plan with an Aexcel network.
Pharmacy

We have selected OptumRx, (a United Health Care Company), as our pharmacy insurance company. Aetna will continue to manage our medical benefits. Optum will manage our pharmacy (prescription drug) benefits.

You will receive a separate identification card from OptumRx that you will need to use for pharmacy services. For medical services, you will need to use your Aetna identification card.

Please refer to the plan specific pharmacy benefits listed on the next page. Based on the plan you select for enrollment, the applicable pharmacy benefits will apply. Additionally, there is a per prescription maximum cost of $300 per 30 day supply. This safeguards you in the event that you are taking a very expensive drug, your maximum cost is capped at $300 per refill. Additionally, your costs are also capped by the medical plan out of pocket maximum. See the pharmacy benefit table for more detailed information.
<table>
<thead>
<tr>
<th>Tier/Plan</th>
<th>Generic</th>
<th>Brand (Preferred/Non-Preferred)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>$9 or less</td>
<td>30% up to $300 Max</td>
</tr>
<tr>
<td>Standard</td>
<td>$9 or less</td>
<td>30% up to $300 Max</td>
</tr>
<tr>
<td>Basic</td>
<td>$9 or less</td>
<td>30% up to $300 Max</td>
</tr>
<tr>
<td>H.S.A.</td>
<td>$9 or less (After Deductible)</td>
<td>30% up to $300 Max (After Deductible)</td>
</tr>
<tr>
<td>Bronze H.S.A.</td>
<td>Covered in Full (After Deductible)</td>
<td>Covered in Full (After Deductible)</td>
</tr>
</tbody>
</table>

**Effective 2/1/19**

### MAINTENANCE MEDICATIONS

<table>
<thead>
<tr>
<th>Tier/Plan</th>
<th>Generic</th>
<th>Brand (Preferred/Non-Preferred)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>$18 or less</td>
<td>30% x 2 up to $600 Max</td>
</tr>
<tr>
<td>Standard</td>
<td>$18 or less</td>
<td>30% x 2 up to $600 Max</td>
</tr>
<tr>
<td>Basic</td>
<td>$18 or less</td>
<td>30% x 2 up to $600 Max</td>
</tr>
<tr>
<td>H.S.A.</td>
<td>$18 or less (After Deductible)</td>
<td>30% x 2 up to $600 Max (After Deductible)</td>
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### MAINTENANCE MEDICATIONS

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<th>Generic</th>
<th>Brand (Preferred/Non-Preferred)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>$18/$54 or less</td>
<td>50% up to $300/$900 Max</td>
</tr>
<tr>
<td>Standard</td>
<td>$18/$54 or less</td>
<td>50% up to $300/$900 Max</td>
</tr>
<tr>
<td>Basic</td>
<td>$18/$54 or less</td>
<td>50% up to $300/$900 Max</td>
</tr>
<tr>
<td>H.S.A.</td>
<td>$18/$54 or less (After Deductible)</td>
<td>50% up to $300/$900 Max (After Deductible)</td>
</tr>
<tr>
<td>Bronze H.S.A.</td>
<td>Covered in Full (After Deductible)</td>
<td>Covered in Full (After Deductible)</td>
</tr>
</tbody>
</table>

### SPECIALTY MEDICATIONS

<table>
<thead>
<tr>
<th>Tier/Plan</th>
<th>Briova/OptumRx Specialty Pharmacy - 30/90 DAY SUPPLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>(Specialty Medications Must be Ordered through BriovaRx)</td>
</tr>
<tr>
<td>Standard</td>
<td>40% up to $300/$900 Max</td>
</tr>
<tr>
<td>Basic</td>
<td>40% up to $300/$900 Max</td>
</tr>
<tr>
<td>H.S.A.</td>
<td>40% up to $300/$900 Max</td>
</tr>
<tr>
<td>Bronze H.S.A.</td>
<td>Covered in Full (After Deductible)</td>
</tr>
</tbody>
</table>
What you need to know
Our covered drug list (formulary) with Optum excludes certain drugs that have preferred brand or generic equivalent drugs available. If you choose a non-covered drug, you will be responsible for the entire cost of the drug and it will not count towards your out-of-pocket maximum. Optum will be sending you a welcome package at your home that will include a list of the excluded drugs.

To fill prescriptions at a Retail Pharmacy just show your new Optum ID card. For Mail Order Pharmacy refills, your refill can be done at retail pharmacy or through Optum's mail order program, which is available online or by completing the form and returning it to Optum.

Diabetes Program: Diabetic medications are covered as indicated on the pharmacy benefit table (page 12), except the maximums are capped at $100 for the first two fills at a retail pharmacy and capped at $150 when using the Optum Rx Mail Order Saver Program.

Note: Maintenance medications at a retail pharmacy for a 30/90 day supply after the 2nd fill will be subject to 50% up to $300/$900 maximum.

Additionally, a free glucose meter from One Touch is available to members with diabetes.

How to save money
Talk to your doctor about the drugs you are taking to see if there is a generic alternative or a less expensive brand option. Since you pay a percentage of the cost of each drug you purchase, it is beneficial for you to comparison shop the pharmacy that you are going to purchase your drugs from. We have identified two websites (that also have smartphone apps) that do the comparison shopping for you.

Helpful websites
www.optumrx.com/myCatamaranRx
www.GoodRx.com

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National Health Care Associates, Inc. and Affiliates has partnered with RxManage to offer you savings on your prescription medications. You can now order medications from the International Program at zero co-pay on Premium plan.

What is the International Program?
The Program allows you to order from a formulary of over 200 brand medications from pharmacies in New Zealand, Australia, Canada and England.

Will my medication be exactly the same as what I currently take?
Yes it will. To be on the formulary a medication must be available from the same manufacturer internationally as the US brand, or from the International license holder.

How do I place an order on the Personal Importation Program?
Ordering is easy! You can place your first order online at the website address below, or phone at 1-800-883-8841. Upload your prescription to your account or fax to 1-800-883-1814. A prescription is required for each medication. https://my.globalrxmanage.com/customers/national-health-care-associates-inc/sign-up. Once established, your online account is available 24 hours a day, 7 days a week. Log into your account from your computer or mobile device using your Account ID and password at https://my.globalrxmanage.com/customers/login.

How long will it take to receive my medication?
10-15 working days after the order has shipped. Please make sure you have a 30 day supply on hand before placing your first order for each medication.

How do I place a refill order?
Refill orders are placed automatically. You will receive a refill reminder by phone or email. Any changes are to be notified to Rx Manage within 48 hours. If no changes are notified the order automatically ships, ensuring a smooth continuous supply of medication.

What is the amount of medication I can order?
Using the Personal Importation Program, you can order a 90 day supply of medication.

Where do I go if I have questions about the program?
Our call center is open 9am-9pm Monday to Friday (EST) and 9am to 4pm Saturday and Sunday to answer simple questions or take your orders. Call us on 1-800-883-8841. Alternatively you can email us on inquiries@rxmanage.com
RxManage Frequently Asked Questions

What is the RxManage Personal Importation Program?
The Personal Importation Program utilizes "Tier 1" countries globally to source your maintenance medication. These countries are New Zealand, Australia, Canada and the United Kingdom. Medications can be sourced with considerable savings from these countries because of different pricing structures internationally for branded medications. Tier 1 countries are ones that have been approved federally as providing medication equivalent to that approved by the FDA.

Does the RxManage Personal Importation Program replace our current prescription benefit plan?
No, the RxManage Personal Importation Program is a voluntary program for brand name medications listed on the RxManage formulary. Medications not listed on the formulary will need to be obtained using your current prescription benefit plan.

Will my medication be exactly the same as what I currently take?
Yes it will. To qualify for the Personal Importation Program a medication must be available from the same manufacturer internationally as the US brand, or from the licence holder for the international version of that brand medication.

Will my medication shipped from a Tier 1 country look the same as my current medication?
Sometimes pharmaceutical companies use different names for the same medication internationally so your medication may not be called the same as it is in the USA. Tablet appearance can also differ between countries for the same medication. Rest assured that to meet the requirements of the Program each medication is thoroughly researched by our pharmacist to ensure it is bio-equivalent and dose-equivalent to the US brand.

How do I place an order for a new or existing medication?
You can place an order in 3 easy ways:
1. Online: On our customer website
2. Phone: call our customer care team at 1-800-883-8841.
3. Fax: Complete an order form, then fax it to 1-800-883-1814.

Can I send in a prescription for a newly prescribed medication?
RxManage is unable to supply newly prescribed medication. When taking a newly prescribed medication a trial supply needs to be obtained locally. This ensures that you have been advised how to take the medication and are aware of possible side effects. The medication trial is to make certain that there are no adverse reactions to the medication and that your physician would like you to continue on the medication long term. After your 30 day trial you can then order a 90 day supply using our program.
Talk to a doctor anytime for $0 copay*
Less than an urgent care or ER visit,
Teladoc's never more than a doctor visit.

Getting started with Teladoc®

Teladoc’s U.S. board-certified doctors are available 24/7/365 to resolve many of your medical issues through phone or video consults. Set up your account today so when you need care now, a Teladoc doctor is just a call or click away.

Set Up Your Account
It’s quick and easy online. Visit the Teladoc website at Teladoc.com/Aetna, click “Set up account” and provide the required information. You can also call Teladoc for assistance over the phone.

Request a Consult
Once your account is set up, request a consult anytime you need care.

Provide Medical History
Your medical history provides Teladoc doctors with the information they need to make an accurate diagnosis

Online:
Log into the Teladoc website at Teladoc.com/Aetna and click "My Medical History".

Mobile app:
Log into your account and complete the "My Health Record" section. Visit Teladoc.com/mobile to download the app.

Call Teladoc:
Teladoc can help you complete your medical history over the phone.

* A $40 copay applies to the HS A and Bronze HSA Plans
<table>
<thead>
<tr>
<th></th>
<th>In Network Services</th>
<th>Premium Plan</th>
<th>HSA Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td><strong>Aetna Network</strong></td>
<td><strong>HSA Eligible Plan</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>Choice POS II</strong> (Choice POS II)</td>
<td>Yes</td>
</tr>
<tr>
<td>Deductible (Based on Calendar year)</td>
<td>$750 per person $2,000 family maximum</td>
<td>$2,000 individual / $4,000 family coverage</td>
<td></td>
</tr>
<tr>
<td>Co-insurance after Deductible</td>
<td>0%</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Maximum (includes deductible and all copayments)</td>
<td>$7,900 per person $15,800 family maximum</td>
<td>$6,750 per person $13,500 family maximum</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td><strong>Hospital Semi-private room and related services</strong></td>
<td>$500 copayment after deductible 15% coinsurance after deductible</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>$250 copayment after deductible</td>
<td>15% coinsurance after deductible 60 day limit per year</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td><strong>Outpatient Procedures/Testing</strong></td>
<td>$500 copayment after deductible 15% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td></td>
<td><strong>$250 copayment</strong></td>
<td>15% coinsurance after deductible</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td><strong>Office Visits to Primary Care Physician</strong></td>
<td>$0 for Routine Annual Physical 15% coinsurance after deductible for all other visits</td>
</tr>
<tr>
<td>Office Visit to Specialist in Aexcel Network*</td>
<td>$40 copayment</td>
<td>10% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Office Visit to Non-Aexcel Participating Specialist*</td>
<td>$55 copayment</td>
<td>25% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Office Visits to Specialty Physician ▲</td>
<td>$45 copayment</td>
<td>15% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Teledoc</td>
<td>Covered in full $0 copayment</td>
<td>$40 copayment</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>$45 copayment - 20 visits per year</td>
<td>15% coinsurance after deductible - 20 visits per year</td>
<td></td>
</tr>
<tr>
<td>Vision Care</td>
<td>Routine Eye Exam covered in full every 24 months</td>
<td>Routine Eye Exam covered in full every 24 months</td>
<td></td>
</tr>
<tr>
<td><strong>Independent Lab, X-Ray, Clinics &amp; Walk-in Treatment Centers</strong></td>
<td></td>
<td>Preventive Lab and X-Ray Covered in full; Preventive Lab and X-Ray Covered in full</td>
<td></td>
</tr>
<tr>
<td>Lab Services</td>
<td>$25 copayment - Hospital</td>
<td>25% coinsurance after deductible - Hospital</td>
<td></td>
</tr>
<tr>
<td>Diet &amp; X-Ray $10 copayment – Free Standing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Machine Tests (MRI, CT and PET Scans)</strong></td>
<td>$250 copayment – Free Standing</td>
<td>15% coinsurance after deductible - Free Standing</td>
<td></td>
</tr>
<tr>
<td>Walk-in Treatment &amp; Urgent Care Centers</td>
<td>$500 - Hospital</td>
<td>25% coinsurance after deductible - Hospital</td>
<td></td>
</tr>
<tr>
<td>Vision Care</td>
<td>Routine Eye Exam covered in full every 24 months</td>
<td>Routine Eye Exam covered in full every 24 months</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health Substance Abuse Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>$500 copayment after deductible</td>
<td>15% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td>$45 copayment</td>
<td>15% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>$45 copayment</td>
<td>15% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Hospital Stay</td>
<td>$500 copayment after deductible</td>
<td>15% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
<td>$45 copayment 30 visits per year per therapeutic category</td>
<td>15% coinsurance after deductible 30 visits per year per therapeutic category</td>
</tr>
<tr>
<td>Physical/ Speech/ Occupational/ Respiratory Therapy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>30% coinsurance</td>
<td>15% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Dependent Coverage Age</td>
<td>Age 26</td>
<td>Age 26</td>
<td></td>
</tr>
<tr>
<td><strong>Out of Network Services</strong></td>
<td></td>
<td>Annual Deductible $20,000 per person $40,000 family maximum</td>
<td>$20,000 individual $40,000 family maximum</td>
</tr>
<tr>
<td>Co-insurance after Deductible</td>
<td>30%</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Out of Pocket Limit</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>


▲ Since the Aexcel network is not available in NH, PA, RI and VT, members residing in these states will pay the regular specialty copay or coinsurance.

** The Bonze H S A plan does not meet the Minimum Creditable Coverage (MCC) in the State of MA.
### Bronze HSA Plan **

<table>
<thead>
<tr>
<th>Choice POS II</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,600 individual / $13,200 family coverage</td>
<td></td>
</tr>
<tr>
<td>0%</td>
<td></td>
</tr>
<tr>
<td>$6,600 per person $13,200 family maximum</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible 60 day limit per year</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>$0 for Routine Annual Physical Covered in full after deductible for all other visits</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>$40 copayment</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible - 20 visits per year</td>
<td></td>
</tr>
<tr>
<td>Routine Eye Exam covered in full every 24 months</td>
<td></td>
</tr>
<tr>
<td>Preventive Lab and X-Ray Covered in full Diagnostic</td>
<td></td>
</tr>
<tr>
<td>Lab &amp; X-Ray Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible; 30 visits per year per therapeutic category</td>
<td></td>
</tr>
<tr>
<td>Covered in full after deductible</td>
<td></td>
</tr>
<tr>
<td>Age 26</td>
<td></td>
</tr>
<tr>
<td>$20,000 individual $40,000 family maximum</td>
<td></td>
</tr>
<tr>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>
Important Benefit Offering
Health Advantage Flexible Spending Accounts

A Health Advantage FSA from Optum is the smart way to save and pay for eligible health care and dependent care expenses. It’s smart because you can set aside pre-tax dollars in your FSA. You don’t have to pay Federal, State (except New Jersey) or FICA taxes on the money you put into your account. Whenever you need to pay out-of-pocket for eligible health care costs, just use your Optum™ Payment Card. It’s that easy. Sign up for a Health Advantage FSA during benefits enrollment. After you enroll, watch the mail for your welcome letter and subsequent delivery of your Optum Payment Card.

Health Care FSA

The money you choose to put into your Health Advantage Health Care Flexible Spending Account (FSA) is available to you on the first day of your plan year. You don’t have to wait until your FSA balance grows to pay for eligible expenses.

How it works.

You can enroll in a Health Advantage Health Care FSA and use the funds for your and any of your IRS dependents’ health care expenses (typically your spouse and children). Allowable expenses typically include your out-of-pocket health care expenses that are not paid or not fully paid by your insurance plan such as deductibles, copays, prescription drugs, vision and dental expenses, etc. (see IRS publication 502 for details as to eligible expenses).

With a Health Care FSA, you choose how much to contribute, from a minimum of $520 up to a maximum of $2,650 per year (subject to change based on release of IRS FSA limits for 2019). Your employer deducts this amount from each paycheck, before taxes. Thus, you save money as you lower your income taxes.

The Health Care FSA is only available to employees who either waive medical coverage or enroll in the Premium, Standard or Basic medical plans.

Dependent Care FSA

With a Health Advantage Dependent Care Flexible Spending Account (FSA)*, you can save for day care, child care, nursery school and preschool tax-free. If you are working, you may also be able to use your account to pay for day camp for your child under 13 or to care for qualifying dependent adults, like elderly parents, who can’t care for themselves.

How it works.

You can enroll in a Health Advantage Dependent Care FSA as long as you and your spouse are working, looking for work or enrolled as a full-time student. With a Dependent Care FSA, you choose how much to contribute, from a minimum amount of $520 up to a maximum of $5,000 per household, per year. Your employer deducts this amount from each paycheck, before taxes. You don’t have to pay Federal, State (except New Jersey) or payroll taxes on the money credited to your account. You save money as you lower your income taxes.
Important to know

Access your funds immediately.
The money in your health FSA is available to you immediately. The money in your dependent care FSA is available based only on the funds you have contributed to date.

The “Use it or Lose it” rule.
The “use it or lose it” rule means that you will lose any money left in your account at the end of the plan year. So be sure to try to use all of your FSA funds. But even if some funds are left in your account at the end of the plan year, you may still come out ahead because of the tax savings.

Save your receipts.
Be careful how you use your Health Advantage FSA. You will want to keep receipts from your doctors, dentists, clinic, pharmacy and hospital for all eligible health care expenses. All receipts should include the date and description of service, provider’s name and amount paid. You may need to provide proof that all of your FSA expenses meet IRS requirements for eligibility.

Changing your contributions.
Generally, you may only elect or change the amount of your FSA contribution annually at open enrollment or upon becoming newly eligible except in special situations.

In special situations — such as marriage, divorce, or, if you have a baby — you may be able to adjust the amount you contribute to your Health Advantage FSA. This is called a qualifying change in status. If you have a change in status, your benefits representative can help you adjust your contributions. For specific details, check your employer’s plan document. If you leave the company during the plan year, you may submit FSA claims for expenses incurred while you were still covered under the plan.

CALL OPTUM CUSTOMER SERVICE AT 1-800-243-5543 WITH QUESTIONS ONCE YOU ARE ENROLLED
Using your HSA
If you choose one of the two eligible HSA Plans, you should consider opening a Health Savings Account.

How it works

Step 1
Visit participating doctors, hospitals and other health care professionals.

Step 2
Pay for covered health care services and prescriptions until you meet your yearly deductible. Use your HSA if you’d like.

Step 3
Then, pay a copay or coinsurance at each visit. Again, you can use your HSA for these costs.

Step 4
Pay until you reach the out-of-pocket maximum. Now your health plan pays for covered services when you visit doctors, hospitals and pharmacies. You pay nothing.

Three easy ways to pay
Flexibility is built in, with three easy ways to pay:

Debit card.
Pay directly with a debit card linked to your HSA.

Online bill payment.
Pay for health care expenses on your computer, directly from your HSA.

Online withdrawal.
Transfer funds from your HSA to your personal bank account.

Check for qualified costs
Here are some costs the IRS lets you use your HSA to pay for:

• Contact lenses and LASIK surgery
• Copays and coinsurance
• Deductible payments
• Dental care and braces
• Hearing aids
• Prescription drugs
• Wheelchairs

Check Aetna Navigator for more information. There’s even a tool to help you organize medical expenses and HSA withdrawals online.

And visit the IRS website at www.irs.gov for a list of qualified health care costs.

HSA Contribution Limits
Individual $3,500
Family $7,000

HSA Catch Up Contribution
$1,000 Age 55 or Older

PAYFLEX®
Online tools, information, tips & programs
To get started, sign up for your Aetna Navigator password protected website. Just go to www.aetna.com. If you’re already a registered member, you’re a step ahead. Just log in.

Once you’ve logged in to Navigator, you can:
• Check your account balance
• Review plan information
• Print a summary of doctor visits, medical tests and other activities
• Print or order ID cards
• Review claims and more

Plus, Aetna Navigator lets you:
Understand the best contribution amount for your needs and project how your account can grow.

See what you’ll pay for certain types of care, based on your actual plan. You can compare estimated costs for up to 10 doctors or health care facilities at a time.

Compare in- and out-of-network cost estimates for office visits, surgeries, medical tests, treatments and more.

Look up costs for prescription drugs — even before you fill a prescription.

HSA Expense Manager
Available through the Navigator website, the HSA Expense Manager allows you to track your out-of-pocket health care expenses by type, dependent or event. Set up customized expense categories to track and manage your out-of-pocket spending according to your own personal preference.

My HSA Receipts
Available through the Navigator website, the HSA Receipt Manager allows you to attach receipts and important documents to your HSA transactions. Use this tool to organize your bills, receipts and paperwork.

Find ways to stay healthier with personalized health searches, online wellness programs and other support. Help is a phone call away, too. Call Member Services with questions. The number is on your Aetna ID card.

How do you make the most of these financial opportunities?
Our online HSA Savings Calculator can help. Find it on your Aetna Navigator® member website at www.aetna.com.
All health plans are different. Read the plan documents from your employer for specific details about your plan.

Make the most of your HSA

It's smart to research costs and quality, no matter what health plan you have. But it's even more important with an HSA. After all, it's your money.

Here's where we can make a big difference. When you choose Aetna, you get access to our many tools and resources. They're at your service 24/7, throughout the plan year, to:

- Pick the right health plan
- Make confident decisions
- Take care of your health
- Get help when you need it

Contribute anytime

You, your employer, and your spouse and family members can contribute anytime, up to a yearly maximum.

The more you contribute, the bigger your account can grow.

And there are convenient ways to contribute. Write a check. Set up an electronic funds transfer from your bank account. Use a payroll deduction if that's available. Do what works best for you.

Avoid surprises

Know how much you have.

You can only use the money that's in your HSA at the time you want to make a payment. Make sure to keep track of how much is available in your HSA. Log in to Aetna Navigator at www.aetna.com and check your account balances.

Know what your health plan covers?

For example:

- Do you need a primary care physician, also known as a PCP?
- How much is your copay or coinsurance?
- Do you have in-network and out-of-network work costs?
- Is a referral needed?
- What about approval for some services?

Know before you go.

Visit www.aetna.com to:

- Find doctors in the Aetna network through our online DocFind® directory
- See what doctors and hospitals will charge you for some common services — before you walk out the front door
# Dental Benefit Comparison

<table>
<thead>
<tr>
<th>Delta Dental PPO™ plus Premier</th>
<th>Low Plan</th>
<th>Medium Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If a Delta Dental, PPO™, Delta Dental Premier® or Non-Network Dentist is Used</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Calendar Year</strong></td>
<td><strong>Per Person Deductible</strong></td>
<td><strong>$50</strong></td>
<td><strong>$50</strong></td>
</tr>
<tr>
<td><strong>Family Aggregate Maximum Deductible</strong></td>
<td><strong>$150</strong></td>
<td><strong>$150</strong></td>
<td><strong>$150</strong></td>
</tr>
<tr>
<td><strong>Calendar Year Maximum (Per Person)</strong></td>
<td><strong>$1,000</strong></td>
<td><strong>$1,200</strong></td>
<td><strong>$1,500</strong></td>
</tr>
<tr>
<td><strong>Plan Pays:</strong></td>
<td><strong>Plan Pays:</strong></td>
<td><strong>Plan Pays:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive &amp; Diagnostic (No Deductible)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exams, Cleanings (2 per calendar year)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Bitewing X-Rays, Fluoride Treatment (1 per calendar year)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Full Mouth X-Rays (1 per yr)</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Remaining Basic (After Deductible)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants (to age 14)</td>
<td>50%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Fillings, Extractions, Root Canals (Endodontics)</td>
<td>50%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Oral Surgery, Space Maintainers, Repair of Dentures</td>
<td>50%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Crowns &amp; Prosthodontics (After Deductible)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crowns &amp; Gold Restorations</td>
<td>N/C</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Bridgework, Full &amp; Partial Dentures</td>
<td>N/C</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Periodontal</td>
<td>N/C</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Orthodontia (Dependent Children to age 19)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coinsurance</td>
<td>N/C</td>
<td>N/C</td>
<td>50%</td>
</tr>
<tr>
<td>Lifetime Maximum</td>
<td>N/C</td>
<td>N/C</td>
<td><strong>$1,500</strong></td>
</tr>
<tr>
<td><strong>Dependent children are covered to age 26.</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Delta Dental has two networks available under this plan. The Delta Dental Premier® network is the largest of the Delta Dental networks with over 339,000 participating dentist offices nationally (80%+). Delta Dental PPO™ is a smaller, but more discounted network with over 269,000 participating dentist offices nationwide. Delta Dental’s network discounts average 25% to 35% less.

You may use any fully licensed dentist under this plan, but it is to your advantage to use a network dentist, especially PPO, since they accept the Delta Dental allowance as their maximum charge and cannot bill Delta Dental patients for amounts above this level. Delta Dental PPO™ dentists offer the lowest fees of our networks.

Participating dentists will be paid directly by Delta Dental for covered services. Non-participating dentists will bill you directly, and Delta Dental may make claim payment directly to you. You will maximize benefits and reduce paperwork by using a Delta Dental participating dentist.

If you do not have a dentist, you may obtain a current listing of participating dentists in any area, by calling 1-800 DELTA OK (1-800-335-8265). Provide your zip code to the representative and a directory for that area will be mailed to your home. If you have Internet access, you may also visit our website at deltadentalnj.com to locate participating dentists.

At the time of your first appointment, tell the dentist that you are covered under this program and provide your group number and ID number. Your dependents, if covered, should provide the employee’s ID number.

Claim questions and other information needs should be directed to Delta Dental’s customer service department at 1-800-452-9310.

This overview contains a general description of your dental care program for your use as a convenient reference. Complete details of your program appear in the group contract between your plan sponsor and Delta Dental of New Jersey, Inc., which governs the benefits and operation of your program. In CT, Delta Dental of Connecticut writes dental coverage on an insured basis and Delta Dental of New Jersey administers self-funded dental benefit programs. The group contract would control if there should be any inconsistency or difference between its provisions and the information in this overview. 9/17/18
Vision Benefits
Eye exams, eyewear and more Aetna Vision℠ Preferred

Smarter is having a vision plan that saves you money.

Savings for routine eye exams, contact lenses and eyeglasses, including designer frames:

<table>
<thead>
<tr>
<th></th>
<th>Retail price</th>
<th>Out-of-pocket cost with Aetna Vision Preferred</th>
<th>Your savings with Aetna Vision Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>$114.00</td>
<td>$0</td>
<td>$94.00</td>
</tr>
<tr>
<td>Frames</td>
<td>$124.41</td>
<td>$0</td>
<td>$124.41</td>
</tr>
<tr>
<td>Lenses</td>
<td>$83.00</td>
<td>$20.00</td>
<td>$63.00</td>
</tr>
<tr>
<td>Total</td>
<td>$321.41</td>
<td>$20.00</td>
<td>$281.41</td>
</tr>
</tbody>
</table>

It’s easy to use
After you sign up, you’ll get a welcome packet. It includes:
• Your member ID card
• Basic plan information
• A list of vision offices and retailers near you

See your way to better health
Your vision insurance plan isn’t just for your eyes. It’s for your overall health, too. That’s because routine eye exams can reveal diseases like glaucoma and other serious health conditions like cardiovascular disease and diabetes.

Go practically anywhere for eye care
Choose from more than 55,000+ vision offices and retailers including these popular chains:
• JCPenney Optical
• LensCrafters®
• Pearle Vision®
• Sears® Optical
• Target Optical®
<table>
<thead>
<tr>
<th>Exam</th>
<th>In Network</th>
<th>Out of Network*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use your Exam coverage once every calendar year.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine/Comprehensive Eye Exam</td>
<td>$0 Copay</td>
<td>$45 Reimbursement</td>
</tr>
<tr>
<td>Standard Contact Lens Fit/Follow up</td>
<td>Member pays discounted fee of $40</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Premium Contact Lens Fit/Follow Up</td>
<td>Member pays 90% of retail</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Eyeglass Lenses /Lens options</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use your Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision lenses</td>
<td>$20 Copay</td>
<td>$35 Reimbursement</td>
</tr>
<tr>
<td>Bifocal Vision lenses</td>
<td>$20 Copay</td>
<td>$55 Reimbursement</td>
</tr>
<tr>
<td>Trifocal Vision lenses</td>
<td>$20 Copay</td>
<td>$65 Reimbursement</td>
</tr>
<tr>
<td>Lenticular Vision lenses</td>
<td>$20 Copay</td>
<td>$80 Reimbursement</td>
</tr>
<tr>
<td>Standard Progressive Vision lenses</td>
<td>$85 Copay</td>
<td>$55 Reimbursement</td>
</tr>
<tr>
<td>Premium Progressive Vision lenses1</td>
<td>20% Discount off retail minus $120 plan allowance plus $85. Copay = member out of pocket*</td>
<td>$55 Reimbursement</td>
</tr>
<tr>
<td>UV Treatment</td>
<td>Member pays discounted fee of $15</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Tint (Solid and Gradient)</td>
<td>$0 Copay</td>
<td>$5 Reimbursement</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>Member pays discounted fee of $15</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Standard Polycarbonate lenses - Adult</td>
<td>Member pays discounted fee of $40</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Standard Polycarbonate Lenses - Children to age 19</td>
<td>$0 Copay</td>
<td>$5 Reimbursement</td>
</tr>
<tr>
<td>Standard Anti Reflective Coating</td>
<td>Member pays discounted fee of $45</td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Contact Lenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use your Contact Lens coverage once every calendar year to purchase either 1 pair of eyeglass lenses OR 1 order of contact lenses.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional contact lenses</td>
<td>$130 Allowance** Additional 15% off balance over the allowance</td>
<td>$105 Reimbursement</td>
</tr>
<tr>
<td>Disposable contact lenses</td>
<td>$130 Allowance</td>
<td>$105 Reimbursement</td>
</tr>
<tr>
<td>Medically necessary contact lenses</td>
<td>$0 Copay</td>
<td>$200 Reimbursement</td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Use your Frame coverage once every 2 calendar years.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Any Frame available, including frames for prescription sunglasses</td>
<td>$130 Allowance Additional 20% off balance over the Allowance.</td>
<td>$70 Reimbursement</td>
</tr>
<tr>
<td><strong>Discounts</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional pairs of eyeglasses or prescription sunglasses. Discount applies to purchases made after the plan allowances** have been exhausted.</td>
<td>Up to a 40% Discount</td>
<td>No Discount</td>
</tr>
<tr>
<td>Non-covered items such as cleaning cloths and contact lens solution</td>
<td>20% Discount</td>
<td>No Discount</td>
</tr>
<tr>
<td>Lasik Laser vision correction or PRK from U.S. Laser Network* only. Call 1-800-422-6600</td>
<td>15% discount off retail or 5% discount off the promotional</td>
<td>No Discount</td>
</tr>
<tr>
<td>Retinal Imaging*</td>
<td>Member pays a discounted fee up to $39</td>
<td>No Discount</td>
</tr>
<tr>
<td>Replacement contact lenses</td>
<td>Receive significant savings after your lens benefit has been exhausted on replacement contacts by ordering online. Visit <a href="http://www.aetnavision.com">www.aetnavision.com</a> for details</td>
<td>No Discount</td>
</tr>
</tbody>
</table>

**Partial list of exclusions and limitations**

Vision insurance plans contain exclusions and limitations. Not all vision services are covered. See your plan booklet for details.

*You can choose to receive care outside the network. Simply pay for the services up front and then submit a claim form to receive an amount up to the out of network reimbursement amounts listed above. Reimbursement will not exceed the providers actual charge. Claim forms can be found at www.aetnavision.com or by calling customer service Mon-Sun @877-9-SEE-AETNA. Submit completed claim form with receipts to Aetna, PO Box 8504 Mason, OH 45040-7111.

**Allowances are one time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

1 Premium progresses and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information.

2 Non covered discounts may not be available in all states.

3 Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

4 Retinal Imaging available at participating locations. Contact your eyecare provider to verify if available.
Group Life & Disability Insurance

Life & Disability Plans

**Group Life Insurance**

**Company Paid Benefit**
Your death benefit is equal to one times your annual salary up to a $50,000 maximum.

**Voluntary Buy-Up Benefit**

**Employees:** May purchase between one and five times your annual salary up to a $500,000 maximum ($375,000 Guaranteed Issue). Employees currently enrolled in Voluntary Life can increase 1 times their annual salary without having to complete an Evidence of Insurability (EOI) form. Any amounts over 1 times salary per year or over the $375,000 Guaranteed Issue amount will require EOI.

**Spouses:** May purchase up to 50% of Employee’s Basic and Voluntary Life Insurance amount combined in $5,000 increments up to $250,000 maximum ($50,000 Guaranteed Issue).

**Children:** May purchase a flat $10,000 through age 26 ($1,000 benefit from birth to 14 days).

**Guaranteed issue is available for newly eligible enrollees. All others will need to complete Evidence of Insurability.**

**Group Short Term Disability**

**Company Paid Benefit**
The short term disability benefit is payable after an eight day waiting period. The benefit amount is up to $200/week with the benefit payable for 26 weeks.

**Voluntary Buy-Up Benefit**
You may purchase up to 70% of your salary up to additional $800/week with the benefit payable for 26 weeks.

* Employees employed by a New Jersey employer are covered under the New Jersey state temporary disability benefits plan.

* Employees working in Rhode Island are covered under the Rhode Island temporary disability benefits plan.

**Guaranteed issue is available for newly eligible enrollees. All others will need to complete Evidence of Insurability.**

**Group Long Term Disability**

**Voluntary Buy-Up Benefit**
You may purchase a benefit amount of 60% of your salary up to $10,000/month maximum. The disability waiting period is 180 days and the benefit is payable through your Social Security Normal Retirement Age.

**Guaranteed issue is available for newly eligible enrollees. All others will need to complete Evidence of Insurability.**
Voluntary Employee Paid Plans
Colonial Life Benefits

To learn more about these voluntary employee paid plans and their cost, please visit our online enrollment system by following the instructions provided in this guide.

Group Non-Occupational Accident Insurance
Colonial Life’s Group Accident Insurance helps you fill some of the gaps caused by increasing deductibles, co-payments and out-of-pocket costs related to an accidental injury. With this coverage you may not need to use your savings or secure a loan to help pay those unexpected out-of-pocket expenses associated with a covered accident. Plan pays $50 annual wellness benefit per covered person.

Group Medical BridgeSM – Plan 1
Colonial Life’s Group Hospital Confinement Indemnity plan, Group Medical Bridge, provides you with additional out-of-pocket protection for services including hospital confinement. Providing benefits for these types of services helps you offset the larger financial exposures of your health insurance plan including deductibles and co-insurance. Plan Pays $50 annual wellness benefit per covered person.

Cancer Insurance
The risk of developing cancer, unfortunately, is very real. In the U.S., men have a 1 in 2 lifetime risk of developing cancer, and for women the risk is 1 in 3. As serious as the threat of cancer may be, new and improved medical treatments are being introduced, and studies are showing that regular screening tests can detect some cancers in the early stages.

Colonial Life will pay benefits if certain routine cancer screening tests are performed or if cancer is diagnosed after the waiting period and while your policy is in force. Plan Pays annual wellness benefit of $75 or $100 depending on the level of coverage.

Critical Illness - Help Employees with Serious Illness Expenses
Would your employees have the money to protect all they’ve worked for if they were to have a critical illness, such as a heart attack or stroke? While these illnesses can be sudden and unexpected, you can help your employees be financially prepared to cope with the costs associated with a serious illness.

Our critical illness insurance complements your major medical coverage offering by providing a lump-sum benefit that can be used to pay for the direct and indirect costs related to a covered critical illness, such as: Heart attack (myocardial infarction), End stage renal failure, Coronary artery bypass surgery, and Stroke. Plan pays $50 annual wellness benefit per covered person on the plan.

Colonial Customer Service Phone
1-800-607-7949
Did you know?
All the benefits and convenience you enjoy from CCA@YourService are available to your family and those you care about. This includes a significant other, children, parents, siblings, grandparents, aunts, uncles, cousins, roommates — anyone who has an impact on your life.

Can everyone I care about use the service, too? Yes

All have access to free consultation, resources and referrals related to:
- Family and caregiving
- Everyday living
- Legal and financial
- Personal health
- Emotional health
- Work-related issues

*All this and more is always @YourService.*

**TOLL-FREE:**
800-833-8707

**WEBSITE:**
www.myccaonline.com

**COMPANY CODE:**
NATIONAL HEALTHCARE

cca@yourservice
National Health Care Associates, Inc. and Affiliates partners with Liberty Mutual to help you save $782 or more a year on auto and home insurance.¹ Enjoy the benefits of being part of a community.

You could save up to $782 a year, and you’ll have access to all the advantages of being a Liberty Mutual customer:

**24-Hour Claims Assistance**
Online or by phone

**Accident Forgiveness²**
No premium increase due to an initial accident

**Better Car Replacement™³**
If your car is totaled, we’ll give you the money for a model that is one year newer.

**24-Hour Roadside Assistance⁴**
Real help when you need it

---

¹ Average combined savings based on countrywide survey of new customers from 8/1/16 to 8/1/17 who reported savings from prior insurers’ premiums when they switched to Liberty Mutual. Savings comparison does not apply in MA. Coverages underwritten by Liberty Mutual Insurance. Equal Housing Insurer.
Right to Continue Medical Coverage

About Your Right to Continue Medical Coverage

What is continuation coverage?
Federal law requires that most group health plans, including Medical Flexible Spending Accounts (Medical Expense FSAs), give employees and their families the opportunity to continue their health care coverage when there is a “qualifying event” that would result in a loss of coverage under an employer’s plan.

“Qualified beneficiaries” can include the employee covered under the group health plan, a covered employee’s spouse and dependent children of the covered employee. Each qualified beneficiary who elects continuation coverage will have the same rights under the plan as other participants or beneficiaries covered under the plan, including special enrollment rights. Specific information describing continuation coverage can be found in the summary plan description (SPD), which can be obtained from your employer.

How long will continuation coverage last?
For Group Health Plans (Except Medical Expense FSAs)
In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months. Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

For Medical Expense FSAs
If you fund your Medical Expense FSA entirely, you may continue your Medical Expense FSA (on a post-tax basis) only for the remainder of the plan year, in which your qualifying event occurs, if you have not already received, as reimbursement, the maximum benefit available under the Medical Expense FSA for the year. For example, if you elected a Medical Expense FSA benefit of $1,000 for the plan year and have received only $200 in reimbursement, you may continue your Medical Expense FSA for the remainder of the plan year or until such time that you receive the maximum Medical Expense FSA benefit of $1,000. If your employer funds all or any portion of your Medical Expense FSA, you may be eligible to continue your Medical Expense FSA beyond the plan year in which your qualifying event occurs and you may have open enrollment rights at the next open enrollment period.

How can you extend the length of continuation coverage?
For Group Health Plans (Except Medical Expense FSAs)
If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify your employer of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability
An 11-month extension of coverage may be available if any of the qualified beneficiaries are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify your employer of that fact within 60 days of the SSA’s determination and before the end of the first 18 months of continuation coverage. All qualified beneficiaries who have elected continuation coverage and qualify will be entitled to the 11-month disability extension. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify your employer of that fact within 30 days of SSA’s determination.

Second Qualifying Event
An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage, resulting in a maximum amount of continuation coverage of 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee or a dependent child’s ceasing to be eligible for coverage as a dependent under the Plan. You must notify your employer within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?
Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee’s spouse, or only one of them, may elect continuation coverage. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the COBRA Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. You should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap.

Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you.

Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse’s employer) within 30 days after your group health coverage ends because
of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available.

**How much does continuation coverage cost?**
Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. This amount may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). For Medical Expense FSAs, the cost for continuation of coverage is a monthly amount calculated and based on the amount you were paying via pre-tax salary reductions before the qualifying event.

**When and how must payments for continuation coverage be made?**

**First Payment for Continuation Coverage**
If you elect continuation coverage, you do not have to send any payment for continuation coverage with the COBRA Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact your employer to confirm the correct amount of your first payment. Instructions for sending your first payment for continuation coverage will be shown on your COBRA Election Notice/Form.

**Periodic Payments for Continuation Coverage**
After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of each month. Instructions for sending your periodic payments for continuation coverage will be shown on your COBRA Election Notice/Form.

**Grace Periods for Periodic Payments**
Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. If you pay periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

**Can you elect other health coverage besides continuation coverage?**
If you are retiring, you may have the right to elect alternative retiree group health coverage instead of the COBRA continuation coverage described in this Notice. If you elect this alternative coverage, you will lose all rights to the COBRA continuation coverage described in the COBRA Notice. You should also note that if you enroll in the alternative group health coverage, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your alternative group health coverage ends.

You must contact your employer if you wish to elect alternative coverage. If your group health plan offers conversion privileges, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy might not be identical to those provided under the Plan. You may exercise this right in lieu of electing COBRA continuation coverage, or you may exercise this right after you have received the maximum COBRA continuation coverage available to you.

You should note that if you enroll in an individual conversion policy, you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.