This guide highlights the main features of many of the benefit plans sponsored by NSTAR Global Services. Full details of these plans are contained in the legal documents governing the plans. If there is any discrepancy between the plan documents and the information described here, the plan documents will govern. In all cases, the plan documents are the exclusive source for determining rights and benefits under the plans. Participation in the plans does not constitute an employment contract. NSTAR Global Services reserves the right to modify, amend or terminate any benefit plan or practice described in this guide. Nothing in this guide guarantees that any new plan provisions will continue in effect for any period of time. This guide serves as a summary of material modifications as required by the Employee Retirement Income Security Act of 1974 (ERISA), as amended.
BENEFITS OVERVIEW

OUR BENEFITS PROGRAM HAS YOU COVERED
Most days, we all count on our simple routines to get us through. Getting the kids to school, beating the traffic to work, and finishing dinner in time to enjoy a favorite hobby. But sometimes things don’t always go as planned. Like when your head cold turns into the flu and you have to be out of work. Or your son’s football game ends with a broken leg. Or even when your spouse learns he or she needs an extensive root canal. That’s when NSTAR’s benefits are there to help you.
Below is an overview of our benefits program, which gives you the coverage you need for all types of things life brings your way. NSTAR’s benefit plans allow you to choose the options that work best for your own needs — and your pocketbook. The key to getting the most from our benefits program is to take an active role in understanding and using the plans so that you are getting the best value for the money you spend.

### Benefits Provided at No Cost to You

<table>
<thead>
<tr>
<th>Benefits Provided at No Cost to You</th>
<th>Benefits You Pay For</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life and AD&amp;D Insurance</td>
<td>Medical and Prescription Drug</td>
</tr>
<tr>
<td>Long-Term Disability</td>
<td>Dental Plan</td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Vision Plan</td>
</tr>
<tr>
<td></td>
<td>Optional Life and AD&amp;D Insurance</td>
</tr>
<tr>
<td></td>
<td>Short-Term Disability</td>
</tr>
<tr>
<td></td>
<td>Flexible Spending Accounts</td>
</tr>
<tr>
<td></td>
<td>Health Savings Account</td>
</tr>
</tbody>
</table>

You are eligible to enroll in NSTAR’s benefit plans if you are a regular, full-time employee scheduled to work at least 30 hours per week. As a regular, full-time employee, you are eligible for benefits on the first day of the month following 30 days of continuous employment.

### DEPENDENT ELIGIBILITY

You may also cover your eligible dependents, including:

- Your legal spouse.
- Your eligible children up to age 26 for medical coverage; your unmarried, eligible children up to age 26 for dental and vision coverage.
- “Children” are defined as your natural children, stepchildren, legally-adopted children, and children for whom you are the court-appointed legal guardian.
- Physically or mentally disabled children of any age who are incapable of self-support. Proof of disability may be requested.

If your child becomes ineligible for coverage (i.e., turning age 26 under the medical plan), you must notify the Human Resources Department at 984-232-0648.
HOLMES MURPHY BENEFIT ADVOCACY SERVICES

As an employee of NSTAR Global Services, you have access to one of Holmes Murphy’s Benefits Analysts. This person is available to you and your dependents to help assist you in your benefits related questions. Simply call or email and your Benefits Analyst will be available to help you with your questions. If your Benefits Analyst doesn’t have an immediate answer, she will research it and get back to you in a timely manner without you waiting on hold. How easy is that?

Some of these questions may be:
• How do I order a new ID card?
• Is my doctor/dentist in the network or out of the network?
• What is my deductible and what on earth does “co-insurance” mean?
• I received a bill from my doctor. Was my claim paid correctly?
• What is an “EOB” and how do I read it?
• I just need to get my teeth cleaned. What is my co-pay?
• How often can I get new eye glasses/contacts?
• I paid for my prescription out of pocket. Where can I find a claim form?
• I can’t find my Benefit Enrollment Guide. Can I get a new one?

YOUR DEDICATED BENEFITS ANALYST

ALICIA VALDEZ
BENEFITS ANALYST
AVALDEZ@HOLMESMURPHY.COM
DIRECT: (214) 265-2299
FAX: (972) 889-7591
MONDAY-FRIDAY from 8 AM TO 5 PM CENTRAL TIME
WHEN COVERAGE BEGINS

INITIAL ENROLLMENT
When you first join NSTAR, you have 30 days to enroll yourself and your dependents for benefits. If you enroll on time, coverage begins the first of the month following 30 days of employment. If you do not enroll within 30 days of becoming eligible, you will automatically be enrolled in company-sponsored benefits, such as Basic Life and Accidental Death & Dismemberment (AD&D) Insurance, Long Term Disability, and the Employee Assistance Program (EAP), but you will have to wait until the next annual Open Enrollment to enroll for other benefits and make changes to coverage.

ANNUAL OPEN ENROLLMENT
For elections made during open enrollment, coverage takes effect on April 1, 2019.

MAKING CHANGES TO COVERAGE
Once you make your benefit elections, these choices remain in effect until the next annual Open Enrollment unless you have a qualified status change or you or your eligible dependents become eligible for coverage through special enrollment rules.
If you have a qualified status change or you have another allowable event, you can make certain changes during the plan year. However, you must make your enrollment change within 31 days of the event. Please notify Human Resource as soon as possible about your qualifying life event and they will provide instructions on how to make election changes. If you do not notify Human Resources and make election changes in 31 days you will have to wait until the next Open Enrollment to make new elections.

Qualified status changes include, but are not limited to:

- Change in number of eligible dependents due to birth, adoption, placement for adoption, or death
- Gain or loss of dependent status (i.e., your child reaches the age limit for eligibility)
- Change in legal marital status, including marriage, divorce, or death of a spouse
- Change in residence or workplace that changes your or your dependent’s eligibility for coverage
- Change in employment status, such as starting or ending employment, for you, your spouse, or your children
- End of the maximum period for COBRA coverage

For a more complete list of qualified status changes, refer to the Summary Plan Description.

**SPECIAL ENROLLMENT RULES**

If you choose not to enroll yourself or your dependents (including your spouse) because you have other coverage, you may be able to enroll yourself and your dependents at a later date if:

- You or your dependents lose Medicaid or Children’s Health Insurance Program (“CHIP”) coverage as a result of a loss of eligibility for such coverage, or
- If you or your dependents become eligible for a premium assistance subsidy under Medicaid or CHIP.

You must enroll within 60 days of the qualified events shown in the “Special Enrollment Rules” above.

If your dependent also had other health coverage and lost that coverage in the above situations, they may be added to your coverage. However, you will not be able to add yourself or your dependents to this coverage if the other coverage was terminated “for cause” (including failure to pay the required premiums on time).

In addition to the changes described previously, you may enroll yourself and your spouse (with or without the new dependent) in an NSTAR’s health plan following marriage or adoption, placement for adoption, or birth of a child, as long as you request enrollment within 31 days of the event. You must be enrolled to cover your dependents. If you have a special enrollment event and want to enroll for health coverage, call Human Resources at 984-232-0648.
CHOOSING A MEDICAL PLAN

NSTAR’s medical options all provide coverage for the same types of expenses, such as doctor’s office visits, preventive care, prescription drugs, and hospitalization. You choose the option that makes the most sense for you and your family based on your needs and what you want to pay for coverage.

When it comes to medical coverage, NSTAR offers you these choices:
- PPO Plan
- High Deductible Health Plan (HDHP)

Preferred Provider Organizations (PPO)
The PPO plans offer in-network and out-of-network benefits. When you need care, you decide whether to go to an in-network or an out-of-network provider. If you receive care from in-network doctors and facilities, your out-of-pocket costs will be lower than if you use out-of-network providers and facilities because network providers discount their fees. And, with in-network providers, you generally do not have to file claims.

All of the providers in the Cigna network change frequently. To find out if your doctor participates in the network, go to www.cigna.com and click on Find a Doctor.

If you choose to receive care from an out-of-network provider, the medical plan pays a lower benefit and you must file a claim to receive reimbursement for covered expenses.
**High Deductible Health Plan**
The High Deductible Health Plan (HDHP) works much like the PPO plan in that you can choose to receive care from in-network or out-of-network providers when you need medical care — and it covers the same types of services — but you pay less out of your paycheck for coverage. However, the HDHP has higher deductibles and no office visit copays. Once you’ve met the in-network or out-of-network deductible, you and the plan begin sharing expenses. Your portion of the expense is the coinsurance. **This also applies to prescription drugs, which are subject to the plan’s deductibles. Once the deductible is met, you pay the applicable prescription drug cost or copay amount.**

In addition, the HDHP offers a tax-savings feature called the Health Savings Account (HSA). With this account, you can pay for certain out-of-pocket medical expenses throughout the year. You can also enroll in the Limited Purpose Flexible Spending Account (FSA) to help you cover eligible out-of-pocket dental and vision expenses.

**What’s a Health Savings Account?**
A Health Savings Account (HSA) is a tax-free account that earns interest. You can set up an HSA through a bank or through Cigna/HSA Bank, our HSA vendor, and make contributions to your account from your paychecks throughout the year. Then, you can use the HSA to pay for eligible health care expenses, such as deductibles, coinsurance, and other out-of-pocket dental, vision, and prescription drug expenses not covered by a health plan. Your account balance can carry over from year to year, and you can take it with you if you leave the company.

**NSTAR’s Contributions**
When you enroll in the HDHP and set up an HSA, NSTAR will also contribute to the account for you. NSTAR contributions are distributed throughout all pay periods. If you enroll in the HDHP mid-year, the amount NSTAR contributes will be prorated.

Here’s a look at what you and NSTAR together can contribute to your HSA each year:

<table>
<thead>
<tr>
<th>Coverage Level</th>
<th>Annual NSTAR Contribution</th>
<th>Bi-Weekly NSTAR Contributions</th>
<th>Total HSA Contribution Allowed Per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$250</td>
<td>$9.62</td>
<td>$3,500</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$500</td>
<td>$19.23</td>
<td>$7,000</td>
</tr>
</tbody>
</table>
**How to Setup an HSA**
After you enroll in the HDHP, you will be auto enrolled in the HSA with Cigna/HSA Bank, our preferred HSA partner. If Cigna/HSA Bank does not have all or the correct federally required information to open an account, you will receive a letter in the mail with instructions on how to complete the enrollment. You must have an HSA account open in order to receive the NSTAR HSA contributions.

**How to Use the HSA to Pay for Care**
Once you've set up your HSA, you will receive a debit card specifically for your account. Then, when you have an eligible expense, you have several choices for how to pay:

1. **Pay with your HSA debit card** if you have funds available in your account.
2. **Write a check from your HSA.** You must order checks when you enroll in the HSA to have this option. And, as with any other type of check, you must have funds available or the check will be returned — and you will be charged an insufficient funds fee.
3. **Pay for expenses out of your own pocket,** and then reimburse yourself from your HSA.

**WHO IS ELIGIBLE FOR THE HSA?**
You can participate in the HSA only if you enroll in the HDHP. You are not eligible to contribute if:
- You are enrolled in Medicare.
- You are covered by another medical plan (such as your spouse’s plan) that does not qualify as a high deductible health plan.
- You or your spouse participates in a Health Care Flexible Spending Account (FSA) at NSTAR or at your spouse’s employer.

Note: Even if you do not contribute to the HSA, you cannot contribute to NSTAR’s Health Care FSA if you are enrolled in the HDHP.
# MEDICAL PLAN COMPARISON

<table>
<thead>
<tr>
<th></th>
<th>PPO Plan</th>
<th>HDHP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td><strong>Annual Calendar Year Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>Annual Out-of-Pocket Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$3,000</td>
<td>$4,000</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$8,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>You Pay</strong></th>
<th><strong>You Pay</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coinsurance/Copays</strong></td>
<td></td>
</tr>
<tr>
<td>Preventive Care</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$20 copay</td>
</tr>
<tr>
<td>Specialist</td>
<td>$40 copay</td>
</tr>
<tr>
<td>Diagnostics, X-Ray, and Lab Services</td>
<td>$0</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>$50 copay</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$0 after $150 copay</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>80% after deductible</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>80% after deductible</td>
</tr>
</tbody>
</table>
PRESCRIPTION DRUG COVERAGE

If you enroll in one of the NSTAR’s medical plans, you will automatically receive prescription drug coverage. For the PPO and HDHP plans, prescriptions are provided through Cigna. When you need prescriptions, you can purchase them through a local retail pharmacy or, for medications you take on an ongoing basis, through the mail order program.

Retail Prescription Program
The retail prescription program uses a network of participating pharmacies. To receive the highest level of benefits, you must use a participating pharmacy which can be found on mycigna.com. Prescriptions you fill at non-participating pharmacies are generally not covered.

Mail Order Program
The mail order program offers a convenient and cost-effective way to fill prescriptions for medications you take on a regular basis (maintenance medications). When you use the mail order program, you receive a 3-month supply of medication for the cost of a 2 and a half-month supply. Your medications are mailed directly to your home. To order prescriptions through the mail order program, you can simply request that your doctor request the prescription be filled thought the mail order pharmacy. For question, additional information and refilling your mail order prescriptions visit the Cigna website at myCigna.com.

Specialty Prescription Program
If you have a chronic condition and take specialty medications, you must purchase these through a designated specialty pharmacy that provides the best available pricing and additional support. If you have a prescription that meets this requirement, Cigna will contact you and provide you with the necessary information to fill your prescription.

Prescription Drug Plan Highlights

<table>
<thead>
<tr>
<th></th>
<th>PPO Plan</th>
<th>HDHP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Retail Prescriptions (up to 31-day supply)</td>
<td>In-Network</td>
<td>Out-of-Network</td>
</tr>
<tr>
<td>Tier 1</td>
<td>$15 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$30 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Tier 3</td>
<td>$60 copay</td>
<td>40% after deductible</td>
</tr>
<tr>
<td>Specialty</td>
<td>$100 copay</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mail Order Prescriptions (up to 90-day supply)</td>
<td>Tier 1</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 2</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Tier 3</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>
YOUR LIFE JUST GOT SIMPLER

WELCOME TO COMPASS PROFESSIONAL HEALTH SERVICES

Navigating healthcare these days seems impossible—but now you have a Compass Health Pro® consultant on your side. From explaining complex insurance protocol to solving billing problems, we’re here to help at no additional cost to you and your family. As your PERSONAL HEALTHCARE ADVISOR, you can rely on Compass to take the hassle out of tedious healthcare tasks, and to help you make the most out of your benefit plans.

How Compass takes care of you:

1. UNDERSTAND YOUR BENEFITS
   Receive guidance in understanding your benefits throughout the year.

2. FIND A GREAT DOCTOR
   Find highly-rated doctors, dentists and eye-care professionals in your area and network that meet your personal preferences and healthcare needs.

3. SAVE MONEY ON MEDICAL CARE
   Get price comparisons before receiving care. Depending on doctor, hospital or facility, costs can vary by hundreds or thousands of dollars—even in-network.

4. PAY LESS FOR PRESCRIPTIONS
   Let Compass compare medication prices and explore lower cost options for you.

5. GET HELP WITH MEDICAL BILLS
   Have your medical bills reviewed to make sure you are not overcharged.

CONNECT WITH ME TODAY!
Shannon Duffie
member.compasphs.com | Shannon.Duffie@compassphs.com | 800.513.1667 x5295
**DENTAL PLAN**

NSTAR’s Dental Plan is administered through Cigna and provides you and your family with coverage for typical dental expenses, such as cleanings, X-rays, fillings, and orthodontia for children.

**Dental PPO Plan**
The Dental PPO allows you the freedom to visit any dentist, without referrals, for all of your dental care. If you receive care from one of Cigna’s preferred dentists, you’ll pay less for your care. If you choose a non-preferred dentist, your share of costs will generally be higher and you may need to file your own claims. For a list of Cigna preferred dentists, go to myCigna.com.

---

**Dental Plan Highlights**

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>Premium Plan – PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Calendar Year Deductible</strong></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$150</td>
</tr>
<tr>
<td><strong>Annual Benefit Maximum</strong></td>
<td>$2,000</td>
</tr>
<tr>
<td><strong>Preventive Services</strong></td>
<td></td>
</tr>
<tr>
<td>(Exams, routine cleanings, fluoride treatments, space maintainers sealants)</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
</tr>
<tr>
<td>(X-rays, fillings, sealants, denture repairs, simple extractions)</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Major Services</strong></td>
<td></td>
</tr>
<tr>
<td>(Crowns, inlays, onlays, bridges, dentures)</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Orthodontia</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50% to $2,000</td>
</tr>
<tr>
<td><strong>Annual Maximum Rollover</strong></td>
<td></td>
</tr>
<tr>
<td>To be eligible for the max rollover, you must utilize your preventive services/visits in the prior year.</td>
<td>Year 1: $2,000</td>
</tr>
<tr>
<td></td>
<td>Year 2: $2,150</td>
</tr>
<tr>
<td></td>
<td>Year 3: $2,300</td>
</tr>
<tr>
<td></td>
<td>Year 4: $2,450</td>
</tr>
</tbody>
</table>

You will not need a dental ID card to receive dental services. When you visit the dentist, give the provider your Social Security number and NSTAR’s name. Your dentist’s office can verify your eligibility for benefits by calling Cigna at 1-800-244-6224.
VISION PLAN

NSTAR’s Vision Plan promotes preventive care through regular eye exams and provides coverage for corrective materials, such as glasses and contact lenses. The Vision Plan is administered through Cigna and uses the Cigna Vision Network.

Vision Coverage

If you enroll in vision coverage, you can go to any eye care provider you choose for care. However, if you choose providers who are part of the Cigna Vision Network, you will receive a discount on services. To find a network provider, go to myCigna.com.

The Vision Plan is designed to cover eye care needs that are visually necessary. You have to pay extra if you choose certain cosmetic or elective eyewear, so be sure to ask your eye doctor what items are covered by the plan before you purchase materials.

Vision Plan Highlights

<table>
<thead>
<tr>
<th>Plan Feature</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exam</strong></td>
<td>$10 copay</td>
<td>Up to $45</td>
</tr>
<tr>
<td><strong>Prescription Glasses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Lenses</td>
<td>$20 copay</td>
<td>Up to $32</td>
</tr>
<tr>
<td>Bifocals – Lined</td>
<td>$20 copay</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Trifocals – Lined</td>
<td>$20 copay</td>
<td>Up to $65</td>
</tr>
<tr>
<td>Frames</td>
<td>Up to $120 + 20% off balance</td>
<td>Up to $66</td>
</tr>
<tr>
<td>Contacts</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective – In Lieu of Glasses</td>
<td>Up to $110</td>
<td>Up to $98</td>
</tr>
<tr>
<td>Contact Lens Exam (Fitting and Evaluation)</td>
<td>Included in allowance</td>
<td>Not included in allowance</td>
</tr>
</tbody>
</table>

Benefit Frequency

<table>
<thead>
<tr>
<th></th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Frames</td>
<td>24 Months</td>
<td>24 Months</td>
</tr>
<tr>
<td>Lenses</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
<tr>
<td>Contacts</td>
<td>12 Months</td>
<td>12 Months</td>
</tr>
</tbody>
</table>
LIFE AND AD&D INSURANCE

NSTAR offers Life and AD&D insurance coverage to provide financial protection in the event you or your dependents die while you are still working. This coverage is administered through Lincoln.

**Basic Life and Accidental Death and Dismemberment (AD&D) Insurance**

NSTAR automatically provides Basic Life and AD&D Insurance for all eligible employees at no cost. Basic Life Insurance is equal $25,000. The benefit is paid to your beneficiaries in the event of your death.

**Optional Life and AD&D Insurance**

In addition to Basic Life and AD&D Insurance, you may also purchase Optional Life and AD&D Insurance for yourself, your spouse, and your dependent children. However, you may only elect coverage for your dependents if you enroll for Optional Life and AD&D coverage for yourself. You pay for the cost of Optional Life and AD&D Insurance on an after-tax basis through payroll deductions.

**Optional Life and AD&D Insurance Coverage**

<table>
<thead>
<tr>
<th>Coverage For</th>
<th>Increment</th>
<th>Coverage Available</th>
<th>Guarantee Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee</td>
<td>$10,000</td>
<td>5x salary up to $500,000</td>
<td>$150,000</td>
</tr>
<tr>
<td>Spouse</td>
<td>$5,000</td>
<td>50% of employee election up to $250,000</td>
<td>$30,000</td>
</tr>
<tr>
<td>Child(ren)*</td>
<td>$10,000</td>
<td>$10,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

*6 months to 25 years old

*Infants age 14 days to 6 months receive $250 newborn ages birth – 14 days do not receive a benefit
**Proof of Insurability**
Late entrants must complete evidence of insurability. A late entrant would be anyone not in their new hire waiting period. If you are currently in your new hire waiting period, you will also have to provide proof of insurability for amounts in excess of the guarantee issue amounts. *Refer to ADP for the evidence of insurability form.

**Beneficiary Designation**
You must designate a beneficiary for Basic Life and AD&D and Optional Life and AD&D Insurance benefits when you enroll. Your “beneficiary” is the person(s) who will receive the benefits from your Life and AD&D coverage in the event of your death. You are always the beneficiary of any Dependent Life and AD&D Insurance you elect. You can change your beneficiaries at any time during the year. If you do not name a beneficiary, or if your beneficiary dies before you, your Life and AD&D benefits will be paid to your estate.

**Benefits Reduce At Age 70**
When you or a covered dependent reaches age 70, Basic and Optional Life Insurance benefits and Voluntary Life and AD&D insurance is reduced. For more information, refer to your Group Life Insurance booklet.
DISABILITY COVERAGE

NSTAR offers you two disability plans that work together to keep all or part of your paycheck coming if you cannot work because of illness, injury, or pregnancy. Disability benefits are administered through Lincoln.

Short-Term Disability

Short-Term Disability (STD) benefits are an optional benefit for those that wish to elect Short-Term Disability. Your STD benefits will replace 60% of your base pay for 11 weeks up to $1,500 per week.

Your STD benefits begin on the 15th calendar day of your disability if you are unable to work. The maximum benefit available is 11 weeks per STD claim.

Anyone not enrolled in voluntary STD can enroll during the annual open enrollment, but they will be required to complete an evidence of insurability form.

The information below will help you to calculate your monthly rate for coverage:

Annual Salary ÷ 52 = Weekly Salary* x 60% = Your Weekly Benefit x $0.210 ÷ 10 = Your Monthly Cost.  *NOTE: If your weekly salary exceeds $2,500, use $2,500 as your weekly salary in the calculation.

Long-Term Disability

If you remain totally disabled and unable to work for more than 11 weeks, you may be eligible for Long-Term Disability (LTD) benefits. NSTAR automatically provides you LTD benefits that replace up to 60% of your base pay, up to a maximum of $10,00 per month, at no cost to you! Your monthly LTD benefit will be reduced by Social Security and any other disability income you are eligible to receive (such as Workers’ Compensation).

When Are You Disabled?

To be considered totally disabled and eligible for LTD benefits, you must be approved by the insurance carrier and seeing a doctor regularly for treatment. In addition:

- Your doctor must certify that you are not able to do your job at NSTAR, and
- You must have lost 20% or more of your pre-disability income due to your illness or injury.
FLEXIBLE SPENDING ACCOUNTS

NSTAR allows you to contribute to one or both Flexible Spending Accounts (FSAs), which allow you to save taxes on certain out-of-pocket health care and dependent care expenses. The FSAs are administered by Wage Works.

How the FSAs Work

NSTAR offers three types of FSAs:

- Health Care FSA
- Limited Purpose FSA
- Dependent Care FSA

If you elect to contribute to one or both of the FSAs, you choose an annual amount to be taken from each of your paychecks and deposited into your account throughout the year.

Your contributions are taken out of your paycheck before you pay taxes, so you save money. Then, when you have eligible health care or dependent care expenses, you can use the account to reimburse yourself, up to the amount you have elected to contribute to your account for the year.

With both accounts, the IRS requires you to use all of the money in your account by the end of the year or you lose it. This is called the “use it or lose it” rule.

HEALTH CARE FSA

You can use the Health Care FSA to pay for eligible out-of-pocket expenses that are not covered by another health plan. Examples include, but are not limited to:

- Medical or dental deductibles
- Office visit copays
- Coinsurance amounts
- Amounts you pay for prescription drugs
- Amounts you pay for certain over-the-counter items
- Eyeglasses, contacts, and other vision-related expenses not covered by the vision plan
- Orthodontia expenses not covered by the dental plan

For a complete list of eligible expenses, visit www.wageworks.com.
**Annual Contribution Amount**
You can contribute up to $2,700 per year to the Health Care FSA.

**Over-the-Counter Medications**
You must have a doctor’s prescription to use the Health Care FSA to reimburse yourself for certain over-the-counter medications. Examples of medications that require you to submit a doctor’s prescription include but is not limited to:
- Acid controllers, digestive aids, and stomach remedies
- Allergy and sinus medicines
- Anti-itch and insect bite remedies
- Cold sore remedies
- Cold, cough, and flu drugs
- Pain relief medications
- Respiratory treatments
- Sleep aids and sedatives

**If you enroll in the High Deductible Health Plan for medical coverage, which has a Health Savings Account (HSA), you cannot enroll in the Health Care FSA.**

**How the Debit Card Works**
If you enroll in the Health Care FSA, you will receive one debit card in the mail. To request additional debit cards for your family members, please contact WageWorks.

You can use your debit card at certain places to pay for eligible expenses up-front, such as prescription drugs and office visit copays, without having to pay with cash and wait for a reimbursement. If you use your debit card at a health care provider’s office or at a vendor that has the software in place to track eligible FSA expenses, you will not be required to submit a receipt. For a list of vendors that have this software, go to www.wageworks.com.

*However, for most debit card transactions, you will need to submit your receipts as substantiation of your expense, so it’s important to keep them.*

If you choose not to use your debit card, you can always pay for your eligible expense and file a claim for reimbursement.

**Dependent Care FSA**
The Dependent Care FSA helps you afford day care for your children under age 13 or for a disabled dependent. There are some special rules for participating in this account:
- The day care expenses must be necessary so you can work.
- You can only be reimbursed for expenses incurred during the plan year.
- If you are married, your spouse must be employed, a full-time student at least five months during the plan year, or mentally or physically disabled and unable to provide care for himself or herself.
In some cases, a federal child-tax credit may save you more money than the Dependent Care FSA. You may want to consult a tax advisor to find which option is better for you.

**Eligible Dependent Care Expenses**
Generally, you may use the money in your Dependent Care FSA for care for:
- Your children under age 13 whom you claim as a dependent for tax purposes.
- Other dependents of any age who are mentally or physically disabled and whom you claim as a dependent for tax purposes (spouses and dependents age 13 and older must spend at least eight hours a day in your home if you are reimbursing yourself for services provided outside the home).

Some typical expenses that are eligible for reimbursement under the plan are:
- Licensed nursery school and day care centers for children
- Licensed day care centers for disabled dependents
- Services from a care provider over the age of 19 (inside or outside the home)
- Day camps
- After-school care

For a complete list of eligible expenses, visit www.wageworks.com.

**Annual Contribution Amount**
You can contribute up to $5,000 per year to the Dependent Care FSA. If you are married and you and your spouse file separate tax returns, the maximum you can contribute is $2,500 each.

**Important FSA Considerations**
- For the Dependent Care FSA, you may only be reimbursed up to the amount in your account at the time you file a claim. If your eligible expenses are greater than the amount in your account, the unreimbursed amount will carry over and be reimbursed after your next deposit. (For the Health Care FSA, you can be reimbursed up to the full amount you have elected to contribute for the year — even if you have not yet contributed that much to your account.)
- The Health Care FSA and the Dependent Care FSA are separate accounts. You cannot use funds from one account to pay for expenses of the other. You also cannot transfer funds between the two accounts.
- If you use the Dependent Care FSA, you must provide your caregiver’s Social Security number or tax ID when you file a claim for reimbursement.
OTHER BENEFITS

Employee Assistance Program (EAP)
You and your covered dependents have free access to NSTAR’s Employee Assistance Program (EAP). This confidential service offers free over-the-phone counseling any time, day or night, to help you with a variety of personal issues. The EAP also provides up to 4 free face-to-face counseling sessions for both you and your covered dependents. Counselors can help with concerns about things like:

- Depression
- Legal and Financial Concerns
- Marital or Family Difficulties
- Substance Abuse
- Stress Management / Anxiety
- Child or Elder Care

To contact the EAP, call 888-628-4824, 24 hours a day, seven days a week, to talk to a professional counselor. You can also get more information online at www.guidance resources.com.

Username – LFGsupport / Password – LFGsupport1
2019 COVERAGE COSTS

For most benefits, NSTAR pays most of the coverage cost for you. You pay a small portion of the overall cost through payroll deductions. **Below you’ll find your bi-weekly/per paycheck cost.**

<table>
<thead>
<tr>
<th>Coverage Tier Level</th>
<th>MEDICAL</th>
<th>PPO Plan</th>
<th>HDHP Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$63.54</td>
<td>$18.93</td>
<td></td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$236.04</td>
<td>$156.18</td>
<td></td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$218.66</td>
<td>$131.64</td>
<td></td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$424.01</td>
<td>$283.75</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Tier Level</th>
<th>DENTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$9.69</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$24.92</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$24.92</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$46.15</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coverage Tier Level</th>
<th>VISION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$3.25</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$5.46</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$5.58</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$8.82</td>
</tr>
</tbody>
</table>

**Voluntary Life and AD&D Rates**

*Rate per $1000 – (rates below include AD&D)*

(spouse premium calculated at employee’s age)

<table>
<thead>
<tr>
<th>Age</th>
<th>Employee</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 29</td>
<td>$0.045</td>
<td>$0.045</td>
</tr>
<tr>
<td>30-34</td>
<td>$0.053</td>
<td>$0.053</td>
</tr>
<tr>
<td>35-39</td>
<td>$0.066</td>
<td>$0.066</td>
</tr>
<tr>
<td>40-44</td>
<td>$0.095</td>
<td>$0.095</td>
</tr>
<tr>
<td>45-49</td>
<td>$0.144</td>
<td>$0.144</td>
</tr>
<tr>
<td>50-54</td>
<td>$0.248</td>
<td>$0.248</td>
</tr>
<tr>
<td>55-59</td>
<td>$0.449</td>
<td>$0.449</td>
</tr>
<tr>
<td>60-64</td>
<td>$0.670</td>
<td>$0.670</td>
</tr>
<tr>
<td>65-69</td>
<td>$1.025</td>
<td>$1.025</td>
</tr>
<tr>
<td>70-74</td>
<td>$1.980</td>
<td>$2.390</td>
</tr>
</tbody>
</table>

Volunteer STD

Rate per $10 of covered benefit

$0.210

**Calculate Your Voluntary Life Rate**

Step 1: Enter your desired voluntary life amount=_______

Step 2: Divide desired voluntary life amount by 1,000=________

Step 3: Multiply your answer from step 2 by your rate from the table=________

Step 4: Multiply your answer in step 3 by 12=_______

Step 5: Divide your answer in step 4 by 24=_______

This is your per paycheck voluntary life deduction.
# IMPORTANT CONTACTS

<table>
<thead>
<tr>
<th>Resource</th>
<th>Carrier</th>
<th>Policy Number</th>
<th>Phone Number</th>
<th>Website/E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Prescription</td>
<td>Cigna</td>
<td>3341747</td>
<td>1.800.244.6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Dental</td>
<td>Cigna</td>
<td>3341747</td>
<td>1.800.244.6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Vision</td>
<td>Cigna</td>
<td>3341747</td>
<td>1.800.244.6224</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Health Savings Account</td>
<td>Cigna/HSA Bank</td>
<td>3341747</td>
<td>Number located on back of ID card</td>
<td><a href="http://www.mycigna.com">www.mycigna.com</a></td>
</tr>
<tr>
<td>Flexible Spending Accounts</td>
<td>Wage Works</td>
<td>N/A</td>
<td>877.924.3967</td>
<td><a href="http://www.wageworks.com">www.wageworks.com</a></td>
</tr>
<tr>
<td>Basic Life Insurance</td>
<td>Lincoln</td>
<td>10199318</td>
<td>800.423.2765</td>
<td><a href="mailto:claims@LFG.com">claims@LFG.com</a> / <a href="http://www.lincolnfinancial.com">www.lincolnfinancial.com</a></td>
</tr>
<tr>
<td>Voluntary Life Insurance</td>
<td>Lincoln</td>
<td>400199320/403005044</td>
<td>800.423.2765</td>
<td><a href="mailto:claims@LFG.com">claims@LFG.com</a> / <a href="http://www.lincolnfinancial.com">www.lincolnfinancial.com</a></td>
</tr>
<tr>
<td>Short Term Disability</td>
<td>Lincoln</td>
<td>10199321</td>
<td>800.423.2765</td>
<td><a href="mailto:disabiitiyclaims@LFG.com">disabiitiyclaims@LFG.com</a> / <a href="http://www.lincolnfinancial.com">www.lincolnfinancial.com</a></td>
</tr>
<tr>
<td>Long Term Disability</td>
<td>Lincoln</td>
<td>10199319</td>
<td>800.423.2765</td>
<td><a href="mailto:disabiitiyclaims@LFG.com">disabiitiyclaims@LFG.com</a> / <a href="http://www.lincolnfinancial.com">www.lincolnfinancial.com</a></td>
</tr>
<tr>
<td>Employee Assistance Program</td>
<td>Lincoln</td>
<td>Username – Username / LFGsupport / Password – LFGsupport1</td>
<td>888.628.4824</td>
<td><a href="http://www.guidance">www.guidance</a> resources.com</td>
</tr>
<tr>
<td>Employee Advocacy</td>
<td>Compass/Compass</td>
<td>NSTAR</td>
<td>800.513.1667 ext 5295</td>
<td><a href="mailto:Shannon.Duffie@compassphs.com">Shannon.Duffie@compassphs.com</a></td>
</tr>
<tr>
<td>Employee Advocacy</td>
<td>Holmes Murphy/Alicia Valdez</td>
<td>N / A</td>
<td>214-265-2299</td>
<td><a href="mailto:Avaldez@holmesmurphy.com">Avaldez@holmesmurphy.com</a></td>
</tr>
</tbody>
</table>
HEALTH COVERAGE NOTICES

FOR YOUR FILES

This guide contains legal notices for participants in group health plan(s) sponsored by NSTAR Global Services. The notices included in this guide are:

- **Health Insurance Marketplace Coverage Options and Your Health Coverage** that describes the Health Insurance Marketplace and eligibility and tax credit information.

- **Notice of Privacy Practices** that explains how the health care plan(s) protect your personal medical information.

- **Medicare Part D Notice** that provides information about how your current prescription drug coverage under the health care plan(s) is affected—and your options for coverage—when you become eligible for Medicare.

- **COBRA Rights Notice** that explains when you and your family may be able to temporarily continue coverage under the health care plan(s) if coverage would otherwise end for you.

- **Newborn & Mothers Health Protection Notice** that describes federal laws that govern benefits for hospital stays for mothers following the birth of child.

- **Women’s Health and Cancer Rights Act** that summarizes the benefits available under your medical plan if you have had or are going to have a mastectomy.

- **Patient Protection Disclosure** that explains who you and your family can designate as a primary care provider under the health care plans and rules around access to obstetrical/gynecological care.

- **Expanded Coverage for Women’s Preventive Care** that explains how the health care plan(s) cover(s) women’s preventive care, including contraceptives, under the Affordable Care Act.

- **Notice of Special Enrollment Rights** that explains when you can enroll in the health care plan(s) due to special circumstances.

- **60-Day Special Enrollment Period** that describes a special 60-day timeframe to elect or discontinue coverage.

IMPORTANT: If you or your dependents have Medicare or will become eligible for Medicare in the next 12 months, the Medicare Prescription Drug program gives you more choices about your prescription drug coverage. Please see 30-32 for more details.
HEALTH INSURANCE MARKETPLACE COVERAGE OPTIONS AND YOUR HEALTH COVERAGE

PART A: GENERAL INFORMATION

Since key parts of the health care law took effect in 2014, there is another way to buy health insurance: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.

What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers "one-stop shopping" to find and compare private health insurance options. You may also be eligible for a tax credit that lowers your monthly premium right away. Typically, you can enroll in a Marketplace health plan during the Marketplace’s annual Open Enrollment period or if you experience a qualifying life event.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn't meet certain standards. The savings on your premium that you're eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.86% of your household income for the year, or if the coverage your employer provides does not meet the "minimum value" standard set by the Affordable Care Act, you may be eligible for a tax credit.

Note: If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution — as well as your employee contribution to employer-offered coverage — is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources at 984-232-0648.
The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

**PART B: INFORMATION ABOUT HEALTH COVERAGE OFFERED BY YOUR EMPLOYER**

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>1. Employer name</th>
<th>4. Employer Identification Number (EIN)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSTAR Global Services</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Employer address</th>
<th>6. Employer phone number</th>
</tr>
</thead>
<tbody>
<tr>
<td>120 Partlo Drive</td>
<td>984-232-0648</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. City</th>
<th>8. State</th>
<th>9. ZIP code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Garner</td>
<td>NC</td>
<td>27529</td>
</tr>
</tbody>
</table>

10. Who can we contact about employee health coverage at this job?

Carolyn Humphrey

<table>
<thead>
<tr>
<th>11. Phone number (if different from above)</th>
<th>12. E-mail address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><a href="mailto:chumphrey@nstarglobalservices.com">chumphrey@nstarglobalservices.com</a></td>
</tr>
</tbody>
</table>

Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to some employees.
  - Eligible employees are: all employees working 30 hours or more per week
- With respect to dependents, we do offer coverage.
  Eligible dependents are:
  - Your legal spouse
  - A child under the limiting age shown in your Schedule of Coverage
  - A child of your child who is your Dependent for federal income tax purposes at the time application for coverage of the child is made;
  - Any other child included as an eligible Dependent under the plan

** If checked, this coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

** Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.
If you decide to shop for coverage in the Marketplace, [www.healthcare.gov](http://www.healthcare.gov) will guide you through the process.

**NSTAR GLOBAL SERVICES NOTICE OF PRIVACY PRACTICES**

*This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

**OUR COMPANY’S PLEDGE TO YOU**

This notice is intended to inform you of the privacy practices followed by the **NSTAR Group Health Plan** (the Plan) and the Plan’s legal obligations regarding your protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The notice also explains the privacy rights you and your family members have as participants of the Plan. It is effective on April 1, 2019.

The Plan often needs access to your protected health information in order to provide payment for health services and perform plan administrative functions. We want to assure the participants covered under the Plan that we comply with federal privacy laws and respect your right to privacy. NSTAR requires all members of our workforce and third parties that are provided access to protected health information to comply with the privacy practices outlined below.

*Protected Health Information*

Your protected health information is protected by the HIPAA Privacy Rule. Generally, protected health information is information that identifies an individual created or received by a health care provider, health plan or an employer on behalf of a group health plan that relates to physical or mental health conditions, provision of health care, or payment for health care, whether past, present or future.

*How We May Use Your Protected Health Information*

Under the HIPAA Privacy Rule, we may use or disclose your protected health information for certain purposes without your permission. This section describes the ways we can use and disclose your protected health information.

**Payment.** We use or disclose your protected health information without your written authorization in order to determine eligibility for benefits, seek reimbursement from a third party, or coordinate benefits with another health plan under which you are covered. For example, a health care provider that provided treatment to you will provide us with your health information. We use that information in order to determine whether those services are eligible for payment under our group health plan.

**Health Care Operations.** We use and disclose your protected health information in order to perform plan administration functions such as quality assurance activities, resolution of internal grievances, and evaluating plan performance. For example, we review claims experience in order to understand participant utilization and to make plan design changes that are intended to control health care costs.

However, we are prohibited from using or disclosing protected health information that is genetic information for our underwriting purposes.
Treatment. Although the law allows use and disclosure of your protected health information for purposes of treatment, as a health plan we generally do not need to disclose your information for treatment purposes. Your physician or health care provider is required to provide you with an explanation of how they use and share your health information for purposes of treatment, payment, and health care operations.

As permitted or Required by Law. We may also use or disclose your protected health information without your written authorization for other reasons as permitted by law. We are permitted by law to share information, subject to certain requirements, in order to communicate information on health-related benefits or services that may be of interest to you, respond to a court order, or provide information to further public health activities (e.g., preventing the spread of disease) without your written authorization. We are also permitted to share protected health information during a corporate restructuring such as a merger, sale, or acquisition. We will also disclose health information about you when required by law, for example, in order to prevent serious harm to you or others.

Pursuant to Your Authorization. When required by law, we will ask for your written authorization before using or disclosing your protected health information. Uses and disclosures not described in this notice will only be made with your written authorization. Subject to some limited exceptions, your written authorization is required for the sale of protected health information and for the use or disclosure of protected health information for marketing purposes. If you choose to sign an authorization to disclose information, you can later revoke that authorization to prevent any future uses or disclosures.

To Business Associates. We may enter into contracts with entities known as Business Associates that provide services to or perform functions on behalf of the Plan. We may disclose protected health information to Business Associates once they have agreed in writing to safeguard the protected health information. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates are also required by law to protect protected health information.

To the Plan Sponsor. We may disclose protected health information to certain employees of NSTAR for the purpose of administering the Plan. These employees will use or disclose the protected health information only as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized additional disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Your Rights

Right to Inspect and Copy. In most cases, you have the right to inspect and copy the protected health information we maintain about you. If you request copies, we will charge you a reasonable fee to cover the costs of copying, mailing, or other expenses associated with your request. Your request to inspect or review your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to inspect and copy your health information. To the extent your information is held in an electronic health record, you may be able to receive the information in an electronic format.

Right to Amend. If you believe that information within your records is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Your request to amend your health information must be submitted in writing to the person listed below. In some circumstances, we may deny your request to amend your health information.
If we deny your request, you may file a statement of disagreement with us for inclusion in any future disclosures of the disputed information.

**Right to an Accounting of Disclosures.** You have the right to receive an accounting of certain disclosures of your protected health information. The accounting will not include disclosures that were made (1) for purposes of treatment, payment or health care operations; (2) to you; (3) pursuant to your authorization; (4) to your friends or family in your presence or because of an emergency; (5) for national security purposes; or (6) incidental to otherwise permissible disclosures.

Your request for an accounting must be submitted in writing to the person listed below. You may request an accounting of disclosures made within the last six years. You may request one accounting free of charge within a 12-month period.

**Right to Request Restrictions.** You have the right to request that we not use or disclose information for treatment, payment, or other administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. You also have the right to request that we limit the protected health information that we disclose to someone involved in your care or the payment for your care, such as a family member or friend. Your request for restrictions must be submitted in writing to the person listed below. We will consider your request, but in most cases are not legally obligated to agree to those restrictions.

**Right to Request Confidential Communications.** You have the right to receive confidential communications containing your health information. Your request for restrictions must be submitted in writing to the person listed below. We are required to accommodate reasonable requests. For example, you may ask that we contact you at your place of employment or send communications regarding treatment to an alternate address.

**Right to be Notified of a Breach.** You have the right to be notified in the event that we (or one of our Business Associates) discover a breach of your unsecured protected health information. Notice of any such breach will be made in accordance with federal requirements.

**Right to Receive a Paper Copy of this Notice.** If you have agreed to accept this notice electronically, you also have a right to obtain a paper copy of this notice from us upon request. To obtain a paper copy of this notice, please contact the person listed below.

**Our Legal Responsibilities**

We are required by law to maintain the privacy of your protected health information, provide you with this notice about our legal duties and privacy practices with respect to protected health information and notify affected individuals following a breach of unsecured protected health information.

We may change our policies at any time and reserve the right to make the change effective for all protective health information that we maintain. In the event that we make a significant change in our policies, we will provide you with a revised copy of this notice. You can also request a copy of our notice at any time. For more information about our privacy practices, contact the person listed below.
If you have any questions or complaints, please contact:
Carolyn Humphrey
NSTAR Global Services
120 Partlo Street
Garner, NC 25729
984-232-0648 & chumphrey@nstarglobalservices.com

Complaints
If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed above. You also may send a written complaint to the U.S. Department of Health and Human Services — Office of Civil Rights. The person listed above can provide you with the appropriate address upon request or you may visit www.hhs.gov/ocr for further information. You will not be penalized or retaliated against for filing a complaint with the Office of Civil Rights or with us.

IMPORTANT NOTICE FROM NSTAR GLOBAL SERVICES ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

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

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

Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

NSTAR has determined that the prescription drug coverage offered by NSTAR’s plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

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

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

If you decide to join a Medicare drug plan, your current NSTAR coverage will not be affected. If you do decide to join a Medicare drug plan and drop your current NSTAR coverage, be aware that you and your dependents may not be able to get this coverage back.

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

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

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

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

Contact the person listed below for further information. **NOTE:** You’ll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through NSTAR changes. You also may request a copy of this notice at any time.

**For More Information About Your Options Under Medicare Prescription Drug Coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the “Medicare & You” handbook. You’ll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare Prescription drug coverage:

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of ”Medicare & You” handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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

**Remember:** Keep this creditable coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: April 1, 2019
Name of Entity/Sender: NSTAR Global Services

---

**OPEN ENROLLMENT / 2019-2020**
COBRA RIGHTS NOTICE

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

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

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

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “qualifying event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

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

- Your spouse dies;
- Your spouse’s hours of employment are reduced;
- Your spouse’s employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.
Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

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

**When Is COBRA Coverage Available?**

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child’s losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to: NSTAR Human Resources. Additional information, documentation, and procedures may be required.

**HOW IS COBRA CONTINUATION COVERAGE PROVIDED?**

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

**Disability Extension of 18-Month Period of Continuation Coverage**

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
Additional information, documentation, and procedures may be required for completion within a certain time period.

**Second Qualifying Event Extension of 18-Month Period of Continuation Coverage**

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

**Are There Other Coverage Options Besides COBRA Continuation Coverage?**

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse’s plan) through what is called a “special enrollment period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at [www.healthcare.gov](http://www.healthcare.gov).

**If You Have Questions**

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

**Keep Your Plan Informed of Address Changes**

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

**Plan Contact Information**

Date: April 1, 2019  
Name of Entity/Sender: NSTAR Global Services  
Contact/Office: Carolyn Humphrey  
Address: 120 Partlo Street, Garner, NC 27529  
Phone Number: 984-232-0648
OTHER NOTICES

EXPANDED COVERAGE FOR WOMEN’S PREVENTIVE CARE

Under the Affordable Care Act, NSTAR provides female plan participants with expanded access to recommended in-network preventive services, including contraceptives, without cost sharing.

Additional women’s preventive services that will be covered without cost sharing requirements include:

- Well-woman visits
- Gestational diabetes screening
- HPV DNA testing
- STI counseling, and HIV screening and counseling
- Contraception and contraceptive counseling
- Breastfeeding support, supplies, and counseling
- Domestic violence screening

For a description of what these items include, visit https://www.healthcare.gov/preventive-care-women/.

PATIENT PROTECTION DISCLOSURE

NSTAR generally allows the designation of a primary care provider. You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Human Resources at 984-232-0645.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from NSTAR or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Human Resources at 984-232-0645.

60-DAY SPECIAL ENROLLMENT PERIOD

In addition to the qualifying events listed in this enrollment guide, you and your dependents will have a special 60-day period to elect or discontinue coverage if:

- You or your dependent’s Medicaid or Children’s Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility; or
- You or your dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.
**NOTICE OF SPECIAL ENROLLMENT RIGHTS**

If you decline enrollment in medical coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may be able to enroll yourself or your dependents in NSTAR Global Services medical coverage if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). However, you must request enrollment no more than 30 days after your or your dependent’s other coverage ends (or after the employer stops contributing to the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you can enroll yourself and your dependents in NSTAR medical coverage as long as you request enrollment by contacting the benefits manager no more than 30 days after the marriage, birth, adoption or placement for adoption. For more information, contact NSTAR Human Resources at 984-232-0645.

**NEWBORN & MOTHERS HEALTH PROTECTION NOTICE**

For maternity hospital stays, in accordance with federal law, the Plan does not restrict benefits, for any hospital length of stay in connection with childbirth for the mother or newborn child, to less than 48 hours following a vaginal delivery or less than 96 hours following a Cesarean delivery.

However, federal law generally does not prevent the mother’s or newborn’s attending care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). The plan cannot require a provider to prescribe a length of stay any shorter than 48 hours (or 96 hours following a Cesarean delivery).

**WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultations with the attending physician and the patient, for:

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

These benefits will be provided subject to the same deductibles, copays and coinsurance applicable to other medical and surgical benefits provided under your medical plan. For more information on WHCRA benefits, contact the NSTAR Human Resources or your medical plan administrator.