Benefits Frequently Asked Questions

Aeries Software

What's Inside

Welcome to your Benefits Frequently Asked Questions (FAQs). Click on a section in the Table of Contents to go directly to it.

Contents

Open Enrollment

Employee Navigator

Q. When does Open Enrollment take place?

A. Open enrollment takes place in the Fall every year. Aeries will communicate with you when Open Enrollment begins and ends as we come up to the dates.

Q. What type of changes can I make during Open Enrollment?

A. You can add or remove eligible dependents; elect new coverage; and waive current coverage; and re-enroll in your Health Savings Accounts.

Q. How do I enroll or make changes to my benefits after Open Enrollment?

A. Outside of Open Enrollment you can only make coverage changes if you experience a Qualified Life Event. However, for some plans you may be able to change elective deferral percentages. Please refer to your Benefit Guide for more information.

Q. If I do not want to enroll in benefits, do I still need to complete Open Enrollment?

A. Yes, if you do not want to enroll in any benefits, please waive coverage through Employee Navigator during Open Enrollment.

Q. What happens if I do not need to make any changes during Open Enrollment?

A. For this year's open enrollment, you are required to elect your benefits in Employee Navigator. In addition, *you must re-enroll in the HSA plan each year.* Lastly, the cost of your benefit elections may have changed, so it is recommended that you review your elections, even if you don't make changes.

Q. Whom do I contact for assistance during Open Enrollment, or if I have benefits questions?

A. You can email Nica Tahsequah at nicat@aeries.com or call her at (714) 575-3685.

Medical Plan

Cigna

Q. How do I get my medical ID card?

A. You can view, print/download, and request physical ID cards be mailed to you through your portal on myCigna.com. ID cards will not be automatically mailed. You can order ID cards for your dependents, also. It will take up to 2 weeks for the cards to arrive at your address on file.

Q. Will my medical services be covered if my doctor is listed in Cigna's health care professionals directory?

A. Even when a doctor is listed in the directory, it doesn't guarantee that the services provided by that doctor are covered under your specific medical plan. Check your plan documents, which describe your particular plan coverage, or call Cigna Customer Service using the number listed on the back of your ID card for information about the services covered under your plan.

Q. How do I find a doctor who is in Cigna's health care professional network?

A. The best way to find in-network doctors while searching the directory is to log in to your myCigna account, so the search is done with your plan settings. On myCigna you can also view information on preventive care and other health topics, and learn more about your plan's coverage and your health and wellness programs.

Q. How do I know what doctors and services my health plan covers?

A. You can see details of your coverage and the types of services covered simply by logging in to your myCigna account. Your coverage details show whether you have prescription drug coverage, coverage for mental health and substance abuse, and/or vision care coverage as a part of your health plan. Read your Summary of Benefits and other plan documents. If there are any differences between these and what you see on myCigna, your Summary of Benefits is correct.

Q. What is PCP?

A. PCP stands for Primary Care Physician. Your PCP will be your source for basic care, advice and direction. Your PCP will also coordinate your total care - from preventive checkups and routine medical care to specialized care and hospitalizations.

Q. Do I have to get a referral from my PCP to see a specialist?

A. No, none of your current plans require you to select a PCP. When choosing a specialist, please take care to choose one from your plan's network. You will save money on that care when visiting a contracted provider.

Q. Do I need a referral to see my OB/GYN? (Obstetrician/Gynecologist)

A. You do not need a referral to see your OB/GYN for an annual preventive care exam, often called a Well Woman exam. Also, if your OB/GYN identifies a medical condition during a Well Woman exam, your OB/GYN can continue to treat you for that condition.

Q. How do I find a physical therapist or a health care professional who's not a doctor?

A. You can search for people by specialty ("physical therapy") or proper name using the search boxes or you can browse the directory using the "Find a Person" selections. To find a Physical Therapist, or another health care professional that is not a doctor, dentist, eye doctor, or mental health professional you can:

- Go to "Find a Person"
- Click the link for "Other Health Care Professionals"
- Navigate through the "Other Health Care Professionals" list (it's arranged in A-Z order) to "Physical Therapist"
- Click the link to view results for physical therapists near your search location

Q. How do I contact Cigna to ask a question?

A. You can get consistent, relevant, and timely information about your plan any time that's convenient for you by:

- Logging in to your myCigna account from cigna.com to find contact information
- Calling us on the phone and talking to a Customer Service representative
- Talking to us through our automated telephone system

For more information, please call Cigna Customer Service at the toll-free number on your Cigna ID card.

Q. What is a Deductible?

A. A deductible is the amount you pay before your health insurance benefits kick in.

Q. What is a Copay?

A. A copay is flat fee you pay toward the cost of covered medical services and prescriptions under your medical plan.

Q. What is Coinsurance?

A. Coinsurance is the amount or percentage you pay for certain covered health care services under your health plan. This is the amount paid after your deductible is met.

Q. What is an Out-of-Pocket Maximum?

A. The highest out-of-pocket dollar amount paid for covered services during a benefit period.

Q. What does In-Network mean?

A. Health care services received from your primary care physician or from a specialist within a contracted list of health care practitioners, determined by Cigna.

Q. What does Out-of-Network mean?

A. Health care or services received by non-contracted providers. Out-of-network health care and plan payments are subject to coinsurance, deductibles, and copays. There are

often higher deductibles and out-of-pocket maximum costs if you choose to go out of network.

Cigna Customer Support Contacts:

Customer Support for claims, medical, and pharmacy questions: (866) 494-2111

Mental Health/Substance Use Coverage: (800) 433-5768

Health Information Line: (855) 673-3063

Coverage While Traveling Internationally: (866) 763-8442

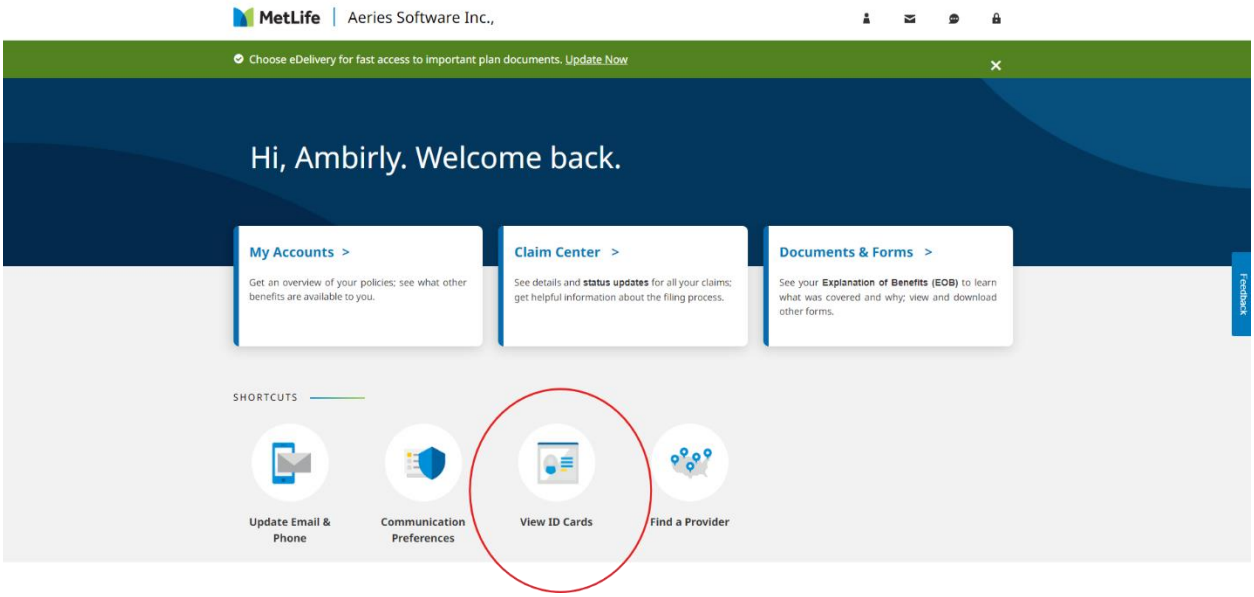
* If employees need immediate support, they can use the live chat (the quickest option) for immediate assistance. If employees have non-urgent questions, they can Email customer support directly through the website. These communication methods can be found on the "Contact Us" page.

Vision Plan

MetLife – VSP Network

Q. How do I get my vision ID card?

A. Employees can view their ID cards for both dental and vision coverage on the MetLife portal. You **do not** need to present an ID card to confirm that you are eligible for benefits. ID cards are provided for subscribers online only. Separate cards are not provided for each covered dependent.



Q. How do I use my vision benefits?

- Visit Find a Vision Provider to find an in-network eye care provider who is right for you.
- Review your plan coverage before your appointment.
- At your appointment, tell them you have the MetLife Vision plan. No ID card is necessary.

MetLife will handle the rest – there are no claim forms to complete when you see an in-network provider.

If you visit an out-of-network provider, you will need to pay the provider the full amount for any services and materials you receive. Then you will submit a claim form to MetLife to be reimbursed according to your plan. You may find the claim form online at MyBenefits.com or obtain a copy by calling the Customer Service Call Center phone number listed below.

You can submit the claim form online and upload copies of your receipts. Claim forms are available on the MyBenefits site or call Customer Service at 1-800-988-8333.

Q. Do I have to choose from a select set of eyewear, or can I choose any eyewear and apply my benefits?

A. You can choose the eyewear that is right for you and your budget. All in-network private practice and retail locations offer a broad range of eyewear options. From classic styles to the latest designer frames, you will find hundreds of options for you and your family.

Q. Are contact lenses covered under this plan?

A. Yes. Contact lenses and glasses are allowed once every 12 months.

Q. Can I order contact lenses through the mail?

A. Yes, you can purchase contact lenses via mail. Contact lenses purchased via mail will be considered an out-of-network expense. MetLife will reimburse you once you submit your claim and receipts.

Q. Can my dependents visit different providers than the provider(s) I visit?

Yes. You and your dependents each have the freedom to choose any provider.

MetLife Vision – VSP Choice Network Customer Support Contacts:

Customer Service Phone Number: (800)-438-6388

Monday-Friday, 08:00 AM to 11:00 PM EST

Saturday, 09:00 AM to 08:00 PM EST

*If employees have non-urgent questions, they can Email customer support directly through the website. These communication methods can be found on the "Contact Us" page.

Dental Plan

MetLife

Q. How do I get my dental ID card?

A. Employees can view their ID cards for both dental and vision coverage on the MetLife portal. You **do not** need to present an ID card to confirm that you are eligible for benefits. ID cards are provided for subscribers online only. Separate cards are not provided for each covered dependent.

Q. How do I find a dental provider?

A. Visit MetLife's How to Find a Dentist webpage and enter in your plan and zip code to populate in network dentists in your area.

Q. Is orthodontia work provided under the Dental PPO plan?

A. No

Q. What services are covered under my plan?

A. Preventive care such as exams, cleanings and x-rays are fully covered. Basic services like fillings and extractions are also provided under the Dental PPO plan.

Q. Do my dependents have to visit the same dentist that I select?

A. No. You and your dependents each have the freedom to choose any dentist, in or out-of-network, at any time. However, if you choose an out-of-network dentist, your out-of-pocket expenses may be higher.

Dental PPO Plan Customer Support Contacts:

Customer Service Phone Number: (800) 348-6388

Monday-Friday, 08:00 AM to 11:00 PM EST

Life, AD&D, Short-Term and Long-Term Disability, Accident, Critical Illness, Hospital Insurance

UNUM

Q. How do I access my UNUM benefits?

A. Visit the UNUM portal to create an account and view your benefits information.

Q. Do I need a member ID to submit claims and leaves?

A. Employees do not need a member ID to submit claims & leaves. They can start a claim or leave on the UNUM portal.

Q. How do I file a claim or leave of absence?

A. After contacting Human Resources, you can register online through our secure website, MyUnum for Members. After you've registered, you can file and manage all your claims there or on your mobile device. Here some easy tips to start your claim.

When filing a claim or leave, you may be asked for: Your name and address, your employer's information, your job title and your regularly scheduled work hours. For a leave request, you may need to tell us about your absences from work and expected return-to-work date.

Q. What's the difference between FMLA, ADA and WC?

Family and Medical Leave Act — This law, and it's associated regulations, entitle eligible employees of covered employers to take unpaid, job-protected leave for specified family and medical reasons. The employee must be restored to employment and be provided with continuation of group health insurance coverage under the same terms and conditions as if the employee had not taken leave.

Americans with Disabilities Act — This law prohibits employers from discriminating against qualified individuals with disabilities. This includes providing disabled employees

with reasonable accommodations if it does not impose an "undue hardship" on the operation of the employer's business. Reasonable accommodations are adjustments or modifications to a position or workplace that will enable an employee to do his or her job despite having a disability. Leave can be considered a reasonable accommodation if it enables an employee to recover and return to work and as a result, needs to be evaluated if an employee is not eligible for, or has exhausted, FMLA.

Workers Compensation — WC is not a job protection statute, and instead provides financial benefits for employees who have been injured on the job. FMLA runs concurrently with WC if the employee is eligible and has time available under the FMLA.

Q. What are some acceptable reasons for an employee to take FMLA leave?

FMLA provides leave for a range of reasons related to employee and their family members. Those reasons are:

- Birth of a child
- Placement of a child for adoption or foster care
- To care for a spouse, child or parent with a *serious health condition*
- To care for one's own health during a *serious health condition*
- To care for a family member injured in the line of duty (military caregiver leave)
- Because of any qualifying exigency arising out of the fact that the employee's spouse, child, or parent is a military member on covered active duty

Q. Are there withholdings from my paycheck to pay for my short-term disability or long-term disability insurance?

A. Short-term disability is a voluntary benefit that requires employees to pay for that coverage. On the other hand, long-term disability is a company-paid benefit.

Q. What is the maximum duration of STD benefits?

A. Benefits under this plan are payable for up to 12 weeks. There is a 7-day elimination period at the start of your leave, meaning paid benefits start on the 8th day.

Q. What is the maximum duration of LTD benefits?

A. Benefits under this plan are payable for up to your Social Security Normal Retirement Age (SSNRA). Click here to determine your SSNRA.

Q. Are STD and LTD benefits taxable when received?

A. Since Aeries pays your LTD premium for you, your LTD benefit will be taxable when received. On the other hand, voluntary STD benefits will not be taxable since employees enrolled in that plan pay for the benefit on an after-tax basis.

Q. How does accident insurance work?

A. Accident insurance policies can provide you with a lump sum paid directly to you that will help pay for a wide range of situations, including initial care, surgery, transportation and lodging, and follow-up care. Here's how it works:

• A set amount is payable based on the injury you suffer and the treatment you receive.

• Benefits are payable directly to you (unless you specify otherwise) and can be used as you see fit.

• Coverage is available for you, your spouse and eligible dependent children.

• You do not need to answer medical questions or have a physical exam to get basic coverage.

• Accident insurance covers injuries that happen on the job or off the job — unlike workers' compensation, which only covers on-the-job injuries.

• Benefit payments are not reduced by any other insurance you may have with other companies.

Q. How will a critical illness claim get paid?

A. After purchasing Critical Illness insurance, if you suffer from one of the serious illnesses covered by your policy, you'll be paid in a lump sum. The payment will go directly to you instead of to a medical provider.

The payment you receive can be used for many things including:

- Child care costs
- Medical and living expenses
- Travel expenses for you and your family
- Lost wages from missed time at work

Q. How does hospital indemnity insurance work?

A. You pay monthly premiums for your Hospital Indemnity insurance plan. If you are admitted to the hospital for an injury or illness, your Hospital Indemnity plan makes cash payments to you. And with the payments going directly to you, you can use these emergency funds to pay for costs not covered by your Medical insurance, Medical insurance deductibles, copays and coinsurance, child care expenses while you are in the hospital or cost-of-living expenses as you recover.

Customer Support Contacts:

Policy Questions

Customer Service Phone Number: (866) 679-3054

Monday - Friday, 8 AM - 8 PM EST

Claims & Leaves

Leave, Short-Term & Long-Term Disability, Accident, Hospital, Critical Illness, ADA

Customer Service Phone Number: (800) 858-6843

Monday - Friday, 8 AM - 8 PM EST

Life Insurance Claims

Customer Service Phone Number: (800) 445-0402

Monday - Friday, 8 AM - 8 PM EST

Health Savings Account (HSA)

Optum

Q. How do I access my Optum HSA?

A. If you enrolled in the Cigna Low HDHPQ OAPIN medical plan, you can access your Health Savings Account funds in your Optum Bank account. Aeries will contribute funds into your account each pay period account and your pre-tax contributions from your paycheck will be placed into this account each pay period. You can access the available funds in your account for eligible healthcare expenses. You can view eligible HSA expenses and your account balance through the Optum Bank portal.

Q. What is a Health Savings Account (HSA)?

A. An employee-owned medical savings account used to pay for eligible medical, dental, and vision expenses. Funds contributed to the account are pre-tax and do not have to be used within a specified time period. HSAs must be coupled with qualified high-deductible health plans (HDHP).

Q. Can I contribute additional funds towards my HSA account?

A. Yes, you can elect any amount to be withheld on a per-pay-period basis up to the current IRS annual maximum. The IRS annual maximum is $4,150 for an individual with employee-only coverage, or $8,300 for a family.

Q. What are HSA qualified medical expenses?

A. You can find a list of qualified medical expenses from Optum here, or a more comprehensive list by visiting irs.gov and searching for Publication 502 or 969.

Q. How do I pay with my HSA?

A. To pay for qualified medical expenses, choose the option that's most convenient for you:

- Use your Optum Financial debit card.
- Use online bill pay.
- Pay out-of-pocket and then distribute funds from your HSA to reimburse yourself.

Q. How do I get another HSA debit card if I need one for my spouse or I lost it?

A. You can request a card for your spouse or report a card as lost or stolen. This can be found under "Payment Cards" on the Account/Plan Management tab.

Optum Bank Customer Care Contact:

(866) 234-8913

Monday through Friday, 8:00 am to 10:00 pm Eastern time

Saturday and Sunday, 9:00 am to 5:30 pm Eastern time

*If employees have non-urgent questions, they can Email customer support directly through the website. You can email support under the "Help & Tools" page under "Support."